What do they want from me now?

Slater & Gordon
Lawyers

Information for health professionals on report preparation and court appearances

Slater & Gordon has prepared these notes to assist you in dealing with lawyers and your involvement in the court process. More detailed information is available on our website www.slatergordon.com.au.

We welcome any suggestions you may have to minimise the inconvenience, stress and uncertainty that affects all participants in litigation. You can email us at medicallaw@slatergordon.com.au.

Slater & Gordon hopes that your dealings with us will reflect our commitment to assistance of and minimal inconvenience to health professionals.

This document outlines information regarding:

What do they want from me now?

If your patient is pursuing a claim for compensation following an injury, there is a good chance that most if not all of their treating health professionals will be called upon to assist. Most commonly the requests will be for provision of copy records, to write a report and, in some cases, to give evidence in court.

Although report writing can be time-consuming and tiresome, appearing in court is a greater disruption to a health professional's practice. Fortunately, in most cases, a succinct objective report can significantly reduce your chances of being called to court.

Tips on report writing

A report written for medico-legal purposes differs from other types of report writing because of its use as evidence and consequently the close scrutiny that it receives. This brief guide should assist you to produce lucid, objective reports suitable for use in court.

Who is the report for?

A report may be requested by the lawyers acting for the injured person ("the plaintiff") or by the representatives of the party alleged to have caused the injury ("the defendant"). A defendant may be represented by a lawyer, an insurer or an authority such as a WorkCover authority. The report is requested to assess and/or provide evidence regarding the patient's condition, treatment and prognosis.

It is most likely that such a report will be seen by a range of people, including the patient, the representatives of both parties and the court or similar tribunal (which sometimes includes the members of a jury).

Providing a report on the basis that it is "personal and confidential" will not prevent disclosure.

Health professionals are often required to comment on matters of some delicacy such as life expectancy. Most lawyers attempt to relay any such information sensitively.

Confidentiality and privilege

A request for a report should always be accompanied by the patient's signed authority. This allows you to provide the relevant information without being in breach of your duty of confidentiality. You should only accept original authorities, not photocopies.

Until the report is circulated to other parties by the lawyer, its status is usually that of a privileged document. A privileged document is obtained to provide legal advice to the patient and should not be revealed to anyone else without the patient's permission. The report is also covered by health professional -patient confidentiality and the practitioner cannot release copies without the specific authority of the patient.

The content of the report

The amount of information contained in a report will depend on the nature of the matter and the purpose for which the report is sought. In most instances, you will be asked a series of questions in the letter of instruction. It is important that you address each question fully, and in the order asked.

Usually a report should contain:

- the patient's history & complaints
- your findings on clinical examination
- tests performed and the relevant outcomes
- diagnosis
- treatment provided
- opinions as to prognosis
- referrals to other health professionals

The extent of a patient's prior history to be detailed in a report is a matter of judgment and balance. Personal information not relevant to the issues involved in the matter for which a report has been requested, need not be included. Conversely matters relevant to the degree of injury (e.g. a previous injury to the same site) should be included.

Patient histories

Health professionals face time constraints and so it can often be difficult to extract an accurate history from a patient regarding precisely how the injury occurred.

You may not have a precise record of how the patient's injury occurred, for example, whether he or she slipped or fell. In court proceedings, the issue of whether the patient slipped or fell may be fundamentally important. By contrast, this question may be of small relevance to a health professional treating the patient. Courts appreciate that health professionals are not retained to be historians and that a notation of a patient "falling" is not meant to be a definitive declaration of the mechanism of the injury. However in writing a report, some care should be taken in describing the history provided.

If your records do not contain comprehensive information about how the injury occurred, you can avoid these difficulties by beginning this section of your report with the phrase, "A history sufficient for the purposes of treatment only was obtained and the details noted as follows.....".

Symptoms

Similarly, a health professional may not record all symptoms in the clinical notes. Some symptoms may be unimportant for the immediate treatment of the condition. Therefore, a specification of the symptoms in a medical report should not be represented as an exhaustive record. You may avoid triggering debate in court over the content of your report by prefacing your discussion, "Symptoms recorded at the time of attendance....". By clarifying the scope of your report in this way it is more readily acceptable to both parties. The parties may then consent to the report being accepted without your attendance at court.

Clinical findings

In a medical report, clinical findings should be set out as the noted observations made on the clinical examination. Courts understand that it is neither possible nor appropriate to note every clinical finding on examination. Obviously there is little purpose for a treating health professional to note all negative findings and trivial positive findings.

If called to court, you may avoid cross-examination on this issue simply by stating in the report that, "the significant clinical findings which were recorded on examination were.....".

Test results

Although mention of tests and results is usually uncontroversial, comments such as “X-rays were unremarkable and within normal limits” are vague and therefore may promote argument. More helpful may be a direct recitation of x-ray or scan reports, stating whether you have read or viewed the reports and agree with them.

Opinions

It is preferable to give opinions only where you are asked for them specifically. If you are asked for an opinion, it is important to determine that the opinion sought relates to a clinical issue, and one of which you could reasonably be expected to have knowledge.

In some cases you may be asked specifically to discuss the likely prognosis, assess the extent of the patient’s permanent disability, the level of impairment or whether the injury has stabilised. You also may be asked to express an opinion in your report about the cause of a condition, the patient’s capacity for employment or life expectancy.

Particular care should be taken when proffering a general, non-medical opinion. You should ensure that your answers are not based on assumed circumstances but are grounded on ascertained facts. For example, stating that a patient is “not fit for pre-injury work duties” relies on an assumed knowledge of what those duties involve. A health professional will invariably be extensively questioned over this type of broad assertion. By contrast, a statement which accurately describes the person’s capacity, such as “Ms X is fit for work that does not involve lifting weights in excess of X kilograms”, will avoid this problem.

Care should also be taken when making statements that involve a value judgment about a patient’s conduct. Statements to the effect that a patient is “genuine” or “malingering” are undesirable in reports. Impressionistic assessments may be used by one of the parties in the dispute to suggest a lack of objectivity in the writer. Objections to reports which appear biased may necessitate calling the health professional to give evidence in court. Assertions such as “liability should/should not be accepted by the insurer” should never be made in a report.

If you are asked to make an impairment assessment pursuant to the American Medical Association Guides to the Evaluation of Permanent Impairment, you should decline to do so unless you are competent to do so. Some jurisdictions do not accept such assessments unless the health professional has been accredited to provide such an assessment.

Requests for actual notes or original records

On some occasions you may receive a request for your clinical notes and records, either in photocopied or original form.

Where original notes are requested it is wise to make a copy for your purposes and to preserve the continuity of treatment. If you receive a request for original notes and have concerns about the provision of these notes, you should contact your professional association for advice.

There is occasional debate about the status of correspondence received by you from other practitioners who have treated the patient. Whilst it is true that the reports from specialists are the intellectual property of the writer, a court may compel disclosure of that information. Generally the courts will view this correspondence as forming part of your patient history if it contains material you have relied on to make clinical judgments.

Promptness of reports

Report writing can be an unfortunate distraction for health professionals. With the demands of a busy practice and the urgency of patients' needs, a report can easily be delayed. While we appreciate these pressures, it is vital that reports are provided as promptly as possible following the request. A failure to provide a report within a reasonable time can in some cases prejudice your patient's claim.

Court-imposed rules and statutory time limits place great pressure on lawyers preparing cases. Penalties may be imposed for failure to comply with these rules and a patient's entitlement to compensation may be frozen pending the receipt of a report.

Payment for reports

You are entitled to withhold a report until you have received either a fee, or (if you agree) a written acknowledgment that the fee will be met immediately or within the specified period.

If Slater & Gordon requests a report, an invoice or a telephone call to our office requesting payment will be sufficient to ensure that a cheque will be forwarded within a few days.

Attending court

Health professionals who have treated a person involved in the legal process, whether or not they have provided a medical report, may be required to give evidence in court. Like all other members of the public, health professionals are obliged to assist courts in the administration of justice, and at times this may be an inconvenient, difficult and unnerving experience.

Some health professionals may have concerns about the relevance or ambit of their evidence. If the subpoena, or request to attend court, comes from your patient's lawyer and you have those concerns, you should discuss this freely with that lawyer. If the subpoena comes from any other party, you are unable to discuss the details without the patient's express authority which should be obtained through the patient's lawyer. Communications with other parties or the provision of documentation (e.g. records) should never occur without express authority from a court or a patient.

Subpoenas to give evidence

A subpoena is an order to attend court, produce documents and give evidence as a witness.

Receipt of a subpoena should not be interpreted as a discourteous gesture or an affront. Lawyers understand that most health professionals would be happy to assist at court without the need for a court order. Courts however, have an expectation that a subpoena be issued and served. Lawyers are under an obligation to ensure witness availability, and may be criticised by the court for failing to ensure that a witness is under subpoena. Courts have extensive powers regarding the failure to answer subpoenas, and a health professional's cooperation is usually in the best interests of the health professional, the lawyer and the patient.

In some cases a health professional may be reluctant to attend court, believing that his or her evidence is not going to assist the patient's case and may even hinder it. However, there is generally a good reason that you are being called; for example, to prove the chain of treatment received by the patient. It is for this reason that statements such as "Don't call me to give evidence; I can't support your client", will not avoid you being called as a witness. The decision as to whose evidence will be required is one for the lawyer to make, however it is generally helpful to discuss your concerns with the lawyer first.

The subpoena should be "served" in accordance with the court rules. The usual practice is to serve the subpoena at the health professional's practice, rather than serve it on the health professional personally. Process-servers retained by Slater & Gordon are required to act with courtesy and discretion at all times. If you experience a breach of this requirement we invite you to report it to us.

A subpoena will specify a date and time for attendance at court – almost invariably it is the likely date and time for the start of the trial. Life would be easier if a precise time could be allocated for giving evidence. Unfortunately, this is not possible as the time for giving evidence is usually dependent on a number of other factors; for example, whether the preceding case runs longer than anticipated.

Upon receipt of a subpoena it is well worth making contact with the lawyer to discuss the time you will be called upon. Often arrangements can be made to minimise lost time.

If evidence is given, the lawyer requesting the health professional to give evidence in court is required to pay the health professional a reasonable fee for the time spent in giving evidence.

Being called as a witness

Court procedure is unfamiliar to most people, and the reasons for particular rules are often not apparent to witnesses. You are not expected to be conversant with the rules of evidence or procedure, and can rely on the court for guidance.

In most cases prospective witnesses must wait outside the courtroom while other witnesses are giving their evidence. When called, a witness is usually sworn, and the religious beliefs (if any) of the witness should be accommodated in the manner of swearing. A witness who objects to the taking of an oath, or who has no religious beliefs, may make an affirmation. In recognition of the gravity of the oath or affirmation, it is customary for the rest of the court to be silent and still during the swearing or affirming of the witness.

There are a variety of forums in which a case may be heard. Besides the various courts, a number of tribunals have jurisdiction to hear particular types of claims. Each court or tribunal has its own procedures and forms of address, the most common being 'Your Honour'.

If in doubt, it is acceptable to address the judge or magistrate as "Sir" or "Madam".

It is customary to make a slight bow or nod of the head to the judge or magistrate when entering or leaving the court.

If you are called to give evidence you should ensure that you bring your notes to court.

You will first be examined by the plaintiff's barrister. During the examination you may need to refer to your notes, and the barrister may also ask to see them. No witness may refer to notes without the permission of the presiding judge, and the barrister will often ask for permission for the medical witness to refer to his or her notes. Permission is usually granted. If the barrister has neglected to seek permission for you to refer to your notes, it is appropriate for you to ask the court for permission to do so. You should then be guided by the direction of the court.

In some jurisdictions, if you have prepared a report for the lawyers you may be shown the report for identification and it may then be handed to the court to be recorded as a piece of evidence (an 'exhibit'). You may be asked to read the report aloud for the benefit of the jury or for transcription purposes. On some occasions, the flow of your evidence may be interrupted by argument on the relevance or appropriateness of a particular question. Usually this argument will be dealt with by the judge whilst you remain in the witness box. If the argument is extensive the judge may ask you to step down from the witness box until the argument is complete and the judge has ruled on the issue.

When the examination is finished, the opposing party will be given the opportunity to cross-examine you. In some jurisdictions the opposing party's barrister may seek to view your hand-written notes and cross-examine you about those notes. If you have relied on your notes to refresh your memory before giving evidence, the opposing barrister is entitled to again look at them. Following the cross-examination, the plaintiff's barrister is entitled to question you to clarify any matters raised in the cross-examination, a process called 're-examination'.

Giving evidence

Giving evidence may be an unfamiliar and daunting experience. Neither the judge nor the legal advisers expect you to be a polished "performer", nor to be able to remember every piece of information without referring to your notes. Although cross-examination may feel like an attack on your evidence or your recollection, you should not feel that your ability or fitness as a health professional is being personally impugned. In most cases, your evidence will not be the subject of dispute, but will play a part in the wider issue under determination.

In most cases you may have a brief conference with the barrister beforehand.

Observing the following hints can make your experience as a witness easier and smoother.

1. Listen carefully to each question. If unsure of a question, ask for it to be repeated.

2. Do not volunteer information beyond that necessary to answer the question. If additional information or an expanded answer is required, the barrister will ask further questions.

3. If you are asked to give an opinion, confine it to your field of special expertise. If you are asked a question that is outside your area of expertise, you should state that this is the case.

4. Do not display irritation at the questions asked. In cross-examination, a barrister may attempt to impugn or cast doubt on your evidence. The best response is to stay calm and composed; a display of irritation will tend to devalue your evidence and provoke a more extensive cross-examination.

5. Try to explain evidence in lay terms where possible.

6. Be objective and impartial.

Fees for attending court

A medical witness is entitled to a fee for attending court. The amount of these fees is usually a matter for the court to determine. In many circumstances, court scales govern the amount payable to medical practitioners. It is possible in some cases to ask the court to fix the fee at the conclusion of your evidence. This practice is rare and the fee is usually dealt with by the lawyers after conclusion of the case.

The fee fixed by a court will usually reflect the time you are away from your practice but will generally not fully compensate for cancelled appointments. Your medical college or the Australian Medical Association will have information available to assist you in preparing your account.

Our commitment

Slater & Gordon has prepared these notes to assist you in dealing with the pressures of being involved in the court process.

If you are interested in more information on the intersection between health and the law, you may find the following resources helpful:

- A text written by Bill Madden, Slater & Gordon, with Janine McIlwraith entitled 'Health Care & the Law', published by Thomson Lawbook Co.
- A text edited by Rosemary Kennedy, entitled 'Allied Health Professionals & the Law', published by Federation Press.

Slater & Gordon offer seminars regarding health law topics for information regarding this please email *medicallaw@slatergordon.com.au*.

We are committed to making the experience of giving evidence and the writing of reports as painless as possible and welcome any suggestions you may have to minimise the inconvenience, stress and uncertainty that affects all participants in litigation.

Slater & Gordon invites your feedback and suggestions regarding this document to: *medicallaw@slatergordon.com.au*.

Notes:

1800 555 777

Visit our website to find your nearest office:
www.slatergordon.com.au