

**MEDICAL REPORT WRITING TIPS**

General Principles:

The purpose of a forensic medical report is to communicate your medical expertise, in the form of data and opinions, to assist in the legal resolution of a case. Clinicians communicate with each other in a specialized language that is largely inaccessible to attorneys, judges, juries, and even health administrators. Legal concepts of disability, negligence, and injury are often defined without reference to clinically meaningful terms. Your job is to bridge the gap between the medical and legal spheres. Forensic examiners must be aware of the legal standards and be able to apply clinical findings to them in a logical and understandable way, while recognizing that the final factual determination is in the hands of the judge, jury, or administrator.

When you are asked to perform a forensic evaluation, be sure you know what specific legal question is being asked. You should not investigate or report clinical information which is irrelevant to the legal issue.

The most common type of forensic evaluation performed by medical physicians is the Independent Medical Examination (IME) of impairment for purposes of disability determination. The definition of disability varies across jurisdictions, depending on the relevant state and federal laws. Specific forms and procedures may exist for reporting your findings, and you should use them rather than the templates provided on this web site. The American Medical Association's *Guides to the Evaluation of Permanent Impairment* (the *Guides*, currently in a 6<sup>th</sup> edition, though some regulations still refer to the 5<sup>th</sup> edition), with its guidelines and standards for conducting IME's, is a valuable resource and may be specifically referenced in your state's regulations.

Unless you are completing an IME using mandatory forms, you are at some liberty to choose the format for communicating your findings. Some experts write a narrative letter, similar to a consultation letter, addressed to the attorney or insurance carrier who has hired them. I recommend using a more structured approach modeled on the standard clinical report with its chief complaint, history of present illness, past history, physical examination, additional studies, and formulation. The templates on this web site follow this format.

The report should stand on its own and contain all relevant facts, including everything necessary to support your conclusion. The report should present a coherent story or narrative, organized chronologically for the most part. Try to anticipate and address a reader's questions along the way, as you would when presenting a hospital case on rounds. Do not save critical information to the end of the report as a surprise. Your conclusion should seem almost obvious by the time it is presented. You should include any relevant negative findings, any relevant data that goes against your opinion, and alternative explanations that you have considered. The reader (including other medical experts who may be retained on the case) should be able to understand how you reached your conclusion simply by reading your report.

Always proofread. Misspellings, typos, incorrect punctuation, and changes in font and spacing are extremely distracting and make an unprofessional impression. Avoid contractions, slang, and other vernacular. Use complete sentences, and break the habit we all developed during residency of omitting articles and pronouns (e.g. “Patient reports boss tripped her.”) Keep paragraphs to a reasonable, readable length dealing with a single subject. I strongly recommend reading Strunk & White’s *The Elements of Style*, a short and invaluable reference.

Define the medical terms you use, unless the meaning is obvious in context. Laypersons are often unacquainted with, or misinformed about, things we take for granted. Do not use abbreviations, especially for health care terminology, unless you first spell them out. (When listing laboratory findings, it is permissible to use the standard abbreviations, though you may need to explain the significance of some of them later in the report.) Do not assume that the reader will pick up on the significance of a particular fact (for example, an elevation in neutrophils relative to other white cells) unless you explain it.

Try to be consistent in your use of tense. One approach is to always use the past tense. I prefer to use the present tense when describing the present interview and examination findings, as if I were dictating the report during the examination itself. That way you can more easily distinguish between what the subject says now and has said in the past, which is often an important distinction in forensic reports. In any case, records should be referred to in the present tense, because they still exist, though the events they describe are in the past (e.g. “The progress note indicates that the patient lost consciousness.”)

Avoid words that might bias the reader or that imply a bias on your part. For example, if you write that someone “admits” or “claims” something, then you are conveying a subtle judgment on your part that could be avoided by writing instead that the person “says” or “reports” something. (On the other hand, these words may be used sparingly to intentionally convey doubt.) You should generally save implications and opinions (for example, that the subject is exaggerating his or her impairment) until the end of the report, when you can explain them in the context of your formulation. Meanwhile, let the data speak for itself so that you do not appear to be spinning the story.

Throughout your report, avoid referring to the subject as “the patient.” You do not have a doctor-patient relationship with the subject and do not want to appear to be confused about your role. For the purposes of an IME or legal report, the individual being evaluated is a “defendant” or “plaintiff” or “subject.” The most respectful approach is to refer to the subject by his or her last name (e.g. “Ms. Smith says she was prescribed a medication to lower her blood pressure.”)

#### Heading:

You may wish to design your own letterhead. I suggest that you include your name, professional degree, business name (if you have one), correspondence address, and phone number. Some evaluators mention here that they are licensed and/or board-certified; others do so at the end of the report. Do not list a home address, since the report will be shared with all parties. If you are performing an evaluation for a clinic or other health care organization, use whatever format your facility prefers.

The report needs to have a date by which it can be referred to in court proceedings. Generally, it is best to list the date that you finalized the report. The date that you conducted the examination will be listed in the “Sources” section of the report.

#### Identification:

Some identifying information needs to be readily available at the start of the report. Traditionally this includes the subject’s name and date of birth. A hospital record number, docket number, or legal case number may also be important, depending on the setting.

Physicians are trained in medical school and residency to start their case presentations with a demographic nutshell: e.g. “Mr. Wong is a 32 year old, straight, undomiciled, Chinese-American man with hypertension.” This approach has been criticized, even within medicine, because it simultaneously over-emphasizes and over-simplifies the patient’s cultural background. In a forensic report, it thrusts to the forward information which may not even be relevant and may be unintentionally prejudicial. If you wish to start with a paragraph of identifying information, it is better to stick to the immediately relevant information, such as age, legal status, and perhaps language, and save ethnicity, diagnosis, etc. until the proper place later in the report.

#### Reason for Referral:

Briefly describe the legal issue you have been asked to answer. You may wish to restate the nature of the claim from the legal documents. Save the clinical details for later.

Also identify which party has retained you.

Some evaluators like to present their credentials here at the start of the report, presumably to create a presumption of credibility. I recommend that you let your findings speak for themselves. You can list just a few credentials (board-certification, licensure, and academic affiliations, for example) at the end of the report with your signature or unobtrusively place them in your letterhead.

#### Opinion:

Briefly state your opinion on the first page, so others can find it easily. The opinion should be stated in terms appropriate to the legal standard rather than in clinical terms (e.g. “Ms Doe is permanently disabled as a foreseeable and proximate cause of her spinal surgery,” rather than “Ms Doe has been paralyzed below the waste since her surgery.”) Keep it short; you will have the opportunity to explain your opinion at the end of the report.

You may wish to say that you have formed your opinion “with a reasonable degree of medical certainty.” This is the legal threshold for giving an expert opinion in our field. A reasonable degree of certainty has been interpreted to mean that you are more certain than not, i.e. more than 50% certain. That is not a particularly high standard, so it is important, when you get to your formulation, to explain the extent of certainty and limitations upon your opinions and any doubts you might have. That is part of telling “the whole truth.”

Only the judge or jury has the authority to form an opinion on the “ultimate issue” in a case. Expert witnesses technically should confine themselves to providing information that helps the trier of fact reach an opinion. Nevertheless, judges and statutes often expect or even require the expert witness to give an ultimate opinion on the legal issue, though the opinion is not binding. Otherwise, there is a risk that the significance of the expert’s findings may be misunderstood or misapplied to the legal issue. If you are barred in your jurisdiction from giving an opinion on the ultimate issue, word your opinion in a way that stops short of explicitly answering the legal question.

### Confidentiality:

Always mention that you have explained the purpose of the evaluation, your role, and the limits of confidentiality to the subject. You generally do not need to say that the subject understood or consented, since consent is generally not required in forensic contexts (in fact, the evaluation may have been court-ordered).

Even if the evaluation has been court ordered, the subject may refuse to cooperate. In that case, you should clearly explain that the patient refused and that you formed your opinion based on other sources of information, such as a review of medical records.

### Sources of Information:

I recommend that you start filling in this section of the report when you first sit down to read through the records. As you read each document, list it in the sources. I generally list the sources chronologically. All relevant documents and interviews should be listed. Give names and dates. The details will be helpful to you if you have to give a deposition or testify.

If you have requested records but have been told that they cannot be provided, mention this at the end of the section. This makes it clear that you have been diligent in seeking out relevant information. It also puts all parties on notice that you are trying to obtain the records. If the records are not produced, you will not be held at fault. Avoid speculating about whether missing documents might or might not affect your opinion, since you do not know what they contain.

Throughout the report, if you present information that you obtained from a secondary source, identify that source. Primary sources are inherently more valid than secondary sources, so refer to the original documentation whenever possible. Avoid verbal hearsay (“the treating internist told me....”) when possible, as it may be considered inadmissible. Medical documentation is also technically hearsay, but it is generally considered admissible because it is relied upon as valid by physicians in the usual course of business.

Qualify unproven claims of injury or behavior as “alleged” rather than appear to accept the allegations at face value.

You should list and refer to examinations performed by others, including experts retained by the other party. If nothing else, these reports provide a snapshot of the subject’s complaints and physical status at the time that should be mentioned in the history. Generally it is a bad idea to

disparage another expert's observations or opinion, since you were presumably not present for their examination and are not well positioned to second guess their findings. However, you may wish to point out discrepancies or omissions in their reasoning or presentation of the data that you believe would help the reader understand why you have reached different opinions. For example, if an earlier report fails to consider volitional elements or inconsistencies in the subject's presentation, you can indicate that this is lacking from their formulation and that it provides an alternative explanation for their findings.

### History:

You can organize the history in several different ways. I recommend starting with a description of the instant event upon which the legal issue is focused (for example, the alleged injury). This would be analogous to the "chief complaint" and "history of present illness" section in clinical reports and has the advantage of getting right to the heart of the case. The rest of the history can be read with the instant event in mind. If you organize your history this way, you may need to provide a brief summary of the clinical context (mentioning, for example, a relevant pre-existing condition) before describing the injury.

Another approach is to organize the entire history in chronological order, with separate sections for the past history, instant event, and subsequent history (and a "hospital course" section for those currently in the hospital).

You may wish to organize the past history thematically. For example, you might have subheadings for different clinical conditions, social and developmental history, psychiatric history, substance abuse history, family history, and work/home environment. If these different facets of the history are chronologically intertwined, however, it may be difficult, artificial, and redundant to try to tease them apart.

Some forensic evaluators organize the history by source of information. For example, they might separately list information from a hospital admission, employment records, an interview with family members, and a vocational assessment. This approach is more familiar to attorneys and can be convenient when you give testimony. However, this is not how clinical reports are organized, so you run the risk of appearing like a paralegal rather than a doctor who is able to integrate the various sources of information into a coherent clinical narrative.

For many forensic medical examinations, it is important to include functional and environmental information that is not typically gathered by doctors during clinical care. For example, you may need to gather a detailed occupational history, a history of environmental exposures, and a description of current job duties, potential accommodations, and available resources.

The past history should include prior diagnoses. You will explain your own diagnostic opinion at the end of the report, but you need to list the diagnoses made by others along the way. A forensic report should not read like a mystery novel with the diagnosis kept secret till the end.

When you mention medications, explain their therapeutic purpose or class. For example, you could write: "phenytoin (anticonvulsant)" or "atorvastatin (for lowering cholesterol)" or "the

antihypertensive propranolol.” You only need to do this once for each medication, when the medication is first mentioned. You should follow good clinical practice and refer to medications by their generic (uncapitalized) names. If you use the trade names (for example, when quoting someone), capitalize the name and put the generic in parentheses or brackets.

Malingering, minimization, and other forms of deception should always be considered in forensic evaluations, because subjects have inherent motivations in legal contexts. It is crucial to provide corroborating or contrasting evidence from collateral sources. (At one extreme, for example, covert video recording of a subject can provide evidence that a severe impairment has been faked.) Note pertinent positive and negative findings by others, especially those who have observed the subject at length in a variety of different contexts, not just during formal forensic evaluation. False imputation (attributing an impairment to a compensable cause rather than its true etiology) and exaggeration of a genuine injury are commonly encountered situations that blend some genuine impairment with volitional or subconscious motivational elements.

### Physical Examination:

I recommend that you always organize your written examination in the same way to reduce the chance that you leave anything out. You should probably present at least a cursory general physical exam, honing in on the area related to the claim and your area of expertise.

Present the details of your observations. Do not present conclusions (e.g. “weakness on raising the left arm is exaggerated”) without the observations that support them. Include pertinent negatives and objective observations (e.g. “She reports extreme pain with flexion of the back but was observed to bend forward easily earlier in the examination when asked to remove her shoes.”) Quote the subject when his or her own words are ambiguous or particularly illustrative.

If the significance of a subject’s statement or one of your observations is not obvious, you can explain the significance briefly, but save your broader conclusions for the formulation section of your report. (For example, you might want to point out that a positive Romberg sign suggests impaired position sense, or that the ability to recall all of three words after a five minute period of distraction indicates intact short-term memory.)

Do not use technical terminology (e.g. “referred pain”) without explanation or illustration of the observation to which you apply the term. On the other hand, the meaning of a term is sometimes obvious in context, and further definition may be unnecessary or even pedantic.

### Results of Studies:

As in clinical reports, forensic reports can have a separate section where you describe the laboratory, radiographic, and other medical tests (and perhaps vocational functional capacity studies) you have performed or ordered. You should probably only put recent studies, or studies that were obtained for the current evaluation, in this section. Previous testing is probably better placed in chronological context within the history, unless you believe there is greater advantage in putting all of the results in one place, so they can be compared.

### Medications:

List currently prescribed medications and doses. Avoid using pharmaceutical abbreviations (i.e., write “twice daily by mouth” rather than “po bid”). I recommend including the most recent serum levels of medications, when available, as a marker of compliance and therapeutic dosing. You may also wish to include over-the-counter and botanical products that the subject is taking, even if they have not been prescribed.

### Diagnosis:

In the diagnosis section, you should just list the diagnoses (usually one per line) using the language most accepted in your profession. The International Classification of Diseases (ICD, currently in a tenth edition, though the ICD-9 is most commonly used for billing and disability purposes in the United States) is perhaps the most widely accepted, standardized listing of diseases across medical professions, but its designations may not reflect the most recent classifications used in your specialty.

Sometimes clinical findings that do not rise to the level of a named disease may nevertheless be important to answering the legal question, perhaps as part of a syndrome that has not yet been accepted in the ICD. You should not include these findings or syndromes in the diagnosis section. You may use the closest, accepted diagnostic equivalent for which criteria are met, and you can discuss the particular findings in your formulation.

Be parsimonious in your diagnoses. Logically, you should prefer a single diagnosis to multiple diagnoses if the sole diagnosis accounts for the findings equally well. Do not use one clinical sign or symptom to meet criteria for more than one disorder.

Malingering is a volitional strategy, not a diagnosis, but it can be listed in the diagnosis section, so long as you explain the difference in your formulation. Alternatively, you could list “no diagnosis” or list only those diagnoses which are genuine, and explain the malingering later. The rationale for listing malingering in the diagnosis section is to capture the entire clinical presentation. This is the practice, for example, in psychiatric reports.

Be cautious about making diagnoses that are outside of your specialty. If diagnoses have been made by others, but you are not in a position to confirm their validity, then you could list them as “by history.” The safest approach might be to confine yourself to the diagnoses within your area and mention, in your formulation, that examination of the other diagnoses should be left to others. Many who claim physical injury or impairment may also claim secondary psychiatric problems, and these should be assessed by a forensic psychiatrist or psychologist, because of the inherent challenges of assessing subjective emotional complaints in the forensic context.

Remember to spell out “ROMI,” “s/p,” “r/o,” “h/o,” and other diagnostic abbreviations we take for granted in our clinical documentation.

## Formulation:

The formulation is where conclusions are drawn from the objective data that you have already presented elsewhere. The start of the formulation marks the line between your facts and your opinions. There should be no new data presented in this section. Likewise, no major clinical or legal conclusions should be made prior to the formulation.

Ideally, a forensic formulation should present (1) the legal question, (2) the legal standards which will be used to answer the question, (3) the clinical conclusions, and (4) an explanation of how the clinical conclusions relate to the standards, thus answering the legal question. Be sure to fully present the clinical formulation before you address the forensic implications. Explain how your diagnoses arise from the data in the case, as applied to accepted diagnostic criteria.

If you have a differential diagnosis in mind, explain the different possibilities you have considered and why you prefer one over another. Try to anticipate any questions that might arise in an informed reader. For example, if your history lists a number of previous diagnoses of traumatic arthritis, explain why you have diagnosed rheumatoid arthritis instead. Explain how co-morbid and pre-existing diagnoses overlap or interrelate.

Think of the clinical formulation as your opportunity to paint a picture of the subject that differentiates him or her from all other individuals who might have the same diagnoses. Explain the course of illness, precipitating and exacerbating factors, and response to treatment for this particular person. Explain the extent to which he or she is currently in remission or symptomatic, and his or her prognosis, taking into account relevant contextual factors such as workplace accommodations.

After presenting a clinical formulation, you can proceed to apply your findings to the legal question. You may find it useful to restate the legal question and the criteria (from statute, common law, or case law) that are to be used in answering the question.

In order to be as honest and objective as possible, specify any limitations on your opinion and factors which you considered that may go against your opinion. When alternative explanations for data exist, consider the implications for each possibility.

Sometimes, you may find that your forensic opinion depends on how certain facts are resolved in the courtroom. For example, it might be crucial to a determination of worker's compensation whether the injury occurred at work or at home. You may have no expertise to answer that factual question; it is not a clinical matter. In such cases, you can give more than one opinion, acknowledging the different factual possibilities. You should similarly refrain from infringing upon the role of the judge or jury by expressing opinions about the subject's creditability, except when your suspicions arise from inconsistencies in the clinical picture. These are fair game, and it is incumbent upon you to point them out.

You should particularly point out clinical inconsistencies that support a conclusion that the subject is being deceptive. This is crucial when building a case for malingering. When documenting malingering, I suggest you look for three types of inconsistencies: (1) between the

subject's presentation and typical patterns of genuine illness, (2) between reported symptoms and observed signs, and (3) in how the subject presents at different times and in different settings. For example, you might observe that the subject (1) claims dramatic impairments after a mild head injury without loss of consciousness; (2) claims severe weakness in the upper extremities, but gives you a firm handshake; and (3) failed to mention most of the impairments during several visits to physicians shortly after the injury and prior to asserting a legal claim.

Avoid using the word "clearly" to emphasize your conclusion. It tends to be used in place of proof to shore up a point that, in fact, is not so obvious. A clever attorney will pick up on this. It is always better to prove your conclusion than to assert it loudly.

Forensic reports generally should not include clinical recommendations unless they are relevant to the legal issue (appropriate treatments and extent of care needed, for example, in an IME) or specifically requested. You want to avoid appearing confused about your forensic role: you do not have a treatment relationship with the subject of your forensic evaluation.

Above all, your clinical and legal formulations should be expressed logically and transparently. Both your clinical and legal opinions should be built up point by point, connecting the dots between the facts and your opinions, with reference to the diagnostic criteria and legal standards.

#### Signature:

I like to sign off my reports with the phrase "respectfully submitted." This seems more appropriate than the commonly used "sincerely." After all, you are expected to be more than sincere: you are supposed to be telling the truth, the whole truth, and nothing but the truth.

Always include your professional degree (e.g. "M.D.," "D.O.") You may also want to list a few key qualifications under your signature, such as your license, academic affiliation, and whether you are board-certified in your specialty.

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These forensic tips were prepared by James Hicks, M.D. based on his training, review of the literature, and experience writing and reviewing thousands of forensic reports. Please feel free to keep them and share them with others. Other forensic resources are listed on Dr. Hicks' web site. Dr. Hicks can also be contacted for consultation or mentoring through [forensicmind.com](http://forensicmind.com).