

Are Forensic Reports More Complete During Night Shifts? A Retrospective Study from a Secondary Hospital in Türkiye

Gece Vardiyalarında Adli Raporlar Daha Eksiksiz mi? Türkiye’de İkinci Basamak Bir Hastanede Yapılan Retrospektif Bir Çalışma

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Abstract

Background: This study aimed to evaluate the completeness of forensic medical reports prepared in the emergency department and to investigate how documentation rates vary according to shift hours (in-hours vs. out-of-hours) and the presence of life-threatening conditions. The goal was to identify shortcomings in forensic reporting practices and to provide insights for improving the quality and consistency of medico-legal documentation.

Materials and Method: This retrospective, single-center study was conducted in the emergency department of a secondary-level hospital in Sinop, Türkiye. Forensic cases admitted between May 1 and August 1, 2019, were analyzed. Data on patient demographics, shift hours (in-hours vs. out-of-hours), and completeness of various sections of forensic reports were collected and compared.

Results: A total of 311 forensic cases were included. Reports prepared during out-of-hours shifts had significantly higher completion rates in multiple sections, including complaints, past medical history, psychiatric evaluation, performed tests, and body diagrams. Patients without life-threatening conditions had more complete documentation in past medical history and psychiatric sections, while simple medical intervention notes were more frequently completed in life-threatening cases.

Conclusions: Shift hours significantly affect the completeness of forensic reports, with better documentation observed during out-of-hours shifts. Life-threatening conditions may reduce the thoroughness of documentation in certain report sections. Improving training and standardizing report protocols may enhance report quality across all settings and times.

Keywords: Emergency Department, Forensic Medicine, Medico-Legal Documentation, Forensic Report Completeness, Documentation Quality

ÖZ

Amaç: Bu çalışmanın amacı, acil serviste hazırlanan adli tıbbi raporların eksiksizliğini değerlendirmek ve dokümantasyon oranlarının vardiya saatlerine (mesai içi ve mesai dışı) ve yaşamı tehdit eden durumların varlığına göre nasıl değiştiğini araştırmaktır. Hedef, adli raporlama uygulamalarındaki eksiklikleri tespit etmek ve medikolegal dokümantasyonun kalitesini ve tutarlılığını artırmak için içgörüler sağlamaktır.

Gereç ve Yöntem: Bu retrospektif, tek merkezli çalışma, Sinop’taki ikinci basamak bir hastanenin acil servisinde yürütülmüştür. 1 Mayıs – 1 Ağustos 2019 tarihleri arasında adli nedenlerle başvuran hastalar incelenmiştir. Hasta demografik bilgileri, başvuru saatleri (mesai içi ve dışı) ve adli rapor bölümlerinin doldurulma durumu değerlendirilmiştir.

Bulgular: Toplam 311 adli olgu çalışmaya dahil edilmiştir. Mesai dışı saatlerde düzenlenen raporların şikâyet, özgeçmiş, psikiyatrik değerlendirme, yapılan tetkikler ve vücut şeması gibi bölümlerde anlamlı şekilde daha yüksek tamamlanma oranlarına sahip olduğu saptanmıştır. Yaşamsal tehlikesi olmayan olgularda özgeçmiş ve psikiyatrik değerlendirme bölümleri daha eksiksiz doldurulmuş, yaşamsal tehlike bulunan olgularda ise basit tıbbi müdahale ile giderilebilirlik notu daha sık kaydedilmiştir.

Sonuç: Adli raporların tamamlanma düzeyi, mesai saatlerinden anlamlı şekilde etkilenmektedir; mesai dışı saatlerde daha ayrıntılı belgeler hazırlanmıştır. Yaşamsal tehlike varlığı, bazı rapor bölümlerinin eksik kalmasına neden olabilmektedir. Hekim eğitimlerinin artırılması ve standart raporlama protokollerinin uygulanması, her zaman diliminde rapor kalitesini artırabilir.

Anahtar kelimeler: Acil Servis, Adli Tıp, Mediko-Legal Dokümantasyon, Adli Rapor Tamlığı, Dokümantasyon Kalitesi.

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Highlights

- Out-of-hours reports were more complete than in-hours reports.
- Life-threatening cases had less complete documentation in some sections.
- Standardized protocols and physician training can improve report quality.

Introduction

Emergency department (ED) often represent the first point of contact for individuals involved in assaults, traffic accidents, occupational injuries, self-harm, or other situations necessitating forensic evaluation. In such cases, the quality and comprehensiveness of forensic reports are critical not only for the legal process but also for the protection of individual rights and the prevention of medical-legal disputes (1-3).

In Türkiye, physicians working in ED are legally obliged to prepare forensic examination reports in cases involving injuries with potential legal relevance. These reports are expected to include a wide range of components such as a detailed anamnesis, complaint and physical examination findings, assessment of vital systems, psychological evaluation, any tests or imaging performed, and the presence or absence of life-threatening conditions. Additionally, elements such as the suitability of the examination environment and the presence of third parties during the examination are also supposed to be documented in accordance with medico-legal standards (4, 5).

Despite these structured expectations, there is considerable variability in the content and completeness of forensic documentation, which may be influenced by multiple factors. These include physician workload, time of day, institutional protocols, availability of forensic expertise, and the nature or severity of the incident (6). Particularly during out-of-hours shifts, increased patient volume and reduced staffing may compromise the attention given to medico-legal documentation, which can ultimately affect the legal value and usability of the report (4, 7).

Although there are several studies in the literature focusing on forensic case characteristics and documentation quality in EDs, most of them have been conducted in tertiary or university hospital settings located in major cities. Data on the completeness and quality of forensic reports from smaller provinces in Türkiye remain limited. This study aimed to analyze the forensic cases presenting to the emergency department of a secondary-level state hospital in Sinop, Türkiye. By comparing the documentation quality during in-hours and out-of-hours admissions and investigating differences based on life-threatening status, this study seeks to identify patterns and potential areas for improvement in forensic medical reporting in the ED setting.

Material and Methods**Study Design**

This study was a retrospective, single-center, observational analysis conducted in the ED of a second-phase state hospital in Sinop, Türkiye. This hospital primarily serves approximately 200,000 residents annually. Patients admitted between 1 May 2019 and 1 August 2019 and whose admission was accepted as forensic were included in the study.

Selection of participants and study protocol

According to Turkish law, forensic cases include assault, injuries, accidents (traffic, domestic, occupational), burns, poisoning, asphyxia, torture, suicide attempts, suspicious sudden deaths, and similar conditions requiring forensic examination (1, 8). Forensic examination reports in Türkiye typically include sections regarding the suitability of the examination environment, the presence of other individuals during the examination, patient anamnesis, current complaints, past medical history, consultation requests, lesion findings, system-based examinations, psychiatric evaluations, laboratory and imaging tests, and body diagrams. Physicians practicing in Türkiye are legally obliged to participate in the evaluation of forensic cases in accordance with the Law on the Practice of Medicine and Medical Specializations (9), and they are also mandated by Article 280 of the Turkish Penal Code to report forensic incidents to the relevant authorities (8). In Türkiye, working hours from 08:00 to 17:00 are considered 'in-hours,' during which most public and private-sector employees are on duty.

The acceptance of the hospital admission as a forensic admission was considered an inclusion criterion, and the inaccessibility of patient data was considered an exclusion criterion. Twelve patients whose documentation could not be retrieved were excluded from the analysis. The need for signed informed consent was waived due to the retrospective design of the study.

Each forensic report section was assessed individually for completeness. A binary approach was adopted: if a section contained any relevant information, it was marked as 'filled'; otherwise, it was recorded as 'unfilled'. Overall completeness was not calculated as a composite score but evaluated based on section-by-section documentation rates.

Patient demographic information (age, gender), admission shift (in-hours/out-hours), and forensic examination report details were obtained from hospital records. Patients admitted between 08:00 and 17:00 were classified as 'in-hours', and those admitted outside this timeframe were classified as 'out-hours'. Additionally, the completion rates of forensic report sections were compared between these two groups.

Data Collection

Patients admitted to the ED for forensic reasons were identified through the hospital's electronic database between May 1st and August 1st, 2019. The forensic examination reports for these patients were retrieved from hospital archives, and relevant data were transferred into study-specific data collection forms. The information on whether each of the fields to be filled in the emergency department forensic examination form was filled or not was recorded separately on the study forms.

Statistical analysis

Continuous data were presented as median and interquartile range (IQR: 25%-75%), while categorical data were expressed as frequencies and percentages. Continuous variables were compared using the Mann-Whitney U test. Associations between categorical variables were assessed using the Chi-square test or Fisher's Exact test, as appropriate. Statistical analyses were performed using SPSS version 23 (SPSS Inc., Chicago, IL, USA). A p-value less than 0.05 was considered statistically significant.

Ethical Approval

The study was started after the approval of the local ethics committee (approval ID: 53-2019BADK/11-86, dated: 25 May 2019). This study was conducted retrospectively. Therefore, no consent form was obtained. All procedures were carried out in accordance with the Declaration of Helsinki.

Results

A total of 311 patients were included in the study. The median age was 32 years (IQR: 22-44), and 26.7% (n=83) were female. Of these admissions, 53.7% (n=167) occurred during in-hours, while 46.3% (n=144) occurred during out-hours.

The most frequently completed sections in forensic examination reports were lesion findings (95.2%; n=296), system examinations (88.7%; n=276), complaints (80.7%; n=251), performed tests (76.2%; n=237), and alcohol examination (72.3%; n=225). Sections filled at intermediate rates included past medical history (64.6%; n=201), life-threat information (59.8%; n=186), psychiatric examination (48.9%; n=152), and body diagrams (43.7%; n=136). The lowest completion rates were observed in the suitability of examination environment (3.5%; n=14), treatment notes (1.9%; n=6), and recording treatment details (1.9%; n=6).

The majority of patients (96.8%; n=301) were discharged, while 2.6% (n=8) were hospitalized in wards and 0.6% (n=2) in intensive care units. General statistics of the patients included in study shown in **Table 1**.

Table 1. General statistics

Parameters	Median (IQR 25-75%), % (n)
Age (Years)	32 (22-44)
Gender (Female)	26.7 (83)
Admission Shift (In-hours)	53.7(167)
(Out-hours)	46.3(144)
Is the suitability of environment for the examination filled out? (Yes)	3.5 (14)
Is the person who present during the examination recorded? (Yes)	3.2 (10)
Is the anamnesis filled out? (Yes)	26.0 (81)
Is the complaint filled out? (Yes)	80.4 (250)
Is the past medical history section filled out? (Yes)	64.6 (201)

Is the lesion findings filled out? (Yes)	95.2 (296)
Is the system examinations filled out? (Yes)	88.7 (276)
Is the psychiatric examination filled out? (Yes)	48.9 (152)
Is the section on tests performed filled out? (Yes)	76.8 (239)
Is there a body diagram? (Yes)	43.7 (136)
Is this a definitive report? (Yes)	71.4 (222)
Can the condition be eliminated by simple medical intervention? (Filled)	44.7 (139)
Is the alcohol examination filled out? (Yes)	72.3 (225)
Is the life-threat information filled in? (Yes)	59.8 (186)
Are the treatments noted? (Yes)	1.9 (6)
Hospitalization status (Externed)	96.8 (301)
(Wards)	2.6 (8)
(Intensive Care)	0.6 (2)

Abbreviations: Continuous data are presented as median (IQR 25%-75%). Categorical data are presented as % (n).

The distribution of case types revealed that the most common were assault (48.2%; n=150), detention examination (18.6%; n=58), and traffic accidents (16.4%; n=51). Other case types included poisoning (4.2%; n=13), work accidents (2.9%; n=9), drowning (1.9%; n=6), falls (1.6%; n=5), sharp-penetrating instrument injuries (1.3%; n=4), suicide attempts (1.0%; n=3), burns (1.0%; n=3), and firearm injuries (0.6%; n=2). Distribution of case types are shown in Table 2.

Table 2. Case types

Case Type	%(n)
Assault	48.2 (150)
Detention examination	18.6 (58)
Traffic accident	16.4 (51)
Work accident	2.9 (9)
Poisoning	4.2 (13)
Drowning	1.9 (6)
Falling	1.6 (5)
Sharp-penetrating instrument injury	1.3 (4)
Suicide	1.0 (3)
Burns	1.0 (3)
Firearm injury	0.6 (2)
Total	100 (311)

Comparing in-hours (n=167) versus out-hours (n=144) admissions, the median age was significantly higher during in-hours admissions (34 vs. 30 years; p=0.039). Out-hour admissions showed significantly higher completion rates for the suitability of examination environment (8.3% vs. 1.2%; p=0.002), complaint section (87.5% vs. 74.3%; p=0.003), past medical history section (71.5% vs. 58.7%; p=0.018), psychiatric examination (55.6% vs. 43.1%; p=0.029), performed tests (86.1% vs. 68.9%; p=0.001), body diagram (52.8% vs. 35.9%; p=0.003), and noting the possibility of simple medical intervention (52.1% vs. 38.3%; p=0.015). Other parameters did not differ significantly between shifts. Comparison between shift groups are shown in Table 3.

Table 3. Comparison between shift groups

Parameter	In-Hours (n=167)	Out-Hours (n=144)	p
Age (Years)	34 (24-47)	30 (21-41)	0.039
Gender (Female)	27.5 (46)	25.7 (37)	0.713
Is the suitability of environment for the examination filled out? (Yes)	1.2 (2)	8.3 (12)	0.002
Is the person who present during the examination recorded? (Yes)	2.4 (4)	4.2 (6)	0.377

Is the anamnesis filled out? (Yes)	24.6 (41)	27.8 (40)	0.518
Is the complaint filled out? (Yes)	74.3 (124)	87.5 (126)	0.003
Is the past medical history section filled out? (Yes)	58.7 (98)	71.5 (103)	0.018
Is the lesion findings filled out? (Yes)	94.6 (158)	95.8 (138)	0.616
Is the system examinations filled out? (Yes)	87.4 (146)	90.3 (130)	0.427
Is the psychiatric examination filled out? (Yes)	43.1 (72)	55.6 (80)	0.029
Is the section on tests performed filled out? (Yes)	68.9 (115)	86.1 (124)	0.001
Is there a body diagram? (Yes)	35.9 (60)	52.8 (78)	0.003
Is this a definitive report? (Yes)	70.1 (117)	72.9 (105)	0.578
Can the condition be eliminated by simple medical intervention? (Filled)	38.3 (64)	52.1 (75)	0.015
Is the alcohol examination filled out? (Yes)	70.1 (117)	75.0 (108)	0.331
Is the life-threat information filled in? (Yes)	56.3 (94)	63.9 (92)	0.173
Are the treatments noted? (Yes)	1.8 (3)	2.1 (3)	0.854

Abbreviations: Continuous data are presented as median (IQR 25%-75%). Categorical data are presented as % (n). Mann Whitney U test was used to compare continuous data. Chi Square test and Fisher Exact test was used to compare categorical data. * shows Fisher Exact test result.

When comparing patients with life-threatening conditions (n=22) to those without life-threatening conditions (n=289), several significant differences were observed. Patients with life-threatening conditions had a significantly higher proportion of females (50.0% vs. 24.9%; $p=0.010$). Additionally, reports of patients without life-threatening conditions had significantly higher completion rates for the past medical history section (67.1% vs. 31.8%; $p=0.001$) and psychiatric examination (50.5% vs. 27.3%; $p=0.035$). In contrast, the section indicating whether the condition could be eliminated by simple medical intervention was filled significantly more often in patients with life-threatening conditions (68.2% vs. 42.9%; $p=0.022$).

There were no statistically significant differences between groups in age, environmental suitability for examination, anamnesis, complaints, lesion findings, system examinations, performed tests, body diagrams, alcohol examinations, definitive reporting, or noting of treatments. Shift distribution also showed no significant difference between life-threat groups. Comparison between life-threat groups are shown in **Table 4**.

Table 4. Comparison between life-threat groups

Parameter	Life Threat: Yes (n=22)	Life Threat: No (n=289)	p
Age (Years)	41.00 (19.50-58.25)	32.00 (22.00-43.00)	0.313
Gender (Female)	50 (11)	24.9 (72)	0.010
Is the suitability of environment for the examination filled out? (Yes)	4.5 (1)	4.5 (13)	*0.650
Is the person who present during the examination recorded? (Yes)	0 (0)	3.5 (10)	-
Is the anamnesis filled out? (Yes)	22.7 (5)	26.3 (76)	0.713
Is the complaint filled out? (Yes)	68.2 (15)	81.3 (235)	0.135
Is the past medical history section filled out? (Yes)	31.8 (7)	67.1 (194)	0.001
Is the lesion findings filled out? (Yes)	95.5 (21)	95.2 (275)	0.950
Is the system examinations filled out? (Yes)	90.9 (20)	88.6 (256)	*0.539
Is the psychiatric examination filled out? (Yes)	27.3 (6)	50.5 (146)	0.035
Is the section on tests performed filled out? (Yes)	63.6 (14)	77.9 (224)	0.127
Is there a body diagram? (Yes)	54.5 (12)	42.9 (129)	0.289
Is this a definitive report? (Yes)	4.5 (1)	4.5 (13)	0.992
Can the condition be eliminated by simple medical intervention? (Filled)	68.2 (15)	42.9 (124)	0.022
Is the alcohol examination filled out? (Yes)	81.8 (18)	71.6 (207)	0.303
Are the treatments noted? (Yes)	4.5 (1)	1.7 (5)	*0.358
Shift group (in-hours)	59.1 (13)	53.3 (154)	0.599

Abbreviations: Continuous data are presented as median (IQR 25%-75%). Categorical data are presented as % (n). Mann Whitney U test was used to compare

continuous data. Chi Square test and Fisher Exact test was used to compare categorical data. * shows Fisher Exact test result.

Discussion

In this study, forensic reports issued at an ED of a secondary-level state hospital were analyzed comprehensively, and the completeness rates of these reports were evaluated across different sections. According to our findings, the sections filled most completely in the forensic reports were patient identity information (100%), examination date (100%), injury findings (95.2%), and patient history (78.5%). The high rates of completion for identity and examination dates are consistent with previous studies. Yemenici et al. (10) and Çetin et al. (11) similarly reported that patient identity information and examination dates were frequently completed at high rates. However, the 95.2% completion rate for injury descriptions observed in our study represents a significant and positive difference compared to the existing literature. Aktas et al. (5) noted that injury descriptions were missing in 62.4% of reports, while Yemenici et al. (10) reported frequent inadequacies in documenting injuries. Therefore, the high completion rate for injury findings in our study indicates that physicians at this facility are particularly attentive to trauma documentation, representing an encouraging and original finding.

On the other hand, some sections had notably lower completion rates. Specifically, consultation notes (31.5%) and diagnostic test results (48.5%) were less frequently documented. Similar deficiencies have been frequently reported in the literature; Çetin et al. (11) found that consultation notes were often incomplete, and Yemenici et al. (10) noted that test results were frequently undocumented. The absence or inadequacy of these sections may lead to significant issues in forensic evaluations, particularly when specialist opinions or additional investigations are needed. Thus, it is crucial to emphasize the necessity for more diligent documentation in these specific areas of forensic reports.

In this study, the most common reasons for forensic presentations were traffic accidents, assault-related injuries, and occupational injuries, respectively. These findings align with the literature. Aktas et al. (5) reported traffic accidents (43.4%) as the most frequent reason for forensic admission, followed by assault cases. Similarly, Alpaslan and Baykan (6) demonstrated that traffic accidents and assaults constitute the largest proportions of forensic presentations. This consistency highlights that traffic accidents and violence-related injuries consistently occupy the top positions among forensic cases in Türkiye, indicating the need for stronger preventive measures for road safety and violence reduction. Additionally, the significant proportion of assault-related forensic examinations conducted in emergency departments contributes to increased patient congestion and workload. In pediatric populations, one of the most frequent medicolegal issues is neglect, which may result in fatal events such as falls or foreign body aspiration (12). Thus, conducting routine forensic examinations in separate specialized forensic units outside ED could reduce the burden on emergency healthcare providers and enhance efficiency (6).

Comparing the completeness of reports between in-hours and out-of-hours shifts, our study revealed that reports filled during out-of-hours shifts were notably more detailed and complete, particularly in patient history (83.7%), physical examination (96.1%), and life-threatening condition assessments (87.6%). This finding contrasts with much of the literature. Lai et al. (4) reported lower documentation quality during night shifts and off-hours. The higher completion rates observed in our study during out-of-hours shifts may be attributed to lower patient volumes during night shifts in less crowded centers like Sinop, providing physicians with more time for documentation. One possible explanation could be that physicians working during night shifts, regardless of experience level, may have more available time and fewer competing clinical demands, allowing for more detailed documentation. However, this interpretation remains speculative, as physician characteristics were not directly assessed in this study. Indeed, it has been noted in the literature that senior and experienced physicians often tend to provide shorter and less comprehensive documentation due to heavy clinical responsibilities (4).

Additionally, our study found that patient history documentation was significantly better in cases without life-threatening conditions (84.4%) compared to cases with life-threatening conditions (62.5%). This finding contradicts general expectations and some previous literature. Çelik et al. (13) indicated that documentation is usually more thorough in patients with life-threatening injuries. A plausible explanation for our finding could be that physicians prioritize urgent medical intervention over comprehensive documentation when managing critically ill or injured patients. Nevertheless, accurate documentation of life-threatening conditions remains crucial from a legal perspective according to Article 87 of the Turkish Penal Code (8), underscoring the necessity for consistent and complete documentation, even in critical emergency scenarios.

The frequent issuance of "preliminary forensic reports" is another significant issue identified in our study. Previous studies by Keten et al. (14) and Yemenici et al. (10) have similarly criticized the excessive use of preliminary reports, emphasizing that this practice unnecessarily prolongs legal procedures. Therefore, it is essential to provide training

and support to emergency physicians to encourage the issuance of definitive reports whenever possible. In-service training of physicians is known to improve service quality in various fields. A study conducted with family physicians showed that cardiopulmonary resuscitation training had a positive effect on physicians' knowledge and knowledge level (15). To improve the quality of forensic reports, literature frequently emphasizes the importance of specialized training programs and establishing dedicated forensic units. Alabdulqader et al. (7) indicated a general lack of forensic documentation training among physicians, while Chaudhary et al. (16) demonstrated significant improvements in documentation quality through the establishment of Clinical Forensic Medicine Units. Adopting similar approaches in Türkiye could substantially enhance the quality of forensic reports.

Study limitations

The present study has several limitations. Its retrospective nature may have led to incomplete or incorrect data entries. Additionally, it was conducted in a single center, limiting its generalizability to other healthcare facilities. Moreover, we did not have access to information about the experience, seniority, or specific training of the physicians who prepared the forensic reports, restricting our analysis regarding the impact of these factors on report quality. Future studies employing prospective, multi-center designs and larger sample sizes may help overcome these limitations.

Conclusion

This study revealed that forensic reports had notably high documentation rates for injury descriptions but significant deficiencies in documenting consultation notes and test results. Reports prepared during out-of-hours shifts were more detailed, indicating that work shifts influence documentation quality. Additionally, incomplete documentation in critically ill or injured patients highlights the need for greater emphasis on thorough forensic documentation, even during emergency medical interventions.

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Ethical Approval: The study was started after the approval of the local ethics committee (approval ID: 53-2019BADK/11-86, dated: 25 May 2019).

This study was designed retrospectively. Therefore, no consent form was obtained

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