

# Medical Practitioners and the Litigation Process

## Part Two: *Writing Medical Reports.*

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Longer versions of Part One (in *New Doctor* 80) and Two of this paper are available at [www.drs.org.au](http://www.drs.org.au)

A key to the litigation process is the preparation of witnesses for court. Perhaps the most significant part of such preparation is based on the proper medical reporting process. Courts have recently given guidelines to writing medical reports for litigation purposes.

There is, of course, no ideal medical report and because every court case is different and every patient has a different medical condition it would be unrealistic to propose strict guidelines for the preparation of medical reports.<sup>1</sup> A sample medical report is available with the full text of this paper as it appears on the Doctors Reform Society website ([www.drs.org.au](http://www.drs.org.au)).

Even though a single feature of the medical report may be crucial, it is still essential that the report be comprehensive in all respects. In *Re Croser; Ex parte Rutherford & Anor* [2003] WASCA 8 (“*Rutherford*”) the Supreme Court of Western Australia attempted to provide some general guidance for medical panels in the preparation of certificates.

Firstly, His Honour observed that there is often a legitimate difference of opinion between medical practitioners on matters of diagnosis and prognosis. Where this occurs, the difference cannot be glossed over in arriving at a conclusion. To merely state its conclusions in a case of this nature will not discharge the onus on either a panel or medical practitioner to provide reasons for decision.

Secondly, it may be that a panel or medical practitioner has discretion as to whether or not it examines or re-examines a worker. Should the panel or medical practitioner decide in the negative on this question, reasons for such a decision should be stated as a matter of course. Where a worker is examined or questioned by a panel or medical practitioner, the nature of the examination or questioning as the case may be should be disclosed in the determination.

In *Re Gillet; Ex parte Rusich* [2001] WASCA 111 (“*Rusich*”); the Supreme Court of Western Australia considered the question of what matters should be addressed in a certificate issued by a medical panel. Miller J observed that the medical panel should describe the following when considering the assessment of a lower-back injury;

- a) an analysis of the medical evidence it accepted;
- b) the findings on examination of the applicant;
- c) the extent to which the work-related injury had caused or contributed to the applicant’s condition;
- d) the extent to which (if any) the work-related disability had been aggravated by any specific work incidents and, if so, to what extent;

- e) the specific distinction (if it existed) between non-compensable disability and compensable disability;
- f) the ultimate disability in terms of Item 36A of Schedule 2 of the *WorkCover Act*.

These guidelines can be applied to medical reports generally.

In *Re Monger; Ex parte Dutch* [2001] WASCA 220 (“*Dutch*”), the Supreme Court considered what matters need to be addressed when a medical practitioner certifies as to a workers condition. The requirement that a certificate or report be supported by sufficient medical evidence to justify the opinion expressed therein is central to this judgement. The Court held that “medical evidence” means more than the mere expression of an opinion. The certificate must show material of a medical kind which is logically capable of supporting the opinion that is ultimately expressed.

### Preparing the Report

Basic details should always be taken from the patient, that is date of birth, occupation and when the injury or accident took place. If the condition is one of gradual onset, details should be taken as to when the onset of symptoms was first noticed. It is important to record the date of any examination(s) in the report.

It is then appropriate to set out the nature of the referral. If a general practitioner referred the patient, then this should be stated. If another specialist referred the patient to the reporting medical practitioner, then this should likewise be detailed. If the report is prepared by a general practitioner and no referral has been made, then it is appropriate to state when the patient first presented complaining of the medical condition that is the subject of the report.

If it is anticipated that a medical report will be used for court purposes then it is basic to the court’s enquiry to establish the material upon which the medical practitioner has formed their opinion. Where a patient gives a history of work injury, or is referred for opinion because of that injury, it is important in the medical report to state the material upon which the report is based. If other medical reports have been supplied at the time of examination,<sup>2</sup> then details of those reports and materials should be disclosed in the medico-legal report. If there is other extraneous material in the form of X-rays and similar imaging evidence then this should be stated in the medical report. This attention to detail can avoid embarrassment in the open forum of court.

### History

To a large extent the medical profession must accept the his-

tory of any injury or disease given to them by the patient. Unfortunately, from time to time the implicit trust placed in the patient as a result of this general principle can be misplaced. For this reason it is suggested that details of the history should be recorded as the patient has stated them.

### Treatment

After a history has been obtained from a patient, full details of the treatment administered prior to examination, should be noted. If for example an X-ray report is available at the time of review then, where relevant that report should be quoted. The practitioner should also make their own assessment of the X-ray report if this is appropriate. Where the new assessment results in divergence, a comment should be made to that effect in the report. It is critical to the medico-legal report that where a medical practitioner has reviewed more than one set of X-rays then they should detail exactly which X-rays have been viewed. If changes in the X-rays are noted over time then it is important to detail precisely when the X-rays were taken. The medical practitioner should also note the treatment that is being administered to the patient at the time of examination.

### Work History

Assuming that the purpose of a medico-legal report is to express an opinion as to work capacity, it is critical to obtain details of the patient's work history. If the medical practitioner has been asked to give an opinion as to capacity for work, then it is important to establish the precise duties that the worker was performing at the time of the onset of the pathology in question. The medical report should set out what it is understood that the worker was doing at the time of the accident, or what the duties were when the onset of the pathology occurred. If the patient has been absent from work for some period, this should be noted in the report and details given as to whether or not the worker has returned to work.

### Current Complaints

It is important that the patient should disclose their symptoms without prompting. One should only ask specific questions if these are relevant to the pathology that has been presented.<sup>3</sup> Any suggestion of symptoms by the medical practitioner to the patient may compromise the opinion given. As near as possible, the details of the current complaints should be noted in the language of the patient with as little prompting as possible in describing their current systems.

### General Health and Past History

Where relevant, the medical practitioner should make a statement in the report of the patient's general health and past history. If there is an indication of a past history of like pathologies, then specific details should be taken as to the circumstances of the previous instances. It is quite common for medical practitioners to be asked to express an opinion as to whether the incapacity results from a particular injury.

### Examination

The nature of the examination will obviously depend upon the nature of the condition or injury. It is paramount that details

of the examination be specific, clear and comprehensive. If the medical practitioner performs any tests during the examination, these should be detailed. If blood tests are taken, or further X-rays ordered, this should be noted and the results detailed. It is also useful to record how the patient felt on the day examined. If necessary, review of X-rays and CT scans should be made and comments made as to their outcomes.

### Diagnosis

Diagnosis and prognosis are, in many ways, the critical parts of the report. Whatever the opinion expressed it is important that the medical practitioner show the basis of that opinion.

Often a medical practitioner will be asked to view a film taken by an investigator. There are a number of issues that should be raised about investigator's films. The first is that the film should clearly establish the identity of the patient. If there is any doubt as to the identity of the patient in the film, then this should be stated in the report. The medical report should state clearly what is seen in the film. If the patient is seen bending and lifting various objects, then this should be described. The medical report should include the date the film was taken.

It may be that at the time of making the report it is the first occasion the patient has been examined and a film is available for review. It is also possible that other medical practitioners have examined the patient. In such situations it is advisable to obtain copies of pre-existing medical reports so that a comparison of statements in these reports can be made with personal observations of the film.

### Prognosis

It is frequently the task of medical practitioners to give an opinion as to the future prospects of the patient. This may be an opinion as to the prospects of recovery from traumatic circumstances, an operation or the prospects of return to work. In the case of recovery from an operation, the medical practitioner should consult well-recognised medical texts when expressing a view. In the case of opinions concerning return to work or as to the capacity to perform certain duties, it is critical to establish what duties the patient is required to perform. When asked to express an opinion as to whether a patient is fit for a particular job, then a request should be made for a duty statement setting out the duties and tasks to be performed in that occupation. Without having such a duty statement, there is a strong likelihood that the opinion of the medical practitioner will be questioned in court as to whether the practitioner understood the nature of the work that was required for that occupation.

### Endnotes and References

<sup>1</sup> A fact noted in *Wong; Ex Parte Hays* (unreported SC(WA) 980575S 5 October 1998) per Wheeler J; and in *Re Croser; ex parte Rutherford & Anor* [2003] WASCA 8 at 19 per Rolfe AJ.

<sup>2</sup> e.g. A GP's referral note or another specialist report, copies of X-rays or CT scans etc.

<sup>3</sup> Scarf, Dr GE, *The Expert Medical Report*. Working with Experts and Expert Reports. LAAMS Publications, 1992 at 8.