

angiography. The timely detection and subsequent removal of cannula prevented development of complications.

Thus, the point of care, “ultrasound” proved its mettle to prevent a complication from occurring. Accidental cannulation of such rare vascular malformations can result in a diagnostic dilemma, and ultrasound can be an impeccable tool that should be used at the slightest suspicion. There is also a word of caution that drugs administered through such lines may result in catastrophic consequences, so vigilance is of utmost importance.

Conflict of Interest

None declared.

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Treating an International Patient: An Uncommon Experience

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We felt relieved when we discharged our patient home, after a stay of 2 months at our hospital. It was as much a relief for us, as it was for the patient. Over the preceding 2 months, we had repeatedly felt lost regarding the medicolegal implications of treating the patient.

Two months back, a middle-aged European citizen was admitted to our neuro intensive care unit (NICU). He was flying alone on a 14-hour long international flight, with neither origin nor destination in India. He suffered a generalized tonic-clonic seizure on-board and the flight made an emergency landing. He was deboarded and brought to our hospital, accompanied by airport personnel who completed the admission formalities. When admitted to NICU, the patient was postictal. For the next 2 days in ICU, he was aggressive, occasionally cooperating with our instructions, and repeatedly expressing displeasure over being admitted. Treatment was initiated based on initial investigations and whatever little discussion was possible with him. The international help

desk (IHD) at our hospital informed the embassy about the patient's condition and admission. The embassy contacted his family, who were unwilling to visit. On day 3, when the patient developed respiratory distress and needed intubation, obtaining consent for intubation proved to be a difficult task. There was no family member available, nor were embassy officials available for consent. The embassy contacted the patient's family who were still reluctant to come. After trying for an hour and consulting both embassy and hospital management, we had to intubate the patient without written informed consent due to deteriorating clinical condition. We only had telephonic assurance from the embassy that we could do whatever was medically necessary for the patient. A minor bedside diagnostic procedure was then planned. We again performed the procedure without written informed consent. However, after detailed discussion with hospital management, medical superintendent (MS) of the hospital later signed the consent forms. Subsequently, the patient gradually improved and was

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to deteriorating clinical condition. We only had telephonic assurance from the embassy that we could do whatever was medically necessary for the patient. A minor bedside diagnostic procedure was then planned. We again performed the procedure without written informed consent. However, after detailed discussion with hospital management, medical superintendent (MS) of the hospital later signed the consent forms. Subsequently, the patient gradually improved and was extubated a few days later. When it was planned to shift the patient to ward, his family was still not available. The embassy could not provide personnel to stay with him in ward 24×7. Consequently, the patient continued to stay in ICU for next 1 month. When discharge was planned, the challenge was who would accompany the patient in flight. He was skeptical to travel home alone; family had not turned up; embassy was finding it difficult to arrange someone to accompany him home. After many efforts, the patient was discharged home after 2 months, accompanied by an embassy official.

Patients, opting for medical treatment in a foreign country, generally make well-thought informed decisions. They have resources to take care of their finances and other requirements, when opting for treatment in a different country. On the other hand, for patients who fall ill while living abroad, there is travel insurance and rules/policies in place. The gray area pertains to patients who fall ill in a different country, when en route their destination. They neither have visa nor medical insurance for that country. Just as our patient, who neither had Indian visa nor medical insurance.

What could be the implications for us, had the patient deteriorated further? What if the patient had died in our ICU? Can the patient or family members question our decisions later? What are the medicolegal implications for physicians treating such patients? Under whose jurisdiction would a legal hassle fall? These questions crossed our minds when treating this patient.

In India, laws regarding medical consent state that in cases of emergency, a patient may be unable to give consent, a substitute decision maker, if readily available, should be approached. If, however, such a person is not available, then it is the duty of the medical professional to do what is essential to save life even without consent. We do encounter such

situations once in a while, and we do what is essential for the patient with consent of two treating doctors and MS. But in the present case, the patient was not an Indian national. Nor had the patient volunteered to be treated at our hospital or in our country.

Others might have faced similar situations earlier. For us, this was the first experience and we felt lost about the medicolegal aspects of this case. The patient may not question our decisions. However, every patient may not be the same. We may not lose if there is a legal issue, since we were not ethically wrong in whatever we did. But why have even the possibility of going to court for doing what is right and in good faith?

There are well established government policies to guide medical management of international patients. Ideally, the hospital should inform the Ministry of External Affairs and Ministry of Health and Family Welfare (Government of India) in such circumstances. Also, it should be noted that Embassy officials are authorized to give consent in such circumstances. The MS of the hospital also has the authority to give consent, just as in case of Indian patients, if there is no attendant available. Further, the concerned airlines can be involved; even legal guidance can be sought from court while managing these patients. This will help treating physicians in a safer position legally. The Ministry of External Affairs and Ministry of Health and Family Welfare were not informed in this case, nor did we involve the airlines or take legal advice. The learning point is that awareness of existing policies and options is lacking. Encountering such patients is relatively rare. While this case raised a lot of questions in our minds, we found relatively few answers. By writing about this case, we wish to emphasize that in present times, it is essential to be aware of health policies, both national and international. Hospital administration and legal advisors must be involved from the beginning in such cases. Approaching court for clarification, in case of doubt, is also an option. Regular orientation sessions for physicians regarding laws and policies established by the Government of India will prove beneficial.

Conflict of Interest

None declared.