good to have a hospital committee that oversees all the requirements for quality EOLC viz., presence of trained health care staff, stocking of essential medication for symptom control, institutional EOLC policy and standard operating procedure etc. They may also serve to counsel family or treating physicians in case of dispute. Any legal advisor in the committee should be well-versed in the needs of the terminally ill patient as the law in India relating to FLST is relatively primitive and ambiguous at present. Detailed practice points are spelt out in the joint statement[2] so that EOLDs are possible for any physician caring for the critically ill whether in a big hospital or in a peripheral facility.

The main barrier to EOLD is the physician apprehensions of litigation and legal liabilities.[2] This is contrast to the industrialized world where such decisions are increasingly found to be less difficult.[8] In the US, Europe, and Australia, laws are more settled although still in evolution. The newer sophistication of organ support has brought with it new ethical dilemmas and interpretation of ethical principles.[9] Although the end-of-life practices vary with cultural and religious differences, a powerful international consensus has emerged.[10] Against this backdrop, we find ourselves seriously mired in an outdated legal framework. The ISCCM-IAPC position statement is an effort at motivating physicians to offer reasonable and practical end-of-life solutions.

Indian Society of Critical Care Medicine and IAPC have also taken initiatives for education and training in EOLC.[11] The training module addresses the entire gamut of issues from early recognition of dying, initiating discussions, communication skills, breaking bad news, documentation and implementation of decisions, and palliative support to bereavement care. In addition, joint initiatives are on to inform legal opinion in the country about EOLC. With increasing awareness, the consensus among healthcare professionals and determined advocacy, appropriate FLST and care of the dying should be possible without too much procedural difficulties.

Raj Kumar Mani, Sheila Nainan Myatra1,
Naveen S Salins2

Department of Critical Care and Pulmonology, Tata Memorial Hospital, 1Department of Anaesthesia, Critical Care and Pain, Tata Memorial Hospital, 2Department of Palliative Medicine, Tata Memorial Centre, Parel, Mumbai, Maharashtra, India

Correspondence:
Dr. R. K. Mani
Critical Care and Pulmonology, Tata Healthcare Pvt. Ltd., Gurgaon, Haryana, India E-mail: raj.rkmjs@gmail.com

References
6. Aruna Ramachandra Shanubh vs The Union of India & Ors. WRIT PETITION (CRIMINAL) NO. 115 OF 2009. (Supreme Court of India Proceedings).

Acute ammonium dichromate poisoning in a 2-year-old child

Sir,

I have two comments on the interesting case report by Sunilkumar et al.[1]

First, I do agree with Sunilkumar et al.[1] in their statement that the diagnosis of a poisoning case
mainly depends on the history, direct identification of the compound, if available and clinical examination. Though the history was suggestive of ingestion of ammonium dichromate, I wonder why the authors did not estimate the blood level of chromium in their studied patient. I presume that Sunilkumar et al.\(^1\) did not seek to perform that measurement as they addressed in their study that ammonium dichromate is a highly dissociable compound and it is not easily demonstrable by chemical analysis of viscera or body fluids. Actually, toxicological documentation of chromium poison and measuring its blood level are of paramount importance in clear cut and suspected chromium poisoning as blood chromium concentration exceeding 1 mg/100 mL is of diagnostic and prognostic value indicating an ingestion and absorption of the high doses of this metal.\(^2\) Hence, it would be of high value in planning suitable therapeutic interventions.

Second, it is well-known that the vast majority of poisonings in young children are due to exploratory ingestions that could be prevented by meticulous family supervision. However, poisoning, particularly in infants and young children could be one form of child abuse.\(^3\) An interesting American study recruiting a cohort of poisoning victims under the age of 6 years was conducted to evaluate for suspected maltreatment and referral to child protective services (CPS). The study showed that 6% of referrals to CPS were secondary to concerns for intentional poisoning.\(^4\) In the case report in question intentional poisoning as a part of child abuse cannot be ruled out. Psychological assessment of parents and exploring marital conflicts, if any, ought to be considered.

**Mahmood Dhahir Al-Mendalawi**
Department of Paediatrics, Al-Kindy College of Medicine, Baghdad University, Baghdad, Iraq

**Correspondence:**
Prof. Mahmood Dhahir Al-Mendalawi,
P.O. Box 55302, Baghdad Post Office,
Baghdad, Iraq,
E-mail: mdalmandalawi@yahoo.com

**References**
