KARNATAKA STATE OBSTETRICS AND GYNECOLOGY ASSOCIATION

ETHICS AND MEDICOLEGAL COMMITTEE

MEDICOLEGAL BULLETIN

Week 17:Maternal Death Review (MDR), Documentation,and Medicolegal Protection of the Treating Obstetrician

1. REAL LIFE CLINICAL SCENARIO

A 24-year-old primigravida with severe preeclampsia was referred from a peripheral hospital after prolonged labor. On arrival,she was in pulmonary edema with uncontrolled hypertension and fetal distress. An emergency cesarean section was performed. Despite aggressive ICU management, she developed disseminated intravascular coagulation (DIC), multiorgan failure, and died 36 hours later. Following the death, the family alleged negligence and demanded action against the treating obstetrician. Simultaneously, a Maternal Death Review (MDR) was initiated by the district health authorities. The doctor's clinical management was appropriate. However, the quality of documentation became the primary focus during the inquiry.

One minute of verification prevented a lifetime of litigation.

2. MEDICOLEGAL RISKS IN SUCH CASES

Maternal deaths almost always undergo administrative and medicolegal scrutiny.

Common allegations include:

- Delay in diagnosis
- Delay in referral
- Delay in cesarean section
- Failure to recognize deterioration
- Inadequate monitoring
- Poor communication with relatives
- Incomplete documentation
- Missing referral records
- Absence of ICU notes
- Incomplete death summary

Many inquiries focus more on documentation than on technical management.

3. WHAT THE LAW EXPECTS

A Maternal Death Review is not a criminal investigation. Its primary objective is to identify avoidable factors and improve maternal healthcare systems. However, during legal proceedings, MDR documents may become important evidence.

Doctors are expected to:

- Maintain accurate contemporaneous records
- Document clinical reasoning
- Record exact timelines
- Explain decisions clearly
- Maintain referral documentation
- Record counseling of relatives
- Complete death summaries honestly

Never alter records after a maternal death.

4. DOCUMENTATION – THE DOCTOR'S STRONGEST DEFENSE

- Time of admission.
- Clinical diagnosis & risk assessment.
- Senior consultations.
- Blood products transfused.
- ICU management notes.
- Time and cause of death.
- Vital signs on arrival
- Investigations ordered and results
- Treatment administered
- Time of surgery
- Counseling records
- Referral chronology if applicable.

The timeline should tell the complete clinical story. Good documentation allows reviewers to understand why each decision was taken.

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5. PRACTICAL SAFE PRACTICE – WHAT TO DO

Identify high-risk pregnancies early
- Escalate care promptly
- Involve senior colleagues whenever necessary
- Counsel relatives regularly
- Record every major clinical decision
- Maintain complete ICU documentation
- Participate honestly during MDR meetings
- Learn from each review

The purpose of MDR is improvement — not blame.

6. COMMON MISTAKES TO AVOID

- Retrospective documentation
- Incomplete referral notes
- Missing counseling entries
- Failure to document deterioration
- Poor communication with family
- Altering records after death
- Defensive documentation

An honest record is always stronger than a reconstructed record.

7.CLINICAL–LEGAL PEARL

After a maternal death, emotions fade.
Documentation remains.

8. REAL COURT CASE INSIGHTS (FOR UNDERSTANDING)

Indian courts and consumer forums have repeatedly emphasized that an adverse maternal outcome alone does not establish negligence. The courts generally evaluate:
- Whether the accepted standard of care was followed
- Whether deterioration was recognized appropriately
- Whether referral or escalation occurred without unreasonable delay
- Whether documentation accurately reflects the clinical events

Well-maintained records frequently become the doctor's strongest defense during both departmental inquiries and court proceedings.

9.TAKE-HOME MESSAGE

Maternal death is one of the most emotionally and professionally challenging events in obstetric practice. While every death deserves honest review, every treating doctor also deserves fair evaluation. Accurate documentation, transparent communication, timely escalation, and participation in MDR protect both patients and healthcare professionals.

Good clinical care saves LIVES.
Good documentation protects CAREERS.

Next Week's Topic:Medicolegal Issues in Blood Transfusion During Obstetric Emergencies — Consent, Refusal, Massive Transfusion, and Documentation

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