

Fallacies of Wound Certificate Documentation in Medico-Legal Cases by Treating Indian Doctors: A Retrospective Study in Rural Medical College

Keywords

Wound certificate; Medico-legal cases; Indian doctors

Abstract

An injury is any harm, illegally caused to any person in body, mind, reputation or property (sec 44 IPC). A wound is a break of the natural continuity of any of the tissues of the living body¹. Objective: To know the types of errors are being committed by the physicians while filling up the wound certificates. On detailed analysis of the wound certificates issued by treating doctor in our hospital in the year 2019 yielded the following results. Out of a total of 100 certificates analyzed, only 44(44%) of the 100 certificates were found to be completely filled and correct. A Total of 32(32%) certificates contained major errors and 20(20%) contained minor errors. 4(4%) certificates contained both major and minor errors. Errors, be it manual or instrumental are not acceptable. Especially in the profession as great as Medicine. There is no scope for errors here. Even when error is such a fatal mistake in medical profession, globally 1,42,000 people died in 2013 from adverse medical treatment effects⁶.

Introduction

An injury is any harm, illegally caused to any person in body, mind, reputation or property (sec 44 IPC). A wound is a break of the natural continuity of any of the tissues of the living body [1].

Man, the maker of his destiny also makes some mistakes and doctors are no exception to it. Wound certificate forms an essential part of medico legal cases. Medico legal cases may be filed against a doctor for avoidance, failure to communicate, failure to diagnose. Most of times a doctor investigates foul play and issues a wound certificate in a Medico-Legal Case. Wound certificate is a document prepared by the doctor in all medico-legal cases. Wound certificate is a kind of medico-legal report [2].

A medico legal case of injury or ailment where attending doctor after taking history and clinical examination of the patient thinks that some investigations by law enforcing agencies are essential. Even though a wound certificate is an important aspect in any medico-legal cases, errors in issuing and documentation of these certificates is not something very uncommon. These certificates play very important role and the error can lead to many fatal consequences. Issuing of wound certificate becomes important in case of injuries which include road accident, suicide, homicide or grievous hurt (sec 320 IPC) [3].

The legal, ethical and moral liabilities of the doctors are enshrined in the Hippocratic Oath that we take when being ordained in to



*Address for Correspondence

Nithin Gowda K, Adichunchanagiri Institute of Medical Sciences, Adichunchanagiri University, B G Nagara, Nagamangala Taluk, Mandya, Karnataka State, India; E-mail: vijay.fmt@rediffmail.com

Submission: 14 February, 2020

Accepted: 16 March, 2020

Published: 18 March, 2020

Copyright: © 2020 Vijay Kumar AG, et al. This is an open access article distributed under the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

the medical fraternity. They are detailed in the International Code of Medical ethics, The Declaration of Geneva as well as the Indian Medical Council (Professional Conduct, Etiquette and Ethics) regulations, 2002 (Amended up to 2010).

The main ethical principles (modified from the principles of Bio-Ethics as described by Beauchamp and Childress, 1977) to guide the medical fraternity in treating the patients are: 1. Autonomy 2. Beneficence 3. Non-maleficence 4. Compassion.

The principle of justice implies fair distribution of the resources that are available to the doctor in his health care-delivery system, amongst his patients. It addresses the questions of distribution of scarce healthcare resources, respect for people's rights and respect for morally acceptable laws.

Following issuing a certificate the doctor is duties bound to handover the original to the police and keep one copy with them.

Objectives

To know the types of errors are being committed by the physicians while filling up the wound certificates.

Methodology

Study design: A retrospective study.

Study duration: 3 months

Place of study: Adichunchanagiri hospital and research centre, B G Nagara

Study population and sample size: 100 medico-legal cases registered at casualty

Inclusion criteria: all medico-legal cases coming with history of road traffic accident, occupational injuries, firearm injuries, self-inflicted injuries, homicidal injuries.

Ethical clearance: Ethical clearance for the study will be obtained from the institutional ethical committee.

Demographic data and clinical data of the patients will be obtained from patient's record.

Analyzing wound certificate records of the patients being admitted to hospital

- Graph plotting
- Comparing records

Format of wound certificate is as follows:

- Pre-amble indicate date, time, place of examination and name, address and occupation of patient.

- Body includes complete description of the injuries
- Post-amble includes

Nature of injuries- simple or grievous.

Weapon used- blunt or sharp or firearms, etc.

Duration of injuries- characteristics of external injuries.

To be signed with full name of attending physician in capital letters.

Statistical analysis: The results of the study will be expressed as error percentage in comparing and contrasting patient report and wound certificate. The obtained data will be entered and analyzed using computer software SPSS 17 version. Complete confidentiality will be maintained throughout the process.

Errors will be classified into

Type-1 errors including:

Error in writing date, time, place of examination and name, address.

Type 2 errors including:

Errors in writing

Complete description of identification marks

Complete description of the injuries

Simple or grievous injuries

Weapon used- blunt or sharp or firearms

Duration of injuries- characteristics of external injuries.

Signature, complete name, registered number, designation, seal, date, time

Observation and Results

On detailed analysis of the wound certificates issued by treating doctor in our hospital in the year 2019 yielded the following results. Out of a total of 100 certificates analyzed, only 44(44%) of the 100 certificates were found to be completely filled and correct. A Total of 32(32%) certificates contained major errors and 20(20%) contained minor errors. 4(4%) certificates contained both major and minor errors.

Discussion

Two identification marks must be taken. They are necessary to

identify the person in court One identification mark is more likely to lead to mistaken identification, as it can be duplicated in another person. Two identification marks are less likely to lead to errors. Three would cause still less errors, but it is not practical to take more than two. They should be on exposed parts, and not on hidden parts, so patient faces no embarrassment in court where these marks may be tallied [3].

All injuries, however insignificant they may appear, should be recorded. Proper, adequate, and complete documentation is very necessary for all medico-legal work. Remember the maxim: Legally, only those injuries are present that have been recorded. Whatever has not been recorded was not present. Similarly, whatever procedures have been recorded were performed; whatever was not recorded was not performed. If necessary, photographic documentation should be performed. Although this is a common practice in the West, it has not yet caught on in India.

Even old injuries should be recorded. Type of each injury (e.g. whether it is an abrasion, contusion, laceration, incised wound, stab, burn, scald, fracture, dislocation of tooth etc.) should be noted. Systematic entries - In order not to miss any injury, a systematic plan should be adopted. The best is to go round the patient in this manner; start with head and neck → right upper limb → right lower limb → left lower limb → left upper limb → front of the chest and abdomen → genitalia → back of chest and abdomen. Lens must be used in order to be able to differentiate between incised and incised looking lacerated wounds, or for noting other minute details such as singeing of hairs around firearm entry wounds. Presence of any foreign material - (i) Note presence on the body or within the wound e.g. broken off point of a knife, bullets, coal, dirt, dust, fibers, glass, grass, gravel, grease, hair, metal, mud, oil, paint, pellets, powder, sand, shots, splinter of wood, synthetic materials, wads etc., These can often help identify the weapon, and indicate the manner in which injury was inflicted. Similarly, recovered bullet can be matched to the suspect firearm). (ii) Detection by optical methods - magnifying glass, stereo microscope. (iii) All recovered foreign material should be preserved, sealed, and handed over to the police official for further examination by the forensic scientist [4].

Size of each injury should be noted, after measuring them with a ruler. No reliance should be made on guesswork. Shape of injuries - whether linear, triangular, circular, elliptical, oval, irregular or any peculiar shape. Direction of wounds - Whether horizontal, vertical, oblique or in any particular direction. Relationship with an organ is desirable (e.g. directed toward the heart or away from the heart). Beveling of edges is particularly helpful in determining this. Labeled sketches of all injuries should be made. This helps lay persons like judges and lawyers to understand the injuries better.

Exact location of the injury in relation to important landmarks (e.g. midline, navel, nipple, outer canthus of the eye, a joint, a bony structure [e.g. knuckle]) should be noted. Distance from landmarks should be noted. Avoid technical terms as far as possible (e.g. instead of writing "medial malleolus", write "inner bony prominence of the ankle"). There is nothing wrong in writing technical terms, and if the doctor cannot think of a suitable common name, he can use technical terms too. Writing in layman's language makes it more comprehensible to laymen like judges and lawyers. A good alternative

is to use the technical term and then common name within brackets, e.g. "Right anterior superior iliac spine (bony prominence on the right side of the waist)". Concealed wounds - If the patient is unconscious (i.e. can't point to areas of pain), a careful search must be made for wounds in areas such as ears, nostrils, vagina, rectum, etc.

Age of each injury should be noted after noting gross changes in the wounds (e.g. color of a bruise, condition of scab in abrasions, infection etc.). Routine histological, histo-chemical and immuno-histochemical examinations are not possible in casualty setup, and should be undertaken only in extremely sensitive cases. If necessary, help of a pathologist may be taken. Age of injury confirms or refutes the allegations of the victim. For instance, he may be alleging that he was attacked in the morning and showing some old injuries to corroborate his statement. In the case of battered baby syndrome, since the injuries occur at different time periods, all injuries will be of different ages. The step-parent may falsely allege that the child fell down the stairs. If that be the truth, all injuries must be of the same duration [5].

Against each injury, its nature should be noted (e.g. simple, grievous or dangerous). If nature of injury is not immediately apparent, patient must be kept under observation and following entry made in the relevant column "patient under observation." Similarly, if X-rays or other investigations have been ordered and their reports awaited, following entry should be made "Awaiting X-ray report."

Examination of wounds and clothes can indicate the nature of the weapon - whether sharp edged or blunt; or if sharp-edged, whether single-edged or double-edged.

It is of great importance to examine and document presence of wounds in the area surrounding the main injury as it may help to identify the causative instrument or to differentiate inlet of firearm injuries. Hence, all injuries even those appear insignificant should be recorded.

Most of the doctors were seeing the legal issues as being a fundamental hospital's responsibility not physician's responsibility. Similar findings were reported by a previous study on Dutch general practitioners that found 75% of them were seeing assessment and description of abuse-related injuries as not being the responsibility of attending physicians [6].

Writing ML report was found as the most frequently encountered difficulty faced the participants during handling of MLCs (67.1%). This indicates the need for structured format of MLR designed to all hospital to enhance both of readability and accuracy of the report. Also, it is important to train the physicians to use Arabic terminologies of the injuries to write MLR in an understandable language [7].

According to a study, most of the doctors always document wound's characteristics as type, size, site and shape; only 10.5% of them care with accurate measurement of the wound's size. About 51% of them always describe the location of the wound in relation to

anatomical land marks. This is in accordance with previous studies that reported inaccurate and inadequate documentation of injuries by physicians in ED [8,9].

Conclusion

Documentation is very essential - condition of the patient, consent, procedure performed or treatment given, etc. at that instant time & do not leave anything for completion later on. It should be remembered that: "If you have not documented it, you have not done it."

Knowledge is power and knowledge about legal duties, liabilities and rights is the only way to safeguard ourselves during current climes of strife and litigation. In repetition, meticulous record keeping is the one talisman which will help guard against spurious and malafide complaints, as recorded facts speak bear witness in a court of law. Following standard procedural examination/ management protocols in medico legal situations go a long way in securing the doctor against malpractice.

Errors, be it manual or instrumental are not acceptable. Especially in the profession as great as Medicine. There is no scope for errors here. Even when error is such a fatal mistake in medical profession, globally 1,42,000 people died in 2013 from adverse medical treatment effects⁶. This project aims to highlight mistakes in wound certificate documentation and installing a check system to prevent these mistakes from becoming fatal for Indian judicial system. The results obtained from the studies will help in imparting proper training to doctors in writing wound certificates and also it helps in maintaining statistical records.

References

1. Reddy KSN (2017) *The Essentials of Forensic Medicine & Toxicology*. (34th edn). Jaypee publishers, India pp: 648.
2. Joga RSV (2009) Medical negligence liability under the consumer protection act: A review of judicial prospective. *Indian J Urol* 25: 361-371.
3. Aggrawal A (2015) Salient features regarding medico legal certificate. *MEDICOLEGAL CORNER* 1: 45-51.
4. Bajanowski T, Hüttenbrink KB, Brinkmann B (1991) Detection of foreign particles in traumatized skin. *Int J Legal Med* 104: 161-166.
5. GBD (2013) Mortality and Causes Collaborators. *Lancet* 385: 117-118.
6. Reijnders JL, Baasbank MV, van der Wal G (2005) Diagnosis and interpretation of injuries: a study of Dutch general practitioners. *J Clin Forensic Med* 12: 291-295.
7. Whedon JM, Fulton G, Herr CH, Friedrich M, Recklinghausen FMV (2009) Trauma patients without a trauma diagnosis: the data gap. *J Trauma* 67: 822-828.
8. Stevens S (2004) *Forensic Nurse: The New Role of the Nurse in Law Enforcement*. (12th edition), Martin's Press, New York pp: 288.
9. Henderson E, Harada N, Amar A (2012) Caring for the forensic population: recognizing the educational needs of emergency department nurses and physicians. *J Forensic Nurs* 8: 170-177.