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MANAGEMENT OF BROUGHT-IN-DEAD (BID) PERSONS IN NIGERIA: MEDICOLEGAL IMPLICATIONS

BY

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Abstract

Brought-in-dead (BID) or dead-before-arrival, is a term used to define persons who were evaluated by a physician to have no sign of life, at the time of presentation to a health facility. Emergency medical services in Nigerian hospitals, especially with respect to the management of suspected BID persons, are plagued by a lack of standard protocol for the management of BID, poor infrastructure and nonavailability of life-saving equipment; low manpower to handle the huge burden of patients presenting at the emergency department; and poorly trained or lack of emergency response team. Legal provisions are sometimes ignored by some hospitals and may lead to medicolegal issues later. Withholding resuscitation and/or discontinuation of life-saving treatment is unethical and could have serious medicolegal implications. Objections to hospital care-of-the-dead and autopsy, by relatives of the deceased, based on religious and cultural beliefs, have become an ethical and medicolegal dilemma for medical experts. This article examines the medicolegal implications concerning the management of BID patients in Nigeria. A medical practitioner has a legal responsibility towards his/her patient, dead or alive, and may be called upon to appear in a panel or court. It is therefore essential that all medical practitioners are armed with the basic knowledge and understanding of the law to perform their professional responsibilities with due diligence. There is a need for a standardized definition of BID, based on the proper definition of death using electrocardiographic (ECG) and electroencephalographic (EEG) criteria. The need for all hospitals in Nigeria to establish a legal medicine department or a medicolegal unit, cannot be overemphasized. More efforts are needed towards community sensitization and health education, aimed at reducing cases of BID.

Keywords: *Brought-in-dead, Resuscitation, Medicolegal.*

BACKGROUND

In late 2022, a former minister of the Federal Republic of Nigeria expressed dissatisfaction about how the dead body of his brother-in-law was maltreated at an Abuja hospital. In his words, “Early hours of this morning at about 5 am, he suffered, what we suspected to be a cardiac arrest. My sister rushed him to the hospital. A doctor came out and saw him in the car and pronounced him dead. They gave her a form and told her to take him to the mortuary. Yes, you read right. A tertiary health facility told a grieving woman, without any preparation, to take her dead husband to the morgue” (1).

Another aggrieved Nigerian who wrote to a Nigerian newspaper from Canada said, “It was a shocker I got on January 8, 2022, at 7 am, sitting in my car when I called my wife to give her my usual morning gossip. Her words were, Honey; I have very unpleasant news for you; your friend is dead. He was sitting just at the back of his vehicle parked at the premises of a private hospital. I was stunned for God

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knows how long, and my first words were, what was he doing in the back seat of the car in a hospital? Any cardiopulmonary resuscitation? Oh, my word, I forgot I was probably daydreaming; wake up, boy, it's Nigeria we are talking about here. I completely lost it because that would be the second time Nigeria would stab me in the back in less than five years" (2).

From the above two scenarios, it's like all that is needed for one to die in Nigeria is, unresponsiveness, and an absent pulse. Most deaths in Nigeria are disturbing, because the victims struggle silently, to live, but no one gives them the chance.

If you have ever worked in an emergency department long enough, you probably have witnessed several patients that were brought in, and suspected to be dead, during your shifts. But the question is, would you have considered your patient already dead or still alive? Are you sure about that? (3).

Brought-in-dead (also known as dead-on-arrival, or dead-before-arrival) is a term used to describe patients who were assessed by an attending physician to have no sign of life at the time of presentation to a health facility (4).

It means a patient was found to be already clinically dead upon the arrival of professional medical assistance, often in the form of first responders such as emergency medical technicians, paramedics, firefighters, or police. (5)

Unlike the mortality rate in the emergency room, which could serve as an assessment of the quality of health care offered at a health facility, the prevalence of BID gives an idea of pre-hospital and community factors affecting health and health care (4).

Emergency medical services in Nigerian hospitals, especially concerning the management of suspected dead persons, are plagued by a lack of standard protocol for the management of BID, poor infrastructure and nonavailability of life-saving equipment; low manpower to handle the huge burden of patients presenting at the emergency department; and poorly trained or lack of emergency response team. (6)

CAUSES OF BID

Untimely and avertible deaths from severe injuries and life-threatening illnesses are a major health problem worldwide. Between 10 and 50 percent of these deaths happen before reaching the nearest health facility. (7)

The causes of BID may differ from place to place. Common causes of BID include trauma, cardiac arrest, respiratory failure, and severe infections among others. In some instances, the cause of BID might be connected to the patient's health status, such as a medical history of heart disease and so on. (3)

In a retrospective study to establish a record of BID patients seen at the surgical emergency room of the Lagos State University Teaching Hospital (LASUTH) from April to November 2011, a total of 144 BID patients were seen during the study period. Out of these, trauma accounted for 104 patients (72.2%), of whom 52 (50% of trauma cases) had road traffic injuries (RTI) and 21 (20.2% of trauma cases) had gunshot injuries. While the remaining 40 (27.8%) were from other causes of BID (6).

Another study evaluated the causes of death among BID at the accident and emergency department of the Effia-Nkwanta Regional Hospital over a 3-year period, there were 31% (180) of BID cases out of 574 total deaths within the study period. The ages ranged from below 1 year to over 70 years. The majority of the BID cases (20.7%) were patients above 70 years and most cases (40.8%) had no known clinical condition associated with the death. The majority of the unexplained deaths were highest among young adults between the ages of 30 and 40 years (22.6%). The study showed a concerning trend of BID cases in the hospital with a high prevalence among the elderly and unexplained death among young adults. (4)

In a cross-sectional, descriptive study done at the Children's Emergency Ward (CEW) of a tertiary health facility in southwestern Nigeria, between January 2014 and December 2018. The patterns of BID showed that 98 BID cases were seen during the study, constituting 2.5% of the total number of patients seen during the period. Most of the cases had symptoms related to the hematologic (36.7%), respiratory (24.5%), or digestive (20.4%) systems. Severe anemia accounted for 31(31.6%), gastroenteritis 19(19.4), and aspiration 17 (17.3%). (8)

MANAGEMENT OF BID

When presented with a suspected BID person, medical professionals are required to perform cardiopulmonary resuscitation (CPR), unless specific conditions are met that allow them to immediately pronounce the patient as deceased. (9)

In most places, examples of such criteria include:

1. Injuries not compatible with life: These include but are not necessarily limited to decapitation, catastrophic brain trauma, incineration, severing of the body, or injuries that do not permit effective administration of CPR. If a patient has sustained such injuries, it should be instinctively obvious that the patient is non-viable. (5)
2. Rigor mortis, a postmortem change resulting in the stiffening of the body muscles due to chemical changes in their myofibrils, indicating that the patient has been dead for at least a few hours. This can sometimes be difficult to determine, so it is often reported along with other determining factors, such as the livor mortis and algor mortis. (5)
3. Obvious decomposition (5)
4. Livor mortis (lividity): indicating that the body has been pulseless and in the same position long enough for blood to sink and collect within the body, creating purplish discolorations at the lowest points of the body. (5)

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5. Stillbirth: If it can be determined without a doubt that an infant died before birth, as indicated by skin blisters, an unusually soft head, and an extremely offensive odor, resuscitation should not be attempted. However, if there is the slightest hope that the infant is viable, CPR should be initiated. Some jurisdictions maintain that life-saving efforts should be attempted on all infants to assure parents that all possible actions were performed to save their child, futile as the medical practitioner may have known them to be. (5)
6. Identification of valid "do not resuscitate" order. (5)

The above list may not be an all-inclusive picture of medical practice in all jurisdictions or conditions. A pronouncement of death must always be made with absolute certainty and only after it has been determined that the patient is not a candidate for resuscitation. This type of decision is rather sensitive and can be difficult to make. (9)

In some jurisdictions, first responders must consult verbally with a physician before officially pronouncing a patient dead, but once cardiopulmonary resuscitation (CPR) is initiated, it must be continued until a physician can pronounce the person dead. (9)

Cardiopulmonary Resuscitation (CPR), is simply giving the heart a kick start, and all it takes is to kneel beside a person and expend your energy by pressing on their chest. The American Heart Association lists the adult chain of survival care for an out-of-hospital cardiac arrest patient to include activation of emergency response, high-quality CPR, defibrillation, advanced Resuscitation, post-cardiac arrest care, and recovery. The high representation given to CPR is because quality chest compressions are all one needs to provide the heart with a fighting chance to restart and continue with its duties, which is to aid blood circulation. (10). The 2010 guideline didn't even put it lightly "The lay rescuer should not check for a pulse and should assume that cardiac arrest is present if an adult suddenly collapses, or an unresponsive victim is not breathing normally." It further advised the rescuer not to spend more than 10 seconds checking for a pulse but to commence chest compressions within that time frame instead. The guidelines were reviewed and updated in 2020 and now recommend laypersons to initiate Cardiopulmonary Resuscitation for presumed cardiac arrests because the risk of harm to the patient is significantly low even if the person is not in cardiac arrest. (11).

What is the procedure to be followed in cases of BID?

1. All cases of suspected BID must be accepted by the emergency department for urgent medical attention. Doing otherwise has medicolegal implications. (12, 13, 14).
2. History taking, regarding events preceding the death, especially connecting to any disease, drug usage, or injuries. This includes the past medical and social history of the deceased. Details regarding the events before and circumstances surrounding the death should be obtained from family and friends or the investigating officer. Where necessary, an examination of the scene of death or crime has to be conducted. (12, 13, 14, 15).
3. Physical examination of the dead body. To identify external stigmata of underlying disease or the presence of injury or signs of poisoning. This has to be done simultaneously with history taking. Then decide whether to initiate resuscitation, as fast as possible. (12, 13, 14, 15).
4. Documentation: All cases of BID to the hospital have to be documented clearly in the death register or brought-in-dead register. (12, 13, 14, 15).
5. All persons brought to the hospital as BID should be declared a suspected medicolegal case, and a medical certificate of cause of death (MCCD), should not be issued. Issuing a death certificate in such a situation will be at your own risk. (12, 13, 14, 15).
6. If there are injuries, poisoning signs, or suspicion regarding the nature of death, the case should be registered as a medicolegal death, and the jurisdictional police must be informed. The body must not be handed over to the relatives. If the hospital has a mortuary, the dead body should be moved there, after making necessary entries in the mortuary register, and then wait for the local police to take over. (12, 13, 14, 15).
7. If the hospital does not have a mortuary, the dead body should be preserved in a safe room, and the doctor should wait for the police to arrive and take the necessary course of action.
8. If there are no injuries or poisoning signs, and it looks like a case of natural death, and if the patient is a known patient of that hospital, the nursing care of the dead can commence, then the medical certificate of cause of death can be issued, and the body can be released for final burial. (12, 13, 14, 15).
9. Autopsy: To ascertain the exact cause of death, complete autopsies have to be performed. For most cases of Medicolegal deaths, an autopsy is critical. (12, 15).

MEDICOLEGAL PERSPECTIVE

Even though there is no consensus definition of death before arriving at the hospital, the comprehensive definition of BID may include patients who were already dead before reaching the emergency department with no attempt at resuscitation and persons who died following an abortive resuscitative effort, within 15 to 60 minutes of presentation. (7). Also note, that the legal definition of death varies from place to place. (9)

BID situations create difficulties in defining the cause of death for a casualty doctor in the emergency department of a

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hospital. Section 19 of the Births and Deaths (Compulsory Registration) Act, gives guidelines for doctors who have attended to persons during their last illness, to issue a medical certificate of cause of death (MCCD); but once a person is brought dead to the emergency department of a hospital, it becomes a medicolegal case and must be reported to the police, and according to section 20 of the Act, a qualified medical practitioner shall not be required to give a medical certificate. (16).

Legal provisions are ignored in some cases by some hospitals and this may lead to medicolegal issues later on. It is common knowledge that, some hospitals issue brought-dead certificates and some release the body without proper documentation. (17)

Withholding resuscitation and/or discontinuation of life-saving treatment, unnecessarily, is unethical and could have serious medicolegal implications. If the prognosis is not clear, starting resuscitation without delay is reasonable, which also gives more time for relevant information about the death to be gathered. (17).

Cases of medical negligence or medical malpractice could come up, especially when the appropriate standard of care, with regards to the management of a dying person, BID persons, and care of the dead, are not adhered to (18).

Section 33 of the 1999 constitution (as amended), guarantees the "right to life" of every individual, while section 34 guarantees the "dignity of the human person" (19). Therefore, every dying person must be given the chance to live.

Section 20 Subsection 1, of the National Health Act 2014, states that "A health care provider, health worker or health establishment shall not refuse a person emergency medical treatment for any reason" (20).

Medicolegal death can broadly be described as any sudden, unclear, or vaguely suspicious death that requires investigation. (21).

Sudden death, by its nature, is controversial, even though it can be due to either natural or unnatural causes. It is not uncommon for unnatural causes of sudden death to mimic natural causes; the two most widely cited examples are that of cyanide and arsenic poisoning which leave no visible clues of their non-natural nature. (21).

In Nigeria, sudden unexplained deaths are considered unnatural deaths. It is then the responsibility of the forensic pathologist to examine and unravel the cause of death in such cases. These are medicolegal autopsies conducted under the Births and Deaths (Compulsory Registration) Act and the coroner law of the state, to ascertain the cause, manner, and mechanism of death. (16).

It is therefore imperative that analyses on BID cases are conducted systematically with due consideration to relevant aspects which include; history taking, physical examination, autopsy, and the examination of scenes where necessary. (21).

The accurate preservation of evidence and documentation of a medicolegal protocol during the medical examination at the emergency points is essential not only for future legal development but especially to guarantee overall health concerning suspicious deaths. Proper medical and forensic interventions are necessary for the management of BID and evaluation of sudden death, but the absence of relevant and detailed history, descriptions, and photographs as well as of the sampling of evidence, is probably due to the lack of time, resources, and specialized personnel in the emergency room (22). Therefore, given that casualty doctors are busy with non-forensic clinical responsibilities, it should be ensured that there are definite forensic clinical personnel in the emergency room. It is however crucial that when unfortunately, there is no forensic expert, at least casualty doctors are properly trained to appropriately apply essential medicolegal procedures (22).

Objections to hospital care-of-the-dead and autopsy, by relatives of the deceased, based on religious and cultural beliefs, have become an ethical and medicolegal dilemma for medical experts. (23).

CONCLUSION AND RECOMMENDATION

All disciplines particularly the medical profession, are governed by ethical standards as well as legal limitations and every health worker will at some point be exposed to clinical situations that could give rise to medicolegal issues.

Management of BID persons poses difficulties to Emergency Medical Officers and other health workers, as many hospitals in Nigeria do not have a protocol for the management of BID.

A medical practitioner has a legal responsibility towards his/her patient, dead or alive, and may be called upon to appear in a panel or in court. It is therefore essential that all medical practitioners are armed with the basic knowledge and understanding of the law in order to perform their professional responsibilities with due diligence.

Note that, sociocultural and religious considerations are also important in the management of BID and end-of-life care in clinical practice, concerning patient's and family preferences about death, autopsy, rituals, and involvement of health professionals. Hence, healthcare workers must be aware of cultural and religious aspects of dying and care of the dead.

There is a need for a standardized definition of BID, based on the proper definition of death using electrocardiographic (ECG) and electroencephalographic (EEG) criteria.

Hospitals should ensure a BID register at emergency points; this is imperative for proper record keeping, clinical audit, and research purposes.

The need for all hospitals in Nigeria to establish a legal medicine department or a medicolegal unit, cannot be overemphasized. As such department or unit would be saddled with the responsibility to participate in multiple working groups and committees, preparing guidelines, working documents, protocols, and recommendations, and to

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be consulted on legal and ethical issues concerning patient management.

More efforts are needed towards community sensitization and health education, aimed at reducing cases of BID.

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