Research article

Medical Negligence Pertaining to Medical Records: A Retrospective Study

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Abstract

Background: Medical record is a vital document, and the doctor/hospital has to maintain these records properly. Most medical negligence cases rely heavily on medical records to establish a case of negligence against the doctor. Poorly filled or incomplete medical records will usually work against the favour of the treating doctor. **Methods:** A total of 242 cases of medical negligence cases decided by the National Consumer Disputes Redressal Commission (NCDRC) from 2015 to 2019 (5 years) were analysed, and negligence/deficiency in service was proven in 126 cases of these lacunae in the medical records were found in 37 cases. **Results:** Some of the common mistakes were missed entry in the medical records (37%), deficient consent form (20%) and missing medical records (17%). **Conclusion:** Medical records play a vital role in medical negligence cases. Not maintaining proper medical records can leave the doctors/hospital vulnerable in liability cases.

Keywords: *Medical negligence, Medical records, Consumer court cases, Liability, National Commission.*

Introduction

The medical record is a very important document and plays a vital role in liability disputes concerning medical negligence. It includes documentation of the patient's history, clinical findings, diagnostic test results, preoperative and postoperative care, operation notes, a daily record of the patient's progress, a valid consent form etc[1].The Hon'ble Supreme Court and the National Consumer Commission in various judgments, have held hospitals/doctors liable for medical negligence for nonproduction of medical record and non-maintenance of medical records[2]. Poorly maintained medical records, e.g. missing pre-anaesthetic checkup, incorrectly filled consent forms, improper discharge summary etc., can play a huge role in deciding on the doctor's sentencing or acquittal. Almost every case of medical negligence will involve careful analysis of the patient's medical records, which is critical in establishing a case of negligence. These records will be scrutinised by experts in that field and opine on whether the treatment was given as per standards of medical practice. It is the primary responsibility of the treating doctor to make sure that the medical records are in order, and any lacunae found in not maintaining medical records properly, the liability will fall on the treating doctor/hospital. This study was done to identify the type of lacunae in the medical records in consumer dispute cases.

Material and Methods

A total of 242 cases of medical negligence cases decided by the NCDRC from 2015 to 2019 (5 years) were analysed (data was obtained from the monthly periodical "Consumer Protection Judgements", DLT publishers). Of the 242 cases, negligence/deficiency in service was proved, and compensation was awarded

in 126 cases (Fig. 1). And in the 126 cases, lacunae in the medical records were found in 37 cases (Fig. 2).

Results

Of the 37 cases with lacunae in the medical records (Fig. 3), the commonest mistake was missed entry in the medical records found in 15 (37%) cases which includes the following: the doctors signature was missing, name of the doctor conducting the procedure not furnished, pre-anaesthetic checkup details not included, preoperative treatment history not recorded, operative notes of the procedure not entered, no entry of the treatment given to the patient, preoperative evaluation of the patient was not recorded, postoperative progress notes were not entered, postoperative treatment not recorded and pre-evaluation of the patient prior to the operation was not entered. Some of the interesting cases in this category are as follows:

A pregnant lady died due to postpartum haemorrhage. The allegation was that the nurses conducted the delivery, and no doctor was present at that time. The medical records, i.e. the case sheet, bedhead ticket and prescriptions were devoid of the doctor's signature. There was no evidence to prove that a doctor was present during the delivery, amounting to deficiency of service[3].

A 70-year-old lady underwent corrective surgery for a left leg fracture. She developed a loss of sensation and blueish discolouration of the left leg a day after the operation but was assured that she would be fine. The leg became gangrenous and was amputated. Detailed progress notes were absent with respect to the condition of the patient after the surgery amounting to a breach of the standard of care. The doctor was found guilty of not rendering proper postoperative care[4].

An adult male underwent corrective surgery for a fracture of his left femur. Postoperatively he had undergone prolonged treatment in the hospital for pain and swelling at the fracture site to no avail. A second opinion revealed non-union of the bones. The medical records were devoid of the treatment given postoperatively and no explanation of how the infection had set in and what steps were taken to treat the complication[5] .

A female developed vesicovaginal fistula (VVF) post caesarean section and alleged that the operation was conducted carelessly, leading to VVF. The medical records did not reveal who performed the procedure. As the letterhead had the treating doctor's name (an MBBS graduate), it was presumed that she had conducted the operation and was found guilty of negligence for not being qualified to perform the procedure as she was only an MBBS graduate[6].

Deficient consent form was found in 8(20%) cases which includes the following: columns in the forms were not filled up or struck out, procedure not mentioned, blanket consent was taken, risks of the procedure was not mentioned, informed consent for procedure not taken, consent form singed by next of kin instead of the patient when concious. The following are some examples.

A female developed quadriparesis following surgery for atlantoaxial dislocation. No deficiency in treatment could be proved against the doctor. However, it was found that the consent form was not filled properly, many blanks were not filled up, and unwanted columns were not struck out, amounting to deficiency in service[7].

An adult female diagnosed with gall bladder sludge underwent endoscopic papillotomy. She developed postoperative pancreatitis and expired due to acute pancreatitis with septicemia and respiratory failure. The patient underwent a risky procedure with a lot of pros and cons. This should have been explained in detail to the patient and the relatives well ahead of the procedure and given adequate time to decide. In this case, the consent obtained was a "Blanket Consent," which was not acceptable[8].

A pregnant woman underwent a caesarian section and was transfused two units of blood. A few months later, she started falling ill frequently, and a blood test revealed HIV positive status. The consent form did not reveal the nature of the operation, the risks involved in the procedure, the necessity of blood transfusion, and the perils involved in transfusion. A valid consent was not taken, amounting to a deficiency in service[9].

An adult female was diagnosed with acute cholecystitis with cholelithiasis and underwent endoscopic retrograde cholangiopancreatography (ERCP) and laparoscopic cholecystectomy (LC). During the procedure, she suffered a cardiac arrest and died a month later. ERCP was a high-risk procedure, and the medical records showed that the doctor had failed to take informed consent from the patient to conduct the operation[10].

Missing medical records were found in 7(17%) cases which includes the following: medical records were not available, purchase records not available, absence of records of the anaesthetist, physician nor anaesthetist certifying the patient fit for surgery was absent, consent form was lost. Some examples are as follows:

A baby developed foetal distress after delivery and was diagnosed with birth asphyxia. The suit was filed five years after the incident. The case was taken into consideration as the consequence of the birth asphyxia was noticed in the defects which occurred during the developmental milestones establishing a continuous course of action. The defence claimed that the medical records were not available, and as per MCI guidelines, the medical records need to be maintained only for a period of 3 years. The Commission was of the opinion that this was a complicated case of birth asphyxia and had a potential for litigation in the future; hence the doctor/hospital should have been more vigilant and preserved the records for a longer period[11].

An adult male sustained a fracture, and plaster was applied. He subsequently developed compartment syndrome, and his leg had to be amputated. No medical records were present, and all evidence was based on the affidavits filed by the doctors. The doctors in their defence claimed that the necrotic area of the skin was small, but the extent of the necrosis could not be confirmed due to the lack of medical records. It was quoted by the National Commission, "Poor medical records mean poor defence; no records mean no defence"[12].

An elderly patient underwent an operation, and a biliary stent was placed; she, unfortunately, died ten days later due to complications. It was alleged that the stent was defective. The doctors were found not negligent in conducting the operation; however, the stent's purchase records were missing. It could not be proved whether the stent used was defective or expired, as alleged, without the purchase record. Hence compensation of Rs. 1 lakh was paid for an administrative lacuna and not due to negligence[13].

Deficient discharge summary was found in 6(15%) cases which includes no precautions/ follow up instructions and treatment, details of the procedure not mentioned, injuries caused during operative procedure not mentioned.The following are examples that fall in this category.

An elderly lady underwent partial cholecystectomy instead of complete cholecystectomy as planned, and she did not get relief. The doctor was found not negligent however the compromised cholecystectomy was not informed to the patient, nor was this information recorded in the discharge summary, which amounted to deficiency in service[14].

An adult male with a complaint of irritation in his eye underwent a cataract operation at the hospital. Postoperatively he continued to have pain and swelling in his eye and was referred to another centre. There he was diagnosed with endophthalmitis, and his eye was removed. The allegation was negligence in conducting the first operation. On perusal of the medical records, it was found that the patient received no follow-up instructions and precautions to be taken following the first operation, amounting to failure in

duty of care[15].

Error in entry was found in 3(7%) cases which includes wrong date of death entry, wrong cause of death recorded in the discharge summary, wrong blood group entered in the records. The following are examples that fall in this category.

The patient was provisionally diagnosed with empyema (the investigations were not conclusive of empyema) but later was diagnosed with septicaemia, leading to acute renal failure. The doctors were found not negligent in the treatment given to the patient. However, the provisional diagnosis of empyema entered in the hospital record was subsequently entered in the discharge summary due to clerical error. The Commission held that the medical record is a vital document, and in this case, the documentation was done casually. The hospital was liable for the wrong act of its employees, and punitive damages of Rs. 5 lakhs was awarded to the complaint[16].

A 70-year-old male underwent a CABG operation and expired ten days later. The doctors were found not guilty of negligence; however, it found the hospital deficient in not maintaining proper medical records. A part of the treatment history (over a week) before the operation was missing, and the date the patient died was wrongly recorded as on the day of surgery when in fact, he died about ten days later[17].

Other lacunae were wrong reporting 1(2%) case and tampering with records 1(2%) case with the following examples.

A 60-year-old female underwent endoscopic polypectomy and did not recover consciousness after the operation. The allegations were that proper consent was not taken before conducting the surgery, and preoperative tests were not done. The consent form did not mention the procedure performed on the patient, and details of the pre-anaesthetic checkup were not recorded. There was an apparent disparity in the CT scan reports issued by the same radiologist on the same day, one stating acute injury to the brain and another stating normal findings. All amounting to deficiency in service[18].

The delay in caesarean section CS and heavy doses of syntocinon resulted in foetal distress and brain damage. Medical records were tampered with, i.e. the dosage of syntocinon was altered by erasing, amounting to professional misconduct for which ten lakhs in punitive damages was levied[19].

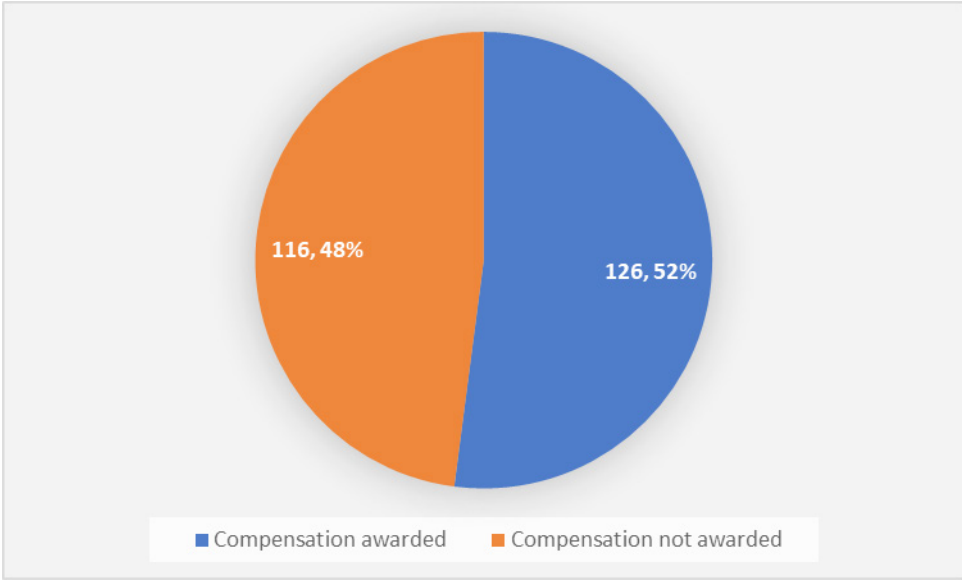

Figure 1: Distribution of Medical negligence cases.

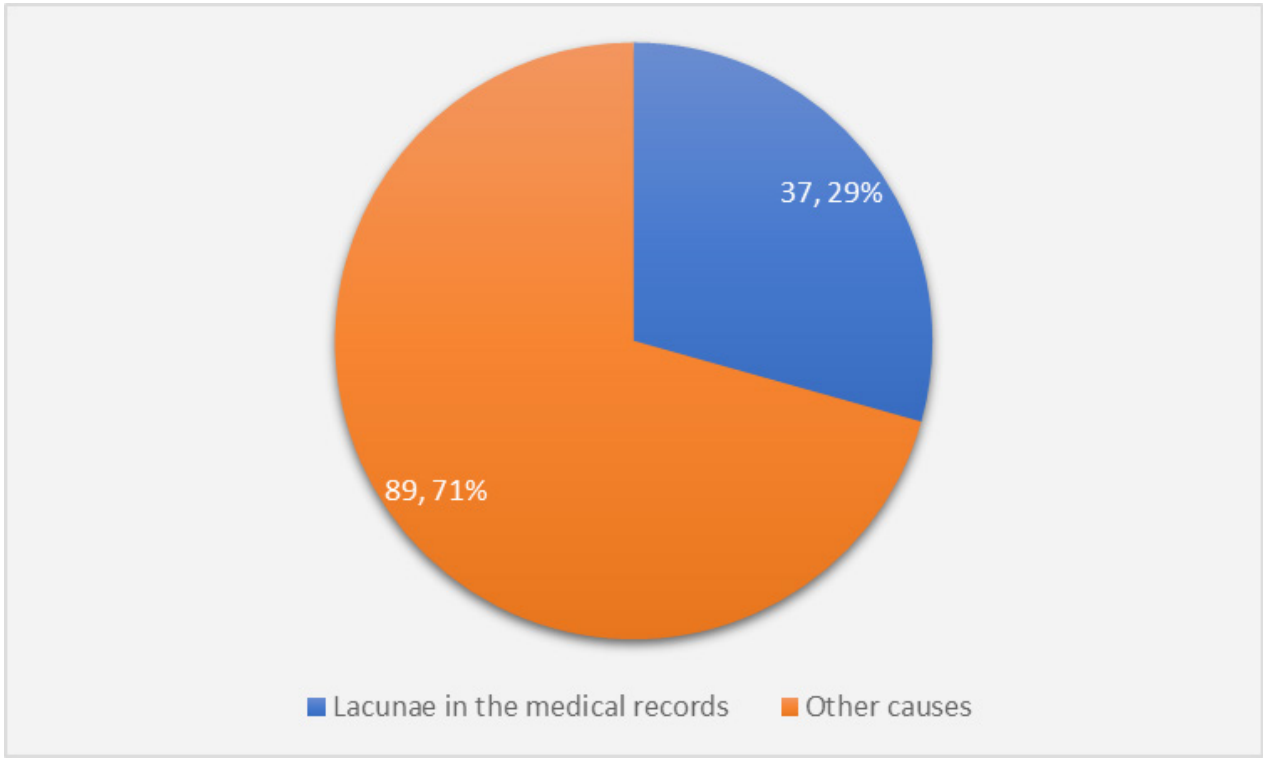

Figure 2: Cases with lacunae in the medical records

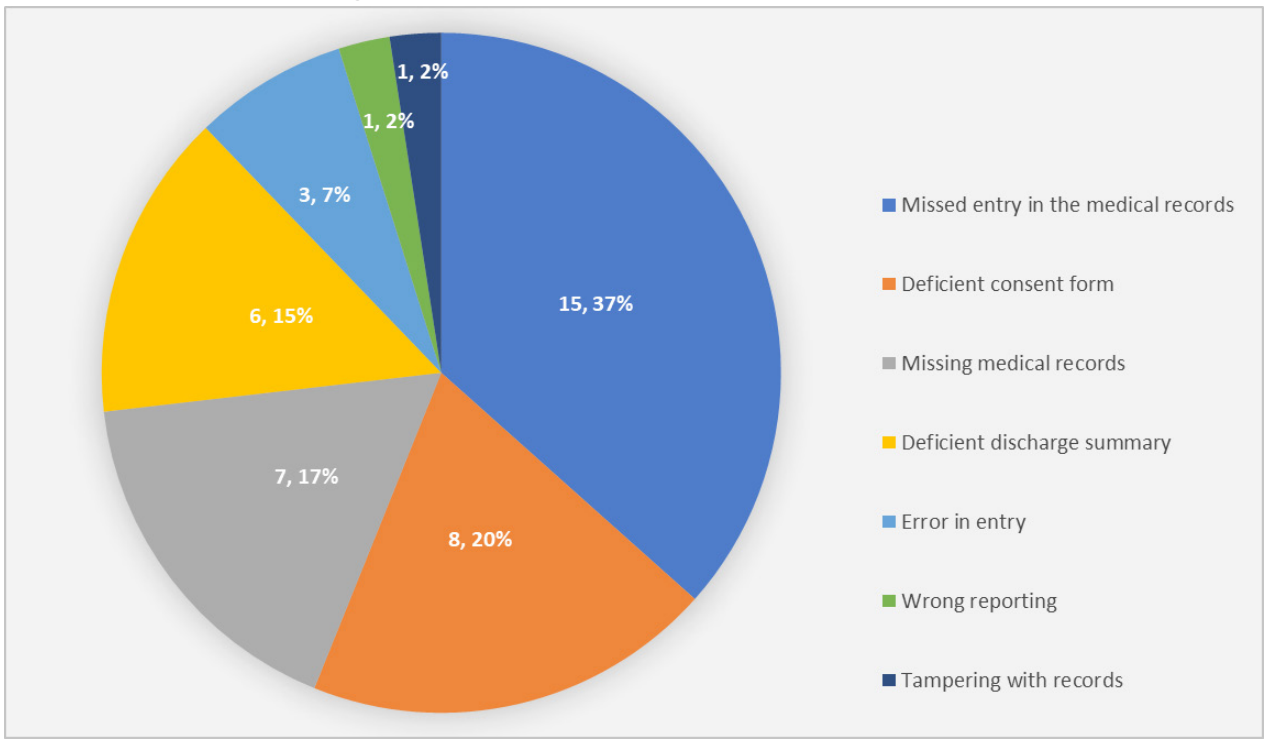

Figure 3: Type of lacunae in the medical records

Conclusion

From the above cases, it is evident that medical records play a vital role in medical negligence cases. Not maintaining proper medical records can leave the doctors/hospital vulnerable in liability cases. Incomplete or poorly filled medical records can attract punitive damages even when the doctor is found not guilty of negligence. Doctors should be prudent in preserving medical records, especially in cases that have a potential for litigation, and should be maintained for a more extended period. Careless entry into the medical records leading to errors will reflect poorly on the treating doctors/hospital. The discharge summary should have all details of the treatment / operation /procedures and follow-up instructions. Medical records should never be tampered with. The doctor/hospital, if found guilty of tampering, can face severe penalty.

Ethical Clearence: The data was obtained from monthly periodicals. The research was done following ethical standards

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Conflict of Interest No conflict of interest reported.

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