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Medical Negligence in Pediatrics







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Foreword
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CHAPTER 3

Medical Documentation: The Only Defense for Doctors

Dnyanesh DK, Suma Dnyanesh

Court always says—"If it is not documented, then it did not happen"!

Keywords: Documentation, EHR systems, Expert testimony

Aim: Doctors must be ready to produce written documents which should be their ultimate defense for medical negligence is documentation in court of law.

Objective: Doctors are best givers of medical care but are lazy to document that care on paper. This is to wake up entire medical fraternity to shed lethargy and start documenting whatever good care they give to their patient's.

INTRODUCTION

Medical documentation is an essential component of modern healthcare practice. Beyond its role in patient care, medical documentation holds immense medicolegal significance. A medical document is a document containing the chronological account of patient's examination and treatment.[1] Medical documentation is the lifeblood of the healthcare industry, serving as both a record of patient care and a crucial defense for doctors. Medical evidence comprises a good proportion of civil and criminal law suits brought to trial in legal proceedings. Therefore the documents which are properly stored can become protective armors for doctors against the fiery darts of litigation in a court of law. This chapter explores the multifaceted world of medical documentation, delving into its importance in legal matters and healthcare systems.

THE ESSENCE OF MEDICAL DOCUMENTATION

Medical documentation is comprehensive repositories of patient information, encompassing a diverse range of data such as patient histories, diagnoses, treatment plans, test results, medication logs, surgical notes, and informed consent records.[2] They serve several pivotal functions:

- *Patient care continuity:* Medical documentation ensure the continuity of patient care. They provide a historical account of a patient's health, helping healthcare providers make informed decisions.
- *Adherence to standards:* Medical documentation reflect adherence to established medical standards and guidelines. They serve as a benchmark for evaluating the quality of healthcare provided.
- *Informed consent:* Proper documentation of informed consent is pivotal in

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protecting both patient's rights and healthcare providers' interests.
- *Communication tool:* Medical documentation facilitate effective communication among healthcare professionals, reducing the risk of misunderstandings and errors.

MEDICOLEGAL IMPORTANCE OF MEDICAL DOCUMENTATION

Medical documentation plays a central role in medicolegal matters, encompassing areas such as:
- *Evidence in legal proceedings:* In legal disputes, medical documents serve as primary sources of evidence. They provide a detailed account of patient care and can significantly influence court decisions.
- *Standard of care:* Adherence to the standard of care is a crucial element in medical malpractice cases. Properly maintained documents can establish whether healthcare providers followed established protocols.
- *Informed consent documentation:* The absence of well-documented informed consent can expose healthcare providers to legal liabilities. Medical documents are instrumental in substantiating the consent process.
- *Chronology of events:* Medical documentation create a chronological timeline of a patient's medical journey. This timeline is essential for determining the sequence of events and assessing whether negligence occurred.

THE LEGAL IMPORTANCE OF MEDICAL DOCUMENTATION: A GLOBAL PERSPECTIVE

The medicolegal importance of medical documentation extends worldwide, with numerous legal systems recognizing its significance. Some prominent examples include:
- *United States:* In the United States, medical documents are governed by the Health Insurance Portability and Accountability Act (HIPAA). HIPAA not only regulates the confidentiality and security of medical documents but also emphasizes their legal importance in medical disputes. Courts often rely on medical documents to establish standards of care and evaluate the merits of medical negligence claims.
- *United Kingdom:* In the United Kingdom, the General Medical Council (GMC) issues guidance on documentation for healthcare professionals. Failure to maintain accurate and comprehensive documents can result in disciplinary action. In legal cases, medical documents are pivotal in establishing whether healthcare providers met their professional obligations.
- *Australia:* Australia's healthcare system emphasizes the importance of proper medical documentation. In legal proceedings, medical documents serve as primary evidence, shaping the outcomes of medical negligence claims. The Australian Medical Association (AMA) provides guidelines for maintaining quality medical documents.
- *Canada:* Canada recognizes the legal importance of medical documentation, and healthcare providers are expected to maintain accurate and complete documents. In medical malpractice cases, courts rely on these documents to assess the standard of care and determine liability.

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CASE LAWS DEMONSTRATING THE MEDICOLEGAL IMPORTANCE OF MEDICAL DOCUMENTATION

White versus Brown (1981)—United States

In this landmark case, the court emphasized the crucial role of medical documents in medical malpractice claims. The plaintiff alleged negligence in the administration of anesthesia. The court relied heavily on medical documents to assess the standard of care and determine whether negligence had occurred.

Bolam versus Friern Hospital Management Committee[3] (1957)—United Kingdom

The Bolam test, established in this case, is widely used to assess whether a healthcare provider has met the standard of care. Properly maintained medical documents that reflect adherence to established medical practices can support a healthcare provider's defense in cases where the Bolam test is applied.

Rogers versus Whitaker (1992)—Australia[4]

This Australian case highlighted the importance of informed consent documentation. The court ruled in favor of the plaintiff, emphasizing that healthcare providers must provide comprehensive information to patient's and document the informed consent process adequately.

Snell versus Farrell[5] (1990)—Canada

In this Canadian case, medical documents played a pivotal role in assessing the standard of care. The court used the documents to determine whether the healthcare provider had followed established protocols, ultimately influencing the legal outcome.

Legal Importance of Medical Documentation—Indian Perspective

In the Indian healthcare landscape, comprehensive and accurate medical documentation serves as the primary line of defense for doctors facing allegations of malpractice and negligence.

CASE LAWS DEMONSTRATING THE ROLE OF DOCUMENTATION IN DEFENSE FOR DOCTORS IN INDIA

Jacob Mathew versus State of Punjab[6] (2005)

In this landmark case, the Supreme Court of India underscored the pivotal role of comprehensive medical documents. The court held that well-maintained documents provide essential insights into the treatment process and can protect healthcare providers from unfounded allegations of negligence. The case set a precedent for the importance of medical documentation in establishing the standard of care.

Samira Kohli versus Dr Prabha Manchanda[7](2008)

This case reaffirmed the significance of informed consent documentation. The Supreme Court emphasized that consent must be properly documented. Failure to do so can expose healthcare providers to legal liabilities, even if the treatment was medically sound. This decision reinforced the importance of meticulous documentation of patient consent.

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Martin F D'Souza versus Mohd. Ishfaq[8] (2009)

The court in this case stressed the importance of clear communication among healthcare professionals, which can be achieved through proper documentation. Effective communication can prevent misunderstandings and reduce the risk of medical malpractice claims. This case illustrates how proper documentation can foster a collaborative healthcare environment.

Malay Kumar Ganguly versus Sukumar Mukherjee[9] (2009)

This case underlines how medical documentation can serve as crucial evidence in court. The court heavily relied on medical records to determine whether negligence had occurred. The meticulously maintained records played a decisive role in shaping the legal outcome, showcasing the power of comprehensive documentation.

Maharaja Agrasen Hospital versus Rishabh Sharma[10] (2020)

Brief facts: Complainant, Pooja Sharma, mother of Master Rishabh Sharma, preterm child admitted in Maharaja Agrasen Hospital for preterm care nearly for 5 weeks. Doctors did not carry out retinopathy of prematurity (ROP) screening much later mother noticed baby's abnormal visual response. Eye checkup then showed total retinal detachment. Parents approached National Consumer Disputes Redressal Commission (NCDRC) for medical negligence. The hospital and its doctors denied allegation of negligence, claimed ROP screening was carried out and it had not revealed any problems. The NCDRC appointed expert medical board from AIIMS. Report said no negligence. The NCDRC in its order said that "we are not convinced whether the ROP screening was done by the ophthalmologist. The progress sheet is devoid of details about ROP examination, viz., who performed it, the method, instruments used, and drugs used during ROP testing. The discharge summary also has not mentioned ROP advice. Thus, "no record means, it was not done". Both the parties aggrieved by the NCDRC judgment, appealed to honorable Supreme Court. Honorable Supreme Court upheld the order of National Commission and awarded INR 76 lakh compensation.

CHALLENGES IN MEDICAL DOCUMENTATION

While medical documentation is undeniably crucial, several challenges persist:

- *Time constraints:* Healthcare providers often face time constraints, making it challenging to maintain meticulous records.
- *Electronic health records (EHRs):* While EHRs offer convenience, they come with their own set of challenges, including data security concerns and potential inaccuracies.
- *Interoperability:* Ensuring seamless sharing of electronic records across healthcare institutions remains a challenge, potentially hindering patient care continuity.
- *Legibility and completeness:* Illegible or incomplete entries in medical records can undermine their legal value.

ERRORS IN MEDICAL DOCUMENTATION

Errors in medical documentation can have consequences for patient care and safety.

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Some common types of errors in medical documentation include:

- *Incomplete records:* Missing or incomplete information can lead to misdiagnosis or inappropriate treatment. This may include omitting essential patient history, medications, or test results.
- *Illegible handwriting:* Poor handwriting can result in misinterpretation of notes and medication errors. Many healthcare facilities have transitioned to EHRs to address this issue.
- *Incorrect information:* Entering incorrect information, such as patient demographics, can lead to confusion and potential harm. Verifying patient identity is crucial.
- *Abbreviation errors:* Using abbreviations without proper context can be confusing and lead to medication errors. There are standardized lists of medical abbreviations to reduce this risk.
- *Lack of date and time:* Failing to timestamp entries can make it challenging to track the timeline of a patient's condition and treatment.
- *Failure to document changes:* Failing to document changes in a patient's condition or treatment plan can result in miscommunication among healthcare providers.
- *Copy-paste errors:* Reusing text from previous notes without updating or verifying its accuracy can lead to misinformation.
- *Disorganization:* Poorly organized documentation can make it difficult for healthcare providers to find essential information quickly.
- *Privacy violations:* Unauthorized access to or disclosure of patient information violates privacy regulations and can lead to legal and ethical issues.

WHEN MEDICAL DOCUMENTATION IS VIABLE IN COURT OF LAW AND WHEN IT IS INVALID?

Medical documentation can be critical evidence in a court of law, especially in medical malpractice cases, personal injury claims, and other legal disputes involving healthcare. Whether medical documentation is considered viable or invalid in court depends on several factors:

- *Legibility and accuracy:* Viable medical documentation must be legible and accurate. Illegible or erroneous records can be challenged and may be considered invalid.
- *Timeliness:* Timely documentation is crucial. Courts may question the credibility of medical records if there are unexplained delays in recording information.
- *Authentication:* Medical records should be properly authenticated to ensure their validity. This often involves the signature of the healthcare provider or an authorized staff member.
- *Chain of custody:* In cases involving laboratory test results or medical imaging, maintaining a secure chain of custody is essential to ensure the integrity of the evidence.
- *Compliance with standards:* The documentation should adhere to established standards and protocols. Deviations from these standards may raise doubts about the validity of the records.
- *Documentation of informed consent:* In situations where medical procedures or treatments were performed, documentation of informed consent is vital. Patient's should be adequately informed about the risks and benefits before giving consent.

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- *Hearsay:* Courts generally do not accept hearsay evidence, which includes second-hand accounts or statements. Medical documentation should primarily contain firsthand observations and assessments.
- *Patient privacy:* Healthcare providers must comply with patient privacy laws. Unauthorized disclosure of patient information can render documentation invalid.
- *Retrospective alterations:* Any alterations or additions to medical records should be properly documented, dated, and explained. Retrospective changes without clear justification can damage the credibility of the documentation.
- *Documentation by qualified personnel:* Medical records should be generated by qualified healthcare professionals or authorized personnel. Notes from unqualified individuals may not hold up in court.
- *Expert testimony:* In many cases, expert witnesses, such as medical professionals, are called upon to interpret and testify about the validity and significance of medical records.
- *Preservation of records:* Medical records should be preserved according to legal requirements and institutional policies to prevent loss or tampering.

In summary, viable medical documentation in a court of law is typically:

- Legible, accurate, and timely
- Properly authenticated and compliant with standards
- Generated by qualified personnel
- Free from unauthorized alterations or additions
- Protected patient privacy
- Supported by expert testimony when necessary.

Invalid medical documentation often involves issues with legibility, accuracy, authenticity, or compliance with legal and ethical standards. It is important for healthcare providers and institutions to maintain meticulous and legally compliant medical records to ensure their credibility and usefulness in legal proceedings.

DOCUMENTATION DURING MEDICAL EMERGENCY[11]

It should be done as comprehensively and accurately as possible, considering the urgency of the situation. Here is a general guideline on how and when to document a medical emergency:

- *Patient safety first:* In any medical emergency, the immediate priority is patient safety and providing necessary medical care. Ensure the patient receives appropriate and timely interventions without unnecessary delays.
- *Initial assessment:* Begin documenting as soon as possible after ensuring the patient's initial stabilization. This might involve assessing vital signs, starting treatment, or performing lifesaving interventions.
- *Continual updates:* Continuously document changes in the patient's condition, interventions performed, medications administered, and the response to treatments. Document with time stamps to create a chronological record.
- *Conciseness and clarity:* In emergency situations, brevity and clarity are essential. Use concise language to describe observations, interventions, and responses. Avoid unnecessary details that do not directly impact patient care.
- *Standardized forms or electronic records:* Use standardized forms or her,

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if available. These systems often have predefined templates for emergencies, making documentation more structured and efficient.

- *Timestamps:* Always include timestamps for entries to establish a clear timeline of events. This is crucial for assessing the patient's progress.
- *Patient information:* Clearly document the patient's name, date of birth, and other identifying information. This ensures accurate identification.
- *Chief complaint:* Note the patient's chief complaint or reason for seeking emergency care.
- *Allergies and medications:* Document any known allergies and the patient's current medications. This information is vital to prevent allergic reactions and drug interactions.
- *Vital signs:* Record vital signs, such as heart rate, blood pressure, respiratory rate, temperature, and oxygen saturation, at regular intervals.
- *Interventions:* Document all interventions performed, including procedures, medications administered, and the rationale behind these actions.
- *Response to treatment:* Describe how the patient responds to interventions and any changes in their condition. This information guides ongoing care decisions.
- *Patient statements:* If the patient is conscious and able to communicate, document any statements or information provided by the patient. This may include allergies, medical history, or details about the onset of symptoms.
- *Witness information:* If there are witnesses or bystanders who provided assistance, document their names and contact information in case further information is needed.
- *Legal and ethical considerations:* Be mindful of legal and ethical considerations, such as patient confidentiality and informed consent. Ensure that your documentation complies with relevant laws and regulations.
- *Handoff communication:* When transferring care to another healthcare provider or facility, provide a clear and concise handoff report that summarizes the patient's condition and ongoing treatment plans.
- *Review and corrections:* After the emergency, review your documentation for accuracy and completeness. Correct any errors or omissions promptly.

In an emergency, the focus should always be on providing immediate care to the patient. However, maintaining good documentation practices throughout the process is essential for continuity of care, legal protection, and quality improvement efforts. Documenting critical information during or shortly after the emergency ensures that vital details are not lost.

Healthcare providers should prioritize documenting the most critical information while ensuring that the documentation process does not impede the delivery of lifesaving interventions.

MEDICAL DOCUMENTATION OF TELEPHONIC CONSULTATION AND TELE-CONSULTATION

Medical documentation of telephonic consultations and teleconsultations is essential for maintaining accurate and comprehensive patient records, ensuring continuity of care, and complying with legal and ethical requirements.

Remember that teleconsultations should be conducted with the same level of professionalism, confidentiality, and

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documentation diligence as in-person consultations. Thorough and accurate documentation is essential not only for patient care but also for legal and regulatory compliance when providing healthcare services through telemedicine.

BEST PRACTICES IN MEDICAL DOCUMENTATION FOR LEGAL DEFENSE

To overcome these challenges and maximize the role of medical documentation as a defense for doctors, healthcare institutions, and professionals can adopt best practices.

- *Training and education:* Providing training to healthcare professionals on proper documentation practices is essential.
- *Standardized templates:* Implementing standardized templates for documentation can ensure consistency and completeness.
- *EHR integration:* Ensuring that EHR systems are integrated seamlessly and securely can enhance the efficiency of documentation.
- *Quality assurance:* Conducting regular audits of medical records for legibility, completeness, and accuracy can help maintain high standards.
- *Legal review:* Involving legal experts to review and guide documentation practices can be beneficial.

SUMMARY

Medical record keeping is not a mere administrative task; it is a cornerstone of modern healthcare and a linchpin in medicolegal matters. As illustrated by case laws from various jurisdictions, comprehensive and accurate medical records provide critical evidence of patient care, adherence to standards, informed consent, and effective communication. In a healthcare landscape where legal claims are on the rise, healthcare institutions and professionals must recognize the paramount importance of meticulous documentation to safeguard their professional integrity and interests.

By embracing best practices and recognizing the legal significance of documentation, healthcare providers can ensure the highest standards of patient care while protecting themselves from unwarranted legal disputes. As technology continues to evolve, the digital transformation of medical documentation presents opportunities to enhance efficiency, security, and accessibility, further solidifying its role in both patient care and the legal arena.

LEARNING KEY POINTS

- *Legal safeguard:* Medical documentation serves as a crucial legal defense, providing a documented account of patient care that can protect doctors in case of legal disputes or malpractice claims.
- *Evidence of due diligence:* Comprehensive records demonstrate a doctor's commitment to thorough and diligent patient care, showcasing adherence to professional standards and guidelines.
- *Communication clarification:* Clear and accurate documentation enhances communication among healthcare professionals, reducing the risk of misunderstandings and ensuring a collaborative approach to patient treatment.
- *Risk mitigation:* Well-documented medical records serve as a proactive measure in risk management, minimizing the potential for errors, oversights, or misinterpretations in patient care.
- *Informed decision-making:* Thorough documentation provides a basis for informed

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decision-making, offering a comprehensive overview of a patient's medical history, treatments, and responses, aiding both current and future healthcare providers.

TAKE-HOME MESSAGE

"Good documentation means a good defense, poor documentation means poor defense, and no documentation means no defense".

MUST AVOID THINGS

Reusing text from previous notes without updating or verifying its accuracy can lead to misinformation.

DO NOT DO

Do not fail to document any known allergies.

WARNINGS

Medical records should be preserved according to legal requirements and institutional policies to prevent loss or tampering.

MUST DO THINGS

Medical documentation is must even during emergency.

ONLY ONE FACT TO REMEMBER

Medical documentation is only defense available for doctors in case of medical negligence.

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Medical Negligence in Pediatrics

Medical Negligence in Pediatrics presents an ongoing set of legal challenges that continually evolve and impact pediatric specialists in their practice. These legal issues continue to catch pediatricians off guard regularly. The use of seemingly harmless terms such as "iatrogenic", "known cases of", "known complications", and "known causes of death or disability" can be linked to allegations of medical malpractice, among other accusations.

Pediatric medical care, vaccinations, and related services, fall under the jurisdiction of the Consumer Protection Act-2019 and the National Medical Commission (NMC) 2019. The NMC introduced a new code of conduct on 02-08-2023, which kept in abeyance from 23-08-2023, resulting in the continuation of existing code of ethics 2002. The Chimera of s. 106(1) of Bharatiya Nyaya Sanhita 2023 (BNS 2023) is apparently harsher than IPC 304A, a way away from complete decriminalization as promised on December 20th, 2023 by Union Home Minister.

For the first time, pediatricians start recognizing the importance of effective communication regarding material risks, proper documentation, counseling, forewarning, risk disclosures, guarantees, and warranties. All of these elements contribute to creating informed consent/contracts for medical services. This book underscores the importance of knowing why, when, how, where, and what to document on outpatient (OPD), inpatient (IPD) transfer, and discharge papers, as this documentation serves as rebuttable evidence through the proper preservation of medical records.

This book is designed in a reader-friendly format that covers practical and relevant topics comprehensively. Each chapter includes sections like "Aim", "Objective", "Summary", "Key learning points", and "one liner crisp Medicolegal punching wisdoms" to facilitate the retention of crucial legal concepts relevant to medical practice. It will prove beneficial to all pediatricians, addressing preventive measures for legal issues in medical practice and providing guidance for those facing litigation. Undoubtedly, this book will be a valuable resource for pediatricians, the judicial system, and practicing lawyers dealing with medical negligence cases. "Medical Negligence in Pediatrics," underscores the urgent need to address the multifaceted challenges faced by physicians in today's healthcare environment. As physicians increasingly confront legal repercussions for errors or adverse outcomes, they are burdened with not only financial liabilities but also personal threats, acts of violence, professional sanctions, and even imprisonment. These consequences often arise from a lack of awareness and adherence to legal principles, casting a shadow over the noble mission of healthcare.



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