Geoff D Wood

Aspects of Dento/Medico-Legal Report Writing

Abstract: This paper offers some guidance on aspects of dento/medico-legal report writing, citing anonymized examples from the author's caseload for clarification of the points made, and also serves to illustrate that sometimes not everything is as straightforward as it may initially appear. It provides reference to the current Civil Procedure Rules in England and Wales and its relevance in report writing.
Clinical Relevance: To provide guidance on aspects of dento/medico-legal report writing.
Dent Update 2014; 41: 161-166

If you have not done so already, it is likely at some point in your career that you will be asked to provide a report, perhaps in pursuance of a claim, on one of your patients or even a patient of another practitioner. A report may be requested to provide a factual witness-type statement relating to the practitioner's role in the treatment of a patient before or after a specific incident, eg sport-related injury, assault, 'tripping' accident or, possibly, the result of a hard foreign body allegedly found in a food product and bitten on by a patient. Under Civil Procedure Rules in England and Wales an 'expert' is a person who has been instructed to give or prepare expert evidence for the purposes of proceedings. A more detailed 'expert' report request could come from an insurance company; solicitor for the Civil or Criminal Courts; HM Coroner; Professional Body or even an individual patient. These requests could be for a report on 'Liability and Causation' or a 'Present Condition and Prognosis' report. However, a request for an opinion on 'Liability and Causation' in cases of negligence or for a GDC or other hearing is more likely to be asked of a relevant specialist rather than the general dental/medical practitioner, as it may be outside his/her own field of expertise. However, some practitioners in general practice may be asked to produce such reports, as solicitors require opinions as to what would be considered acceptable care from a reasonable, respectable, responsible body of dental professionals,[1] should the litigation involve the care given by a practitioner in general practice. Undergraduate dental/medical courses give little guidance on how to write a report, but there are several organizations offering instruction/courses on legal report writing. Realistically, most practitioners will only be asked very occasionally to produce a report but, nevertheless, it should be regarded as if it were a legal document because it may well become one. It is important that any report is both clear to all that read it and easily understood, while addressing the points and/or questions detailed in the letter of instruction. In a civil case in England and Wales, the report must also comply with the current Civil Procedure Rules for it to be acceptable to the Court.[2,3,4] The purpose of this paper is to give some guidance on aspects of medical/dental report writing citing anonymized examples from the author's caseload for clarification and to illustrate that sometimes not everything is as straightforward as it may initially appear.

Geoff D Wood, BDS, MSc, FDS RCPS, MDS, Consultant Oral and Maxillofacial Surgeon, Spire Murrayfield Hospital, Holmwood Drive, Thingwall, Merseyside CH61 1AU, UK.

Instruction

The requesting party will instruct the practitioner, usually by letter but increasingly by email, clearly stating what is required and what issues are to be addressed in his/her report. The instructing party will often require, prior to formal instruction, an up-to-date summary curriculum vitae, fee rate, an indication of the length of time the report would take to produce, and confirmation that there are no conflicts of interest and, should it prove necessary, an assurance that the practitioner will attend Court. Payment of fees can sometimes be delayed until the conclusion of a case,

occasionally for several years, if there are complex issues to be addressed, and the terms and conditions for payment should be made clear from the outset. In an increasingly litigious society, compensation claims appear to be rising, although the Government is keen to limit the apparent upward trajectory of such claims by legislation. In all publicly funded criminal and civil cases the Legal Services Commission (LSC), since 1st October 2011, implemented changes to cap experts' fees. For a Dental Practitioner the current fee is a maximum of £93.60/hour for both civil and criminal cases and £72/hour in criminal cases for those practising in London.[5]

Most solicitors and other instructing parties are more likely to commission practitioners that can speedily produce a clear, well written report than those that have to be chased for a reply.

It is imperative to read the letter of instruction carefully and ensure that one is an appropriate expert able to provide the information that has been requested. It may be necessary to request other case notes or radiographs relating to a case prior to writing the report and the instructing party should obtain what is required and cover the cost of copying any notes or radiographs that may be needed. A practitioner would be ill-advised to give an opinion without having all the information that they deemed necessary.

The report

The content and layout of a report will vary depending on the instructing party, its rules, regulations and guidance, which should be ascertained before submitting the report to ensure that it conforms to any specific requirements.

All documents provided should be taken into account and included in the list of documents seen by the reporting expert.

The report should be easy to read and any specialist terminology used should be described in an attached glossary, if necessary, to enable understanding by lay readers. Although there is no stipulation that a report should not contain specialist and/or complex details of pathology/treatment, some Judges have criticized experts for producing unfathomable reports which are difficult to interpret and/or understand by the lay person. The use of subheadings helps to divide the report into sections, for clarity, and the numbering of each paragraph enables easy reference.

Specific inclusions are required of dental/medical reports to satisfy the Civil Procedure Rules[2] (Table 1). These reports must be addressed to the Court and experts have an overriding duty to the Court, not the person instructing or paying them. An Expert's Declaration and Statement of Truth must be included in all these reports and their wording is mandatory.

If you are asked to comment on the standard of care provided by another, allegedly negligent, practitioner you are not being asked to pass judgement, that is for others to decide, but rather give an opinion based on whether the standard of care of the practitioner involved is of a standard comparable with his/her peers of similar experience at that time. It must be remembered that sometimes one is asked to give an opinion on care or treatment undertaken some years previously, and it should always be borne in mind that what is now thought to be routine/commonplace might not necessarily have been so then. Practitioners owe a duty of care to the patients they are treating and, should their treatment be less than that of a reasonable, respectable and responsible body of dental professional opinion at that time, a case of negligence may be levied against them. The damage that results from that failure of the duty of care (causation) is used to assess the compensation (quantum) that will be awarded from that failure. Breach of duty and causation has been well explained in Kelleher *et al*'s article[1] in this journal and will not be repeated in depth in this paper.

Chronology

A professionally prepared chronology of events is sometimes provided by the instructing party, but it is always wise to check that these details are correct. A summary of the events that led to the action is often helpful. If this is not supplied then the sequence of events that has led to the injury, with the dates/times of each relevant episode, the name and status of who provided any treatment and exactly what treatment was administered, should be described. Prior to recording this chronology, the practitioner should ensure that he/she has all the relevant information, and sight of the hospital or GP case notes may be required so that the

- Details of the expert's qualifications and summary CV
- The report must be addressed to the Court/Tribunal
- A full list of all documents and other material which the expert has relied on in making the report
- Make clear which of the facts stated in the report are within the expert's own knowledge
- Say who carried out any test or experiment the expert has used for the report, give the qualification of that person and whether or not the test or experiment has been carried out under the expert's supervision
- Where there is a range of opinion on matters dealt within the report: (a) a summary of the range of opinion; and (b) the reasons for the expert's own opinion
- A summary of the conclusions reached
- A declaration and statement of truth the wording of which is mandatory and must not be modified
- A statement setting out the substance of all material instructions (whether written or oral) which are material to the opinions expressed in the report or upon which the opinions are based

Table 1. Summary of requirements from Practice Direction Experts and Assessors Civil Procedure Rules (Part 35). Form and Content of Report.

practitioner is aware of all that transpired. The instructing party should obtain all these documents to enable a report to be completed if it proves necessary. However, in accordance with best practice advice, issued by the Law Society, medical records are often not obtained to limit costs in proportion to the value of the claim.

Example 1

A solicitor requested a report on a patient who sustained a fractured mandible allegedly following a fall in the street. The patient claimed that he/she had fallen as a result of an uneven, non-maintained pavement and was suing the Council for compensation. The patient sustained a bilateral fracture of the mandible which was uneventfully treated by open reduction and fixation by the local hospital. The fracture healed by bony intention without complication but later the patient developed periodic temporomandibular joint noise and pain from both joints, as well as improving numbness of one mental nerve secondary to the fracture. Prior to examining the patient for a report, sight of the General Medical Practitioner's notes was requested where a case note entry recorded that the patient sustained facial injuries from a road traffic accident three days prior to the alleged fall and had attended his/her GP with facial pain and a deranged occlusion. Without sight of the medical case notes, the previous road traffic accident injury may not have been discovered, which was most relevant in this case.

Dental history

Previous relevant dental treatment that the patient had received should be recorded when tooth damage has occurred, especially any treatment that may have been undertaken on any damaged tooth/teeth involved in a possible claim. A regularly attending dental patient who damaged his/her restored teeth subsequent to the teeth restorations would warrant mention. Previous damage/repair to the affected teeth should also be recorded, as previous pathology that existed prior to the present damage from the event giving rise to the claim could, and may, affect the prognosis, irrespective of the present damage. Previous treatment and pathology may affect the amount of compensation, if any is to be awarded.

Example 2

A patient tripped in the street allegedly as a result of a proud paving stone. The maxillary central incisors were completely lost and others loosened in the fall. He/she attended a local hospital for emergency care where an OPG radiograph confirmed no facial fracture and the patient was discharged with the advice to consult his/her own dentist. The patient had not attended a dentist for many years and did not seek to find one but sued the Local Council for damages. Examination of the patient and the OPG taken by the local hospital confirmed gross bone loss around all the patient's teeth, with most teeth having a Miller's III mobility. The medical report stated that this patient's teeth were being retained on borrowed time and that it was likely that they would have been lost in the near future, irrespective of the damage caused in the fall.

Example 3

A patient one month prior to a fall in the street had paid, under a private contract, for four veneers to the maxillary incisor teeth, being entirely satisfied with the functional and aesthetic result achieved. He/she subsequently tripped in the street, allegedly as a result of a proud paving stone and irreparably damaged the four veneers in the fall, as well as fracturing the crowns of the maxillary central incisors into the pulp. Extensive advanced restorative techniques were required to save and repair his/her maxillary dental arch over several visits. The medical report detailed the previous dental treatment, which would assist in any assessment for compensation if the case was to settle.

Medical history

Any relevant past medical history should be recorded and should include any current medication, as well as a smoking habit and alcohol consumption. There may well be something in the past history that can affect the opinion as to the outcome of the claim.

Example 4

A passenger hit his/her chin while travelling in a car involved in a road traffic accident. The patient attended the local hospital for emergency care but was discharged receiving no treatment. He/she later developed acute bilateral facial pain with limited mouth opening, as well as pain when chewing fibrous foods, causing him/her to eat only a soft diet. The patient attended his/her dentist who correctly diagnosed temporomandibular joint pain dysfunction syndrome and constructed a bite raising appliance. The pain eased over several months but he/she continued to suffer chronic pain. The patient was later referred for Specialist care which included analgesics, physiotherapy and another bite raising appliance treatment with limited success. He/she was considered for arthroscopic surgery. The patient consulted a solicitor, seeking compensation for the injuries. Examination of the GP medical records confirmed that the patient had experienced previous facial pain that was diagnosed by another Specialist as temporomandibular joint pain dysfunction syndrome and he/she had been previously counselled as to the nature of the condition. In addition, the patient had an extensive psychiatric history as well as suffering from irritable bowel syndrome. These facts had not been recorded in the patient's dental or other Specialist's case notes. The fact that the patient had previous temporomandibular joint pathology was most relevant in the evaluation of the claim.

Examination of the patient

A 'Present Condition and Prognosis' report is frequently required to enable an accurate assessment of any compensation from an agreed claim whereby the patient's current state needs to be evaluated and particularly his/her capacity for work. A specific appointment for examination should be given with sufficient time allowed so that a comprehensive examination can be undertaken to record the current position of the patient's condition. The patient should be asked as to his/her present complaints and each should be recorded and every one addressed in the report. There may be specific complaints that the patient states that he/she is suffering not related to the

injuries that have been sustained and, as such, will need to be addressed in the report. The findings from the examination should be described so that anyone can understand what was found and how the opinion was derived. In the 'Prognosis' any continuing complaint or disability should be recorded, the level of suffering or inconvenience caused and any impact on daily living.

Radiographic report

A description of any radiographic finding (if taken) should be included in the report. The date taken and type of radiograph should be detailed prior to a description as to the findings on them. The necessity to take further radiographs in the production of the report should be resisted to ensure that unnecessary patient exposure to radiation is avoided.

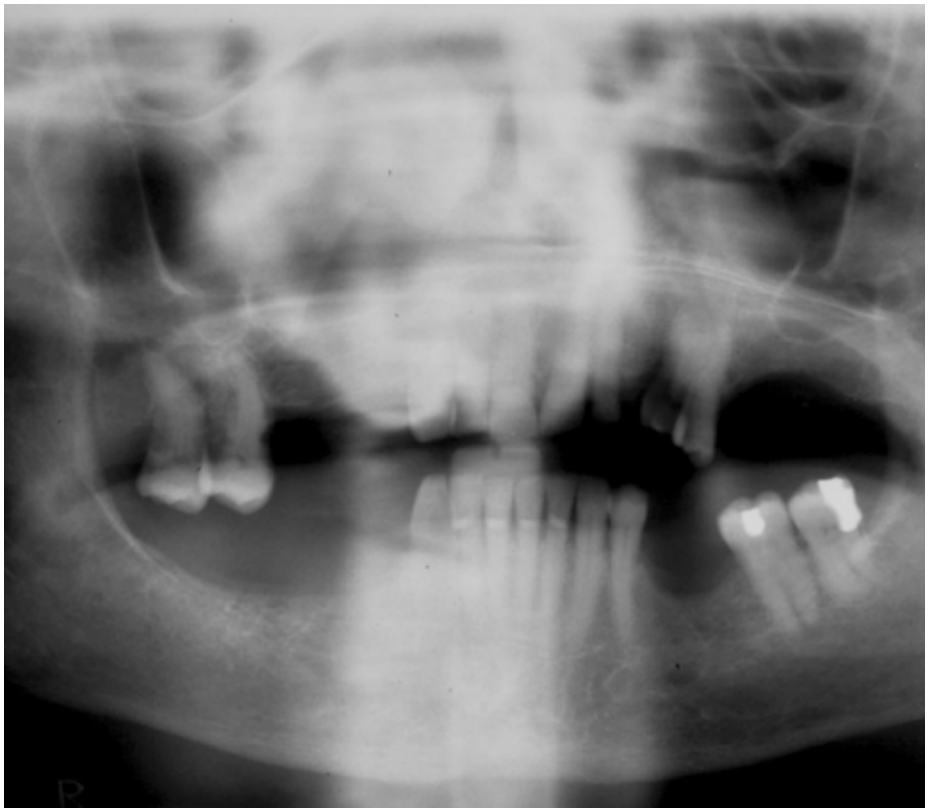
Opinion

The opinion expressed in the report will depend on the nature of the report that has been requested and the issues raised by the instructing party. The issues that have been identified by the instructing party need to be answered in an unambiguous clear manner. Where there is a range of opinion on a particular issue then this should be recorded.

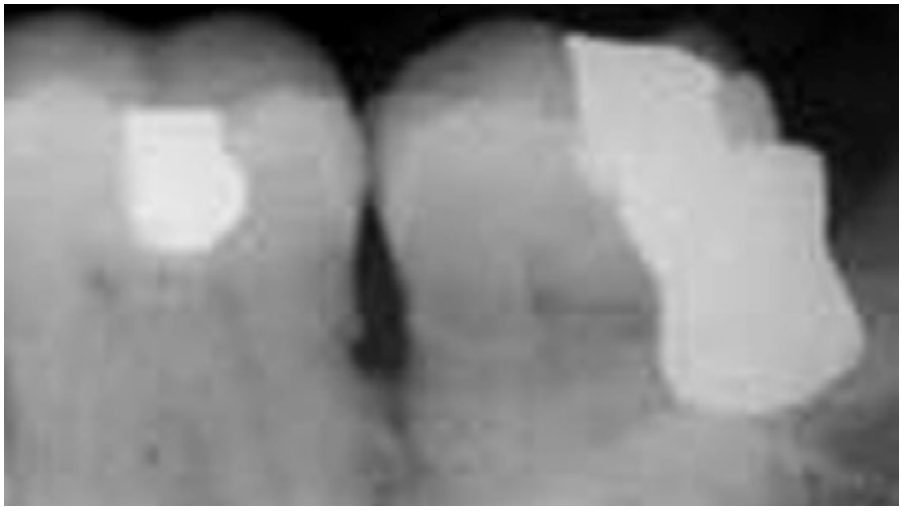
The practitioner in a 'Present Condition and Prognosis' report should detail his/her opinion with respect to the cause of any pain or other symptom that the patient may be suffering, including those that they have told the practitioner about when asked to state his/her present complaints. An opinion must be given as to the prognosis for any injury sustained by the patient, with the possibility and consequence of any long-term effect or other likely sequelae from the damage being addressed.

In a 'Liability and Causation' report, all the issues relating to any perceived failure of duty of care that have

a



b



c

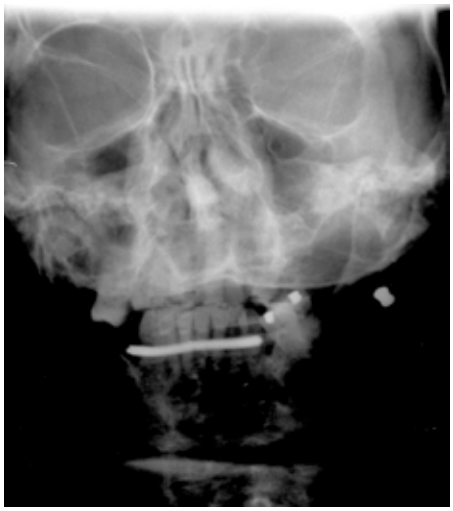


Figure 1. (a) OPG, **(b)** periapical and **(c)** posterior anterior radiographs showing an airgun pellet within the left facial soft tissues superimposed on the restoration in the LL7.

been identified should be discussed, and a well reasoned argument clearly documented as to how the opinion has been derived. Where there is a range of opinion, eg a specific treatment of a condition, then this range should be admitted and recorded.

Copies of any scientific papers that support the opinion should be included in an appendix.

Summary

A summary of the findings of the report should be detailed. Some instructing parties prefer to have a summary at the beginning of a report, others at the end.

Expert's declaration and statement of truth

In civil cases, the Civil Procedure Rules require that a Declaration and a Statement of Truth is included at the end of the report, which was amended to the following from 1st October 2009:[2,3]

'I understand that my overriding duty is to the Court and I have complied with that duty and will continue to comply with it. I am aware of the requirements of Part 35 and Practice Direction 35 and the CJC Protocol for the Instruction of Experts to give Evidence in Civil Claims.'

'I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true. The opinions I have expressed represent my true and complete professional opinions on the matters to which they refer.'

The wording for the Expert's Declaration and Statement of Truth are slightly different for criminal cases.

The completed report should then be dated and signed prior to dispatch to the instructing party.

Example 5

An elderly patient who allegedly tripped on a proud paving stone and fell onto the face was taken by ambulance to his/her local hospital where a fracture of the mandibular condyle was diagnosed, as well as facial soft tissue lacerations. The patient was partially edentulous but was able to wear his/her dentures and achieve centric occlusion, although the mandible deviated to the fractured side when opening the mouth to the maximum. The facial lacerations were debrided and sutured in layers, following which the patient was discharged to outpatient follow-up. The patient was regularly reviewed by the local hospital but he/she complained of pain on the fractured side of the mandible. The patient's dentist took a periapical radiograph and concluded that he/she could find no dental cause for the pain. A referral to the local dental hospital followed and, without taking a further radiographic examination, it was concluded that the pain was a consequence of the patient's medication and fracture. The patient consulted a solicitor to claim compensation from the Council who admitted liability and agreed to settle the claim. An offer was made without having any medical reports. The solicitor considered the offer to be inadequate and commissioned a report. When the radiographs were viewed (Figure 1) the solicitor was contacted to enquire if the patient had ever been shot with an airgun, as there was no record of such an injury in the patient's GP, Accident and Emergency or dental records, and it was confirmed that they were not aware of the patient ever being shot in the face. The radiographs clearly demonstrate an airgun pellet within the substance of the left cheek. One facial soft tissue injury was at the point in the cheek where the pellet was sited and thus, conceivably, the patient may well have been shot in the face that contributed to the 'fall'. The solicitor was informed of the finding. There was no record in the hospital current case notes that the airgun pellet was present and the dentists, when viewing the OPG and periapical radiographs, could easily have mistaken the pellet to be an amalgam restoration.

Over time the expert will develop his/her own report writing style, with refinements resulting from experience, feedback and/or training courses.

If nothing else, writing a report can be a salutary lesson for the practitioner, resulting in a critical appraisal of records and dental practices. Are your own note entries timed, dated, signed and legible? Are your notes clear, recording all that transpired which led to you to make the decision you did?

Your report will reflect both your professionalism and your practice and you may be commissioned again. Some practitioners go on to further training to develop an interesting, rewarding and possibly lucrative second career by becoming an expert in his/her own field.

It should also be remembered that anything included in a report may be subject to challenge in cross-examination.

Following the case of *Jones v Kaney* (2011),[6] which was a case of a client suing his/her own expert, the Supreme Court has now abolished the traditional immunity from civil suit for an expert's participation in civil proceedings. The Court also approved an earlier decision that an expert witness could be made liable for wasted costs and could be the subject of proceedings by his/her professional body for misconduct. Expert witnesses in civil or criminal cases must therefore have adequate professional indemnity insurance in case the expert is sued for a failure of duty in the preparation of the report.

Acknowledgements

I would like to acknowledge the help given by Mrs W A Wood in the preparation of this paper.

References

1. Kelleher MGD, Djemal S, Lewis N. Ethical marketing in 'Aesthetic' ('Esthetic') or 'Cosmetic Dentistry' Part 3. *Dent Update* 2012; **39**: 472–486.
2. Supreme Court of England and Wales. Statutory Instrument 2009 No 2092 (L24). *The Civil Procedure (Amendment) Rules 2009*. London: HMSO, 2009.
3. Supreme Court of England and Wales. Statutory Instrument 1998 No 3132 (L17). *The Civil Procedure Rules 1998*. London: HMSO, 1998.
4. Casey P. Expert testimony in court. 1: General principles. *Adv Psychiatr Treat* 2003; **9**(3): 177–182.
5. The Civil Legal Aid (Remuneration) (Amendment) Regulations 2013 and the Criminal Legal Aid (Remuneration) (Amendment) Regulations 2013.
6. Supreme Court decision: *Jones v Kaney* (2011). UKSC 13.