28 Medicolegal examinations and reports, court procedures and expert evidence

This chapter is designed to help doctors conduct medicolegal examinations and prepare medicolegal reports, and to advise doctors about appearing in court as ordinary or as expert witnesses. Problems that may arise at medicolegal examinations are identified, and advice is provided about the content and scope of medicolegal reports. After briefly describing the adversarial system used in Australian courts, the chapter is then structured around the sequence by which a doctor usually becomes aware that they may be required in court. Last, the matter of jury duty for doctors is touched upon.

28.1 Medicolegal reports

28.1.1 Treating doctors' reports

For doctors who are primarily in clinical practice, the most common involvement with the judicial system will be via a request for a medicolegal report about a current or past patient, most often in the context of an insurance or workers compensation claim. The request should be accompanied by an original signed authority from the patient to release the medical information and by a letter from the solicitor describing what is requested.

In preparing medicolegal reports about the diagnosis, care and treatment of a patient, doctors should take care to answer the questions asked of them and to make the report factual, objective, complete and to the point. Material in the patient's records that is irrelevant to the request should not be included in the report. If the doctor has any doubt in this regard, advice should be sought from the doctor's medical indemnifier. A well-constructed medicolegal report may be sufficient for the solicitor and the court, and obviate the need for the doctor being called to give evidence.

A treating doctor's report is not required to contain an opinion regarding the patient's claim, although some solicitors may request comments on aetiology, diagnosis and prognosis. A treating doctor may decline to answer such questions, especially if the doctor feels unqualified to give such an opinion. At the very least, the report should contain the patient's history, the physical findings, the investigations done, the results obtained and the treatment

given. If the patient was referred to another doctor, this should be mentioned, but it is not the task of the treating doctor to provide any report of another doctor. If the medicolegal report identifies to whom the patient was referred and when, the requesting solicitor will be able to make a decision about approaching that doctor for a report. Above all, no matter how much compassion the doctor might have for the patient, the report must not be written in a partisan manner. The weight and authority of a doctor's report lies in the professionalism with which it is composed, combining factual accuracy, medical expertise and dispassionate judgement. Some of the advice provided below in relation to expert witness reports is also relevant to treating doctors' reports.

A medicolegal report is legally privileged and must not be released to any other party without the permission of the solicitor who requested it. Despite this, doctors need to be aware that the report will usually be exchanged with solicitors for the other side and may be read by many authorised people, again emphasising that care and attention should be paid to the writing. Despite the pressures of medical practice, requests for reports should be handled promptly, so that a patient's claim is not jeopardised and that the administration of justice is not delayed. Undue delay, unless justified, may result in disciplinary action from the Medical Board of Australia.

28.1.2 Medicolegal examinations

Doctors are frequently requested by solicitors or insurers to examine patients for the purpose of providing a report that may be used to assist the solicitor or insurer in determining or pursuing a claim for compensation. The cost of such examinations is not covered by Medicare. It is usual that appointments for medical examinations are first made by telephone and then confirmed by a solicitor's letter. The letter should contain a brief description of the circumstance in which the patient was harmed or injured, particulars of the harms or injuries alleged, copies of the relevant medical certificates and other medical reports, X-ray and pathology reports, and other reports, together with details of the disabilities which the patient claims arose out of the harms or injuries. There will usually be a series of questions included in the letter requesting advice on some or all of the following:

- the patient's physical condition with particular reference to the alleged injuries or disabilities