Medical Practitioners and the Litigation Process Part Two: *Writing Medical Reports*

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It has been noted in part one of this article that 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 reporting process. Recently, the quality of medical certification and reporting has been subject to considerable comment by the Supreme Court of Western Australia, largely as a consequence of the rise of the use of medical panels and impairment guides to establish thresholds for various entitlements to workers compensation.[1]

In relation the former aspect of medical panels, the *Workers Compensation and Rehabilitation Act 1981*(WA) (the "*WorkCover Act*") has, since 1993, placed more emphasis on the use of medical panels in workers compensation disputes. A primary requirement of the *WorkCover Act* is that the determinations of medical panels are final and not subject to appeal. However, this does not exclude the Supreme Court of Western Australia from exercising its supervisory role over all inferior courts and tribunals within the state. Formally, this is referred to as the "prerogative" (as in Royal Prerogative) jurisdiction of the Court[2] to overturn medical panel decisions if their reasons for making decisions are either not clearly stated, are inconsistent with the evidence, do not adequately describe the process by which the decision was made, or are formulated in a manner that is inconsistent with governing statutes.[3]

Medical panels are also used extensively to assess impairment levels of workers who seek to claim common law damages for work-related injury or disease. In such cases, the medical panel is asked to consider the relevant available medical information, to examine the worker (where appropriate) and, using a range of guides, allocate a percentage impairment rating for the injury or disease with which the individual worker presents. Ordinarily, the certification of a medical panel cannot be challenged by the worker unless the method by which the panel arrived at its opinion is not clear, has failed to apply the correct impairment tables or is otherwise inconsistent with statutory requirements.

The foregoing establishes the necessity for medical practitioners who become involved in court processes to adapt their skills in report writing to the specific requirements of the legal system. This should both aid medical practitioners in preparation for any involvement in the litigation process, and in the event that they themselves might also at some stage be a member of a medical panel.

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.[4] There are, however, general guidelines that will assist medical practitioners who have the responsibility of attending court to give evidence in person or who are called upon however frequently, to give medico-legal reports. Attached to this paper is a sample medical report. It deals with a hypothetical patient who has suffered a mechanical lower-back injury. Despite the necessary level of particularity it is hoped that the sample report will illustrate the practical application of theoretical principles elucidated in this article.

A medical report may be requested as evidence in legal processes for one of a number of reasons. It may simply be that the report is required to attain a history of treatment. It may be required to describe either or both diagnosis and prognosis.

It is assumed for our purposes that the majority of medical reports produced by medical practitioners are for the purpose of giving an opinion as to work capacity and fitness. Even though a single feature of the medical report maybe crucial, it is still essential that the report be comprehensive in all respects. Some guidelines appear from the decisions of *Re Croser; Ex parte Rutherford & Anor* [2003] WASCA 8 (*"Rutherford"*); *Re Gillet; Ex parte Rusich* [2001] WASCA 111 ("*Rusich*"); and, *Re Monger: Ex parte Dutch* [2001] WASCA 220 ("*Dutch*").

In Rutherford, the Supreme Court of Western Australia was placed in the embarrassing position of having to set aside a decision of the Medical Assessment Panel for the second time,[5] essentially for the same reasons, namely a failure to provide adequate reasons for decision.[6] Faced with such a frustrating situation, Rolfe AJ (with whom Murray and Templeman JJ agreed) attempted to provide some general guidance for medical panels in the preparation of certificates. In providing this advice, His Honour made a direct link between such situations and the writing of a medical report for the purposes of legal actions. This implies that the advice tendered by His Honour is of relevance in both settings.

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. The panel or practitioner as the case may be must inform itself on the basis of all written evidence, together with its own examination of the worker as viewed through the prism of its own experience before arriving at its conclusion. Such a conclusion will necessarily view certain opinions and facts more favourably than others. 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.

In the words of Rolfe J, the "law does not demand that the reasons should extend beyond those sufficient to enable the lay reader and, in some cases, the medical reader, to determine how the panel reached its decision." Specifically, where certain reports or other evidence are accepted and others rejected, the basis upon which such a determination has been arrived at must be disclosed.

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 addition, the impact on the panel or medical practitioner of the answers provided by the worker, and the way in which these are provided should also be disclosed. Where an examination occurs, any findings, viewed in the light of such history as has been obtained together with complaints made by the worker, should be disclosed.

In *Rusich* the Supreme Court considered the question of what matters should be addressed in a certificate issued by a medical panel. It should be remembered that under the *WorkCover Act* the medical panel is required to answer specific questions depending on the specific circumstances of each case. The guidelines suggested in *Rusich* might not therefore apply to all forms of medical report. Nevertheless, the comments of Miller J are still both relevant and instructive.

His Honour 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 Schedule2 of the *WorkCover Act*.

These guidelines can be applied to medical reports generally. The sample medical report which is set out below adopts the above framework recommended in *Rusich*.

In *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. The concept of certification was discussed the previous year in *Vurlow v Leighton Nursing Homes* [1978] WAR 15 ("*Vurlow*") where Burt J observed[7] that a proper certificate should set out details of the injury that formed the subject of the claim, and express an opinion as to the workers' condition, clearly identifying the grounds upon which that opinion is formed. In combination, these cases provide considerable guidance when approaching the task of drafting a medical report or certificate.

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. These details, however basic, are frequently glossed over by medical practitioners in detailed reports. It is frequently difficult to establish, from reading a medical report, when any examinations took place. The sample report provided demonstrates that these basic details be stated clearly at the commencement of 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. When details of the referral and the background to the referral have been given in a medical report, then a detailed history should be set out in that 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,[8] then details of those reports and materials should be disclosed in the medico-legal report. If at the time of the examination or prior to making the report, the medical practitioner has viewed an investigators' video (discussed below) then the nature of the video should be stated in the medical report. Where possible, details should be given as to when the footage was taken and, where appropriate, where the footage was shot.

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. A frequently asked question for court purposes is; "At the time of making your report what material did you have before you?" If the medical practitioner has detailed this in the report, then the question need not be

asked and the medical practitioner can be saved the embarrassment of searching their file for the answer.

History

To a large extent the medical profession must accept the history 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. In the sample report, the recital of the history reflects the patient's own words. Of course it need not be verbatim, as the medical practitioner should put it down as coherently as possible. Dr Scarf recommends that the practitioner obtain the following information. In determining the basic history of the injury, the dynamics are most important. What actually happened must be understood in mechanical detail. For example, if one falls on a twisted flexed knee then it is likely the cartilage will be torn. If however, in isolation the knee-cap is bumped against something, it is most unlikely that the cartilage will be torn but some other pathological entity may occur. The immediate consequences following an injury should be considered:

Unconsciousness, winded, unable to get up, swelling of a joint all are important initial clinical features. The immediate treatment, continuing treatment and rehabilitation should all be considered in detail. What happened at the scene, was an ambulance involved, was the injured hospitalised, were operations performed, did the injured go home or was a GP called?[9]

Treatment

As in the sample report, 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. It is not uncommon for personal injury cases to take years to come to conclusion. Over that period of time a number of X-ray examinations may have occurred. 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 where 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. If the worker has returned to work details should be given of whether or not this was on reduced duties. Some comment should be made as to whether or not the patient has been able to carry out their assigned duties. The patient would normally supply this information at the consultation.

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.[10] The quality of the medico-legal report can sometimes be affected by the quality of the questions asked on examination of the patient. In contested cases, the veracity of the patient can be critical. 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. If there are a number of reported injuries, details should be taken in respect of each. Some assessment should be made as to the severity of injury at the time. If necessary, the medical practitioner should request copies of previous medical reports relating to past injuries so that a proper assessment can be made. Again this shows the importance of fixing dates to X-ray reports and the like.

Examination

Dr Scarf suggests:

A person sent for assessment should be observed constantly. That observation starts from the moment he/she is sighted in the office, during conversation and in undressing. The use of limbs is noted and the manner in which a person walks and undresses is significant. The posture during conversation and undressing is important, and whether there are any props or orthotic supports.[11]

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

Together, 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. If the opinion expressed is based on the examination and viewing of X-Rays then this should be stated. If the opinion is based on subjective complaints, then that should be stated. If the opinion is arrived at as a combination of all these matters then, again this should be stated. If the medical practitioner takes the extra time to say why the opinion was arrived at, further questions or medical reports may be avoided and perhaps even the need for a court appearance.

It is worth discussing the issue of investigator's videos. 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 the patient "has good and bad days". This may affect your opinion, having regard to the film viewed. If the film was taken some time previously, then a review should be made of notes and records taken at the time, where the patient has been seen over a period of time. 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. All this may take time but the reward will be a more comprehensive report, and if the report resolves some of the issues in contention between the parties, there will be less prospect of protracted litigation.

Prognosis

Finally 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. In the event that the medical practitioner's knowledge of what an occupation requires is based on mere supposition on their part, or has in fact an incorrect perception of the tasks, this can lead to embarrassment for the medical practitioner and may invalidate the opinion expressed.

SAMPLE REPORT

Mr E.X. Pert
MBBS. FACS. FRACS.
Address
Phone

Frank and Candour
Solicitors -

Dear Sir/Madam.
Re: Ms Sandra Foot

Date *of* Birth:	21/10/58
Occupation:	Word Processor Operator
Date *of* Accident:	29/6/86 (*onset of condition from)
Date *of* Examination:	13/12/87

Referral

Ms Foot was referred to me by [her treating GP] or [Mr X a specialist in Y for further review] or [your office].

I obtained the above preliminary details from [Ms Foot] or [the GP notes] or [the reports supplied to me for this review].

Background

At the time of my review on 13/12/87 I had been supplied with the following documents to assist me with the review:

a) Dr Small's referral note 10/12/87;
b) Mr Smith's report 28/10/86;
c) Copy of X-ray report 30/6/86; and,
d) Copy of CT report 26/1 0/86.

In addition, at the time of my review I viewed:

a) X-rays taken at 2 hospitals 30/6/86;
b) CT scan taken by Dr Jones 26/10/86; and,
c) Investigator's film apparently taken between November 1986 and January 1987 in which Ms Foot is clearly identified.

History

Ms Foot told me that on 29/6/87 she was bending over to pick up a box of photocopying paper when she felt a sudden pain in her lower back. She said the box was full, and probably weighted about 20kg *[NB: get weights of objects etc if possible]*. She told me that this event occurred at about 10.30am *[NB: get exact time of events if possible]* and that, as she was about to have morning tea she decided to stop work and rest for a while. She did not tell her workmates immediately about the incident, but returned to her workstation about a half hour later. By 2.30pm the pain in her back had increased, and she reported the incident to her supervisor. The pain became so severe by 4.00pm that she left work early to see her general

practitioner, Dr Small.

Ms Foot showed me where the pain started. She pointed to about the middle of her back at the belt level.

Treatment

Ms Foot said that her general practitioner prescribed *[NB: insert the precise description of drugs if necessary]* and after these medications gave no relief, she was referred for physiotherapy for 3 weeks *[NB: obtain periods of treatment]*. She initially had some relief from this treatment but ceased the treatment when progress slowed. X- rays were taken on 30 June 1985. The X-ray report of Z Hospital reads:
"*[NB: Quote report where relevant.]*"

I have viewed the X-rays. In addition, a CT scan was carried out, 26 October 1986. I have read the CT report *[NB: Or quote relevant portion].*

[NB: As patients often have numerous X-rays, CT scans done and it is important to refer to them by date]

Ms Foot has done some swimming and other exercise with limited relief to her back pain. She was referred to [my colleague] Mr Smith in October 1986 and I have read his report *[NB: Or quote relevant portion].*

Present Treatment

Ms Foot presently takes *[NB: insert the precise description of drugs if necessary]* for her back pain and *[NB: insert the precise description of drugs if necessary]* to assist her sleep.

Work History

Ms Foot is employed as a Word Processor Operator. Her description of her duties prior to the lifting accident were:

a) *[NB: insert the precise description of duties]*
b) …

This description does/does not accord with the formal duty statement provided by Ms Foot's employer.

After the lifting accident on 29 June 1986 she was absent from work for 3 weeks. Ms Foot returned to modified duties after 3 weeks. The modified duties consisted of:

a) *[NB: insert the precise description of the modified duties]*
b) ...

This work differed from Ms Foot's normal duties in that it *[NB: discuss whether the duties were lighter/heavier/radically different etc]*. After 3 months of this regime of modified duties Ms Foot found the lower back pain was increasing and again consulted her general practitioner Dr Small. Dr Small referred her for further physiotherapy. Ms Foot has not returned to work since *[NB: insert dates].*

Current Complaints

Ms Foot stated that her back pain was severe for 3 weeks after the accident in June 1986. When she returned to work after 3 weeks, the pain had reduced. However she stated that after about 2 months on what she described as "light duties" the pain increased until, after about 3 months, she could no longer work.

Ms Foot currently complains of significant pain in the lower back, and she says *[NB: use the patient's own language]* "this pain spreads to either side of my back and towards my coccyx". She indicated that sometimes she gets pain in her right leg down to her knee. The pain in her right leg occurs about twice a month and lasts for a few hours *[NB: careful non-suggestive questioning is needed to understand the patient's own appreciation of the symptoms]*. The general lower back discomfort at the time of my examination was mild and static.

Ms Foot stated that the pain is worse if she sits for longer than 30 minutes, or when lifting anything heavier than her groceries. She can walk for 20 minutes without discomfort but longer walks require her to rest. She reported that she previously played hockey and tennis but has ceased these sports since the accident.

General Health

Ms Foot told me she did not currently have any other medical problems/ did have the following: *[NB: Insert Details]*

[NB: if there are other medical conditions, the medical practitioner should comment on any relationship with the pathology that is the subject of the report].

Past History

Ms Foot indicated that she did not previously suffer any back injuries or pain.

On examination

Ms Foot stated that she had travelled to my rooms by car. Her friend had driven her. She felt a little stiff this morning, but otherwise said she was having a reasonable day.

Ms Foot could stand erect without any list and demonstrated a reasonable range of lower back movement. She could get her fingertips to within 15cm of the floor on flexion before any sign of discomfort. I performed the straight-leg raising test and noted 75 degrees bilateral reflexes were present. There was no neurological deficit that I could determine. On palpitation to the lower half of the lumbar region Ms Foot complained of some pain, this was more marked at the lumbar sacral level. *[NB: All other tests performed on examination- should be noted].*

Review of X-rays/CT Scan

X-rays and CT scans previously referred to were reviewed. I noted from the X-ray, evidence of *[NB Insert details of observations]*. This was confirmed in the CT scan.

Diagnosis

Ms Foot has *[NB Insert condition]*. I have formed this view from *[NB Refer to supporting evidence in detail -i.e. X-rays/ examination/subjective complaints]*. This is also evidence

of *[NB State additional preliminary diagnoses]* -this could be confirmed by *[NB indicate what further tests might be required]* -at present I would be confident that it is. This condition is/is not consistent with the history obtained/diagnosis of Mr Smith *[NB If there is a difference of professional opinion state clearly why this has been reached with direct reference to medical reports]*. My opinion is that after reviewing Ms Foot, and seeing the investigator's film(s) of *[NB Insert date]*, that the subjective complaints and objective test are/are not consistent.

On the investigators film I saw the following activities being performed by Ms Foot:

a) …
b) …
c) …

These activities are/are not consistent with the complaints described to me. They are not/are consistent because:

a) …
b) …
c) …

Treatment

I recommend the following treatment. …

Prognosis

At present Ms Foot is not fit for her work as a Word Processor Operator. This is because from what I have been told by her about that job, and also from the duty statement that I have been provided with, her work involves bending and lifting and constant sitting. She is not capable of this type of work. *NB If you have been requested to give an opinion on alternative employment capacity it is best that this be supported from the finding you make above. Eg:*

a) You have asked whether Ms Foot might be fit to do Clerical Assistant's work. Do not offer a view on this without further details of the work involved.

or,

b) Having read the duty statement of a Clerical Assistant my opinion is that Ms Foot is not fit for that work because it requires standing for extended periods and this is likely to aggravate her back and leg pain.

Endnotes and References

[1] For example, the Western Australian Supreme Court Full Bench decisions in the related cases *Re Croser; ex parte Rutherford & Anor* (2001) 25 WAR 170; and, *Re Croser; ex parte Rutherford & Anor* [2003] WASCA 8.

[2] Accessed by the prerogative writ of *Certiorari*.

[3] See in particular *Wong; Ex Parte Hays* (unreported SC(WA) 980575S 5 October 1998) where the Supreme Court set aside a certificate of a medical panel on the basis that it merely listed the materials upon which it relied and did not disclose any basis upon which it considered the materials, or resolved any conflict between those materials. *Hays* has been followed in a series of cases where the Supreme Court has found the medical panel has not disclosed adequate reasons for its decision. See for example *Re Anastas; ex parte Welshby* [2001] WASC 178 (per McLure J who noted that the panel had failed to discuss all relevant disabilities to which it had referred) and likewise in *Re Babban; Ex parte Suleski* [2001] WASC 289. Wheeler J in *Palazzolo v Brown* [2002] WASC 49 stressed that the panel should not be bound by rigid requirements to give detailed reasons and it was in order for it to refer to the materials before it as reference to some of its findings.

[4] 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.

[5] The first Full Court consideration of this matter was *Re Croser; ex parte Rutherford & Anor* (2001) 25 WAR 170.

[6] *Re Croser; ex parte Rutherford & Anor* [2003] WASCA 8 at 18: "I am of the opinion that the panel has totally failed to comply with this Court's requirements for the giving of reasons. I can only think that this stems from its failure to understand what this Court required." Per Rolfe AJ.

[7] At 16.

[8] Eg: A general practitioner's referral note or another specialist report, copies of X-rays or CT scans etc.

[9] Scarf, Dr GE, *The Expert Medical Report.* Working with Experts and Expert Reports. LAAMS Publications, 1992 at 7.

[10] Scarf, Dr GE, *The Expert Medical Report.* Working with Experts and Expert Reports. LAAMS Publications, 1992 at 8.

[11] Scarf, Dr GE, *The Expert Medical Report.* Working with Experts and Expert Reports. LAAMS Publications, 1992 at 9.