MEDICO-LEGAL DOCUMENTATION: CHALLENGES AND IMPACT ON JUSTICE DELIVERY

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Introduction

Modern criminal justice infrastructure has become increasingly dependent on the accuracy of the intersection of clinical science and the rule of law. Medico-legal documentation, in many ways synonymous with Medico-Legal Reports (MLRs), post-mortem reports, injury certificates, and age estimation dossiers, serves as the main piece of evidence of the biological facts of an offense and their legal determination.[1] The modern legal system has seen a change in the nature of the law which had historically been ruled by oral evidence, to the current status quo that is primarily document-based. Courts now give preference to objective and scientifically proven medical records, as opposed to what is potentially unreliable witness memory. The dependency of law on medicine places the medical practitioner not only in the role of a healer but a very crucial member of the court whose records can alter the course of a trial.[2] Defective documentation is often the consequence of systemic problems, such as insufficient training, slow forensic toxicology, institutional strains, and the absence of national standardization.[3] These inadequacies usually contribute to weakening of the case of the prosecution which leads to faulty acquittals, extensive prolongment of trials and a general loss of trust amongst the masses in the justice delivery machinery.[4]

Thesis Statement: This article argues that while medico-legal documentation is the foundation of justice, there are certain radical structural and technological changes that are necessary at present to reduce fallacies which undermine the quality of legal results.

Nature and Significance of Medico-Legal Documentation

The ontological difference between regular clinical records & prescriptions and medico-legal documentation is inherent in the interpretation of the latter in relation to the justice system.

[1] State of H.P. v. Jai Lal, (1999) 7 SCC 280.
[2] Ratanlal & Dhirajlal, The Law of Evidence 461–63 (27th ed. 2022).
[3] Keshavlal v. State of Rajasthan, (2019) 6 SCC 51.
[4] World Health Organization, Guidelines for Medico-Legal Care for Victims of Sexual Violence 3–5 (2003).

Whereas clinical records are mostly longitudinal instruments, which are supposed to assist in diagnosis, treatment and continuation of patient care, medico-legal records are documents designed specifically to consider legal, insurance and compensation proceedings. A medical record practically goes through a change in its nature, as soon as it moves to legal realm; it stops being a treatment log and turns into a factual basis of arguments, expert opinion, and court ruling. The relevance of such a record can be compared to that of a witness in the stand: once the credibility or technical soundness of such a record is doubted, the whole fabric of the case can be permanently damaged.[5]

Medico-legal documentation has a broad working scope, encompassing situations that a medical practitioner finds an unnatural occurrence: incorporating accidents, attacks, poisoning, burning, and suicides in addition to the crimes against human body including sexual violence, custodial torture, and child abuse. Every document has its specific purpose under the legal matrix in India. For example, an Independent Medical Examination (IME) report is essential in the process of assessing personal injury damages or establishing the ability of an individual to go back to work. On the other hand, a post-mortem report focuses on revealing the truth behind suspicious deaths so as to present evidence of causation as well as the mode of death which would not otherwise have been known.[6]

The persuasive nature of these documents is pegged on their capability to support the ocular testimony or render objective evidence in absence of testimony. Medical evidence in criminal law can frequently resolve a case on how a weapon was used, the distance of a shot, or when a fatal injury occurred, e.g., the presence of particular injury patterns can guide the judiciary to recreate the dynamics of a crime scene on a scientific basis, e.g. in a suspected suicide case a "hesitation cut" can indicate the victim was already dead, or in an assault case a defensive wound can indicate the victim was not resisting the attack. Moreover, biological evidence and trauma can be carefully documented in sexual violence cases, and used to prove that an offense has been committed especially when the victim cannot give a comprehensive account. As a result, such records provide a balance between medicine and law, which makes the process of decision making thorough, balanced and equitable. [7]

[5] Modi, A Textbook of Medical Jurisprudence and Toxicology 1–4 (26th ed. 2018)
[6] Id.
[7] Id.

The Medico-Legal Documentation Process

A strict institutional framework that regulates the creation of a medico-legal documentation is created to ensure that the evidence is not distorted during the initial interaction point. A Medico-Legal Case (MLC) is set in motion when a practitioner has the suspicion that the condition of a patient is due to a criminal act or an unnatural event. Most importantly, it is always the primary duty of the medical professional to treat and save the life of the patient though the documentation, and registration of the MLC should be done during life-saving interventions. [8]

This is a twofold task that necessitates a high level of organizational effectiveness. The organizational structure requires the treating physician to make a decision on whether a case is to be considered an MLC. After such a decision is arrived at, the patient or his family cannot reject the MLC designation, and only informed consent is sought with respect to the specific medico-legal examination and evidence gathering (apart from some instances) against the accused. The physician must then instantly intimate the closest police station in jurisdiction, normally via standard forms like Annexure D in institutional SOPs. [9]

The documentation itself follows determined stages. It starts with a record of the personal particulars of the patient such as the identification marks, such as scars or moles as well as the fingerprints to ensure that the patient is not personified. The clinical examination comes next, and the doctor records the history of the occurrence, the measurements of any injury inflicted on the patient, and the alleged weapon of attack. In case biological samples are needed like gastric lavage cases with poisoning, swabs in sexual assault cases, etc., they should be packed, sealed with wax and signed by the doctor to avoid tampering. The last phase is the reporting and submission of the report and samples to the police or the forensic laboratories. This transfer should be careful and any loophole in the chain of custody might result in the evidence being discredited in court. Records are also crucial to retain; MLC records must be retained by hospitals at least several years and in many jurisdictions throughout the duration of the case.[10]

Problems in Medical-Legal Documentation

Certain structural, technical and educational obstacles that affect the entire lifecycle of a case,

[8] Parmanand Katara v. Union of India, (1989) 4 SCC 286.
[9] Ministry of Home Affairs, Model SOP for Medico-Legal Examination (2016).
[10] Directorate of Forensic Science Services, Manual on Chain of Custody (2019).

as a chain that adversely affects the integrity of the medico-legal documentation. Such difficulties are not mere administrative hassles, as they symbolize a structural malfunction that directly affects the quality of judicial results.[11] Some key fault lines are identified below:

- **Poor Training and Quality Shortcomings**: The first obstacle that is found to be prevalent in the Indian scenario is the absence of specialized training in handling of medical professionals in the art of the forensic documentation. Most junior consultants, medical graduates at rural hospitals, and foreign-trained medical graduates are initiated suddenly into medico-legal obligations without the proper knowledge of the legal consequences of their documentation. The result of this lack of familiarity is vague documentation i.e. the description of injuries without measurement or anatomical localizations and omission of such details as the age of the injury or the weapon that is likely to have caused it. The lack of graphical aids also contributes to the poor quality of documentation. Although most guidelines recommend the use of diagrams or sketches to show the path of a wound or the size of the burns, they often go unobserved in practice and the courts have to rely on the text which can be interpreted in various ways. Worst of all perhaps is the problem of illegibility. In most jurisdictions, handwritten reports still continue to be the standard, and may be so difficult to read that they hinder the prosecution and defense in the cross-examination process. The inability of practitioners witness stand undermines the whole case scientifically. [12]

- **Forensic Backlogs and Viscera Vortex**: One of the greatest bottlenecks in the criminal justice system is the toxicological analysis. The last post-mortem opinion which is usually reserved until the chemical analysis of the viscera is received is that of suspected poisoning or an unexplained death. This forms what may be termed as a vortex of the viscera which traps evidence in a loop of procedural delays and structural breakdowns. The backlog is staggering; reports indicate that forensic laboratories in major states like Uttar Pradesh and Kerala are grappling with tens of thousands of unresolved cases, some dating back decades. These delays not only derail active investigations but also compel the families of victims into an agonizing wait for justice and closure. When a report is finally produced after years of delay, its accuracy is often

[11] B. Chandra et al., Documentation Errors in Medico-Legal Reports, 44 Indian J. Forensic Med. & Tox. 17 (2020).
[12] Comptroller & Auditor General of India, Performance Audit on Forensic Services (2021).

questionable due to the degradation of the biological material, providing the defense with ample opportunity to challenge the findings.[13]

- **Ethical Pressures and Institutional Overburdening**: Medico-legal work in India is normally in a high-stress and dynamic environment. Government/public healthcare infrastructure has been chronically underfunded, resulting in human resource crises and poor facilities. These deficiencies tend to overwork physicians, and a time-consuming process of careful medico-legal documentation is often compromised to provide urgent clinical attention. In addition to workload, medical workers have to deal with serious ethical challenges and outside pressure. The level of violence against doctors is also on the increase, with attackers being the family of the deceased or local political leaders. In some cases, police personnel or politicians who are expected to seek favourable reports or even influence the recording of injuries, harass practitioners. Intimidation coupled with the spectre of litigation makes many doctors either practice defensive medicine or avoid medico-legal practice. This leads to a "second victim effect" as the doctors are psychologically affected by false charges of negligence which further deters them to accurately and truthfully document cases of justice. [14] [15]

- **Inadequate Inter-jurisdictional Standardization**: The deficiency of a national medico-legal code is an important systematic defect. Presently, the examination protocols, evidence collection and documentation protocols differ greatly among states (sometimes even amongst various institutions within the state). Although major institutions such as AIIMS have come up with elaborate SOP manuals, smaller hospitals tend to work on an ad-hoc basis or by using old manuals. This inconsistency makes the work of the judiciary more problematic since a judge who is dealing with cases in different jurisdictions could experience radically different standards of documentation, and it is hard to provide the same standard of evidentiary rigor. [16]

Effects of Ineffective Documentations on Delivery of Justice

The concentric circles of the impact of poor medico-legal documentation run through all levels of the criminal justice system. Once the scientific record and chain of evidence is

[13] Indian Medical Council (Professional Conduct) Regulations, 2002.
[14] Shivaji Sahabrao Bobade v. State of Maharashtra, (1973) 2 SCC 793.
[15] National Human Rights Commission, Guidelines on Post-Mortem Examinations (2010).
[16] Id.

broken, the whole justice system starts to fail. Criminal investigations are often derailed because of how the investigation was conducted and the manner of execution.

- **Derailment of Criminal Investigations**: The first opinion of the medical officer is very crucial in the initial phases of a criminal investigation. When an MLR does not effectively reflect the nature of the injuries, or there is a delay in release of a post-mortem report due to forensic backlogs, then the police may be following the wrong leads or not arresting suspects in the critical period. In situations where the cause and nature of an event is questioned due to medical discrepancies, law enforcers find it hard to construct a consistent argument. For example, failing to record DNA presence at the crime scene may lead to an irreversible loss of DNA, which would have conclusively identified a criminal. [17][18]

- **Burden of Proof and Prosecution:** The prosecution has the responsibility of convincing the jury beyond reasonable doubt on the case in court. The main tools that are employed to address this burden are medico-legal documents. However, in instances where these documents are faulty either by vagueness, or by omissions in procedure, or inconsistency with eye-witness testimony, they are likely to be the key to acquittal. According to legal jurisprudence, while ocular evidence is usually presumed to take precedence, it must be entirely reliable and therefore that the medical opinion opposed by it is overridden. When the medical evidence is too fragile to support the allegations of the prosecution, it is the duty of the court of law to give the benefit of doubt to the accused irrespective of possible guilt. [19][20]

- **Consequences to both the Victims and the Accused**: For the victims, especially in sensitive matters such as sexual assault, broken documentation introduces an extra dimension of re-traumatization. Lack of sensitiveness in examination procedures and the repetition of exposing traumatic events because of poor initial record keeping may result in prolonged psychological distress. Moreover, when a case fails because of a technical error in the documentation, the victim loses the chance to get justice. On the contrary, as far as the accused is concerned, inaccurate documentation may result in the

[17] State of Punjab v. Gurmit Singh, (1996) 2 SCC 384.
[18] Mukesh v. State (NCT of Delhi), (2017) 6 SCC 1.
[19] Solanki Chimanbhai Ukabhai v. State of Gujarat, (1983) 2 SCC 174.
[20] Bharatiya Sakshya Adhiniyam, No. 47 of 2023, § 39.

eventual injustice, i.e. a wrongful conviction. An innocent individual can end up spending years in prison in situations when a medical practitioner does not know how to diagnose a complication, or misunderstands the results of a forensic examination. This is also reflected by the growing amount of medical negligence lawsuits, where documentation is either unavailable or does not match, doctors themselves in many cases cannot demonstrate that they acted within the standard of care, and the result is an enormous compensation award or the destruction of their professional reputation.[21]

Legal Issues and Evidentiary Problems.

The medico-legal evidence legal framework can be defined as one that is highly judicially scrutinized with a current shift towards modernizing the statutes that define its admissibility.

- **Expert Evidence and the Bharatiya Sakshya Adhiniyam (BSA)**: Through the adoption of the BSA, 2023, the regulations that cover expert evidence have been revised to ensure that they are relevant to the digital age. Section 39 of the BSA[22] (which replaces Section 45 of the IEA) retains the applicability of the opinion of specially skilled individuals in such areas as science, art and forensic analysis. Nonetheless, the law is quite explicit: expert opinion is simply a weak fact and it cannot make the court follow it without any other significant facts corroborating this opinion. The expert is supposed to aid the judge in the provision of scientific criteria, that the accuracy of the findings can be tested but the ultimate decision making process is left to the judiciary.

- **Chain of Custody and Judicial Scrutiny**: The past decade has witnessed a sharp rise in courts questioning the procedural integrity of medical evidence. Chain of custody is no longer regarded as a technicality as opposed to the basis of admissibility of any physical sample. Legal jurisprudence has highlighted the importance of the police not having a safe and documented record of evidence transfer, which invalidates the evidence, making it impossible to use it to determine a conviction. In addition, the competence, methodology, and internal consistency of the medical reports may be questioned by the courts under the impression that they are considered as being speculative and based on unrecognized medical literature, thereby rejecting medical

[21] State of Punjab v. Ramdev Singh, (2004) 1 SCC 421.
[22] Bharatiya Sakshya Adhiniyam, No. 47 of 2023, § 39.

evidence.[23] [24]

- **Medical Negligence and the Bolam Test[25]**. The night watchman test of negligence in the case of civil law and consumer protection is the Bolam Test, which is commonly used to assess the negligence in the medical field. In cases such as Jacob Mathew v. State of Punjab, the Supreme Court affirmed that a doctor would not be found negligent, provided he or she behaved reasonably as would have been the case of a responsible body of medical peers. To establish negligence, a patient needs to prove three elements, namely, a duty of care, breach of such duty, and damages. The only defense that a doctor can give in such instances is the watertight feature of the documentation ending up in the informed consent forms and detailed discharge summary.[26]

Suggestions & Recommendations for Reform

The systemic problems in medico-legal documentation can only be addressed through the adoption of a new technology-based national system in contrast to the present fragmented method of medico-legal documentation. The paper tries to draw from global best practices to provide the following recommendations:

- **Online Modernization through Programs like MedLEaPR**: The National Informatics Centre (NIC) has developed the Medico Legal Examination and Post-mortem Reports System (MedLEaPR), which is considered a highly important system. This online system streamlines the process of developing MLRs and PMRs instead of handwritten reports presented to the computer system that generates documents that are readable, organized, and legally acceptable. In such contexts as Durg, where more than 1,300 cases are already digitalized, end-to-end changes between health and law enforcement are being facilitated, the advantages of MedLEaPR have already become noticeable, which is why it is necessary to extend this platform to all states and interconnect it with the National Digital Health Mission. [27]

- **Reforms in Institutions and Infrastructure**. The change in the institutional

[23] Vijay Pandey v. State of Uttar Pradesh, (2019) 3 SCC 778.
[24] United Nations Office on Drugs & Crime, Guidance on Physical Evidence Integrity (2015).
[25] Bolam v. Friern Hospital Management Committee, [1957] 1 WLR 582 (QB).
[26] Jacob Mathew v. State of Punjab, (2005) 6 SCC 1.
[27] National Informatics Centre, MedLEaPR Project Report (2022).

environment cannot be achieved without structural changes and the use of technological tools. The hospitals should develop special medico-legal units, similar to the successful examples of such units as the AIIMS JPNATC, where special personnel will be employed to do the documentation, allowing the treating physicians to concentrate on clinical activities. Moreover, modernization of crime laboratories is a condition that is not negotiable. This incorporates the modernization of the cold chain in transporting viscera, filling of the technical vacancies, and the introduction of new forensic policies that cut down the turnaround times. [28]

- **Educational Standardization**: Medico-Legal Code of National character. The idea of proposing a National Medico-Legal Code or Manual (MLMC) is a crucial suggestion in the provision of uniformity in practices throughout India. This code would offer standard procedures to all aspects of collecting DNA in sexual assault cases to identifying victims in mass disasters. This would ensure the medico-legal practice is in line with the revised criminal laws (BNS, BNSS, BSA) and offer a clear perspective as to how medical students and professionals are to be trained. [29][30]

- **International Standards and Review**: International best practices, including the UK Home Office guidelines on forensic pathologists[31], can offer valuable insights. Among the major practices are the adoption of independent critical conclusions checks and peer review of all reports that are to be submitted to court. Through the inculcation of a culture of objectivity, impartiality, and peer-reviewed documentation, the medical fraternity will be able to make sure that its input to the justice system will not be subject to any criticism.

Conclusion

Medico-legal documentation is much more than a documentation of the clinical facts; it is the foundation of the criminal justice system and the main protection against the breakdown of the rule of law. The shift to document-based adjudication processes and the replacement of oral evidence has converted the matter of truthfulness and responsibility of such records into a national concern. Existing problematic situations, including the toxicological delays of the

[28] Law Comm'n of India, 273rd Report on Speedy Investigation and Trial (2017).
[29] National Medical Commission, Graduate Medical Education Regulations (2023).
[30] K. Sharma, Standardisation of Medico-Legal Practice in India, 12 NLSIU L. Rev. 89 (2021).
[31] UK Home Office, Code of Practice for Forensic Pathologists (2018).

viscera vortex and the absence of professional training and standard codes, are a structural vulnerability that gives the offenders a chance to get away with the crime and exposes the innocent to false conviction.

Nevertheless, the way of reform is evident. The effectiveness of such digital projects as MedLEaPR and the adoption of powerful SOPs in leading institutions proves that the lack of communication between law and medicine may be overcome using technology and the determination of the institutions. The solution involves a national standardization, modernization of forensic infrastructure and a radical change in the manner in which medical professionals are trained and assisted in their medico-legal responsibilities.

Documentation perfection should not be perceived as a red tape issue, but as a moral and legal responsibility. Through the medico-legal system being turned into a professionalized, scientifically sound system, society can be able to ascertain that the result is backed by the evidence as unchangeable as the standards of justice it is supposed to be in its service. It is this kind of extensive reform that can accomplish the ideal purpose of medico-legal documentation as an instrument of fairness, transparency, and ultimate delivery of justice.

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