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Transfer of Patients to Higher Centre – The Medico-Legal Implications

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Abstract

Do no harm is the primary motto of any physician. Anaesthesiologists who are involved in managing critical patients need to be knowledgeable in terms of safe transfer of patients between hospitals. The present article answers the common legal implications of referral, precautions to be taken during referral or transfer and the guidelines on who should accompany patients during transfer. The differentiation of needs during intra or inter-hospital transfer and the pre-hospital transfer is also discussed. We also present some landmark judgements while discussing the medico-legal aspects of intra and inter-hospital transfer.

Keywords: Communication, Ethics, Patient Transfer, Prehospital Care

1. Introduction

Law mandates that every hospital and the doctor must treat an emergency. However there is always a possibility that the complaint of the patient is outside the scope of service provider or the specialists are not available at that point of time. In all such cases, the patient must be immediately referred to tertiary care centre for specific treatment. This strategy should be applied only if it is in the best interest and not as an attempt to bypass the legal duty of providing care to emergency patients.

The important components of transfer of patients to another facility are[1,2]:

Decision to transfer and communication: Referral or transfer does not constitute abandonment if done with a purpose. These decisions need to be taken by the senior consultants and duly explained to the patient's relatives and the patient explaining the merits and the risks. A written consent is mandatory. A proper communication to the receiving hospital and all details of the treatment modalities need to be provided.

Preparation for transfer: The following precautions should be taken before transferring a seriously ill patient and a proper checklist for the measures taken would be helpful. The A,B,C and D of preparation involves:

Airway: always secure an unstable airway

Breathing: Optimise arterial blood gas values treat pneumothorax with a chest drain etc

Circulation: Check on adequacy of intravenous access, titrate vasopressors, adequate blood if needed.

Disability: Document the GCS before and after transfer, use methods to prevent hypothermia.

2. Mode of Transfer

Use the most appropriate mode of transfer, it may be ground transport involving ambulances with varying degree of equipment or air transport by helicopter or

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fixed wing plane. Prepare for the type of transport. Ground and air transport may impose changes in the patient's physiology due to the noise, vibration, altitude, acceleration, motion sickness, disturbance in the circadian rhythm, temperature and humidity.

3. Accompanying the Patient

Patients being treated at the ward can be transferred without a trained person accompanying them. For patients who may deteriorate a paramedic or nurse may accompany them and if the patient has single organ damage a trained, competent person needs to accompany the patient. For patients who require advanced respiratory and cardiac care a trained doctor and nurse need to accompany them.

4. Equipment to be carried

It is important to carry the required drugs and equipment to provide minimum monitoring, appropriate cardiorespiratory care in case of deterioration in adequate numbers. Other equipment such as gloves, dressings, splints etc should also be available adequately. A complete list of drugs and equipment is available on the website https://isccm.org/pdf/Section4.pdf.

The Common Adverse Events that Occur are:[3]

1. Cardiovascular: hypotension, arrhythmias, hypertension and cardiac arrest
2. Respiratory: Aspiration, hypoxia, accidental extubation, endobronchial intubation, bronchospasm, dyssynchrony with the ventilator, pneumothorax etc.
3. Neurological: Raised intracranial pressure, agitation
4. Hypothermia
5. Vehicle breakdowns leading to delays
6. Other equipment malfunction
7. Gas failure
8. Drug error
9. Patient mix-up

5. Intra-Hospital Transfer in the Indian Scenario

In the Indian scenario, transfer of patients is usually for diagnostic or therapeutic procedures to the radiology suite, endoscopy suite, operative room etc. The ICU team remains responsible for safe transfer to and back from the required destination and it is better that a physician accompanies the patient. A separate team will manage the patient during the procedure and proper communication needs to be maintained. Proper equipment, monitoring, and proper care of lines and endotracheal tube during shifting on to the radiology tables and operative tables needs to be maintained. All essential medication needs to be given even during transport. Other required specialists should be available[2].

6. Inter-Hospital Transfer

The inter-hospital transfer of patients makes it difficult in the Indian scenario due to the non-existence of medical retrieval units or regional transport teams. These kinds of transfers are mainly emergent or semi-emergent where emergent transfer may be due to lack of staff or diagnostic facilities or semi-emergent transfer maybe for higher level of speciality care[2].

7. Prehospital Care and Transport

Prehospital care and transport involves recognition of critical illness, on-site stabilisation and safe transport. In India, these facilities are very meagre and are not provided by government funding. These require optimum planning and utilisation of effective communication services. It also includes communication with a physician for further instructions during transfer, management during transfer, communication of transport destination through a centralised system and reduction of transport time using these services[2].

8. Medicolegal Aspects

8.1 When is a Transfer Considered Negligent?

1. Referring the patient for ulterior motives, to cover-up a negligent act or the consequences arising thereof is both unethical as well as illegal.
2. Refer the patient to a qualified doctor or an authorised well equipped tertiary care centre. Otherwise it would be considered as negligence on the part of referring doctor. The referring doctor

should not act, rely on reports and opinions of unqualified doctor as it would amount to negligence.

3. In case there is refusal or delay on the part of patient in following the advice for referral it must be specifically recorded on the case paper. It has been seen in many cases that even after getting referral note, the patient's relatives either refuse or delay in following the advice.
4. When a patient is referred to a specialist by the attending anaesthesiologist with a case summary of the patient, it is advisable that he should communicate his opinion preferably in writing to the attending physician/ anaesthesiologist.

8.2 How to Transfer?

Once the decision to refer/transfer is taken the doctor, nursing home must act to their earliest since delay may amount to negligence. Emergencies know no boundaries. Courts also take into account an emergency situation and appreciate the doctor/nursing home if reasonable time is taken to transfer the patient.

Following are the tips while transferring the patient:

1. Doctor, hospital, nursing home and the other facilities providing ambulance to the patient must first ensure that the ambulance has the requisite facilities that may be required by the patient in transit (Oxygen/equipments/a nurse or a doctor/ emergency drugs/other requisite facilities). Any deficiency would be viewed as negligence by the court)
2. Proper care and caution must be taken in transferring a patient to another hospital/facility[2]. The responsibility of the patient in transit lies with the hospital transferring the patient. In Praveen Gandhi & Ors. vs Dr. K.N. Singla & Anr. (2014)[4] allegations was that the patient was not shifted to another hospital with proper care. In defense the hospital (OP) stated that the patient was transferred "with all medical precautions and respiratory care (Intubation and Ambu bag)".
3. The patient should be transferred with proper transfer note with brief history about the complaints, the diagnosis, investigations carried out, any intervention/surgery performed, medicines given till transfer so as to give the referral centre, an idea, what more they can do to save the life of the patient. Remember to inform the Police if it is MLC.

8.3 What if the Patient Dies while Shifting the Patient to the Higher Centre?

This will not amount to negligence on the part of the referring doctor/hospital. If after providing medical care up to his level of competence, the doctor makes a proper referral note and refers the patient to the higher centre, and if any mishap occurs during the transfer, it would not be the liability of the doctor. Rather non-referral and delay in referring could constitute negligence.

9. Cases

1. Case – *Pandit Paramanand Katare Vs Union of India* (1989)[5] decided on 28-8-1989. Held – Whenever medical professional is approached, if he finds the assistance he gives is not really sufficient to save the life of the patient and thinks better assistance is required, it is the duty of the medical professional to render all help which he could and also see that the person reaches the proper expert as early as possible for further management.
2. When is the patient to be transferred? Case – Paschim Banga Khet Mazdoor Samity Vs State of West Bengal (1996)[6]. It was found in USA that Private hospitals were dumping uninsured indigent persons into the public hospitals. Then US Congress enacted COBRA to prevent this. It said all hospitals mandatorily should perform – (a) Medical screening of all prospective patients regardless of their ability to pay (b) stabilise the patient, and (c) Transfer to the appropriate hospitals otherwise it is the violation of COBRA and can invite civil suit for damages against that hospital.
3. If patient needs to be transferred – How to be transferred to the tertiary care centre?
   - K. Gracy kutty vs Dr. Annamma Oommem (1992)[7]. LSCS done – PPH – subtotal hysterectomy without consent. – Bleeding continued – TAH. – Injury to bladder and repaired – PPH persisted and blood was not available – patient shifted in a taxi to Medical

College for second surgery – complaint was filed. The fact remained that patient was taken to higher center in a taxi in the absence of ambulance and this did not lead to any complication as borne out by the records and all allegations stood rejected.

- Kamalesh Gupta *vs* Dr. Abhijit Roy Chowdhury (SC DRC West Bengal, decided on 28-6-2000 (???) - A sick patient with COPD was transferred to a better hospital in doctor's own car. All the possible treatment was given to the patient, yet the patient expired. Held – There was no negligence either on the part of the doctor or the nursing home.

4. Patient must ideally be shifted in a well equipped ambulance if available.

Case - Mr. Sakil Mohammed Vakil Khan *vs* Dr. Miss Perin Irani (1999)[8] – SCDRC, Maharashtra. Held – Anaesthetist did not monitor intra operatively and did not accompany in the ambulance which he is – professionally, morally and ethically responsible to do such that no further damages done. A compensation of Rs. 4,10,000/- was awarded to be recovered from Anaesthesiologist.

10. Conclusion

Transfer is an important but often neglected phase of continuing care of the patient, who needs initial care. The transfer should be based on concept of – *stabilise and shift*. In Indian scenario – international guidelines may not be followed due to the diversity of ICUs in India. We may follow guidelines made by – ISCCM for intra and inter Hospital transport of the patient. The guidelines may be modified according to the infrastructure available with periodical quality assessment.

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