Prevention of litigation, Documentation, and Medical Audit

Dr. Tushar Shah M.D. (Ped.), LL.b

It is better that we do something proactively before we are forced to do so. What is presented below is an attempt to identify the areas that are potential sources of medico – legal problems and the need to adopt prophylactic measures. There are various laws related to doctors and medical establishment, which are likely to be implemented in the near future. 'Ignorance of law is no excuse', this is a very famous maxim, whereby we understand that we have to have knowledge of various laws pertaining to medical practice and we cannot defend ourself on the ground that I was not aware about the said law.

It is quite apparent to all of us that "Medical Practice" in current times has undergone a sea change, from art of medicine to medical science and now ultimately commerce. The mutual faith between doctor and patient has eroded considerably. The age old doctor – patient relationship is gradually becoming a buyer – seller relationship. Expectations of the public from medical science and doctors have risen sharply in the age of hi-tech medicine. Advert outcome of treatment is now often attributed to suboptimal or deficient treatment amounting to negligence. In general, people are getting more demanding, aggressive and litigious. This has not only prompted the Government but also legal luminaries to bring the medical services under Consumer Protection Act, thus giving a legal sanction to commercialization of health services.

Duties of Doctor:

Every doctor has some basic duties towards a patient. He must **Listen** to the patient (take proper history) and **examine** carefully. In *KB Kamble v. Dr. U Paul*, it was alleged that the patient was given injection penicillin though he was allergic to it. The doctor claimed that he was the family doctor and had injected penicillin in the past. Negligence was not proved. A doctor must **attend** to the patient and give **diligent care**, once he decides to treat. He must **explain** the relevant facts related to the illness and give **correct medicines**. The doctor must have average, recent **knowledge and equipments** in possession, as per his specialty. The practitioners must be able to **foresee** the complications and **refer** the patient timely. The treating doctor must be able **to foresee** common complications, diagnose and treat them at proper time. If the doctor misses this it may amount to negligence. Doctors must maintain a proper **record** of their patients.

Rights of Doctors:

As doctors have duties, they also have rights. A doctor has the right to **turn away** a patient before starting treatment but he should provide minimal basic care especially in emergency. He has a right to select **the drugs** from a wide range of options available, supported by standard medical practice. A doctor can select **the investigations and method of treatment** depending upon various factors and obtain written refusal in case patient does not want to do as advised. If the patient doesn't do the suggested investigations, this becomes contributory negligence on the part of patient or relative. In *P Gupta v. AV Nursing Home*, a patient with fever who was being treated for enteric fever developed bleeding. Blood report indicated leukemia. Bone marrow biopsy was advised but not done. Patient was given many blood transfusions but ultimately died. Negligence was not held. A doctor **can delegate** the powers to properly trained personals or colleagues, usually with the willingness of patient. The better alternative to the practitioners is to start group practice so that one of the regular consultants is always available. Doctor can decide regarding **visit fee** to be charged etc. and to maintain the patient's **record** including its secrecy in certain specific situations.

Rights of Patients:

We must understand rights of patient. In the proposed Gujarat Public Health Bill 2009 which is tabled in the parliament, there are nineteen pages on rights of patients. In general we must acknowledge these rights and try to comply. Patient has right to **get proper medical attention**, especially in emergency situations. Once we decide to treat a patient then we are duty bound to do so. Patient has right to **compassionate and humane behavior** from doctor and nursing staff. Patient has right to **information & explanation** regarding the disease process and complications and the treatment options and its probable outcome. Patient has right to **proper follow-up**. Patient also has a right to **preventive information**, i.e. what precautations should be taken to prevent the disease including vaccination. Patient has right to get **explanation for reason/s for referral**. Patient has right to **attention & hearing** if he has complaint. Patient has right to **refuse treatment or trial**.

Can we refuse a patient?

We can refuse a patient in following situations:

- Doctor is ill or busy
- Strained relations with patients
- Visits outside declared consulting hours
- Night visits
- Home visits
- Consent refused
- Patient 'uncooperative'
- Second opinion without knowledge
- Fee not paid

Be Careful About:

History taking and Examination:

Health care starts with **proper history taking**. The doctor shouldn't only carefully listen to the complaints but he should also ask for **significant positive or negative history** related to those complaints in order to arrive at a proper diagnosis and to rule out important differential diagnosis. In *shajahan v. CMC III(1998) CPJ 242*, a diabetic patient was operated for cataract without asking the history of diabetes. Patient developed infection and required second operation. The negligence was held. Any significant **history of allergy** must be inquired and documented. The attending doctor must **carefully examine** the patient for various signs related to the suspected diagnosis. Missing important signs may result in wrong or missed diagnosis, ultimately resulting in improper treatment.

Investigations:

If it is not possible to diagnose the illness clinically, **investigations should be done**. In, *Rani Devi v. Dr. S R Agrawal III (2002) CPJ 136*, where a patient with fever and swelling in the neck was investigated (FNAC) and treated for tuberculosis. Patient went to other doctor who did biopsy and diagnosed malignancy. In this case also negligence was not held, because practice followed in this case was widely

accepted method. If patient doesn't do the suggested investigations, we must mention in the case paper and try to get their signature, this becomes **contributory negligence** on the part of patient or relatives.

Some basic instruments like BP instrument, torch, otoscope, weighing scale, measure tape, pulse oximeter, oxygen cylinder, resuscitation kit, **basic emergency drugs** etc. should be available with the doctor.

Treatment:

Once we diagnose and start treatment we must select **right drugs in proper dose** which is **age and weight specific**. Worng medicine or overdose or selecting drug which is not approved by drug controller general of India in a pediatric age may amount to negligence. We should take **necessary precautions** like giving test dose before injecting penicillin etc. One must sort to **Second opinion** in difficult situation or when patient demands. Most important one must **avoid crosspathy**. As allopathic consultants we should refrain from using ayurvedic or homeopathic medicines for which we are not trained or authorized to. We should not use ayurvedic preparations like galactogogues (lactare), appetite stimulant (aptivate, apimore), liver tonic(liv 52) etc..Avoiding crosspathy also includes not indulging in other specialties like a pediatrician should refrain from treating adult patients. A surgeon should avoid treating orthopedic problems etc.

Complications:

Some of the illness are self – limiting, while others are progressive. Some of the illness has mild progression while others have fulminant course irrespective of treatment. Hence in any illness doctor should have foresee-ability. If the doctor misses this it may amount to negligence. If the complications are too remote then it is not negligence.

In emergency situation:

In such situations, proper history may not be available. Clinical features may not be obvious. Early diagnosis may be difficult. There may not be sufficient time for investigations. In that situation immediate aim is to save life. Thus error/mistaken diagnosis/judgment in such situation do not amount to negligence. One must get detailed history and investigations after the emergency is over.

Referral:

If the complications are developing or if the doctor feels that the particular case is beyond his skill or competence, a referral to a higher, better – equipped center is always preferable. Timely referral after explaining the reasons for getting expert opinion may prevent many cases of negligence in day to day practice. One must **not attempt to handle cases for which matching resources are not available** to him.

Transferring a Patient:

Whenever you need to transfer a patient to another hospital, especially a critically ill patient, certain **Dos and Don'ts** needs to be observed. Please remember there is more than average potential for some medico – legal problem cropping up when a patient is transferred. Hence there is need to be **cautious**. The patient should be shifted in **proper and safe condition – in ambulance preferably with escort**. We must **supervise personally or delegate to competent person**. Give **relatives few options and let**

them decide. Depending on how critical the patient is, keep proximity of the hospital in mind. Before transferring ensure availability of bed and facilities (ventilator) etc. It is our responsibility to ensure **proper handover** to the referred hospital. We must **keep a copy of transfer note**. Make sure you closely f/up progress of the patient subsequently. Very often loose, though unintended (but sometimes intended!) comments by the doctors at referred hospital are at root of future problems. **Communicate with relatives in this situation sympathetically, confidently and tactfully**. We must **document** in our case record the need to transfer, that it was explained to relatives and proper consent was obtained to shift to particular hospital.

Taking Second Opinion:

In obscure or complicated cases, whenever you feel the need, **do not hesitate** to take an another opinion of a colleague. Far from casting any aspersions on your competence, it will most certainly **indicate diligence** and conscientiousness on your part. If relatives suggest a second opinion, **do not feel offended**. It is always appreciated by relatives. When we are giving second opinion we must take due care and **never criticize our colleague.**

Delegation of Duties:

A doctor can delegate his duties to a qualified and competent junior, assistant, partner, nursing staff. In such situation it is the responsibility of the person to whom the duty was delegated. If the qualified staff makes a mistake then the doctor may not be held responsible. This is vicarious liability.

Inform Police:

M U S T	**A D V I S A B L E**
*Homicides	*Accidents
*Suicides	*Poisonings
*Unknown, unconscious	*Undiagnosed death (within 24 hrs)
*OT table death	*Suspected unnatural death

Documentation:

While all pediatricians try to do their best for patients, they have an innate reluctance to keep record of all the good done. We must admit, with widespread use of personal computers, several practitioners are now resorting to storage of patient data, but the percentage of such practitioners is abysmally small. We must remember the dictum, ***"People forget but Records remember"***.

There are several reasons for poor medical records-

1. Each pediatrician consults with several patients in a day. We find it **bothersome and time consuming** to enter records of each patient in a busy clinic.
2. Unlike our western counterparts we **do not employ secretary** to store and retrieve patient data.
3. We are happy to offer a **restaurant type of service**, where the client enters, avails of the service (consultation, hospitalization, investigation), pays and leaves without leaving any trace behind.

4. In an attempt to **cut maintenance costs**, we remain understaffed, do not use adequate and appropriate stationery, and do not buy a PC.
5. As **patients switch doctors** with regularity, we are not motivated to maintain their records.
6. **Our medical training** does not include record keeping. Therefore we simply have not learnt to do it.
7. Unless we are faced with a medico legal problem, we **do not realize the true importance** of record keeping

There are several good reasons to maintain Medical Records –

a. Medical record today is a **Coordinative Vehicle** for efficient diagnosis and management of patients. With medical records we can treat patients competently and safely, and maintain effective communication between various members of medical team. They are also useful for us to track the patient's progress from day to day, and in long term.
b. Good record keeping is critical to the delivery of **Good quality medical care**. E.g. record of allergy to particular drug, or record that the patient is G6PD deficient.
c. Media and consumer activism has created **awareness in patients** regarding the qualities expected of a good doctor. Maintaining accurate medical records is a necessary quality.
d. Good Medical records are our **best defense against allegations of negligence** and malpractice. Good records establish transparency and credibility, while the lack of records indicates incompetence.
e. Medical records are **instruments of medical education.**
f. Medical records **offer opportunity of research** into epidemiology and management of diseases, which is important for public health.
g. **Medical statistics** can be gleaned from the records.
h. Medical records can be **audited for medical and financial aspects**.
i. Medical records can be used as **evidence in civil and criminal proceedings**, and could be a key factor in life insurance claims, workmen's compensation etc.

What is a good Medical Record –

Good medical Record should be: **C**orrect (without manipulation), **C**lear, **C**omprehensive, **C**hronological, **C**omplete and **C**ontemporaneous.

What should be documented?

1. **Date and time of examination**, for both indoor and out patients.
2. **Keep Copies of all Reports** that are handed to patients. This can be done by requesting the pathologist/ radiologist to send two copies. If a patient looses a report, or tampers with or withholds a report in case of litigation, then a copy with practitioner can save the day.
3. **Keep copy of discharge card-** A discharge card is representative of the management in your nursing home/ hospital, and reflects your medical competence. It could prove or disprove several matters in case of litigation. Patients not carrying out instructions as advised in discharge care could be charged with 'contributory negligence'.
4. **Indoor Case records-** A copy of indoor case record id frequently required by insurance companies before settling a claim, and will be demanded by dissatisfied relatives of a patient, as also demanded in the court of law in the event of litigation. Whatever is not documented on indoor case sheets will be deemed as 'never happened' by the court. Some essentials of indoor case sheet documentation are –

- **Continuation sheet-** each continuation sheet must bear the name and bed number of the patient besides the mandatory dates and times of examination and treatment.
- **Legible handwriting**- Handwriting should be decipherable by nursing staff to avoid mistakes in treatment and it is also an important defense in the court of law.
- **Alterations**- Shabby alterations and overwriting can create doubts in the minds of patients and the law, in case of litigation. Wrong entries should be scored out with a single line, initialed and the correct entry written alongside.
- **Abbreviations**- Avoid abbreviations always. Write the complete form of any disease or treatment or investigation to avoid confusion, as the abbreviations may be interpreted in more than one way.
- **Prescriptions**- All prescriptions must carry date, patient's name, clearly written drug name, strength, dosage and your signature with stamp.
- **Investigation reports**- the attending pediatrician must initial all the reports of a patient that he has seen and acted upon.
- **Consent-** consent and other declarations must be obtained on a separate sheet, with a witness's signature attested alongside the patient's and attached to the main case sheet.
- **Transfer note-** Whenever a patient is transferred to another institute for management, the detailed transfer note should be photocopied/carbon copied and attached to the main case sheet after obtaining a signature on the copy from the patient's relative, indicating that the original transfer note along with other documents is handed to them.
- **Police case or medico legal case-** whenever a medico legal case is being treated by a pediatrician, such as head injury, poisoning, road accident, burns and scalds, alleged physical or sexual abuse of minor etc., the history and clinical findings along with date and time should be very carefully recorded and a copy should be given to the police and relatives with signatures of both obtained on the pediatrician's personal copy.
- **Receipt for documents handed**- On discharge, it is prudent to prepare a list of all documents (investigation reports, radiology reports, specialist referral notes, hospital bill etc) the originals of which are handed to relatives, and obtain their signature on it, as a proof of one's transparency.

5. **Outpatient documents**- Most pediatricians hand over their OPD case papers(history, clinical findings and treatment written on letterhead) to patient, without maintaining a copy of the same. This has two fold disadvantages, if the patient looses the record, then treatment continuity is lost and in case of medico legal litigation, the pediatrician has no records to build his defense on.
6. **Consent**- should be Voluntary (without pressure), by an adult of sound mind who is not under intoxication, after explanation, and reasonable understanding. It should be not by misrepresentation or hiding facts. It should be Informed consent, writing (not implied or blanket). It should be on a separate sheet, and then attached to case record. Also get signature of witnesses - two from hospital side and two from patients side. A denial of consent for a procedure, investigation or treatment should also be duly recorded with date, time and caretaker's signature and that of witness.
7. **Time period for records maintenance**- the emerging consensus is that while OPD records and indoor case records should be maintained for 5 and 10 years respectively, records of medico legal cases should be maintained for 20 years. In case of minors records should be maintained for 25 years.
8. **Confidentiality of records**- a patient's medical records should only be shared with parents, or caretakers, or with the lawyers and court in case of litigation, and income tax authorities when

demanded. Not only is this a moral obligation but it is also a legal obligation, violation of which can cause you liable to pay damages.

9. **Issuing certificates**- One should be extremely careful in issuing certificates, whether they be leave, fitness or death certificates. Many doctors have landed in difficulty because of trying to oblige a patient by fiving a certificate carelessly and casually.