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Evaluation of Errors in Medico Legal Records in the Emergency Department of a Tertiary Care Hospital in North India, New Delhi

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Abstract

Medicolegal cases (MLC) are injuries or medical conditions which require additional input from law enforcement agencies to help in the diagnosis and determining the nature of injury sustained by the patient. Any incorrect input or incomplete documentation may lead to delay in the legal proceedings and thus, patient rights will be violated. In this article, we will enlist the errors in the medicolegal records over the period of 3 years in our institute and guide the doctors in the emergency department for proper documentation of the medicolegal cases.

Keywords: MLC - Medico Legal Cases; MLR - Medico Legal Records

INTRODUCTION

Medico legal cases are medical conditions which require the intervention of both a medical expert for the diagnosis and treatment part and legal expert for handling the legal aspects of the case.[1] From a doctor's point of view, MLC is a medical condition with some legal implications. A case is considered as MLC either when the patient directly visits the hospital and the reporting doctor, after detailed history and examination, concludes the need for legal team to be a part of the case or when a law agency wants to requests the doctors for the medical expertise for the final conclusion of the case[2] MLC vary from road traffic accidents, physical assault, poisoning, suicidal attempt, falls.[3]

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Medico legal records are hand written documents mostly prepared by the emergency physicians after brief history taking and detailed clinical examination of the victim or accused (in some cases) for legal proceedings. Proper documentation of this record is vital for the smooth functioning of the judiciary system. The MLR is considered as a hand written proof by a subject expert in the court of law.[3]

A MLR provides the comprehensive details of the case regarding the medical diagnosis, the injuries sustained and criticality of the patient condition (or diagnosis).[4] An MLR acts as a

supporting document, giving boost to the case and helping the agencies for better and correct decision making. The injury description in the MLR consists of type, number, location, size and any further details mentioned by the treating physician.[4] The injury description helps the law agency to also identify the nature of injury and any weapon used to the injury or not.[2] The major errors recorded in the MLR, from previous studies, generally include incomplete documentation, improper marking and poor external injuries marking in the MLR.[2]

METHODOLOGY

This is a retrospective, observational study where the medicolegal documents over a period of 3 years were evaluated in a retrospective manner and the errors encountered were noted.

The variables noted were: name, age, sex, time of arrival in the ER, time of police information sent from the ER, date and time of incident, date and time of recording the MLC, patient identification (marks), proper documentation of the incident (name, date, age, place and time of injury), injury sustained, time of completion of MLC, final diagnosis, signature and name and DMC number of doctor making the

MLC, thumb print of the patient, injuries marking on the MLR.

RESULTS

A total of 720 MLC records were evaluated in this study (average 20-30 MLC per month over the last 3 years).

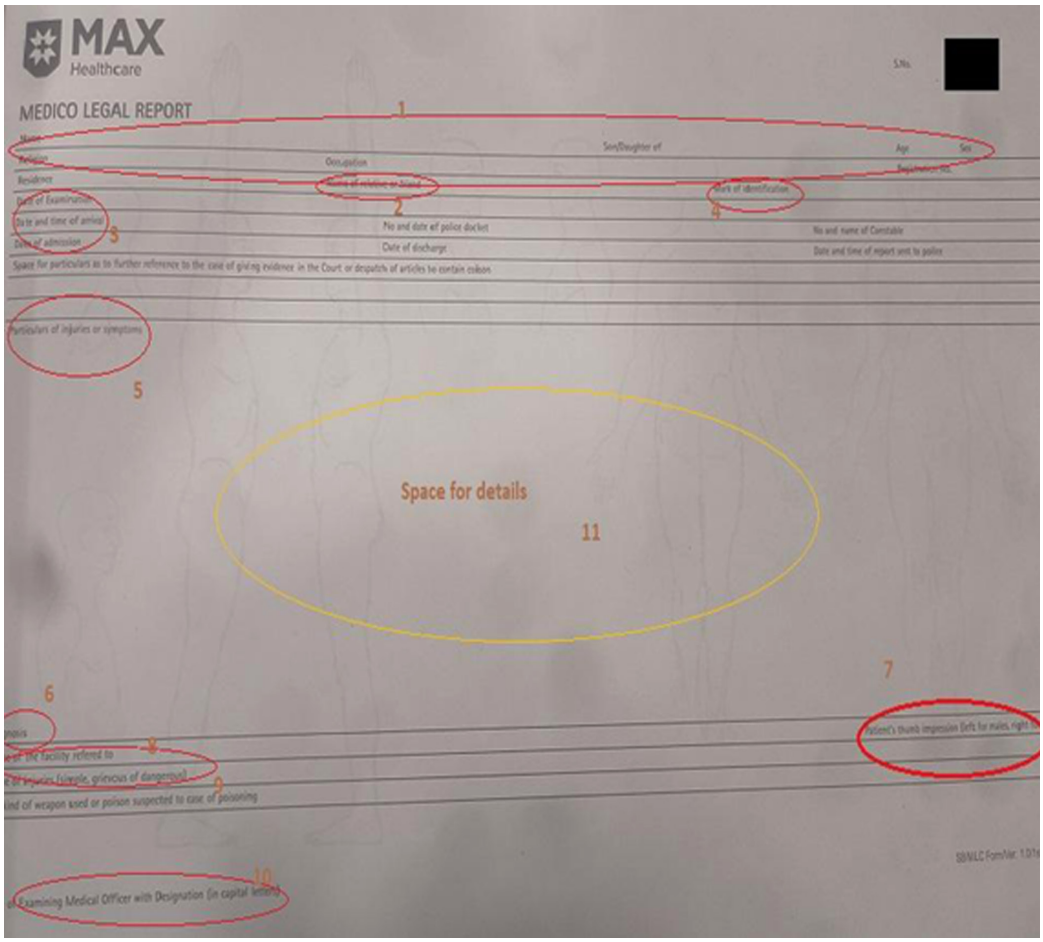
Sl. No.	Observations	Total (out of 720)
1	Missing Patient details (Name, Age, Sex)	0 (Nil)
2	Missing patient identification marks	382
3	Missing attendant / brought by details (Name, relation, Phone number)	322
4	Missing "date and time of arrival in ER"	140
5	Missing "delay / time and date of police intimation given"	80
6	Missing "incident details"	36
7	Missing patient injuries (in detail)	441
8	Missing correct final diagnosis	348
9	Missing proper referrals	130
10	Missing investigations and treatment given in the ER	36
11	Missing "opinion given for the case"	134
12	Missing "signing off doctor details (Name, Signature, DMC number)"	548
13	Missing "patient thumb print"	34
14	Missing "marking of injury location in the MLR"	658
15	Missing "MLC receiving details by police"	148

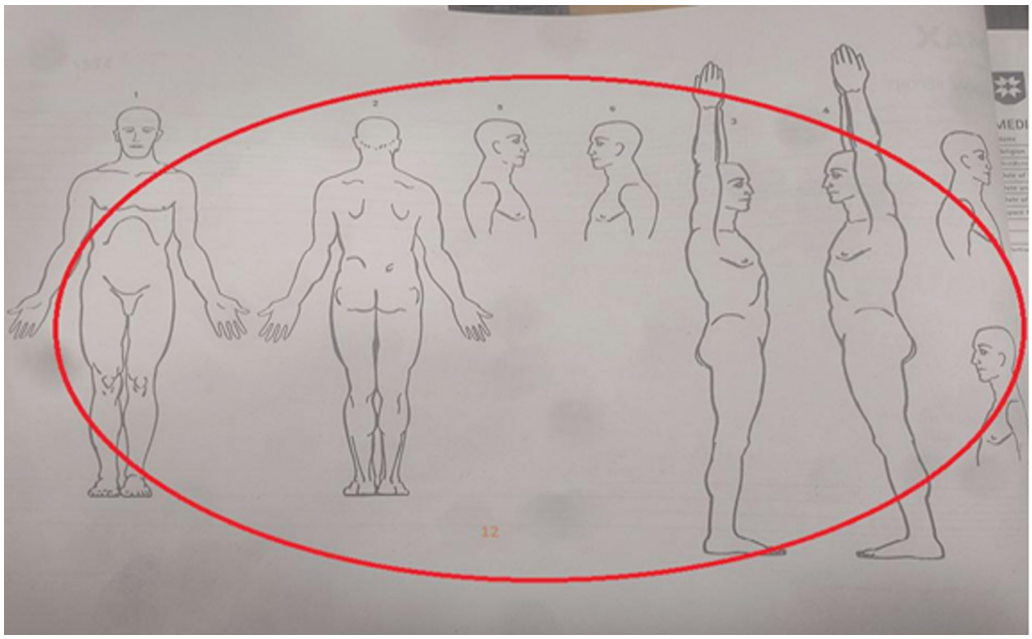
The following observation were noted in the study conducted:

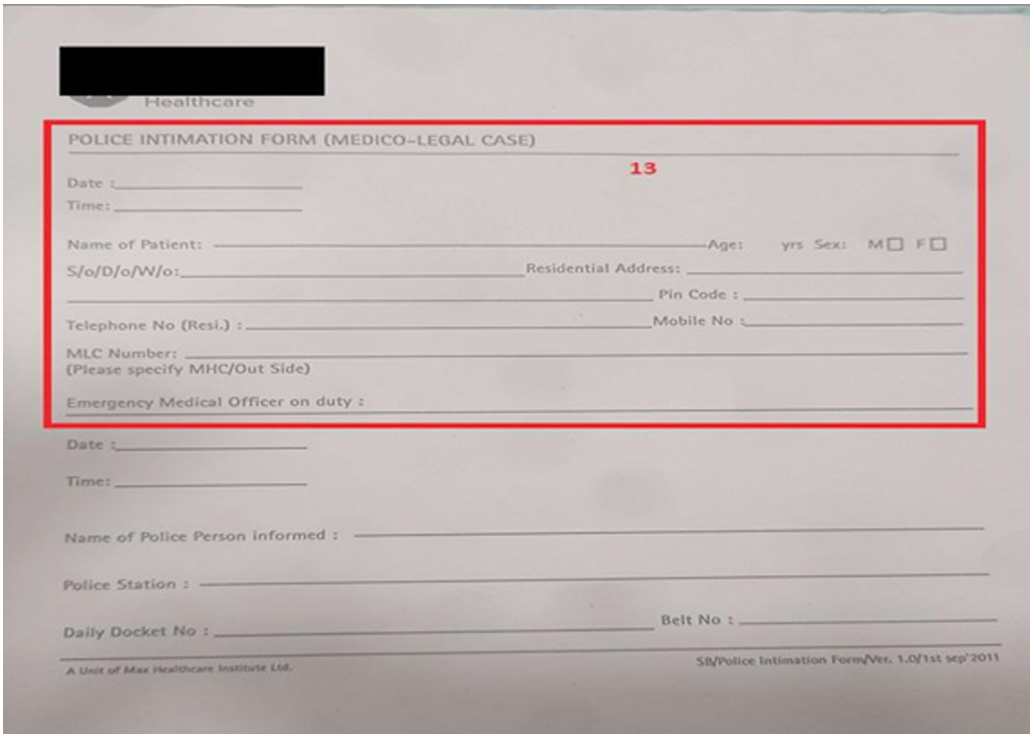
Based on the records obtained in this study, it was observed that the major missing in the MLR were missing injury marking in the MLR sheet, missing doctors details involved in making the MLC, missing in details mention of patient injuries, missing patient identification marks, missing correct final diagnosis.

All the details mentioned above must be

MLR sheet details (of our institute) is described below with specific headings:






[redacted]
Healthcare

POLICE INTIMATION FORM (MEDICO-LEGAL CASE)

13

Date :

Time:

Name of Patient: Age: yrs Sex: M F

S/o/D/o/W/o: Residential Address:

Pin Code :

Telephone No (Resi.) : Mobile No :

MLC Number:
(Please specify MHC/Out Side)

Emergency Medical Officer on duty :

Date :

Time:

Name of Police Person informed :

Police Station :

Daily Docket No : Belt No :

A Unit of Max Healthcare Institute Ltd.

SB/Police Intimation Form/Ver. 1.0/1st sep'2011

1	Patient details
2	Brought by / relative details (with contact number)
3	Date and time of arrival, MLC completion
4	Identification mark of the patient
5	Patient injury details, case summary
6	Final diagnosis
7	Patient thumb print
8	Referral of the patient
9	Opinion by the primary / treating physician about the nature of injury
10	Doctor (making the MLC) details (name, signature, DMC number)
11	Patient injury details, case summary
12	Marking of injuries as present on the patient
13	Police information sheet

filled while writing a MLC for proper MLR documentation, which will not only help the investigating team but also be used as a proof of evidence in the court of law.

DISCUSSION

The present study was conducted in a tertiary care center located in North India. The ER department of our hospital is considered one of the busiest ER in the north region, with an average MLC of around 15-20 cases (average) per month. In this study, no single MLR was found error free. The major missing in the MLR was lack or absence of marking of injuries in the MLR sheet. Special mention about the consciousness level of the patient was not made in detail and was only mentioned in the Glasgow coma scale (GCS) column of the MLR under the subheading of "disability".

Majority of the articles worldwide have shown that the major problem was lack of proper documentation, marking of injuries and complete furnished details of the physician/doctor making the MLR.[5]

There must be standard procedure and principle to document the MLR and doctors (especially emergency physicians) must be trained in documenting a MLC in a proper, well precise manner. In a study conducted in Egypt, it was observed that around 61% of emergency physicians found it difficult to document a MLC in the MLR in a proper manner. The physicians must understand that documenting a MLC in a well precise manner is as important as treatment of the patient in the ER. A well written MLR must contain the the details of the patient, details of the relatives/person bringing the patient to ER, date and time of arrival, identifications marks, "in detail" description of patient injuries in the MLR, marking of injuries in the MLR, opinion and details of the doctor making

the MLC.[7]

CONCLUSION

This study was conducted in a tertiary care hospital with an average of 20-30 MLC cases in a month. A standard, precise, detailed document for writing a MLC must be made and followed universally. Physicians must be trained and educated in writing a proper MLC record for better functioning of the legal agencies for improving the outcome and prevention of violation of patient rights.

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