Written Medical Communication

– *Skills in Writing Medical Reports*

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Introduction

Medical school and residency training curricula place strong emphasis on interpersonal oral communication skills. The UK General Medical Council's guidance on good medical practice places importance on maintenance of good medical record keeping.

Doctors in clinical practice, whether in hospital or ambulatory care, are often required to write medical reports by various persons for various purposes throughout their professional career. Once doctors have attended to patients in their professional capacity, they have a duty to share their findings for the benefit of the patient's continued care, insurance claims or medico-legal reasons. Medico-legal reports may be requested from the police, courts, lawyers, government agencies and even patients themselves. Doctors should therefore acquire essential knowledge and appropriate skills in good medical report writing as these reports are expected to be prepared with accuracy, clarity, diligence and an understanding of legal implications. The quality of such medical reports will reflect the competency and professionalism of the doctors concerned.

Definition

A report is a communication or advice from a person who has collected and studied the facts, given to a person

who has asked for the report to fulfil a purpose. In addition, the report is a product of a diligent and deliberate effort.

Employing an initial checklist

As a doctor, after you have received and read the request for a medical report, you should employ a preliminary checklist, before writing the report:

1. Who has requested for the report? (For example: police, coroner, insurance company or the patient.)
2. What is the requestor's purpose of the report?
3. What does the requestor need from the report?
4. What are the particular issues that you need to cover in the report? (For example: the scope and extent.)
5. Which areas are not relevant for the report?
6. What is your purpose of writing the report?

Determining the exact purpose for the report

If the requestor's purpose for the medical report is unclear, speak to the party concerned and clarify its intended use. Some of the common reasons behind requests for a medical report include:

1. Court proceedings
2. Medical litigation cases
3. Coroner's inquiries
4. Workmen's compensation
5. Insurance claims
6. Patients' wishes

In order to ensure that the medical report will not be misused, it is always useful to begin the report by stating the purposes for which it was requested from you and by whom.

Assessing the best person to write the medical report

Upon receiving the request, you should assess whether you are the most qualified person to write the report. In the case of an expert witness report, doctors should reflect on whether they are considered to be experts or have specialised knowledge on the subject.

In public hospital practice, doctors would sometimes be appointed to write a medical report on behalf of another doctor who would have been better qualified, but is for some reason, unable to furnish the report. In such situations, it is important to clearly state your status as the report writer. The status could be:

1. Treated the patient
2. Saw the patient in the A&E
3. Was part of the team who treated the patient
4. Never seen the patient in person

Recognising the ethical and legal requirements for consent

Before medical reports are provided to third parties, you are required to obtain written consent from the patient, legally sanctioned guardian (person of parental authority) or surrogate (person with a Lasting Power of Attorney). However, exceptions will be made for situations where the medical report is required by law, as in a Coroner's inquiry or by a court order.

When you obtain written consent, it is necessary for you to inform the patient why the report was being requested, as well as the consequences of the disclosure of the medical information and of not consenting for the medical report.

The anatomy of the medical report

A good medical report should be well structured, preferably according to the following sequence:

1. The name of the person requesting the report
2. The purpose for which the report is written
3. The patient's identification details
    a. Check for accuracy
    b. State at least three of their particulars (for example, full name, IC number date of birth, and home address)
4. Whom the request was made to and for what purpose
    a. Include the date and manner of request
5. The capacity in which you are writing the report, including
    a. Your personal involvement
    b. Your relationship to the report and case
6. Your qualifications (if appropriate)
7. The sources of materials which the report is based on
    a. Read the entire case notes thoroughly before preparing your report
8. Events written in chronological order
    a. State date, time, person and events
9. Facts must be supported by documents and written medical records
    a. Provide definitions and explanations when medical terminology is used, especially if the report is for a non-medical audience
    b. Avoid medical acronyms and abbreviations if possible
10. Information should be factual and accurate
    a. Verify and validate facts
11. Information must be complete
    a. Important and relevant details must not be left out
12. Relevant laboratory and imaging reports
    a. Attach the documents to the report
13. Opinions must be stated as such
    a. State the reasons when giving an opinion
    b. Provide evidence and sources to support your reasons

Organising the medical report

It is important to ensure that a report is well organised, to enable easy reference, further explanations and clarifications, or identification of issues in the report. The general rules are as follows:

1. All medical reports must be dated
2. All pages must be numbered
3. All sections must have headings
4. All paragraphs must be numbered
5. All documents must be signed with designations and qualifications
6. All medical reports must be printed with official letterhead
7. All references must be provided when they are quoted in the reports

Understanding the professional and legal nature of medical reports

It is important to know that as medical professionals, the writing of medical reports carries professional, ethical and legal implications. Professional standards and duty of care must always be upheld as medical professionals are expected to exercise due diligence, apply medical facts appropriately, and exercise good medical judgement and care in their conclusions and recommendations.

Doctors should prepare and complete medical reports in a reasonable period of time. If this is not possible, it is important and only courteous to inform the requestor or the patient of your inability to meet the dateline.

Writing medical reports is part of your professional and legal responsibility as a registered medical practitioner. Medical reports have the potential to become medico-legal documents, so you may be called to defend it if the need arises. As such, it is best not to speculate or make statements that you are unable to substantiate later.

In addition, you may be asked supplementary questions and to provide further clarifications, even after you have completed the medical report. As such, you should be prepared to be called as a witness in court, if your medico-legal report is requested by the police or the court. In addition, medical reports may also resurface many years later for odd reasons and in odd places. As such, it is best for you to keep a copy and store it in a manner to ensure that it can be easily retrieved.

Doctors whose reports contain misrepresentation, inaccurate and false statements, risk being reported to the Singapore Medical Council and being charged for committing perjury for false or misleading reports. So do keep in mind that important and relevant information must not be left out. It is inappropriate for doctors to offer opinions or comments of medical management carried out by their medical colleagues unless they are appointed as expert witnesses. It is only appropriate to confine the report to your own scope and the part for which you are directly involved.

Conclusion

It will be difficult to retract a medical report which has been signed and sent off. Therefore, before signing the report, you should read the document carefully to check for mistakes. Grammatical and spelling errors will reflect your competence. It is also prudent to get someone more senior and experienced to read and check the report.

When checking it, you should also ensure that it satisfies the following guidelines:

1. Does it flow smoothly?
2. Does it make sense and logical?
3. Is it clear and concise?
4. Is it complete?
5. Does it contain any factual errors?

Clarity, comprehensiveness, coherence and consistency are the features of a good medical report. Since there is a possible risk of the report being used for medical litigation, it is prudent to get medico-legal advice from your medical indemnity organisation, where indicated.

A medical report is a medico-legal document prepared by a qualified person who has collected and studied the documents and stated the facts, to a person who has asked for the report for a purpose. It is crucial that the person writing the report must exercise due diligence and meet up to the standards and duty of care expected of that professional. SMA

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