



KARNATAKA STATE OBSTETRICS AND GYNECOLOGY ASSOCIATION ETHICS AND MEDICOLEGAL COMMITTEE

MEDICOLEGAL BULLETIN

Week 11: Medical Record Alteration, Backdated Entries, and How Courts View Tampered Documentation

1. REAL LIFE CLINICAL SCENARIO

A patient underwent emergency cesarean section for fetal distress. The baby was born depressed and required NICU admission. Several weeks later, a legal notice alleged delay in intervention. When the medical records were reviewed, multiple entries appeared to have been added later using different ink, different handwriting, and without date or time. The decision-to-incision timing was unclear. The defense argued that the entries reflected actual events but were completed later due to workload. The court focus shifted away from the clinical care itself and toward the integrity of the records.

2. MEDICOLEGAL RISKS IN SUCH CASES

Nothing damages a medicolegal defense faster than allegations of record tampering. Common allegations include backdated entries, alteration of timings, overwriting without authentication, missing pages, retrospective documentation after complications, modification of consent forms, and changes made after receiving legal notice.

Even when treatment is appropriate, suspicion regarding records can weaken the entire defense.

3. WHAT THE LAW EXPECTS

Courts understand that minor corrections may occasionally be necessary. However, courts expect original records to be preserved, corrections to be transparent, date and time of correction documented, signature of the person making correction, and honest contemporaneous record keeping. Medical records are legal documents and their credibility often becomes the foundation of the defense.

4. DOCUMENTATION – THE DOCTOR'S STRONGEST DEFENSE

Never use whitener, erase entries, or rewrite records without disclosure. Corrections should retain the original entry, record the corrected information, include the date and time of correction, and be authenticated with signature and designation. Transparency builds credibility.



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5. PRACTICAL SAFE PRACTICE – WHAT TO DO

Document events in real time whenever possible. Record exact timings.

Complete records before the end of duty.

Preserve original notes. Maintain electronic audit trails where available.

Secure records immediately after adverse events.

6. COMMON MISTAKES TO AVOID

Reconstructing records from memory days later, modifying consent forms retrospectively, adding details after legal notice, removing pages, incomplete time documentation, and attempting to improve records after complications.

7. CLINICAL–LEGAL PEARL

A bad outcome can be defended. A dishonest record usually cannot.

8. REAL COURT CASE INSIGHTS (FOR UNDERSTANDING)

Indian courts and consumer forums repeatedly place significant weight on medical records. Doctors are often protected when records are complete, contemporaneous, transparent, and internally consistent.

Courts become highly suspicious when entries appear retrospective or altered.

9. TAKE-HOME MESSAGE

Medical records are not merely clinical notes. They are legal documents.

Incomplete records may weaken a defense. Altered records may destroy it.

Document honestly.

Correct transparently.

Preserve faithfully.

Next Week's Topic: Failed Sterilization – Pregnancy After Tubectomy and Medicolegal Liability



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