

**Medico-legal Documentation of Emergency
Department Patients: A Short Course
Training as a tool to Better Knowledge,
Attitude and Practice Outcomes among
Emergency Medicine Physicians**

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INTRODUCTION

Medico-legal documentation is one of the responsibilities of an EM physician, together with reporting those medico-legal cases and delivering appropriate management. However, the residents' skill in proper medico-legal documentation has not been emphasized during the training program. It is imperative to quantify residents' level of awareness on this topic to find areas of improvement, to gauge what concepts in terms of proper documentation needs more focus in the development of that skill.

SIGNIFICANCE OF THE STUDY

During training period, EM residents encounter merely everyday in the ED different medico-legal cases, involving adults or a child, and even both, as they are the first line in assessing patients consulting at the ED. The practice of proper documentation of each case is essential always to maintain standard of care. Even after the training, medico-legal cases will arise during private practice, in any institution, globally. Medico-legal considerations are a significant part of the process of making many patient care decisions and determining definitions and policies for appropriate treatment.

KAP survey data are essential to help plan, implement and evaluate work or improve capabilities and skills of target respondents to maintain in the guidance of a protocol. This type of survey can identify knowledge gaps, cultural beliefs, or behavioral patterns that may facilitate understanding and action, as well as pose problems or create barriers for existing medico-legal documentation pattern, also find solutions for improving quality and accessibility of services. KAP studies are more cost-effective and resource conserving than other research methods because they are highly focused and limited in scope. As this study will be able to gather and understand data from our residents, it also aims to provide suggestive efforts for the residents as far as improving medico-legal documentation is concerned.

Few studies have but established significant findings regarding this topic. In our setting, little have paid attention to conduct similar studies which has great impact in every institution on the management of each medico-legal patient, as nowadays we encounter in our everyday practice more and more patients being aggressively involved in medico-legal state. As clinicians, being trained and tamed to be better along the rest of our colleagues in the medical field, and to avoid being placed in preventable legal matters, proper documentation, especially medico-legal cases, has its benefits in providing utmost healthcare to our patients.

Through this study, may lead opportunities to develop and integrate proper medico-legal training for Emergency Medicine physicians in the future for more relevant and efficient management of medico-legal cases.

RESEARCH PROBLEM

How effective will be a Short Course Training on Medico-legal Documentation of ED patients in the Improvement of Knowledge, Attitudes, and Practice of Emergency Medicine Physicians from different Emergency Medicine Training Institutions of the Philippines?

OBJECTIVES

General Objectives:

1. To assess the knowledge, attitudes and practices among emergency medicine physicians in the Philippines in relation to proper medico-legal documentation of patients in the ED.
2. To assess EM physicians' KAP improvement after undergoing medico-legal documentation short course training.

Specific Objectives:

1. To gauge awareness among EM physicians in regards to their knowledge in medico-legal documentation of patients in the ED.
2. To identify EM physicians' current attitudes about medico-legal documentation of patients in the ED.
3. To determine the practices of the EM physicians regarding medico-legal documentation of patients in the ED
4. To assess how the knowledge, attitudes and practices improve among the EM physicians after undergoing short course training on medico-legal documentation.

DEFINITION OF TERMS

- **Medico-legal case** - any case of injury or ailment where, the attending doctor after history taking and clinical examination considers that investigations by law enforcement agencies are warranted to ascertain circumstances and fix responsibility regarding the said injury or ailment according to the law.
- **Medico-legal documentation** – a record of patient's present and past state of health, documents the impact of ill health from the patient's own perspective, and analyzes the current illness in terms of diagnosis and prognosis resulting from the injury.
- **Emergency Medicine Training Institutions** – ten (10) hospitals in the Philippines providing training program for Emergency Medicine, accredited by the Philippine College of Emergency Medicine, a subspecialty society under the Specialty Division of Family and Community Medicine. These institutions include Department of Emergency Medicine of: Manila Doctors Hospital, UP-PGH, St. Luke's Medical Center, East Avenue Medical Center, Pasig City General Hospital, University of Perpetual Help Dalta Medical Center, Makati Medical Center, Daniel Mercado Medical Center, Ospital ng Makati, and De La Salle University Medical Center.
- **Torture** – (according to the Istanbul Protocol) any act by which severe pain or suffering, is intentionally inflicted on a person for such purposes as obtaining from him or from a third person information or a confession, can be physical and/or mental, the purpose is to destroy deliberately physical and emotional well being of individuals, as well as the integrity of the person involved.
- **KAP survey**– Knowledge, Attitude, Practices survey.
 - Knowledge possessed by the subjects refers to their understanding of any given topic.
 - Attitude refers to their feelings towards this subject, as well as any preconceived ideas that they may have towards it.
 - Practice refers to the ways in which they demonstrate their knowledge and attitude through their actions.
- **The Medical Action Group, Inc.** – a non-stock, no-profit organization of physicians, nurses, dentists, psychologists, health students, and healthcare workers, which promotes and defends the human rights, renders total health services to the urban poor, political prisoners, internally displaced people and workers.
- **Likert Scale** – is a psychometric scale commonly involved in research that employs questionnaires, which often use five ordered response levels measuring either positive or negative response to a statement.

REVIEW OF RELATED LITERATURE

Among the primary focus of ED healthcare providers, the ED patient's chart, however, is the only solid proof and reliable account of an ED visit and medical treatment, and that attention must be paid to proper and accurate documentation.(8)(9)(11) Proper documentation of each and every case is of paramount importance. Many of the medico-legal cases eventually land up in courts after a gap of some months to few years. It is but natural that we can't remember the details of each and every case after such a long time gap. (3)(6) It is also pertinent to highlight certain essential principles of medico legal documentation. Proper documentation reflects the quality of care that has been given to the patients and is evidence of the management required or ordered. (31)

Well-written and factually accurate medical records are one of the cornerstones of Emergency Medicine. In aiming better documentation of trauma cases, studies and audits were conducted on ways of improved data collection and consequently led to improved patient's recovery and survival. An audit was done and aimed to assess whether documentation could be improved for head injured patients admitted to the Emergency Department observation ward using a pre-printed proforma. (7) In one study also involved the American College of Surgeons Advanced Trauma Life Support (ATLS) protocols, which the authors have designed a document that records dynamically what happens to the multiply injured victim on arrival in the Emergency Room. Even the international working group of ITACCS has drafted a document, 'Recommendations for uniform reporting of data following major trauma--the Utstein style', for better documentation and reporting of cases. (25)(26) Significant improvements were noted in all measured variables after the introduction of the proforma and templates. Documentation of all important positive and negative signs in head injured patients can be time consuming and often a challenge for physicians working at the ED. Accurate documentation is however important from both a clinical and a medico-legal position and this audit have shown that the introduction of a customized proforma can improve the quality of documentation, prompt for their subsequent investigation and treatment. (7)(10)(12)(13) The documentation can act as a basis for teaching and a medico-legal record, while providing the necessary data for quality assurance and outcome audit. The same conclusion was also made in studies conducted in UK, where documentation of major trauma cases have received little attention in the ED, and came up with deficiencies in trauma care. (12)

It was suggested by Dr. Emory Petrack in his study, as one of the four guidelines to dramatically decrease legal risk is to document with care, and care about the documentation. (6) "If it isn't written down, it never happened." (6)(31) Every physician who has had the unfortunate experience of facing a legal action knows how absolutely essential chart documentation is to defending patient care.(6)(11) It has been observed in another study, in reviewing many pediatric charts, both for quality improvement and medical legal reasons, that frequently there has been seen sloppy or inadequate documentation, as there were also encounters of illegible handwriting, missing key elements and inadequate descriptions of physical findings. The best way to ensure proper documentation is to document care as if the case is going to have unexpected, adverse clinical outcomes in the latter that will require the attendance of the attending physician. In the same study, these essential elements should be included in the documentation at the start of seeing first the patient: Times the patient is seen, as well as times that labs, procedures and reassessments are accomplished. This is essential, but often missing. Equally important to document are the patient's vital signs (and repeat vital signs, as needed), including how and when abnormal vital signs are addressed. (6)

Children, compared to adults, often present to emergency departments for evaluation and treatment of injuries or conditions that may be a result from abuse. When child abuse is suspected, the physician must properly and completely document the history, examination, medical impression, and appraise those concerns to the appropriate agency. Although physicians, especially EM physicians are often the first identifiers of abuse, if there's any, in a study on medico-legal documentation conducted on maltreated children, confirms that there is inadequate medical documentation for suspected child abuse victims. What is written in the medical record for these children significantly contributes to the success or failure of investigations and litigation. Therefore, emergency physicians must know what to document and put it into practice.(2) In short, focusing on excellence as it relates to providing care for children will translate both into reduced medical legal risk and improved pediatric emergency management.(2)(9)

In 2004, the office of the United Nations established the Istanbul Protocol which was intended to provide international guidelines on the assessment of individuals, investigation and reporting of cases of allege torture and other means of ill treatment. In this manual of procedures included principles of effective documentation of torture and the related details pertaining to the alleged ill treatment. However, in spite of its international standing among legal, health, and human rights experts, awareness of the Istanbul Protocol is still relatively limited. In many cases, medical institutions do not provide proper instruction on the examination and documentation of torture victims or of any cases of medico-legal issues, and how to report the identified cases. As a result, many healthcare professionals have little or no training in the investigation and documentation of torture, which requires specific technical skills and knowledge on both medical and legal procedures to be conducted effectively. (30)(34) In our country recognition and proper documentation of identified torture cases are also inadequate, as well as proper reporting to the authorities. The Commission on Human Rights of the Philippines with the support of the British Embassy in Manila and the Medical Action Group, Inc. coordinated to produce a manual on recognition and documentation of torture, to help in spreading awareness about the significance and effects of torture in our society. (45) As stated in the manual that torture cases have been underestimated due to several factors affect the gravity of torture, aside from the absence of a law against these cases

before, there is also lack of properly trained medical personnel to attend to such cases. This manual was created based on the Istanbul Protocol, which provide guidelines on proper recognition, documentation, reporting of torture cases and other human rights violations, as well as proper management of the involved victims.

A KAP survey is a representative study of a specific population to collect information on what is known, believed and done in relation to a particular topic, usually outreach, demonstration or education, in this case, medicolegal documentation done by EM residents. It has been widely used and valued around the world for at least forty years in public health, water supply and sanitation, family planning, education and other programs. (16)(17)(18)(19) This type of survey may be studied using a variety of questions/statements and/or the 5 grade Likert methodology. (4)(18)(21) In most KAP surveys, data are collected orally by an interviewer using a structured, standardized questionnaire. Both quantitative and qualitative (include focus group discussions, open-ended stories, mapping, role plays, Venn diagrams, etc) methodologies may be used depending on the objectives and design of the study. (4)(5)(16) KAP should be conducted twice, both pre- and post-intervention, in order to measure impact. (18)

A self-administered structured questionnaire about knowledge of healthcare ethics, law and the role of an Ethics Committee in the healthcare system was devised, tested and distributed to all levels of staff at the Queen Elizabeth Hospital in Barbados. Many of the staff had no knowledge of existing hospital ethics, or the law pertinent to their work. It has been identified in this study, certain unethical behavioral patterns among medical staffs. (20)

Another survey was done using KAP, about billing and documentation practices in the ED among emergency medicine residents and attending physicians. The three concepts were assessed and analyzed based on the data gathered. The residents and attending physicians in this survey were identified billing and documentation as an area in which residents need further education. Emergency medicine residents are not confident in their knowledge of medical record documentation and coding procedures, nor of charges for services rendered in the ED. (21) (22)

In sustaining better quality of patient care, after assessing or measuring the knowledge, attitudes, and practices of EM residents, they may also have the need for further development of their skill in relation to proper medico-legal documentation. In order to do so, subjects may undergo a special training workshop; such an instance was developed for the personnel who handle sexually abused women in Bangladesh. A part of the said workshop conducted and was focused on “exploring the attitudes, values and assumptions related to violence against women and on sexual assault and the clinical and the forensic management of affected women”. (15)(23) A program designed specific steps for the course or workshop: Conduct staff assessments, prior to implementing sensitization and training, as mentioned, the use of KAP assessments to determine the level, scope and type of sensitization and training that will need to be conducted for the staff, also provide the staff sensitization and proper training. This includes holding intensive training workshops for staff with the help of outside experts or institutions or sending selected staff to course or workshops in other organization or universities, and possibly hiring new staff with specific expertise among other methods. (24) The last step in the course is to provide on-going supervision and support to specialized staff.

METHODOLOGY

A descriptive comparative and experimental approach was adopted for the study. A self-administered, 51-item questionnaire (see Appendix C), with the use of the Likert scale; yes/no and a few open-ended questions, in addition to some demographics (age, gender, year level, institution, previous medico-legal documentation training), assessing knowledge, attitudes and current practices of EM physicians about medico-legal documentation of patients in the ED was developed. A test (see Appendix D) consisting of 40 multiple choices type of questions about medico-legal documentation, legal terms and legal issues, was also given to the selected participants, before attending the training, and given one month post training course. A study information sheet with an informed consent form from each participant was explained and obtained before the start of the study (Appendix A and B).

The questionnaire and pre-test were distributed to the selected EM physicians, currently on Emergency Medicine training program in different Philippine College of Emergency Medicine-accredited training institutions. Data from a sample of 20 Emergency Medicine physicians were obtained. Same participants underwent one-day training for medico-legal documentation of torture. The training consisted series of lectures delivered by invited guest speakers, topics included about human-rights, the anti-torture law and administrative order, introduction to the Istanbul Protocol, forensic documentation and doctors testifying in court (see Appendix E), which was held at the Manila Doctors Hospital, conducted with the assistance of the Medical Action Group. A post-training questionnaire (Appendix C) and test were given thru email to the same selected residents after one month.

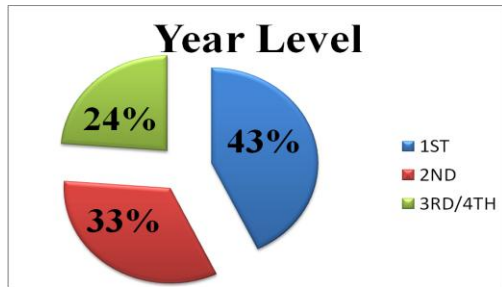
DATA ANALYSIS

In this study, the mean \pm SE (standard error) and t-test for each question in a tabulated data sheet (EXCEL software). The author considered differences and correlations, with P value < 0.05 as statistically significant. Summary statistics were calculated and residents' responses were compared for each question using chi-square test. Alpha was 0.05 for all comparisons for knowledge, attitudes and practices categories.

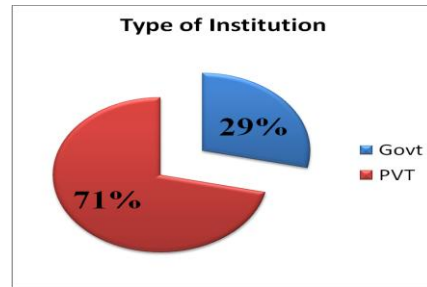
RESULTS and DISCUSSION

Out of 120 total target populations, only twenty six of these residents were able to attend the training for the medico-legal documentation on torture. However, only twenty of them consented to be included in the study, and only 18 responses returned and were analyzed during the post-training evaluation. Among the majority of the respondents were first year residents (43%), 33% and 24% belong to the second year and third year levels, respectively. Majority of these participants were currently on training in a private institution (71%). Only 10% among the participants had a previous training on medico-legal documentation before undergoing the short course, but none of them had undergone rotations to a crime laboratory or forensic pathology section during their residency training. (Table 1) (Pie Graph 1 and 2)

N= 20		1 st year	2 nd year	3 rd /4 th year
Percent of participants by year level		43%	33%	24%
Previous MLC documentation training	Yes	5%	0%	5%
	No	42%	29%	19%
Public MD	29%	19%	0%	10% - 33%
Private MD	71%	28%	28%	15%
Crime lab/forensic pathology section rotation	Yes	0%	0%	0%
	No	100%	100%	100%

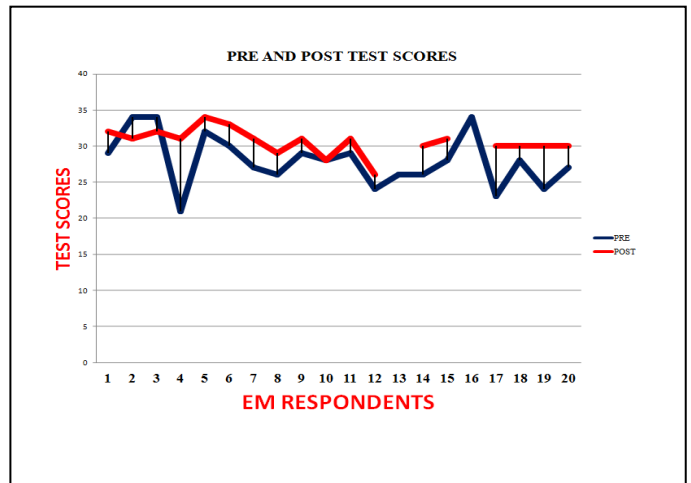


Pie Graph 1: Participants' characteristic by Year Level



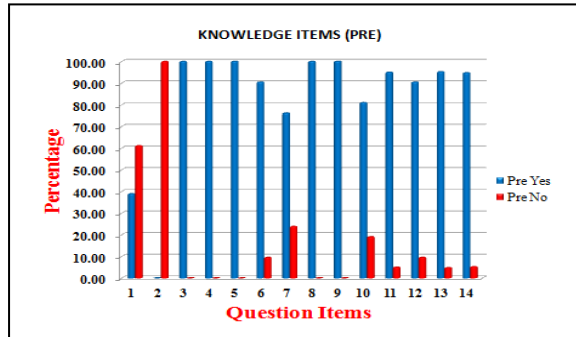
Pie Graph 2: Participants' characteristic by Type of Institution

Respondent	PRETEST	POST TEST
1.	29	32
2.	34	31
3.	34	32
4.	21	31
5.	32	34
6.	30	33
7.	27	31
8.	26	29
9.	29	31
10.	28	28
11.	29	31
12.	24	26
13.	26	-
14.	26	30
15.	28	31
16.	34	-
17.	23	30
18.	28	30
19.	24	30
20.	27	30

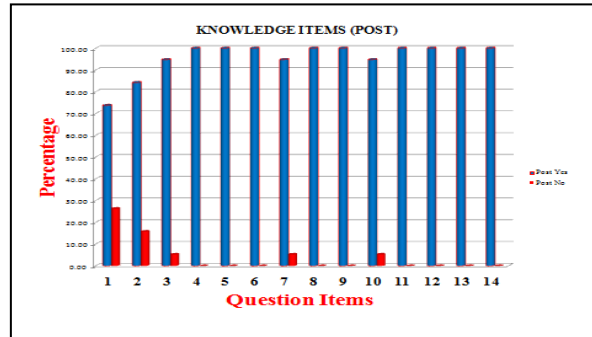


Line Graph 1: Pre Test and Post Test Scores of Participants

There were fifteen (15) EM physicians exhibited better test scores after taking the short course training, while 2 of these residents did not improve but rather exhibited lower test scores compared to the pre-test. (Table 2) Only 1 participant has the same test score for both pre and post tests. Line graph 1 shows the same results with Table 2, 78% (15/19) of the participants increased their knowledge through the post test given about medico-legal cases and issues after attending the training.



Bar Graph 1: Responses on Knowledge Items (Pre Training)



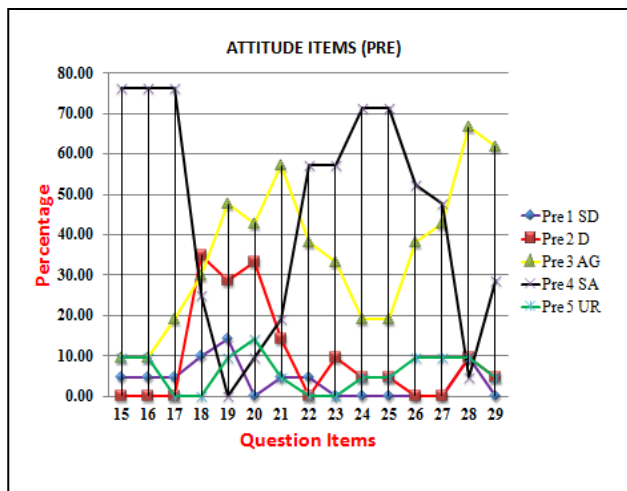
Bar Graph 2: Responses on Knowledge Items (Post Training)

The EM physicians' overall knowledge on the importance of proper medico-legal documentation was good during the pre-training evaluation which showed on Table 3, evaluation of their degree of knowledge after taking the training became excellent. The EM physicians' overall awareness on the types of medico-legal cases that may be present in ED patients, including torture, was also good. The participants need a well-conceived education program on specific areas of legal aspects such as legal terms and concepts in testifying in court, basic human rights, because their knowledge was low in these areas. (Bar Graph 1)

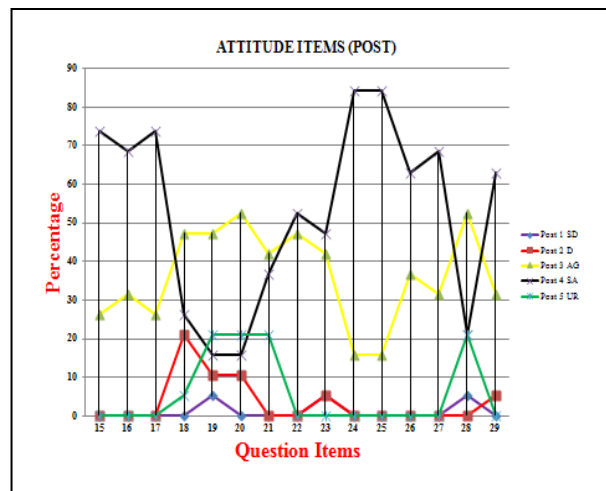
The question items number 1, 2, 3, 9 and 10 in Table 3 pertain to knowledge on medico-legal cases, their different types and presentation that the participants became more aware of. EM physicians have well awareness about the importance of medico-legal and its purposes.

Question Item	PRE TRAINING		POST TRAINING	
	YES	NO	YES	NO
1. I have a good knowledge of medico-legal cases.	38.89	61.11	73.68	26.32
2. I am aware of the Istanbul Protocol, a manual used for effective investigation and documentation of torture and ill treatment.	0.00	100.00	84.21	15.79
3. I know that a medico-legal injury can be accidental, suicidal, or self-inflicted or a result of assault.	100.00	0.00	94.74	5.26
4. I know that medico-legal injury/injuries may be a result of human right violation such as torture.	100.00	0.00	100.00	0.00
5. I know that documentation includes all forms of documentation by a doctor, nurse or allied health professional recorded in a professional capacity in relation to the provision of patient care.	100.00	0.00	100.00	0.00
6. The purpose of medico-legal documentation is to provide expert opinion on the degree to which medical findings correlate with the patient's allegation of abuse and to communicate effectively the physician's medical findings and interpretations to the judiciary or other appropriate authorities.	90.48	9.52	100.00	0.00
7. I know that a medico-legal document is a record of patient's present and past state of health, documents the impact of ill health from the patient's own perspective, and analyzes the current illness in terms of diagnosis and prognosis resulting from the injury.	76.19	23.81	94.74	5.26
8. I know that a medico-legal document serves as information may be extracted by the court for evidence.	100.00	0.00	100.00	0.00

9.	A medico-legal case can be received at the ED as– After history taking and thorough examination, if the examining physician suspects that the circumstances/ findings of the case are such that registration of the case as an MLC is warranted.	100.00	0.00	100.00	0.00
10.	A medico-legal case can be received at the ED as– Directive of court.	80.95	19.05	94.74	5.26
11.	A medico-legal documentation may include written and electronic health records, audio and video tapes, emails, facsimiles, images (photographs and diagrams), observation charts, check lists, communication books, incident reports and clinical anecdotal notes or clinician’s personal reflections pertaining to the patient care provided.	95.00	5.00	100.00	0.00
12.	An EM physician can be called to stand as witness to court to give expert opinion regarding to a medico legal case being investigated.	90.48	9.52	100.00	0.00
13.	An informed consent includes information that: the examination to be conducted would be a medico legal one and would culminate in the preparation of a medico-legal injury report, all relevant investigations needed for the said purpose would be done.	95.24	4.76	100.00	0.00
14.	The qualifications of an expert witness include opinion/s on a matter requiring special knowledge, skill, experience or training which he/she is shown to possess.	94.74	5.26	100.00	0.00



Line Graph 2: Responses on Attitude Items (Pre Training)



Line Graph 3: Responses on Attitude Items (Post Training)

Tables 4 and 5 were summarized by the Line Graphs 2 and 3 respectively, which showed that the overall EM residents' attitude score was good in the areas that were directly related to fundamental duties on documentation i.e., completion and rules in alteration of data, early registration, proper storage, patient-focused, proper release or issuance of prepared medico-legal document, as responses shown on Items number 15, 16, 17, 24, 25, and 26. Seventy six percent (76%) of the respondents strongly agree on treatment priority of emergent patients including medico-legal case, on maintaining case confidentiality, and on maintaining professional confidence. (Table 4) Among the respondents, 48% only agrees that they consider themselves as medico-legal officers as 29% opposes it. On the belief that an EM physician cannot refuse to examine a medico-legal case in private setting, majority of 33% of the residents said to disagree while only 24% of the residents strongly agree. Sixty seven percent (67%) of EM physicians would agree to testify as expert witness when called into a court case proceeding, while 10% strongly would not subject to.

Item (Likert Scale)	1 SD*	2 D*	3 A*	4 SA*	5 UR*
15. I believe that the treatment of any injured person is the first priority for an Emergency physician. However, ER physician cannot ignore the recording and documentation of the injury.	4.76	0.00	9.52	76.19	9.52
16. I believe that it is extremely important to remember that physicians' case reports must be treated with utmost confidentiality and should be stored securely.	4.76	0.00	9.52	76.19	9.52
17. I believe that Medico-legal case should be registered as early as possible.	4.76	0.00	19.05	76.19	0.00
18. I believe an ED physician cannot refuse to examine medico legal case on the basis of being a private practitioner or citing a jurisdiction problem.	10.00	35.00	30.00	25.00	0.00
19. I consider myself as a medico-legal officer.	14.29	28.57	47.62	0.00	9.52
20. I believe that the quality of medico-legal documentation in our department/institution is precise as compared to that of other institutions.	0.00	33.33	42.86	9.52	14.29
21. I believe that the physician who has first contact with the patient should prepare a medico-legal case report.	4.76	14.29	57.14	19.05	4.76
22. I believe that documentation is representative and reflective of professional observations and assessment.	4.76	0.00	38.10	57.14	0.00
23. I believe if I'm not trained in medico-legal matters, I should confine my service to health care provision and documentation of findings, and leave the interpretation of physical and other observations to a suitably qualified expert.	0.00	9.52	33.33	57.14	0.00
24. I believe that documentation must be patient focused and based on professional observation and assessment that does not have any basis in unfounded conclusions or personal judgments.	0.00	4.76	19.05	71.43	4.76
25. I believe that every document should be clear, concise, complete record of clinical care (including, assessment, plan of action outcomes and evaluation of care).	0.00	4.76	19.05	71.43	4.76
26. I believe that notes on the patient's record should not be altered unless this is clearly identified as a later addition or alteration. Deletions should be scored through once and signed, and not erased completely.	0.00	0.00	38.10	52.38	9.52
27. I believe that MLC documentation should be easily be interpreted over time and after significant time has elapsed.	0.00	0.00	42.86	47.62	9.52
28. I am willing to testify to the court as expert witness if necessary.	9.52	9.52	66.67	4.76	9.52
29. I believe that the medico-legal certificates are released/ issued a copy to the concerned investigating agency, patient or patient's relative only.	0.00	4.76	61.90	28.57	4.76

*- SD = strongly disagree, D = disagree, A = agree, SA = strongly agree, UR = unable to rate

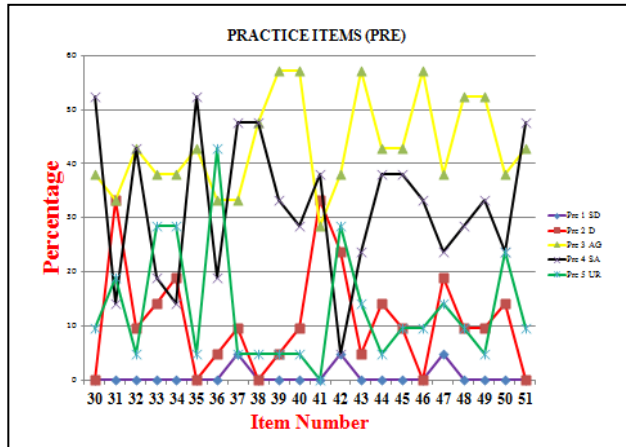
Item (Likert Scale)	1 SD*	2 D*	3 A*	4 SA*	5 UR*
15. I believe that the treatment of any injured person is the first priority for an Emergency physician. However, ER physician cannot ignore the recording and documentation of the injury.	0	0	26.32	73.68	0
16. I believe that it is extremely important to remember that physicians' case reports must be treated with utmost confidentiality and should be stored securely.	0	0	31.58	68.42	0
17. I believe that MLC should be registered as early as possible.	0	0	26.32	73.68	0
18. I believe an ED physician cannot refuse to examine medico legal case on the basis of being a private practitioner or citing a jurisdiction problem.	0	21.05	47.37	26.32	5.26
19. I consider myself as a medico-legal officer.	5.26	10.53	47.37	15.79	21.05
20. I believe that the quality of medico-legal documentation in our department/institution is precise as compared to that of other institutions.	0	10.53	52.63	15.79	21.05
21. I believe that the physician who has first contact with the patient should prepare a medico-legal case report.	0	0	42.11	36.84	21.05
22. I believe that documentation is representative and reflective of professional observations and assessment.	0	0	47.37	52.63	0
23. I believe if I'm not trained in medico-legal matters, I should confine my service to health care provision and documentation of findings, and leave the interpretation of physical and other observations to a suitably qualified expert.	5.26	5.26	42.11	47.37	0
24. I believe that documentation must be patient focused and based on professional observation and assessment that does not have any basis in unfounded conclusions or personal judgments.	0	0	15.79	84.21	0
25. I believe that every document should be clear, concise, complete record of clinical care (including, assessment, plan of action outcomes and evaluation of care).	0	0	15.79	84.21	0
26. I believe that notes on the patient's record should not be altered unless this is clearly identified as a later addition or alteration. Deletions should be scored through once and signed, and not erased completely.	0	0	36.84	63.16	0
27. I believe that MLC documentation should be easily be interpreted over time and after significant time has elapsed.	0	0	31.58	68.42	0
28. I am willing to testify to the court as expert witness if necessary.	5.26	0	52.63	21.05	21.05
29. I believe that the medico-legal certificates are released/ issued a copy to the concerned investigating agency, patient or patient's relative only.	0	5.26	31.58	63.16	0

*- SD = strongly disagree, D = disagree, A = agree, SA = strongly agree, UR = unable to rate

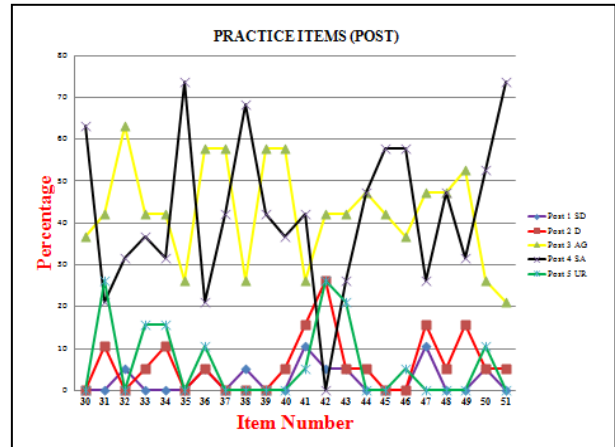
Question Item	1 SD*	2 D*	3 A*	4 SA*	5 UR*
30. I always make it a point to record all the vital status of the patient, and enter the date and time correctly.	0.00	0.00	38.10	52.38	9.52
31. I prepare the medico-legal documents in duplicate, with utmost care in giving all necessary details in each case.	0.00	33.33	33.33	14.29	19.05
32. I am confident that I always document briefly and objectively each patient case.	0.00	9.52	42.86	42.86	4.76
33. I make it a point to inform the appropriate police authority when medico-legal case is considered.	0.00	14.29	38.10	19.05	28.57
34. I make sure to inform the police if the patient involved in a medico-legal case is discharged, admitted, transferred to other hospital or expired.	0.00	19.05	38.10	14.29	28.57
35. I am confident that I document all pertinent information accurately, factual and honest.	0.00	0.00	42.86	52.38	4.76
36. I always make an appropriate entry into the MLC register in our department.	0.00	4.76	33.33	19.05	42.86
37. I never chart data before it is provided as this can lead to charges of falsification.	4.76	9.52	33.33	47.62	4.76
38. I document physical assessment of patient with particular attention to injuries and document clearly if NO injury occurred.	0.00	0.00	47.62	47.62	4.76
39. My documentation is as timely and complete as close as possible after examination.	0.00	4.76	57.14	33.33	4.76
40. I secure first an informed consent before any examination or procedure needed to be done to the patient.	0.00	9.52	57.14	28.57	4.76
41. In our ED, we use a separate medico-legal form/chart.	0.00	33.33	28.57	38.10	0.00
42. I wear a PPE when conducting a physical examination of a medico-legal case.	4.76	23.81	38.10	4.76	28.57
43. In our institution/department, we follow policies or guidelines for medico-legal case documentation/reporting.	0.00	4.76	57.14	23.81	14.29
44. If the patient was brought unconscious to the ED, I always make a note of the person/s who had brought him to the hospital.	0.00	14.29	42.86	38.10	4.76
45. If an unconscious patient has some valuables on his person I always make a note of these in the property register. Seal these valuables and keep them in the safe custody until the police or the relatives arrive.	0.00	9.52	42.86	38.10	9.52
46. In our ED, all consultations with patients are documented in the form of hand-written notes, diagrams or body charts.	0.00	0.00	57.14	33.33	9.52
47. If appropriate, I take photographs of medico-legal case as part of my documentation.	4.76	19.05	38.10	23.81	14.29
48. I always make it a point that it is a legible and non-erasable, permanent, retrievable medico-legal documentation.	0.00	9.52	52.38	28.57	9.52
49. I avoid using abbreviations in the patient's record.	0.00	9.52	52.38	33.33	4.76
50. In case of discharge/transfer/death of such medico-legal case in the ED, the proper authority/agency is always informed.	0.00	14.29	38.10	23.81	23.81
51. I always make sure that my data in the patient's chart is comprehensive, and I always affix my name and signature for every completed chart/documentation/report.	0.00	0.00	42.86	47.62	9.52

*- SD = strongly disagree, D = disagree, A = agree, SA = strongly agree, UR = unable to rate

Line Graphs 4 and 5 represent data on responses of the participants on Practice Category acquired on Tables 6 and 7 respectively. These graphs showed that the EM residents' current practice on medico-legal documentation relatively displaces with strong confidence to what a proper documentation should be done, in terms of complete and accurate information on each patient record including authorship, the use of other related forms e.g., body diagrams, laboratory and other ancillary results. However, the avoidance of using abbreviations and writing legible notes were less practiced. Residents practice less confidently in terms of involving or informing proper authorities of a medico-legal case patient, the disposition for the patient, entry to the department's registry.



Line Graph 4: Responses on Practice Items (Post Training)



Line Graph 5: Responses on Practice Items (Post Training)

Obtaining informed consent from the patient or relative before doing a procedure, duplication of a medico-legal record, use of protective equipments during examination of patients, taking actual photos of injured body areas, were not well observed in their practice.

Fifty seven percent of the participants agree that they follow policies in their department for documentation and reporting of medico-legal cases, whereas, 24% among residents strongly agree compliance to policies, and only 5% disagrees, showed in Line Graph 5 as well. Both in pre and post training evaluations almost similarly showed same behaviors were frequently practiced and as to those items not observed during their duties. However, less responses from the participants those disagree and unable to rate on items were observed as compared to the pre training responses gathered. Evidently, an improvement in practice relating to the knowledge these participants gained from the training conducted.

Question Item	1 SD*	2 D*	3 A*	4 SA*	5 UR*
30. I always make it a point to record all the vital status of the patient, and enter the date and time correctly.	0	0	36.84	63.16	0
31. I prepare the medico-legal documents in duplicate, with utmost care in giving all necessary details in each case.	0	10.53	42.11	21.05	26.32
32. I am confident that I always document briefly and objectively each patient case.	5.26	0	63.16	31.58	0
33. I make it a point to inform the appropriate police authority when medico-legal case is considered.	0	5.26	42.11	36.84	15.79
34. I make sure to inform the police if the patient involved in a medico-legal case is discharged, admitted, transferred to other hospital or expired.	0	10.53	42.11	31.58	15.79
35. I am confident that I document all pertinent information accurately, factual and honest.	0	0	26.32	73.68	0
36. I always make an appropriate entry into the MLC register in our department.	5.26	5.26	57.89	21.05	10.53
37. I never chart data before it is provided as this can lead to charges of falsification.	0	0	57.89	42.11	0

38. I document physical assessment of patient with particular attention to injuries and document clearly if NO injury occurred.	5.26	0	26.32	68.42	0
39. My documentation is as timely and complete as close as possible after examination.	0	0	57.89	42.11	0
40. I secure first an informed consent before any examination or procedure needed to be done to the patient.	0	5.26	57.89	36.84	0
41. In our ED, we use a separate medico-legal form/chart.	10.53	15.79	26.32	42.11	5.26
42. I wear a PPE when conducting a physical examination of a medico-legal case.	5.26	26.32	42.11	0	26.32
43. In our institution/department, we follow policies or guidelines for medico-legal case documentation/reporting.	5.26	5.26	42.11	26.32	21.05
44. If the patient was brought unconscious to the ED, I always make a note of the person/s who had brought him to the hospital.	0	5.26	47.37	47.37	0
45. If an unconscious patient has some valuables on his person I always make a note of these in the property register. Seal these valuables and keep them in the safe custody until the police or the relatives arrive.	0	0	42.11	57.89	0
46. In our ED, all consultations with patients are documented in the form of hand-written notes, diagrams or body charts.	0	0	36.84	57.89	5.26
47. If appropriate, I take photographs of medico-legal case as part of my documentation.	10.53	15.79	47.37	26.32	0
48. I always make it a point that it is a legible and non-erasable, permanent, retrievable medico-legal documentation.	0	5.26	47.37	47.37	0
49. I avoid using abbreviations in the patient's record.	0	15.79	52.63	31.58	0
50. In case of discharge/transfer/death of such medico-legal case in the ED, the proper authority/agency is always informed.	5.26	5.26	26.32	52.63	10.53
51. I always make sure that my data in the patient's chart is comprehensive, and I always affix my name and signature for every completed chart/documentation/report.	0	5.26	21.05	73.68	0

*- SD = strongly disagree, D = disagree, A = agree, SA = strongly agree, UR = unable to rate

CONCLUSION

The data gathered from this study is obviously insufficient due to a small sample size acquired and inconclusive if these data represent the whole target population. Nevertheless, the study concludes that the training conducted showed overall improvement on the knowledge of the residents towards medico-legal documentation, thus, the training is said to be effective. This study also indicates that our EM residents are not alert enough to document medico-legal cases properly, although they have degree of knowledge about the importance of making a medico-legal documentation as part of their responsibilities. However, they must be sufficiently well informed on what to document and put into proper practice. Practice of concepts gained should make accurate and improved results. Therefore, EM residents were identified a need for further education and proper supervision in terms of attitudes and practices on medico-legal documentation. It also seems evident that additional research on this study is needed in this regard.

It is necessary to quantify residents' awareness of issues on medico-legal case and how to document it, also necessary to find areas of improvement for making resident education more relevant to continuous changes medical care. This study indicates that EM residents in different training institutions have different approach in making documentation on medico-legal cases.

Training on documentation of torture was used for this study since torture cases remains to be one of the pervasive and harmful entities in our society. It is becoming under reported due to less awareness of its details. In relation to the enacted Anti-Torture law of 2009 by our congress, this study project also intend to involve Emergency Medicine physicians in the recognition of acts of torture as a human rights violation, the value of documenting such cases and proper case reporting, which in many instances may be included as medico-legal cases, as maybe seen in the everyday practice at the Emergency Room. This study, in a larger scale, may result in a concept of constructing uniform or standardized documentation systems, through effective training, thus, documentation would be even more accurate and complete wherever and whenever it is written. It also stands to reason that if continuous use of a standard documentation system, documentation expertise should continue to improve, thus, improvement also on identification and reporting of cases, and improvement on performing invaluable services in patient management.

RECOMMENDATIONS

This study may be replicated on a larger sample, spread over different EM training institutions in all year levels to correlate and validate the findings, and further expanding the methodology such as personal interviews and group discussion, Pilot testing of the questionnaire should be done in order to evaluate its the contents and relevance to the study and to the target respondents. Follow up studies may also be conducted to assess and compare the knowledge, attitudes and practices not only for EM residents but including also the ER nurses, ER consultants, medical interns and other residents from other departments rotating in the ED regarding medico legal documentation responsibilities as part of patient care.

Comparisons of residents among year levels and type of training institutions should be included in the investigation, to precisely depict differences relating to their level of knowledge, attitude and common practices.

Training on proper medico-legal documentation and education on medico-legal cases and issues may be conducted regularly on ED staff, especially to the residents and interns to be integrated in their training program, such as rotation to a crime lab or forensic pathology section, to increase their awareness and improvement on their skills in proper handling those kinds of cases.

A clinical practice guideline may be formulated included in the patients chart for those presenting as medico-legal cases as a support tool for healthcare providers to maintain standard patient care and immediate delivery of assistance.

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APPENDIX A

SAMPLE OF STUDY INFORMATION SHEET AND PARTICIPANT INFORMED CONSENT FORM

You are being invited to participate in a research study. Before you take part in the research study, the study must be explained to you and you must be given the chance to ask questions. Please read carefully the information provided here. If you agree to participate, please sign the informed consent form. You will be given a copy of this document to take home with you.

STUDY INFORMATION:

Proper Medico-legal Documentation of Emergency Department Patients: How effective will be a Short Course Training on the Improvement of Knowledge, Attitudes, and Practice of Emergency Medicine Physicians from different Training Institutions in the Philippines.

Principal Investigator: Catherine Anne N. Dacanay, MD
Department of Emergency Medicine, Manila Doctors Hospital

Purpose of the Study:

You are being invited to participate in a research study of documentation of medico-legal cases seen at the Emergency Department. We hope to collect data from a survey from EM consultants and residents of different training institutions. You were selected as a possible participant in this study.

Study Procedures:

If you agree to take part in this study, you will be asked to complete a self-administered questionnaire which consist of fifty one (51) items, a pre-training test, will be asked to attend training on medico-legal documentation, and finally a post-test after one month from the training date.

Withdrawal from the study:

You are free to withdraw your consent and discontinue your participation at any time without prejudice to you. If you decide to stop taking part in this study you should tell the Principal Investigator. If you withdraw from the study, data gathered from your questionnaire will not be included in the research study.

Risks, Discomforts and Inconveniences:

If you decide to take part of this study, it would take a moment of your time to complete a survey, attend to a training program, and answer the pre- and post-training tests.

Potential Benefits:

You are given an opportunity to acquire information and knowledge from the series of lectures on medic-legal documentation of torture and be able to use to your medical practice.

Rights of Participants:

Your participation in this study is entirely voluntary. Your questions will be answered clearly and to your satisfaction. By signing and participating in the study, you do not waive any of your legal rights to revoke your consent and withdraw from the study at any time.

Confidentiality of Study and Medical Records:

Information collected for this study will be kept confidential. Your records to the extent of the applicable law and regulations will not be made publicly available. Only your investigators will have access to the confidential information being collected.

Costs of Participation:

No cost will be involved if you participate in this study.
No reimbursement will be paid out for you participation in this study.

Who to Contact if you have questions:

If you have questions about this study and your rights or in the case of any injury during the course of this study, you may contact the Principal Investigator, Dr. Catherine Anne N. Dacanay (0922 869 8107 or 0928 909 1066).

APPENDIX B

SAMPLE OF CONSENT BY THE RESEARCH PARTICIPANT

Study Title:

Proper Medico-legal Documentation of Emergency Department Patients: How effective will be a Short Course Training on the Improvement of Knowledge, Attitudes, and Practice of Emergency Medicine Physicians from different Training Institutions in the Philippines.

Principal Investigator: Catherine Anne N. Dacanay, MD
Department of Emergency Medicine, Manila Doctors Hospital

Department of Emergency Medicine, Manila Doctors Hospital
Telephone Number: (02) 5243011 local 8114

Participant's Information:

Name: _____

Address: _____

Sex: M F Age in years: _____ Date of Birth: _____

I, _____ (name of participant) agree/do not agree to participate in the research study as described and on terms set out in the Study Information Sheet. The nature of my participation in the proposed research study has been explained to me through in written information.

I have fully discussed and understood the purpose and procedures of this study, I have been given the Study Information Sheet and the opportunity to ask questions about this study and have received satisfactory answers and information.

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reasons.

I also give permission for information in my completed survey form and results of my pre- and post-training tests to be used for research. In any event of publication, I understand that this information will not bear my name or other identifiers and that due care will be taken to preserve the confidentiality of this information.

Signature over Printed Name

Date of Signing

(To be filled by parent or legal guardian where applicable)

(To be filled witness when applicable)

An important witness should be present during the entire informed consent discussion if a participant or the participant's legally acceptable representative, and after the participant or the participant's legally acceptable representative has orally consented to his/her participation in the study and if capable of doing so, has signed and personally dated the consent form, the witness should sign and personally date the consent form

Signature over printed name of witness

Date of Signing

Investigator's statement

I, undersigned certify to the best of my knowledge that the patient/patient's legally acceptable representative signing this informed consent form had the study fully explained and clearly understands the nature, risks, benefits of his/her participation in this study.

Signature over Printed Name of Investigator

Date of Signing

Appendix C

MEDICO-LEGAL KAP QUESTIONNAIRE

Welcome! This survey gives you an opportunity to share your opinions and ideas about medico-legal case documentation done at the Emergency Room. This is not a test. Since the items ask for your opinions, there are no correct or wrong answers. Try to answer every item. However, if you feel an item does not apply to you, kindly answer Not Applicable (N/A). Please indicate an X mark in the appropriate box.

Date:	TRAINING INSTITUTION:	
NAME	AGE/SEX:	
Please Select Year Level: <input type="checkbox"/> 1 st year <input type="checkbox"/> 2 nd year <input type="checkbox"/> 3 rd year/4 th year	Please State your Institution of Training: <input type="checkbox"/> Government <input type="checkbox"/> Private	
Have you undergone a previous training on medico-legal documentation? <input type="checkbox"/> YES <input type="checkbox"/> NO		
If yes, please state when and where, how long?		
Have you ever rotated in a crime lab or forensic pathology section during your residency training? <input type="checkbox"/> YES <input type="checkbox"/> NO		
If yes, please state when and where, how long?		
KNOWLEDGE:		
52. I have a good knowledge of medico-legal cases.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
53. I am aware of the Istanbul Protocol, a manual used for effective investigation and documentation of torture and ill treatment.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
54. I know that a medico-legal injury can be accidental, suicidal, or self-inflicted or a result of assault.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
55. I know that medico-legal injury/injuries may be a result of human right violation such as torture.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
56. I know that documentation includes all forms of documentation by a doctor, nurse or allied health professional recorded in a professional capacity in relation to the provision of patient care.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
57. The purpose of medico-legal documentation is to provide expert opinion on the degree to which medical findings correlate with the patient's allegation of abuse and to communicate effectively the physician's medical findings and interpretations to the judiciary or other appropriate authorities.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
58. I know that a medico-legal document is a record of patient's present and past state of health, documents the impact of ill health from the patient's own perspective, and analyzes the current illness in terms of diagnosis and prognosis resulting from the injury.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
59. I know that a medico-legal document serves as information may be extracted by the court for evidence.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
60. A medico-legal case can be received at the ED as— After history taking and thorough examination, if the examining physician suspects that the circumstances/ findings of the case are such that registration of the case as an MLC is warranted.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
61. A medico-legal case can be received at the ED as— Directive of court.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
62. A medico-legal documentation may include written and electronic health records, audio and video tapes, emails, facsimiles, images (photographs and diagrams), observation charts, check lists, communication books, incident reports and clinical anecdotal notes or clinician's personal reflections pertaining to the patient care provided.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
63. An EM physician can be called to stand as witness to court to give expert opinion regarding to a medico legal case being investigated.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
64. An informed consent includes information that: the examination to be conducted would be a medico legal one and would culminate in the preparation of a medico-legal injury report, all relevant investigations needed for the said purpose would be done.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
65. The qualifications of an expert witness include opinion/s on a matter requiring special knowledge, skill, experience or training which he/she is shown to possess.	<input type="checkbox"/> YES	<input type="checkbox"/> NO

Likert Scale Equivalent					
For each item, respondents are asked to indicate their level of agreement using the following scale:					
Kindly shade the circled number as your answer.					
ITEM	SCALE				
	STRONGLY DISAGREE	DISAGREE	AGREE	STRONGLY AGREE	UNABLE TO RATE
	①	②	③	④	⑤
ATTITUDES:					
66. I believe that the treatment of any injured person is the first priority for an Emergency physician. However, ER physician cannot ignore the recording and documentation of the injury.	①	②	③	④	⑤
67. I believe that it is extremely important to remember that physicians' case reports must be treated with utmost confidentiality and should be stored securely.	①	②	③	④	⑤
68. I believe that MLC should be registered as early as possible.	①	②	③	④	⑤
69. I believe an ED physician cannot refuse to examine medico legal case on the basis of being a private practitioner or citing a jurisdiction problem.	①	②	③	④	⑤
70. I consider myself as a medico-legal officer.	①	②	③	④	⑤
71. I believe that the quality of medico-legal documentation in our department/institution is precise as compared to that of other institutions.	①	②	③	④	⑤
72. I believe that the physician who has first contact with the patient should prepare a medico-legal case report.	①	②	③	④	⑤
73. I believe that documentation is representative and reflective of professional observations and assessment.	①	②	③	④	⑤
74. I believe if I'm not trained in medico-legal matters, I should confine my service to health care provision and documentation of findings, and leave the interpretation of physical and other observations to a suitably qualified expert.	①	②	③	④	⑤
75. I believe that documentation must be patient focused and based on professional observation and assessment that does not have any basis in unfounded conclusions or personal judgments.	①	②	③	④	⑤
76. I believe that every document should be clear, concise, complete record of clinical care (including, assessment, plan of action outcomes and evaluation of care).	①	②	③	④	⑤
77. I believe that notes on the patient's record should not be altered unless this is clearly identified as a later addition or alteration. Deletions should be scored through once and signed, and not erased completely.	①	②	③	④	⑤
78. I believe that MLC documentation should be easily be interpreted over time and after significant time has elapsed.	①	②	③	④	⑤
79. I am willing to testify to the court as expert witness if necessary.	①	②	③	④	⑤
80. I believe that the medico-legal certificates are released/ issued a copy to the concerned investigating agency, patient or patient's relative only.	①	②	③	④	⑤
PRACTICES:					
81. I always make it a point to record all the vital status of the patient, and enter the date and time correctly.	①	②	③	④	⑤
82. I prepare the medico-legal documents in duplicate, with utmost care in giving all necessary details in each case.	①	②	③	④	⑤
83. I am confident that I always document briefly and objectively each patient case.	①	②	③	④	⑤
84. I make it a point to inform the appropriate police authority when medico-legal case is considered.	①	②	③	④	⑤

85. I make sure to inform the police if the patient involved in a medico-legal case is discharged, admitted, transferred to other hospital or expired.	①	②	③	④	⑤
86. I am confident that I document all pertinent information accurately, factual and honest.	①	②	③	④	⑤
87. I always make an appropriate entry into the MLC register in our department.	①	②	③	④	⑤
88. I never chart data before it is provided as this can lead to charges of falsification.	①	②	③	④	⑤
89. I document physical assessment of patient with particular attention to injuries and document clearly if NO injury occurred.	①	②	③	④	⑤
90. My documentation is as timely and complete as close as possible after examination.	①	②	③	④	⑤
91. I secure first an informed consent before any examination or procedure needed to be done to the patient.	①	②	③	④	⑤
92. In our ED, we use a separate medico-legal form/chart.	①	②	③	④	⑤
93. I wear a PPE when conducting a physical examination of a medico-legal case.	①	②	③	④	⑤
94. In our institution/department, we follow policies or guidelines for medico-legal case documentation/reporting.	①	②	③	④	⑤
95. If the patient was brought unconscious to the ED, I always make a note of the person/s who had brought him to the hospital.	①	②	③	④	⑤
96. If an unconscious patient has some valuables on his person I always make a note of these in the property register. Seal these valuables and keep them in the safe custody until the police or the relatives arrive.	①	②	③	④	⑤
97. In our ED, all consultations with patients are documented in the form of hand-written notes, diagrams or body charts.	①	②	③	④	⑤
98. If appropriate, I take photographs of medico-legal case as part of my documentation.	①	②	③	④	⑤
99. I always make it a point that it is a legible and non-erasable, permanent, retrievable medico-legal documentation.	①	②	③	④	⑤
100. I avoid using abbreviations in the patient's record.	①	②	③	④	⑤
101. In case of discharge/transfer/death of such medic-olegal case in the ED, the proper authority/agency is always informed.	①	②	③	④	⑤
102. I always make sure that my data in the patient's chart is comprehensive, and I always affix my name and signature for every completed chart/documentation/report.	①	②	③	④	⑤

Comments/suggestions:

Thank you for completing this survey. Your response will be very helpful as part of the current study on medico-legal documentation at the Emergency Department. Rest assured that your answers are strictly confidential.

Appendix D

**MEDICO-LEGAL DOCUMENTATION OF EM PHYSICIANS
PRE- and POST TEST**

Please write the letter of your final answer before each corresponding number.

NAME: _____
INSTITUTION: _____

- _____ 1. Medico-legal is
 - A. A legal case requiring medical expertise when brought by the police for examination
 - B. Any harm whatever illegally caused to any person in body, mind, reputation or property
 - C. A medical case with legal implications
 - D. All of the above

- _____ 2. Forensic Science is
 - A. Use a systematic collection and analysis to establish facts that can be used as evidence in a legal proceeding, usually related to criminal cases
 - B. A large group of scientific disciplines applied in the legal system
 - C. A and B
 - D. None of the above

- _____ 3. In the Philippine law, an act penalizing torture and other cruel, inhuman and degrading treatment or punishment and prescribing penalties is known as
 - A. Republic Act No. 9745
 - B. Republic Act No. 4678
 - C. Republic Act No. 6324
 - D. Republic Act No. 4189

- _____ 4. How long should a medico-legal case in the hospital records be preserved or kept
 - A. After one (1) year
 - B. A period of twenty (20) years
 - C. Within ten (10) years
 - D. After five (5) years

- _____ 5. A consent is not required
 - A. Before examining a minor or child
 - B. Performing a PE on a conscious adult patient
 - C. Before conducting a contemplated procedure
 - D. Performing medical emergency management on a patient

- _____ 6. A Medico-legal case report or record as how many parts?
 - A. 5
 - B. 10
 - C. 3
 - D. 1

- _____ 7. Dr. Tan refused to attend on several occasions a court hearing citing as reason that he has a lot of OPD patients to see. He may be cited for:
 - A. Direct contempt of court
 - B. Indirect contempt of court
 - C. Disrespect for the court
 - D. Unduly prioritizing his clinic practice

- _____ 8. A physician must appear in response to a subpoena if his place of residence is how many kilometers from the court issuing the subpoena?
 - A. 100 kilometers
 - B. 50 kilometers
 - C. Less than 50 kilometers
 - D. Must appear no matter what the distance

- _____ 9. While being treated for gunshot injuries, Abu Sabayad confided to Dr. Teron that he was responsible for the kidnapping and beheading of twenty hostages. Sabayad was captured and Dr. Sharon was called to testify. What should he do?
 - A. Refuse to testify to protect his life
 - B. He must not testify as the information is privileged
 - C. He must testify in the interest of justice, public safety and welfare as this involves a criminal matter
 - D. Feign loss of memory about the incident

- _____ 10. True on photographic evidence regarding medico-legal cases
 - A. It is always better to take poor quality photographs than to have none.
 - B. It is will always possible to record photographically lesions of patients who have been tortured
 - C. Photography should only be optional to the patient/victim, as a part of examinations
 - D. None of the above

11. Injury causation in torture include the following:
- A. Sexual assaults
 - B. Ligatures
 - C. Electrical shock
 - D. All of the above
12. Role of physician in the implementing anti-torture act
- A. To alleviate the distress of his or her fellow men, and no motive whether personal, collective or political shall prevail against this higher purpose.
 - B. Not to be involved or present during an act of torture or any inhumane treatment
 - C. Assist the government in the administration of justice in relation to the act
 - D. All of the above
13. A physician who testifies in court cannot be compelled to answer a question if the answer will
- A. Not be relevant to the matter at issue.
 - B. Antagonize the lawyer posing the question.
 - C. Be self-incriminatory.
 - D. Implicate a physician colleague, a relative or friend.
14. What distinguishes the entrance wound from the exit wound caused by a gunshot
- A. The entrance wound is smaller than the exit wound.
 - B. The edges are everted in the entrance wound, and inverted in the exit wound.
 - C. The entrance wound has no definite shape while the exit wound is usually circular.
 - D. There is contusion collar in the exit wound and none in the entrance wound.
15. Definition of torture according to Istanbul Protocol:
- A. Any act by which severe pain or suffering, is intentionally inflicted on a person for such purposes as obtaining from him or from a third person information or a confession
 - B. Can be physical and mental
 - C. Purpose is to destroy deliberately physical and emotional well-being of individuals, as well the dignity of the person involved
 - D. All of the above
 - E. A and C only
16. What is Istanbul Protocol?
- A. An anti-torture law
 - B. A manual for the documentation of extra-judiciary crimes
 - C. A guideline for treatment of torture only
 - D. International guidelines for the investigation and documentation of torture.
17. During physical examination, the patient must understand that he or she is in control and has the right to limit the examination or to stop it at any time.
- A. True
 - B. False
18. It is considered as a medico-legal case if:
- A. A case is brought by the police for examination and reporting, or order of the court for medical examination.
 - B. The person in question was already attended to by a doctor and a medico-legal case was registered in the previous hospital, and the person is now referred for expert management/ advice.
 - C. When the patient himself expressing his intention to register a case against the alleged accused.
 - D. After eliciting history and examining the patient, the attending doctor feels that some investigation by law enforcement agencies is essential.
 - E. All of the above
19. A medico-legal case examination and reporting is one of the legal responsibilities of all doctors working in a hospital, especially at the Emergency Department.
- A. True
 - B. False
20. Time limit for registration of a medico-legal case?
- A. Be registered as soon as a doctor suspects foul play or feels it necessary to inform the police at arrival
 - B. After the doctor's shift, who attended to the case
 - C. Before examining the patient
 - D. Whenever the doctor prefers to
21. This is a category of Human Rights, according to the recipient, that: Rights accorded to individuals such as right to life, education, health work, suffrage, freedom of expression, freedom from torture, cruel or degrading treatment and punishment, right to speedy trial, to be presumed innocent unless proven guilty, etc
- A. Individual rights
 - B. Constitutional rights
 - C. Collective rights
 - D. Civil rights
22. A case may be registered as a medico-legal case even if it is brought several days after the incident if suspected.
- A. True
 - B. False

23. One of the categories of State of Obligations of Human Rights: abstain from doing anything violating the integrity of the individual or his/her freedom of action and refrain from interfering with the enjoyment of the right
- A. Obligation to protect
 - B. Obligation to respect
 - C. Obligation to fulfill
 - D. None of the above
24. The medical case report should be completed as much as possible within
- A. 48 hours
 - B. 24 hours
 - C. 12 hours
 - D. 1 hour
25. Other rights protected by Anti-torture Act
- A. Right to own choice
 - B. Right to physical examination
 - C. Neither
 - D. Both
26. Which among these principles does not apply to human rights?
- A. Accountability
 - B. Inalienability
 - C. Universality
 - D. Independence
27. The Medico-legal case report is only released or given to any of the following except:
- A. Victim/patient
 - B. Legal spouse
 - C. Victim's/patient's lawyer
 - D. None of the above
28. Aside from the medico-legal case report, which other report forms should be included:
- A. Psychiatric evaluation
 - B. Diagnostic procedure results
 - C. Operation record
 - D. Photographs
 - E. All of the above
29. The Medico-legal case record or report should include the following:
- A. Physical examination findings
 - B. Authorship
 - C. An opinion
 - D. Case information and background
 - E. All of the above
30. Torture and any other medico-legal cases should be immediately reported to:
- A. Emergency Department head/chair
 - B. Hospital director
 - C. Proper authorities/agencies
 - D. None of the above
31. The opinion of a witness on a matter requiring special knowledge, skill, experience or training which he/she is shown to possess, may be received in evidence is called:
- A. Ordinary witness
 - B. Expert witness
 - C. Star witness
32. All hearsays are inadmissible to the court
- A. True
 - B. False
33. A witness can testify only to facts which he knows of his personal knowledge, i.e., facts derived from his own perception.
- A. True
 - B. False
34. An ordinary witness can testify with his/her personal opinion on a person's emotional state, behavior, condition or, appearance.
- A. True
 - B. False
35. You are a fact witness when your court testimony proves facts based on your personal knowledge such as:
- A. Cause of death
 - B. Dying declaration
 - C. Time of death
 - D. How the crime took place

- _____ 36. If a question is phrased so that only a yes or no answer is expected, the witness must answer the question but has the right to explain the answer after answering.
- A. True
 - B. False
- _____ 37. There's nothing wrong with the lawyer talking to you before you testify.
- A. True
 - B. False
- _____ 38. As expert witness, you should:
- A. Offering opinions outside your field of expertise.
 - B. Answering questions you don't understand.
 - C. Never lose your temper
 - D. Look at the lawyer for your side when a question is asked on cross-examination or right after you give your answer.
- _____ 39. True in examining a sexual assault patient/victim:
- A. Any physician can examine the victim/patient regardless of the victim's gender
 - B. Physical examination should thoroughly focused on the genital areas only
 - C. Male victims of sexual violence should be triaged in the same manner as female victims.
 - D. Speculums or anoscopes and digital or bimanual examinations of genitor-anorectal areas is routinely done/used in child sexual abuse examinations
- _____ 40. The travel of a particular medico-legal document or an article must be properly recorded at every step. The confidential documents must be properly sealed and labeled before forwarding them. This principle of maintenance is called:
- A. Reporting mechanisms
 - B. Medico-legal correspondence
 - C. Chain of custody
 - D. None of the above

Appendix E

Sample of the Training Programme

The Medical Action Group, Inc.
In cooperation with the
Philippine College of Emergency Medicine, Inc.
(A Subspecialty Society under the Specialty Division of Family and Community Medicine)

Training on Medico-Legal Documentation of Torture for Emergency Medicine Physicians

September 11, 2012
12th Floor, Metrobank Foundation Hall, Inc.
Manila Doctors Hospital

07:00am	Registration	
07:45am-08:00am	Invocation National Anthem	
08:00am-08:30am	Opening Remarks	Dr. Melecia Velmonte
08:30am-09:30am	Human-rights Based Approach	Dir. Karen Gomez-Dumpit
09:30am-09:45am	Open Forum	
09:45am-10:45am	Anti-Torture Law/Implementing Rules and DOH-AO	Edeliza Hernandez, RN
10:45am-11:00am	Open Forum	
11:00am-12:00nn	The Istanbul Protocol (Guide to Medico-Legal Documentation of Torture)	Dr. Benito Molino
12:00pm-01:00pm	Open Forum Lunch	
01:00pm-03:00pm	Testifying in Court: The Doctor as Expert Witness	Atty. Jose Manuel Diokno
03:00pm-03:15pm	Open Forum	
03:15pm-05:00pm	Forensic Documentation: Preserving the Evidence	Dr. Arnel Amata
05:00pm-05:15pm	Open Forum	
05:15pm	Closing Remarks	

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