How to write a medicolegal report

Sara Bird, MBBS, MFM (clin), FRACGP, is Medicolegal Adviser, MDA National.

Case histories are based on actual medical negligence claims, however, certain facts have been omitted or changed by the author to ensure the anonymity of the parties involved.
General practitioners are frequently asked to prepare reports for a variety of medicolegal purposes including court proceedings, worker's compensation and insurance reports. The aim of this article is to provide GPs with some practical advice on how to write a medicolegal report and the common pitfalls to avoid.

Case history

Dr Carroll had looked after Mr Jones and his wife for over 10 years. On occasions, the husband and wife attended together for marital counselling. Mr and Mrs Jones ultimately separated and Mr Jones continued to attend Dr Carroll as his general practitioner.

One morning Dr Carroll received a phone call from Mr Jones during a busy morning of consultations. Mr Jones was quite distressed and said that he urgently needed a letter from Dr Carroll to use in court proceedings involving his landlord. Mr Jones said that he had had to break the joint lease that he and his former wife had on a house. He could no longer afford the rent on his own and was concerned that he may lose his bond money and advance rent. Mr Jones said his landlord had commenced proceedings in the Tenancy Tribunal and he had to appear before the tribunal later that day. Dr Carroll asked Mr Jones what he should write in the report. Mr Jones dictated a few sentences that Dr Carroll transcribed. Dr Carroll left the report at the front desk of the surgery for Mr Jones to collect later that morning.

Two years later, Dr Carroll received a letter from the Complaint's Commission stating that the commission had received a complaint from Mrs Jones alleging that Dr Carroll had breached her confidentiality and provided an inaccurate medicolegal report.

Medicolegal issues

The letter of complaint from Mrs Jones stated that during her divorce proceedings earlier that month, her ex-husband had tendered a report by Dr Carroll. Mrs Jones enclosed a copy of the report which read as follows:

'To whom it may concern
Re: Mr Robert Jones
I have been Mr Jones' GP for over 10 years. I also know Mrs Eve Jones. The marriage broke down after Mrs Jones experienced health and personality problems. I consider the separation and divorce occurred suddenly.
Yours sincerely
Dr Carroll'

According to Mrs Jones' letter of complaint, she had not seen the report before Mr Jones' attempt to introduce it as evidence in the divorce proceedings. Mrs Jones complained that Dr Carroll had breached her confidentiality in describing 'health and personality problems' and also believed the description was inaccurate. Mrs Jones was concerned that she had not seen Dr Carroll as her GP for over a year when the report was actually written by him. Dr Carroll was distressed and angry that his report had been used in such a manner. He responded to the Complaint's Commission that he had intended the report to be used at the Tenancy Tribunal and not during the divorce proceedings. He stated that he did not consider the term 'health and personality problems' comprised a specific medical diagnosis. As Mr and Mrs Jones had attended a number of consultations together, he did not realise at the time he wrote the report that it was a breach of patient confidentiality. Dr Carroll concluded his response to the commission by acknowledging and apologising for the upset and harm that his report must have caused Mrs Jones. In conclusion, Dr Carroll wrote: 'I realise that I was very naïve to write such a report and in future I will give much more careful consideration to any report that I am asked to write'. A copy of Dr Carroll's response was provided to Mrs Jones. A few

weeks later Dr Carroll was informed that the Complaint's Commission had determined no further action would be taken.

Discussion

General practitioners are frequently asked to write reports for a variety of medicolegal purposes. There are two important issues that need to be considered before writing a medicolegal report:

1. Purpose of the medicolegal report – before writing any report, you should know the purpose of the report you have been asked to prepare. For example, if you receive a request from solicitors for a report, you should ensure that the reason for the request is clearly identified. If not, you should write to the solicitors and ask for clarification of the purpose of the report, and
2. Patient authority – you should be careful not to breach your patient's confidentiality. You should ensure that you have a signed authority from your patient(s) before forwarding a medicolegal report to a third party. The authority should be recent and specific for the purpose of the report. The exception to this requirement is a report to the coroner. In this situation, you do not need an authority. However, you should obtain written confirmation from the police or requesting party that the report is being obtained on behalf of the coroner. Difficult situations may arise when the patient has died or where the patient is a child. In these situations the person who has the legal authority to give permission to release information about the patient should be identified and their authority sought to release information. You may need to seek advice from your medical defence organisation in these situations.

In this case, Dr Carroll did not carefully assess either of these issues and, as a result, found himself the subject of a complaint.

Risk management strategies

In preparing a medicolegal report the following steps should be followed:

- know the purpose of the medicolegal report
- if the report is to be sent to a person other than your patient, obtain the written authority of the patient to prepare and release the report to the third party
- use the medical records to prepare the report. Do not rely on your memory or the instructions from the patient or the requesting party
- The report should be:
  - relevant to the request
  - well organised – headings should be used if the report is long
  - confined to the facts and your medical opinion – stay within your area of expertise and avoid the use of legal terminology such as 'negligence' or 'testamentary capacity'
  - understandable to the audience – beware of using medical jargon. If necessary, provide definitions and explanations of medical abbreviations or terminology, eg. 'the patient had dysphagia (difficulty swallowing)'
- There are many ways of formatting a medicolegal report. A suggested format is as follows:
  - patient's name and date of birth
  - requesting party's name, date of the request and purpose of the report
  - your credentials, including qualifications and your position at the time of the event/incident and your current position
  - medical facts in chronological order including:
    - patient's history and symptoms
    - examination findings
    - investigations
    - provisional diagnosis
    - management
    - opinion (if any)
    - response to specific questions (if any)
    - your signature and the date
- There are a number of common pitfalls to avoid:
  - do not breach your patient's confidentiality
  - do not act as an advocate for one party or the other
  - do not provide an opinion beyond your expertise
  - do not alter your report at the request of your patient or a third party. If you receive further information or you have made a mistake, provide a supplementary report
  - remember that you may be cross examined on your report – you should only write what you would be prepared to say under oath in court.

Summary of important points

- The preparation of accurate, comprehensive and timely medicolegal reports is part of the GP's role.
- Before preparing a medicolegal report, ensure that you know the purpose of the report and that you have an authority from your patient.

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AFP

Correspondence
Email: sara_bird@bigpond.com