FACTSHEET

MEDISEC

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Drafting medico-legal reports

Doctors are often asked by patients or their solicitors to provide a medical report for the purpose of initiating a claim to the Personal Injuries Assessment Board (PIAB) or for personal injuries litigation. Doctors may also be asked for medical reports for use in other types of litigation including criminal proceedings, family law, probate law and wardship / childcare applications.

It is important to remember that doctors who prepare medico-legal reports may be asked to give evidence in court in relation to their report.

Factual v Expert Medico-legal reports

This guidance relates to providing **factual** medico-legal reports as opposed to expert reports, where doctors are specifically instructed by a solicitor to provide an expert opinion on issues such as liability / breach of duty and causation for the purposes of medical negligence proceedings. Doctors also act as experts in fitness to practice proceedings providing an expert opinion on poor professional performance or professional misconduct. The distinction is that the specific role of an expert witness is to assist the court or regulatory body in arriving at an independent opinion by providing the necessary specialist knowledge. If you are asked to provide an expert report or to give expert evidence at a hearing, please refer to our factsheet *Acting as an Expert Witness* and feel free to contact Medisec if you have any concerns or require advice.

The Medical Council Guidelines

The Medical Council's *Guide to Professional Conduct and Ethics for Registered Medical Practitioners, 9th Edition, 2024* (available on the Medical Council website) provides some guidance in relation to the provision of medical reports. Paragraph 51 provides as follows:

> *51. Medical Reports*
>
> *Doctors may be requested to provide medical reports relating to their patients to third parties e.g., insurance companies, legal professionals or employers.*
>
> *51.1 If the report relates to the patient's current state of health, you should, where appropriate, carry out an up-to-date examination.*
>
> *51.2 You should be satisfied that the patient understands the purpose and scope of the report and of any examinations or investigations required to support its preparation and that the professional standards for consent and disclosure are followed. (see chapters 2 and 3).*
>
> *51.3 The report should be confined to the purpose for which the report has been requested. You should inform the patient that you have a duty to the third-party as well as to the patient and that you cannot omit relevant information from the report.*
>
> *51.4 In producing your report, you should distinguish clearly between facts identified and verified by you, and information provided to you by the patient or by others.*
>
> *51.5 You are entitled to request a professional fee for providing a medical report. The fee should be appropriate to the service provided and must not be based on the outcome of litigation. The content of reports must not be influenced by financial or other inducements or pressures.*

51.6 You should provide reports promptly so that the patient does not suffer any disadvantage from delay.

The Law Society of Ireland has also produced Medico-Legal Recommendations which do not specifically apply to doctors but are a useful resource (available on the Law Society website).

Consultation with the patient

Before preparing a factual medico-legal report, you should ensure that the patient understands and freely gives consent to you providing the report. You should ensure the patient appreciates the purpose and scope of what will be included in the report and of any examinations or investigations to be carried out in its preparation.

Where a solicitor is instructed by the patient, a request for a report should be made in writing by the solicitor and not the patient. Where a patient is not represented by a solicitor, you should ask the patient to put the request in writing.

You must ensure the patient understands that confidential information provided by them will be given to a third party (i.e. their solicitor, PIAB and other parties defending the claim such as an insurance company or their employer) and this may include confidential medical history.

Once the report is drafted, the best course of action would be to go through your final report with the patient so they understand the information that is being included. This will also give you and the patient the opportunity to spot any errors / inaccurate information included in the report and should avoid the necessity for any supplemental / addendum reports. The report should not go beyond the purpose for which the report has been requested.

You should not be pressurised by your patient to include anything inaccurate in your report. In addition, you should not be pressurised to omit necessary information. If a patient asks you to include inaccurate information or omit essential details, you should explain that you have a duty to the third-party as well as to the patient and that you cannot omit relevant information from the report. Where the patient reports symptoms that are not identifiable on objective examination, you should specify in the report that the symptoms come from the patient's own account: e.g. "*the patient reports ongoing pain and stiffness".*

You should carefully document consultations with the patient in relation to the report and keep all correspondence from the patient or their solicitors on the patient's file.

Content of the report

When providing a report for submission to PIAB, you should where possible, use the template provided on the PIAB website.

By way of general guidance, a medico-legal report should include the following:

- Patient's name, date of birth, occupation and registered address;
- Requesting party's name, date of request, purpose of the report and any reference number they give;
- Your own name, position, address, professional qualifications, practice experience and Medical Council registration number;
- Date of report;
- List of documents considered and relied on for the purposes of the report;
- Patient's medical history (only relevant to the injury). This may include previous accidents;
- List of all *relevant* clinical entries and details in chronological date order, including any relevant telephone consultations and include where possible:

  - Any details given by the patient in relation to the accident including the date of the accident;
  - Presentation history and reported symptoms;
  - Examination findings at time of presentation, noting investigations and provisional diagnosis;
  - Condition at time of the last consultation;
  - Treatment and management of the patient's condition;
- Refer to any specialist involvement and their findings;
- Include details of any physiotherapy attendances if known;
- Results of any *relevant* x-rays, blood tests or any other relevant examinations or investigations, where known;
- Address any specific questions if any are posed by the requesting party;
- If the injury is an aggravation of a pre-existing condition, this should be specified and details provided;
- When doctors are asked to provide a factual medico-legal report, they are sometimes asked to provide an opinion on condition and prognosis. The doctor can give this opinion where appropriate but should be careful not to stray outside their area of expertise. Any opinion on condition and prognosis should include expectations for recovery with timelines and a focus on how the symptoms might affect the patient's everyday life. If it is not possible to give a prognosis, this should be stated.

Report on the basis of clinical notes

If you do not recollect the patient's attendance or if you did not actually see the patient at the relevant time, it is still possible to assist your patient and provide a report based solely on the patient notes. If providing a report on this basis, it must be clearly recorded in the report.

> e.g.: "*I have no specific recollection of my involvement in the care of the patient and am providing a report solely on the basis of my contemporaneous records at the time of attendance at the GP surgery"* or "*I did not examine the patient at the time of the accident but I have reviewed the notes of my colleague Dr X / the discharge letters from her treating consultants, Dr Y at Hospital Z*".

Alterations to your report

After releasing your report, if you are requested to alter it by the patient or a third party having either made an error or received additional information, you should provide a supplementary / addendum report rather than alter your original report. You may be asked to give evidence at a later date so it is important you record your reasons for writing the supplementary report e.g. to correct an erroneous accident date.

Additional advice

Other general points to consider when drafting a medico-legal report include:

- Doctors should work within their own competencies and expertise;
- Consider including a short bio outlining your qualifications and experience;
- Write in the first person;
- Refer to any relevant records in your possession. If some are not accessible document this fact in the report e.g. Emergency Dept. letters etc;
- Explain abbreviations or technical terms;
- Include the names of any other health professionals involved in the patient's care e.g. practice nurse;
- Number the pages in your report;
- Keep sentences short;

- Use subheadings to order the report;
- Check for lack of clarity or contradictions / inconsistencies;
- Remember your role is not to act as a your patient's advocate in this instance but to provide a factual report of your patient's condition;
- Differentiate between facts and opinion;
- Ensure the report is delivered by a secure method (e.g. hand-delivered, courier, registered post or by way of password-protected attachment to an email).

To whom should the report be furnished

Where a solicitor is instructed, the report should be furnished to the solicitor requesting the report. As a general rule, the report should not be copied to the patient unless there are particular reasons for doing so. It is then a matter of legal professional judgment as to whether the report should be disclosed by the solicitor to their client. In order to avoid any confusion or misunderstanding, ensure you inform your patient during your assessment that the report will be provided directly to their solicitor.

Where a patient is not represented by a solicitor, then the report should be furnished directly to the patient.

Payment for reports

Doctors are entitled to request a professional fee for providing a report. The patient, and not the solicitor is responsible for paying for the medical report. A solicitor requesting a report does so as an agent for his client but the overall responsibility for the fee rests with the patient.

Finally, always keep in mind that you can be cross-examined on your medico-legal report on oath in court so great care should be taken to ensure reports are accurate.

If you have concerns or queries in respect of a request to provide a medico-legal report you should contact the advisory team at Medisec for further advice.

"The contents of this publication are indicative of current developments and contain guidance on general medico legal queries. It does not constitute and should not be relied upon as definitive legal, clinical or other advice and if you have any specific queries, please contact Medisec for advice".