AADEP Fellowship Case Report Reviewer's Analysis

AADEP FELLOWSHIP CASE REPORT REVIEWER'S ANALYSIS

Case Report #

Reviewer: Date: Deadline:

If Category does not apply, a minimum of two (2) points should be assigned.

Content Item	Points Assigned
I. Overall Length, Structure and Readability of Report (20 points)	
A. Length - adequate description overall (0-4)	
B. Structure (6 points)	
1. Report divided into labeled sections (0-2)	
2. Identifying information [biographical, referral source, purpose] (0-1)	
3. Short paragraphs - one topic per paragraph (0-1)	
4. Answers to critical questions clearly identifiable (0-2)	
C. Well written / discussion clear to non-physician reader (choose one - 0-10)	
1. Well written / no confusion (10) or	
2. Some difficulty in following text (5) or	
3. Poor or confusing (0)	
II. Medical content - History and Physical Examination (32 points)	
A. Purpose of exam, with disclaimer (0-1)	
B. Date of Injury and Jurisdiction [P.I., W.C., etc.] (0-1)	
C. Examinee's employer/job description provided (if relevant) (0-2)	
D. Chief complaint stated clearly (0-2)	
E. History of injury/event elicited from Examinee (0-2)	
F. Past medical and surgical history elicited (0-4)	
G. Discussion of prior claims (if applicable) (0-2)	
H. Review of systems (0-2)	
I. Medications described (including if taken day of examination) (0-2)	
J. Social history, INCLUDING activities of daily living, hobbies, etc, both prior to and after claim, elicited and described in depth (0-4)	
K. Physical exam thorough/consistent with the Guide's Recommendations:	
1. Examinee's age, height, weight, sex, hand dominance included (0-2)	
2. Examination thorough and focused on area of chief complaint (0-6)	
3. Relevant ancillary areas also evaluated (0-2)	
4. Subjective versus objective "findings" differentiated (0-2)	
5. Use of distraction testing/Waddell's (if appropriate) (0-2)	

III. Medical content - Diagnostic Testing and Record Review (12 points)	
A. Diagnostic tests ordered by Examiner stated, with interpretations (0-2)	
B. Diagnostic tests reviewed by Examiner listed and described (0-2)	
C. Medical records reviewed are listed and discussed	
1. Medical records listed (0-2)	
2. Content of records specifically described, separate from history (0-4)	
3. Potentially useful but unavailable records described and requested (0-2)	

IV. Impressions/Conclusions (36 points)	
A. Content	
1. Diagnosis specifically stated (0-2)	
2. Symptom magnification or not (0-2)	
3. Causation of diagnoses discussed in context of claim (0-4)	
4. Apportionment to old injuries discussed (0-2)	
5. Is Examinee at MMI or not? (0-2)	
6. If at MMI, Impairment rating (if applicable) or prognosis given (0-2)	
7. Impairment rating (if applicable) performed correctly (0-4)	
8. If not at MMI, need for further testing or procedures defined? (0-2)	
9. Work ability/restrictions defined as permanent or temporary? (0-2)	
10. Physical capacities described [based upon objective findings] (0-4)	
B. Conclusions fit with history, exam, testing, records (choose one - 10 points)	
1. Conclusions fit (10) or	
2. Questionable fit (5) or	
3. Conclusions not justified / no fit (0)	

Total Points Awarded		0
Percentage of Total Points Possible	(N / 100) =	0.00%
Fellow Criteria Points	(Percentage X 40) =	0

Reviewer's Comments:
PLEASE PUT CONSTRUCTIVE, CONCISE, CRITICISM THAT THE EXAMINEE CAN UTILIZE EASILY

Signature of Reviewer: MD or DO, FAADEP

[redacted]

Occupational Health Services

NOTICE OF INFORMED CONSENT FOR INDEPENDENT MEDICAL EVALUATION

This is to verify that I have been scheduled to undergo a medical evaluation related to my claim of disability at the office of Douglas W. Martin, MD on _____ at _____.

I understand that this evaluation is to include my giving information about myself and my personal circumstances as well as my health.

I understand that there is also to be a physical examination which may be performed on any relevant part of my body, and that I may be asked to undergo certain tests and X-rays.

I understand that the results of this evaluation will not be given to me, but that all of the findings will be neutral (that the evaluators are completely independent and not involved in my disability claim or the results thereof.)

(Signed) _____

(Date) _____

GARY C. FREEMAN, M.D.
ORTHOPAEDICS

INDEPENDENT MEDICAL CONSULTANT
SURGERY OF THE HAND

THESE ARE THREE SAMPLE DISCLAIMERS WHICH I FIND USEFUL FOR INCORPORATION IN THE MEDICAL REPORT.

The opinions rendered in this case are the opinions of this evaluator. This evaluation has been conducted on the basis of the medical examination and documentation as provided, with the assumption that the material is true and correct. If more information becomes available at a later date, an additional service/report/reconsideration may be requested. Such information may or may not change the opinions rendered in this evaluation. This opinion is based on a clinical assessment, examination, and documentation. This opinion does not constitute per se a recommendation for specific claims or administrative functions to be made or enforced.

This Independent Medical Evaluation is based upon the subjective complaints, history given by the patient, the objective medical records and tests provided to me, and the physical findings of the patient. Impairment ratings are given according to the Guides to the Evaluation of Permanent Impairment, Fourth Edition, American Medical Association. Recommendations regarding work and impairment ratings are given totally independently of the requesting agents. The opinions are based upon reasonable medical probability. Medicine is both an art and a science and although a patient may appear to be fit for return to duty there is no guarantee that the patient will not be reinjured or suffer additional injury once he returns. If further information is required please contact the undersigned.

The opinions rendered in this case are the opinions of the reviewer. The review has been conducted without a medical examination of the individual reviewed. The review is based on documents provided with the assumption that the material is true and correct. If more information becomes available at a later date, an additional service/report/reconsideration may be requested. Such information may or may not change the opinions rendered in this report. This report is a clinical assessment of documentation and the opinions are based on the information available. This opinion does not constitute per se a recommendation for specific claims or administrative functions to be made or enforced.

FORWARD

On October 17, , I evaluated Ms. Jane Doe, who is a 51 year-old, right-handed woman. The examinee brought with her diagnostic studies which included x-rays, bone scan, and MRI scan. I examined these films and returned them to Ms. Doe to return to the appropriate facilities. I also had for review a number of medical records. These records are summarized in this report, and copies of the actual records are attached.

I have seen Ms. Doe only for the purpose of a Comprehensive Medical Record Review and Medical Assessment, and not as a treating physician. The opinions rendered in this case are the opinions of this evaluator. This evaluation has been conducted on the basis of the medical examination and documentation as provided or obtained, with the assumption that the material is true and correct. If more information becomes available at a later date, an additional report may be requested. Such information may or may not change the opinions rendered in this evaluation. These opinions do not constitute per se a recommendation that specific claims or administrative functions be made or enforced.

Recommendations regarding the examinee's ability to work, or participate in activities of daily living, and other opinions provided in this report are given totally independently of the requesting agents. These recommendations and opinions are based upon reasonable medical probability. Medicine is both an art and a science, and although the patient may appear to be fit to participate in various types of activities, there is no guarantee that the individual will not be re-injured, or suffer additional injury as a result of participating in certain types of activities.

I personally interviewed Ms. Doe in order to obtain the medical history, and I reviewed the available medical records. I conducted the physical examination, including the neuro-musculoskeletal evaluation, in the standard fashion. The examinee was advised prior to the physical examination that there might be some soreness or stiffness afterwards.

Range of motion measurements in the extremities were obtained with a goniometer where indicated, based on the protocols described in the *AMA Guides to the Evaluation of Permanent Impairment*. Spinal range of motion measurements were obtained with an electronic inclinometer, where indicated, also based on the protocols described in the *AMA Guides*. The examinee performed the peripheral joint and spinal range of motion movements in an active fashion. The examinee was asked to move the joints to the maximum extent possible that did not cause injury or harm. In some instances, gentle, passive range of motion movements and measurements of the peripheral joints were obtained. Hand grip strength was tested using a computerized hand dynamometer, following the standardized medical protocols.

SOME FIRST PAGE MATERIALS AND FORMS USED BY FORMER WORKSHOP PARTICIPANTS:

Example 1

LETTERHEAD

To:

Attention:
Re:

Claim number
DOI
DOB

Employer:
Date of examination:
Examiner:

Thank you for your referral of Sarah L. Carey. The following is the report on the Independent Medical Evaluation performed at our Etna Clinic on 30 January 1990.

We hope this information will be beneficial in determining the disposition of this claim. If you have any questions regarding this information, please contact . . . .

We appreciate the opportunity to be of service to you.

[Page two follows; headings of the report begin.]

Example 2

LETTERHEAD WITH COMPANY NAMES, PHYSICIANS' NAMES; ADDRESS

Re:
DOB:
D/E:
DOI:

Referral Organization:

BACKGROUND

Mr. Jones was referred for an independent medical examination (IME) at the request of . . . . The IME process was explained to Mr. Jones and he understands that no physician-patient treating relationship exists and that a report will be sent to the requesting party.

The history was provided by the examinee as well as by medical records from ——— . He arrived on time for his appointment. The records which were reviewed included . . . . .

HISTORY etc.

Example 3
Date

Re: Examinee: Damp, Annie
SSN: 000 - 00 - 0000
DOB: 01-01-01
Date of exam : 02-02-02

Comprehensive consultative medical report

Dear Mr. Forbes:

I had the pleasure of evaluating Ms. Annie Damp at your request in my Los Angeles office on February 2, 1992. The following report is a summary of my comprehensive history and physical examination, highlighting the specific report requirements for a musculoskeletal examination.

CHIEF COMPLAINTS:

The patient complained of the following: . . .

Example 4
Letter Head

Date

Address of recipient

Re: Examinee's Name
Employer:
Claim Number:
Date of Exmination:
Date of Injury:
Purpose of Examination:

Dear Mr. Requester:

At your request, I evaluated Ms. Lamar at our Medical Maintainance offices on Wednesday, February 14, 1993. Available to me at the time of the evaluation were a copy of the Bureau ofWorkers' Compensation file, including a previous C-92 evaluation by Dr. Morgan, chart notes from a review nurse, a maximal medical determination letter from a chiropractic physician, Dr. Hill, an evaluation letter from Dr. Gerry Atnic, a radiology report from the chiropractic physician, Dr Hill, and chart notes from Dr. A. Lurie.

Sample 5
The historical portion of the records was dictated in the presence of the examinee for any corrections or additions.

Sample 6
Mr Blank was examined for an independent/impartial medical evaluation. No treatment was rendered No patient physician relationship was established. Examination, testing and dictation were performed and reviewed by this physician. The purpose of the examination was explained to Mr. Blank.

Sample 7
Dear Mr. Lawyer:

Thank you for referring Mr. Sawyer to me for psychiatric evaluation. I saw Mr. Sawyer in my office on 10 May 1992. I spent fifty minutes talking with Mr. Sawyer that day, and an additional thirty-five minutes beginning the review of the records which you had sent, and beginning the preparation of this report.

Mr. Sawyer was aware that I would be sending you a report, and that our conversation was not confidential. Further, he was aware that he did not have to answer any of my questions. Mr. Sawyer's wife accompanied him to the interview, but waited in the waiting room, while I talked with her husband.
Letterhead

Example 8
August 17, 1992

Presiding Judge
Workers' Compensation Appeals Board
100 North Broadway, Room 200
Kalamazoo, Michigan

Re: Mary Worker versus Moonshine Lighting Inc.

AGREED MEDICAL EXAMINATION IN PSYCHIATRY

SECTIONS OF THIS REPORT

VISUAL AIDS, OR,
YOU AND YOUR TYPIST:
The Professional Presentation

Plan with your typist the following typing techniques for presentation.

- White space: arrange its use to help the reader find information. Layout of text matters.

- Type faces (fonts such as Palatino and Avant Garde, the two used on this page): use no more than two per page. More will look cluttered and confusing.

- Vary font size for headings and titles.

- Bullets, *italics*, and <u>underlining</u> guide the reader to headers or important information.

- *Headings* help guide the reader through your report.
    - Indent headers when you need to in order to show relationships between sections.

- LONG PASSAGES WRITTEN IN CAPS ARE HARD TO READ BECAUSE THE WORDS ALL HAVE THE SAME RECTANGULAR SHAPE, AS YOU CAN SEE IN THIS CASE.

- *Italics can be easier to read than caps, but they are hard on your typist.*

- **Boldface** makes an excellent choice for headers.

*Use **diagrams, charts, layout,** and other visual aids*
to create a presentation that is convincing and convenient for the reader.

PHYSICAL EXAMINATION

. . . . .

Forearms, wrists, & hands: Ms. Newfield's hand and wrist strength was tested with a Jaymar Dynometer to determine overall hand strength and to look for symptom magnification. Ms. Newfield's scores indicate a reliable test and no symptom magnification.

TEST	I	II	III
POSITION			
1.	8 kg	10 kg	8 kg
2.	23 kg	25 kg	25 kg
3.	28 kg	21 kg	25 kg
4.	22 kg	21 kg	22 kg
5.	15 kg	16 kg	19 kg

SUMMARY AND CONCLUSIONS

• *Summary of Relevant History and Findings:*

Nancy Newfield is a thirty-two year old female, no longer employed. Her previous employer was Universal Machines. While under employment at Universal Machines, she was taken from a sedentary inspector's job to a machine operator/laborer job. This job required her to operate a machine which frequently jammed. The job thus required her to lift 62.5 pound objects every 2.5 minutes in ten-hour shifts, working five days a week. This shift in job occurred after Ms. Newfield's herniated disc was surgically removed less than one year before. *[etc.]*

• *Diagnoses* :

1) herniated nucleus pulposus L5-S1, second operation performed in 1990.

2) sensory loss of S1-L5 dermatome right foot.

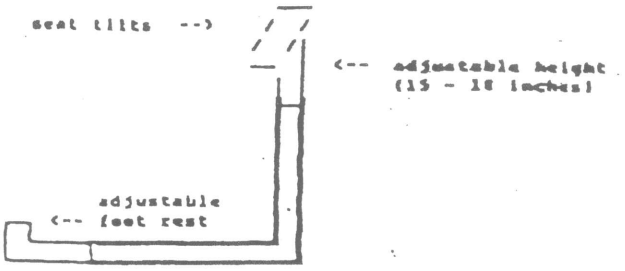
3) somatic dysfunction of the head, cervical, thoracic, lumbar, sacrum, and pelvis.

4) chronic lumbar radiculopathy.

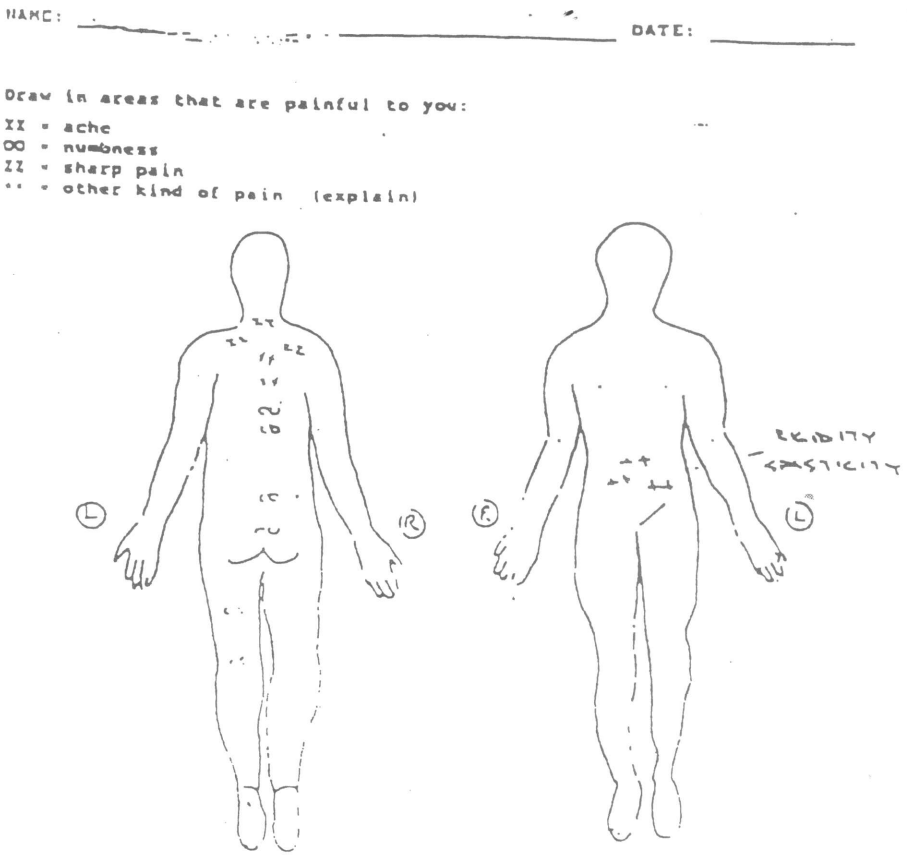
VISUAL AIDS: DIAGRAMS AND CHARTS

Some doctors regularly include pain diagrams with their medical reports, and may insert other helpful diagrams and charts as well. To describe the working conditions of one examinee, a doctor wrote the following:

The examinee says she sorts letters by hand, putting letters into the different carriers' boxes. She used a rest bar when performing this activity. This rest bar had a foot bar on the front to brace against, and then a padded seat that was tilted to lean against while standing up. Ms. Silvus says they were not allowed to sit on the seat, but would just lean against the rest bar. A diagram of the rest bar is pictured below.



A Pain Chart:



USE OF PARAGRAPHS

- *Short paragraphs are better than long ones.*
- *Preliminary dates and headings are helpful.*
- *Be careful not to include irrelevant material or put material in the wrong category or get dates mixed up. If you've used a heading, stick to the relevant material.*

What not to do:

HISTORY

Review of the medical records and discussions with the patient indicate that the patient was serving as a general laborer for the above Employer, where on 07/15/81, he was jumping into a ditch, and "landed wrong" with resultant pain, numbness, and weakness in the lower extremities, but no complaints of urinary incontinence. The patient was able to return to work the next day, and was advised by the Supervisor to seek medical attention, for which he was then given prescriptions and advised to go on bed rest for approximately seven days. The patient states that he was started on Percocet at that time, and has been on long-term narcotic analgesics ever since. Eventually , he was able to return to work in the service area of Ft. Grande, and was later relocated to Littleton for approximately three months, during which time he was working in the same capacity, but was being "over-worked" by his Employer. During that time, a heavy object fell on his chest area with re-exacerbation of his low back symptoms at which point he was re-referred back down to his home of origin in Ft. Grande for further medical work-up. Subsequently, he was seen by Dr. Morris, Orthopedic Surgery, who after appropriate diagnostic imaging and physical examinations, felt that he was suffering a L-4/5 and possibly L-5/S-1 disc herniation. He was taken for surgery on 12/[illegible]/81, where a left-sided intralamellar L-4/5 and L-5/S-1 diskectomy was performed. Post-operatively, the patient reported that his pain was remarkably improved, and he claimed to be highly motivated to return to work at that time. After approximately one and one-half months following surgery, he felt slow, progressive increase in his prior radicular symptoms down the left lower extremity. The patient states that in spite of his symptoms, Dr. Morris recommended that he return to duty, which he felt was not a feasible option and described himself as being "angry" and returned to his hometown in the Atlantis North Carolina area. There, he saw an Orthopedic Surgery, Dr. William Bailey, in September of 1982, where he was eventually taken for a decompressive laminectomy/foramenotomy at the L-4/5 and L-5/S-1 levels. Diagnostic imaging at that time was significant for post-surgical changes and probable clinically significant disc herniations and/or scar adhesions. The patient continued to complain of pain, which was now actually worse with the surgical intervention, and further diagnostic imaging was pursued by Dr. Sharon Old, Orthopedics, in 1983. He continued to show significant post-surgical changes and evidence of scarring and/or clinically significant disc pathology for which the patient underwent a decompressive lumbar surgery and laminectomy on 02/17/84. Following this, the patient reported reduction in his pain profile and improvement in his lower extremity function, but again makes note of excessive utilization of narcotic and benzodiazepine medications. The patient then claims that he underwent chimopapane disc procedures in the mid-1983's, although I can not find any report of these in his medical records to substantiate this. He also underwent physiotherapy, which included mostly thermotherapies and TENS-Unit application, with him reporting temporary relief, but no lasting symptomatology. During the year of 1984, the patient reports that he was frequently admitted to hospitals in the North Carolina area for symptomatic relief of his severe pain, during which time he continued to receive large amounts of narcotics and muscle relaxants. He states the frequency of these visits ranged anywhere between ten and 20 times. By the conclusion of 1984, the patient underwent his final surgical procedure, where as best as can be described, included a scar release, foramenotomy, and possibly spinal fusion. He did report some symptom relief with this, but again noted that he had various difficulties with continued dependence on Halcion, Valium, Percodan, and other narcotics. In 1985, he was admitted for a course of alcohol and narcotic detoxification in Madrid, Spain, which he states was unsuccessful in achieving independence from these agents. In 1986, a Functional Capacity Evaluation was performed, which basically

Paragraphs

Example A.

Review of Records

A Report of Neurological Consultation by Dr. Henry Hanson (01/09/86) indicates that Ms. Gregson had been referred by a Dr. Plimpton for evaluation of seizures, after the examinee had had an apparent grand mal seizure on12/31/85. Her boyfriend said she had tonic-clonic movements. She was on no medications at the time, except for birth control pills. Ms. Gregson had been seen by a neuro-ophthalmologist in Tampa and had been told that she had "bleeding behind her left eye." Two prior CT scans had been normal. During the examination "the patient appeared lethargic and somewhat confused." Dr. Hanson's impression was "Convulsive disorder–possible post-traumatic/Post-concussion syndrome." Incidentally, a report by neuro-ophtalmologist Joseph A. Randel, of Tampa (12/18/85), mentions normal occular fundi. Dr. Randel was of the opinion that Ms. Gregson's visual complaints had "a nonorganic cause." A letter by Dr. Randel to Federated Insurance Company (01/08/86) releases the patient to work from an ophtalmological [sic] standpoint. On the other hand, Dr. Randel states "whether she was able to work prior to the initial office visit here is uncertain. She claimed only 20/400 vision left eye, and I found a tubular visual field. Perhaps she needed the 2 weeks for improvement".

Revised paragraph:

In a report on 12/18/85, neuro-ophthalmologist Joseph A. Randel, of Tampa, mentions normal occular fundi for Ms. Gregson. Dr. Randel believed Ms. Gregson's visual complaints had "a nonorganic cause." In a 1/08/86. letter to Federated Insurance Company. Dr. Randel releases Ms. Gregson to work from an opthalmological standpoint. On the other hand, Dr. Randel states "whether she was able to work prior to the initial office visit here is uncertain. She claimed only 20/400 vision left eye, and I found a tubular visual field. Perhaps she needed the 2 weeks for improvement."

Dr. Hanson, in a 1/09/86 A "Report of Neurological Consultation," indicates that Ms. Gregson had been referred by a Dr. Plimpton for evaluation of seizures, after the patient had had an apparent grand mal seizure on 12/31/85. Her boyfriend said she had tonic-clonic movements. She was on no medications at the time, except for birth control pills. Ms. Gregson had been seen by a neuro-opthalmologist in Tampa and had been told that she had "bleeding behind her left eye." Two prior CT scans had been normal. During the examination "the patient appeared lethargic and somewhat confused." Dr. Hanson's impression was "Convulsive disorder–possible post-traumatic/Post-concussion syndrome."

Paragraphing

Example B.

Review of Records

I reviewed a C4 form signed by Dr. Gordon Oslo of December 2, 1991, with a diagnosis of a fracture of the right radial head. I also reviewed a C4 form from December 22, 1991 signed by Dr. James Herbert with the same diagnosis, as well as office follow-up from Dr. Herbert of December 21, 1991 describing an x-ray showing union of the radial head fracture with a small exostosis formation. Follow up notes and C4 forms from Dr. Tokacs describing the patient's evolution in physiotherapy, dated December, 1991 and February 22, 1992 were read. I also read an initial report from Dr. Michael Victor from January 13, 1992 followed by another report on March 29, 1992 describing the patient's evolution and authorizing a CT scan of the right elbow. A CT scan report of April 21, 1992 was reviewed from Montana Diagnostic Imaging reporting: 1) a mild deformity and compression of the lateral aspect of the right radial head, consisten: with a n old impacted fracture, 2) small cortical defects involving the posterior aspect of the radial head as well as the posterior aspect of the adjacent capitellum, and 3) multiple small calcified loose bodies demonstrated posteriorly with an associated posterior joint effusion, signed by Dr. Silver. I reviewed a consult from Dr. Jane Rooney, dated May 20, 1992, in which surgery of the right elbow was recommended. I also reviewed a record of the operation performed by the same doctor on June 16, 1992, with surgery consisting of an arthrotomy and removal of bone fragments at the right elbow. A follow up office visit of June 22, 1992 from Dr. Rooney, mentioning complete healing of the wound and instructing the patient in range of motion of the right elbow, was reviewed.

Use the space below to sketch out a revision of the above paragraph:

Example B. Possible revisions:

Revision 1:
Dr. Gordon Oslo diagnosed a fracture of the right radial head (C4 form signed by Dr. Oslo 2 December 1991). Dr. James Herbert's office follow-up on 21 December 1991 describes an x-ray showing union of the radial head fracture with a small exostosis formation; he signed a C4 form with diagnosis of fracture of the right radial head on 22 December 1991.

Dr. Tokacs's follow-up notes and C4 forms from December 1991 and 22 February 1991 describe the patient's evolution in physiotherapy.

Dr. Michael Victor's initial report of 13 January 1992 and subsequent report on 29 March 1992 describe the client's evolution and authorize a CT scan of her right elbow. The CT scan report from Montana Diagnostic Imaging, signed by Dr. Silver, 21 April, 1992, reports: 1) a mild deformity and compression of the lateral aspect of the right radial head, consistent with an old impacted fracture, 2) small cortical defects involving the posterior aspect of the radial head as well as the posterior aspect of the adjacent capitellum, and 3) multiple small calcified loose bodies demonstrated posteriorly with an associated posteriror joint effusion.

Dr Janey Rooney's records show that on 20 May 1992 she recommended surgery of the right elbow. On 16 June, 1992, Dr. Rooney performed surgery. Surgery consisted of an arthrotomy and removal of bone fragments at the right elbow. A follow-up office visit of 22 June 1992 from Dr. Rooney mentions complete healing of the wound and instructions given the patient in range of motion of the right elbow.

Revision 2:
A fracture of the right radial head was diagnosed by Dr. Gordon Oslo (C4 form signed by Dr. Oslo 2 December 1991). The diagnosis was confirmed by Dr. James Herbert (see C4 form signed by Dr. Herbert on 22 December 1991; an office follow-up on 21 December 1991 describes an x-ray showing union of the radial head fracture with a small exostosis formation).

The patient's evolution in physiotherapy is described in Dr. Tokacs's follow-up notes and C4 forms from December 1991 and 22 February 1991.

In an initial report of 13 January 1992 and subsequent report on 29 March 1992, the client's evolution is described and authorization is given for a CT scan of her right elbow by Dr. Michael Victor. The CT scan report from Montana Diagnostic Imaging, signed by Dr. Silver, 21 April, 1992, reports: 1) a mild deformity and compression of the lateral aspect of the right radial head, consistent with an old impacted fracture, 2) small cortical defects involving the posterior aspect of the radial head as well as the posterior aspect of the adjacent capitellum, and 3) multiple small calcified loose bodies demonstrated posteriorly with an associated posteriror joint effusion.

Surgery of the client s right elbow was recommended by Dr. Jane Rooney according to records dated 20 May 1992. On 16 June 1992, surgery was performed by Dr. Rooney. Surgery consisted of an arthrotomy and removal of bone fragments at the right elbow. According to a follow-up office visit of 22 June 1992 from Dr. Rooney, healing of the wound was complete and the patient received instructions in range of motion of the right elbow.

Example B. Possible revisions:

Revision 3:

- December 2, 1991. A C4 form was signed by Dr. Gordon Oslo, with a diagnosis of a fracture of the right radial head.
- December 21, 1991: An office follow-up by Dr. Herbert describes an x-ray showing union of the radial head fracture with a small exostosis formation. December 22, 1991.: A C4 form was signed by Dr. James Herbert with the same diagnosis as Dr. Oslo's above.
- December, 1991 and February 22, 1992.: Follow up notes and C4 forms from Dr. Tokacs describe the patient's evolution in physiotherapy.
- January 13, 1992: An initial report from Dr. Michael Victor is followed by another report on March 29, 1992 in which he describes the patient's evolution and authorizing a CT scan of the right elbow.
- April 21, 1992. A CT scan report from Montana Diagnostic Imaging signed by Dr. Silver reports: 1) a mild deformity and compression of the lateral aspect of the right radial head, consistent with a n old impacted fracture, 2) small cortical defects involving the posterior aspect of the radial head as well as the posterior aspect of the adjacent capitellum, and 3) multiple small calcified loose bodies demonstrated posteriorly with an associated posterior joint effusion.
- May 20, 1992: A consult from Dr. Jane Rooney recommends surgery of the right elbow. June 16, 1992: A record of the operation performed by Dr. Rooney reports that surgery consisted of an arthrotomy and removal of bone fragments at the right elbow. A follow up office visit of June 22, 1992 from Dr. Rooney mentions complete healing of the wound and instructing the patient in range of motion of the right elbow.

When using headings to organize paragraphs, be careful that information goes into the right spots. The following examples contain misplaced information:

A.

SUBJECTIVE HISTORY:
Mr. Farrell was seen at my office on May 19, 1990 as a result of injuries sustained in an accident which occurred on May 10, 1990.

The following narrative is a report of my evaluation and findings.

At the time of the initial office visit a complete history, physical examination and radiographic examination was made. The following are the results of my findings.

The examinee stated that on May 10, 1990, he was a passenger in an automobile that was involved in a collision in Ithaca, New York.

B.

HISTORY: I appreciate the opportunity to evaluate this 30-year-old man for an Independent Medical Evaluation. I have reviewed the patient's medical records which you sent: these consist of John Doe, D.C., Initial Evaluation and subsequent office notes, and a second opinion by Kate Smith, D.C., on 10/20/90. There are no X-rays to review today.

The examinee is a good historian, and states that he is the owner and manager of . . .

CLOSINGS FOR MEDICAL REPORTS

Possible material to include:

- Your signature and credentials
- Polite final comments.
- The initials of your typist; the date the report was typed
- Notification of enclosures
- Notification of duplicate reports distributed elsewhere

A. If you have any questions, do not hesitate to contact me through Etna Medical in Tompkins County.

Sincerely,

J. James Jameson
Fellow, American Academy of Disability Evaluating Physicians

JJJ: sp

c: Dr. Blank, 212 Cayuga Street, Ithaca, New York

B. If I can be of any further help, please call me.

Sincerely,

Donald L. Kelp, M.D., F.A.C.E.P.
DJK/

Disclosure Notice:
This is to certify that this report was entirely dictated and reviewed for content and completeness by me in accordance with California W.C.A. B. Rule Number 10606.

C. No additional diagnostic tests or consultations are deemed necessary for the completion of this assignment.

_____ _____
Joan I. Physician, M.D. Date of Signature

JIP: slw/kc: 01-07-90

D. CLOSING INFORMATION:
If you have any questions regarding this report, please do not hesitate to contact me. Thank you for your referral; I hope this information is helpful.

Sincerely,

Samuel Goldstein, M.D
Orthopedic Surgeon

Closings

E. Thank you for referring Ms. Alice James to me for an evaluation. I hope this report will satisfactorily comply with your requirements. Should you have any other questions, please do not hesitate to call.

Sincerely,

Sharon A. Henkel
Physical Medicine and Rehabilitation

Note:
Reference: Engelberg AL, Editor, *Guides to the Evaluation of Permanent Impairment* by the American Medical Association; 3rd edition (revised) 1990.

DO NOT DO EITHER OF THE FOLLOWING:

A. If I can be of any further assistance, please feel free to contact me.

Very truly yours,

Roland R. Bard, D. O.
(Dicated [sic] but not read by Dr. Bard)

RRC/cc

B. Typed name, no written signature.

TECHNIQUES FOR WRITING CLEARLY

Subjects of Sentences

Principles:

- *Choose consistent subjects--doing so helps the reader to follow you.*
- *Make sure you have chosen the important subject--the one you want the reader to notice.*

Example:

This--

I reviewed a C4 form signed by Dr. Gordon Oslo of December 2, 1990, with a diagnosis of a fracture of the right radial head. **A C4 form** from December 22, 1990 signed by Dr. James Herbert reveals the same diagnosis.

can be more helpfully (for the reader) rewritten as this--

Dr. Gordon Oslo diagnosed a fracture of the right radial head (C4 form signed December 2, 1990). **Dr James Herbert** made the same diagnosis (C4 form, December 22, 1990).

or as this:

A diagnosis of fracture of the right radial head was made by Dr. Gordon Oslo according to the C4 form he signed, December 2, 1990. **The same diagnosis** was made by Dr. James Herbert according to a December 22, 1990 C4 form.

SENTENCE SUBJECTS

PRACTICE MODELS

Rewrite the samples so that you have chosen consistent and appropriate subjects for each sentence. The current subjects are underlined.

1. *[from the Review of Records]:* On December 7, 1988, Dr. White felt that the patient had reached a Permanent and Stationary status other than the discomfort and disability of his left shoulder. The left shoulder injury was felt to be 100 percent representable to the injury of April, 1988. It was felt that the patient would need vocational rehabiliation. The patient had been seen several times by Dr. White after he was seen by Dr. Brown.

2. *[from the Review of Records]:* The examinee states that therapy made him worse. He was re-evaluated again at Slatersville on 6/9/88. Inconsistencies and signs of magnified illness behavior were noted by the therapist and evaluation to a pain management program was recommended.

3. *[from Examinee's Complaints]* Ms. Newman's left knee pain is described as retro and peropatellar with occasional buckling, swelling and locking. She also complains of popping.

EXAMPLES OF SENTENCES WITH CLEAR BEGINNINGS
APPROPRIATE AND CONSISTENT CHOICES

1. Knee range of motion on the left is from 7 degrees of hyperextension to 140 degrees of flexion, with the heel missing the buttock by 4 inches. Right knee range of motion is from 5 degrees of hyperextension to 135 degrees of flexion, with the heel missing the buttock by 6 inches. Snap extension is not painful.

2. My recommendation is that we make another attempt to do an adequate MRI by giving the patient IV sedation. If this is approved I will schedule it at Foster Medical Center. If this is unsuccessful or if it does not demonstrate clear pathology, then my next suggestion is a limited myelogram with particular emphasis on a CT scan of L4-5 and L5-S1, with an attempt to visualize the lateral recesses.

3. He flexes to approximately 60% of normal, laterally bends to the left to 50% of normal, and to the right to 80% of normal. He extends in the lumbar region to 50% of normal, and he rotates in both directions to the full normal extent. He is tender in the lubosacral region, and seems to overreact somewhat to rather light tactile stimulation.

4. PHYSICAL EXAMINATION: The examination reveals a petite, middle-aged woman, who is well built, who presents no postural defect, who moves about the room without complaint . . . .

"HE/SHE STATES/RELATES THAT . . . ."

CHIEF COMPLAINTS:
The examinee states he has pain in the lower back that is with him all the time. However, some days it is more intense than others. The back pain is accompanied with pain into the legs, primarily the right leg down into the foot and at times into the left leg down into the foot. Along with the leg pain the examinee states that he will get numbness and a dead feeling into the legs. The pain in the legs will usually be in one leg or the other but it is more frequent in the right leg then the left leg. The examinee states that if he is up on his feet and walking this will increase the back and leg pains. He states that if he is on his feet and walking about 1/2 hour that the back and leg pain will intensify. He states that he has to sit down and rest sometimes after he has walked two or three blocks. He states at times when he is driving his car his leg and foot will be so numb that he will not feel his foot on the gas pedal. Examinee states that the cold weather seems to aggravate his complaints. Examinee states that he tries to get some relief at times by putting heat on the lower back or trying to lie on his stomach.

Rewritten
EXAMINEE'S ACCOUNT OF COMPLAINTS:
Mr. Hughes says he has pain in the lower back that is with him all the time. Some days, however, it is more intense then others. The back pain is accompanied with pain into the legs, primarily the right leg down into the foot and at times into the left leg down into the foot. Along with the leg pain, Mr. Hughes experiences numbness and a dead feeling into the legs. The pain in the legs will usually be in one leg or the other but it is more frequent in the right leg than the left leg. If Mr. Hughes is up on his feet and walking, this increases the back and leg pains. If he is on his feet and walking about 1/2 hour, the back and leg pain will intensify. He has to sit down and rest sometimes after he has walked two or three blocks. At times when he is driving his car his leg and foot will be so numb that he will not feel his foot on the gas pedal. The cold weather seems to aggravate his complaints. He tries to get some relief at times by putting heat on the lower back or trying to lie on his stomach.

VERBS (AND DICTATION HABITS)
Active and Passive Verbs

Active verb: Dr. Green operated on Mr. Jones.
Passive verb: Mr. Jones was operated on.

Principles:

- The passive voice can conceal who did what.
- It often leads to wordiness.
- It can make prose sound "official"—like a boilerplate report.
- Don't let the passive voice control you; be able to choose when to use it.

Below are some sentences made unclear by use of the passive voice.
Try to rewrite each one (you may have to invent information).

1. Medical review of records have been submitted and reviewed as follows.

2. X-RAYS: An AP and lateral of the right knee were obtained. These films are normal. . . . .

3. *Record Review:*
   Mr. Black was initially evaluated at Upstate Hospital in Ithaca, New York. X-rays were obtained which revealed no evidence of fracture.

4. *Review of Medical Records*
   When seen for a follow-up examination on 01/03/90, Dr. Winters felt Mr. Jones was at maximum medical improvement . . .

5. *From the History:*
   After continued suspicion of rotator cuff pathology, it was elected to proceed with an M.R. I. Scan on 05/17/90, which showed . . . .

Active and Passive Verbs

1. *Review of Records—a model of active verbs that work:*

I reviewed the medical records which you provided. These were limited to the records of treatment at Fictional Hospital.

The records begin with an Employee Accident, Injury Report completed on July 10, 1989. One portion evidently completed by the examinee indicates that . . .

Sometimes it is obvious who did what or it is unimportant: using the passive verb is therefore appropriate so that you can put the sentence's emphasis where it belongs:

2. *An occasion when the passive verb is appropriate:*
(from the Forward): I examined these films and returned them to Ms. Doe to return to the appropriate facilities. I also had for review a number of medical records. These records are summarized in this report, and copies of the actual records are attached.

3. *Another occasion when use of the passive verb is appropriate:*
(from a statement about the physical examination): Spinal range of motion measurements were obtained with an electronic inclinometer, where indicated . . . The examinee performed the peripheral joint and spinal range of motio movements in an active fashion. The examinee was asked to move the joints to the maximum extent possible that did not cause injury or harm.

SENTENCE LENGTH AND ORGANIZATION

- *When in doubt, keep your sentences short or start over with a new one.*
- *Don't include material you forgot to mention earlier anywhere you happen to think of it.*
- *Start sentences with names and dates and important words--material to guide the reader.*
- *Check for "and," and "which," "this is" and "there is." Using too many of these allows you to string sentences on too long for the reader.*

1. This was a red, swollen toe that just appeared inflamed and she was given soaks once a day for a week and came back with an infection on the bottom portion of her toe. This infection grew worse and eventually she required a small debridement of the toe, opening the skin and cleaning it out, and then subsequently developed an ulcer on the toe at the DIP joint medially..

3. In this type of injury, there is a tearing of the soft tissue components, such as muscles, tendons and ligaments, which result in healing with scar tissue which will never be as flexible or elastic as the original counterparts, contributing to limitation of motion and chronic recurrent fibromysositis.

4. The examination is so faulted by lack of volitional and cooperative effort that it is inaccurate, but I see no evidence of true radiculopathy, certainly there is no measured atrophy in the lower extremities and the overall performance during the examination is more a function of supratentorial and functional input than real pain patterns that I have recognized throughout thirty years of orthopedic practice, with a strong experience in spine and extremity problems.

5. Certainly with the amount of pain present in both the right and left shoulders, and right and left elbows, having had steroid injections multiply in all these areas and physical therapy which was recently done by the Dallas Physical Therapy, (she did receive therapy on 8/13/89, 8/19/89, 8/19/89, 8/21.89, 8/21.89, 8/21.89, 8/21.89, 8/21.89, 8/21. 89.8/21.89 8/21.89, 8/21.89.8/21.89, 8/21.89.8/21.89.8/21.89.8/21.89 8/21.89, 8/21.89.8/21.89, 8/21.89, 8/21.89, 8/21.89, 8/21.89, 8/21.89, and 8/21.89) with nonsteroidal anti-inflammatory drug use, narcotic analgesics and four surgical procedures failed to relieve this patient's pain.

This is the first paragraph of a letter to an Appeals Board. Try rewriting it, using the active and passive voice as needed, and choosing subjects and verbs that will serve this writer best to argue his case. Be sure that the important point of each sentence occurs at the end of the sentence.

This letter is being sent on behalf of the above named examinee regarding his worker's compensation injury. This worker's compensation claim was denied on 8/8/90 and this letter is part of the appeal process for his claim. On page 2 of the claim review from Larry Smart, the last paragraph states that deficiencies in medical evidence were found and further medical information was requested. At no time did I receive a request for further medical evidence, in fact, my entire office notes as well as test reports and x-ray examination reports were sent along with the original letter. However, the records were apparently never reviewed by the examiner. These notes are all included in this appeal.

Use the space below for your rewrite:

Language and Neutrality/Objectivity

Issues of gender and race:

1. Choose terms designating race carefully, and be aware of when and why you are mentioning race or ethnicity. *Asian* (not *Oriental*); *African American* or *Black* (not *Negro*); *White* (*Caucasian* is no longer considered a scientific term, according to at least one major dictionary); *Hispanic, Latino/a*—check on preferred usage in your area.

Avoid problems such as those that occur in the following sentences:

1. *History of Injury:* The examinee is a 40-year-old left-handed black female. *(Disability reports from the same physician for white examinees do not mention race.)*

2. *The examinee had had an accident while at work; the firm is listed in the opening data of the medical report. Here is the first sentence of the medical report :*
Mrs. Dickins is a 41-year-old right-handed housewife who sustained a work-related injury in July of 1989; it was ultimately diagnosed as a recurrent fifth lumbar disk by Walter White, M.D.

3. If I can answer any further questions regarding this lady's situation I'd be happy to do so. I note that a work performance sheet is attached to the folder here. I think it would be premature to fill this out since this lady has not reached maximal medical improvement at this time.
[Throughout the report the examinee is referred to primarily as "this lady."

Questions of tone or unintended connotations:

4. I feel the examinee has reach maximum medical improvement.

5. The examinee admits to the following diagnoses/difficulties: migraine . . . .

6. The examinee commits to two types of severe headaches; one is the TMJ headache . . . .

7. The examinee is 40 years of age, and alleges two injuries, one of which was a work-related injury . . . the other a motor vehicle accident.

8. *Present Complaints:*

   Mrs. Goneril complains of intermittent moderate pain in her right wrist which is worsened by repetitive lifting, pushing and pulling. She complains also of numbness in her right fourth and fifth fingers and of less frequent numbness throughout all five of her fingers. She complains that she gets stabbing pains in the right fourth and fifth fingers at times as well.

9. *Compare to 8 above:*

   Mr. Edmund notes mid-thigh lateral pain and aching . . . . He experiences parapetellar pain on the medial aspect of the knee . . . He notes occasional swelling . . . . He continues to note loss of full extension . . . He believes his knee condition has deteriorated . . . .

10. *Cumulative statements from a disability report—note choice of modifiers:*

    The patient did not seek any medical care at all until two days after the accident. . . . The patient is significantly inconsistent, and particularly circumlocutory with regard to her present complaints. . . . She moved . . . the upper and lower extremities without the slightest evidence of physical discomfort. . . . Examination of the cervical spine reveals a complete painless range of motions including flexion, extension . . . . The patient clearly has no disability whatever in the cervical spine. She clearly has no sequelae whatever in the cervical spine as a result of the 1-20-85 incident.

10. *From "Summary and Conclusions":*

    "This [the previous treatment] was a sum total of two weeks of conservative treatment at which point Dr. Fox noted: 'She [the patient] will give it one week and see how the pain does. If she still continues to have significant pain, she will call us back and we will schedule her for release of same.' The patient was not prescribed physical therapy. She was not even prescribed soaks at home. The first dorsal compartment was not injected with any steroid. It is very clear that a sufficient attempt at conservative treatment was not made in this patient and the patient was clearly operated upon prematurely, and without sufficient indication."

VOCABULARY

Principles:

- *You are writing for a lay reader.*
- *Use plain, lay language whenever you can and when technical language is not appropriate.*
- *When you use technical terms, try to "translate them."*
- *Avoid wordiness.*

Inappropriate or unnecessary use of medical vocabulary:

1. Ms. Newman's left knee pain is described as retro and peropatellar with occasional buckling, swelling and locking. She also complains of popping.

2. Heart sounds were regular. No murmurs were appreciated.

3. At your request, Mr. Roberson presented to our orthopedic offices in LaPorte, Indiana, on 1/29/92 for an independent medical evaluation.

Wordiness:

4. [The examinee] stated that the pain is disabling in character and that the above mentioned pain is constant. This pain makes it difficult for her to do substantially all of her usual and customary activities.

Translating for the lay reader:

5. Attempts at torsion (the examinee is asked to look behind him) of the trunk produced no observable torsion. All motion was with shrugging of the shoulders and torsion (rotation) of the neck.

Relying on formulaic language can be hazardous:

6. WORK CAPACITY: At this point, I feel that with his recurrent injuries and after a prolonged absence with significant training and in a reasonably good functional capacity, he was unable to perform at all on the job and has been out of work since.

Leaving out articles (the, a) can make one's prose seem mechanical and awkward to read. In an Independent Medical Evaluation Report:

7. WORK RESTRICTIONS: . . . Examinee should be allowed to walk, however, should be provided mandatory time to sit and rest her foot. Examinee may need a new pair of total contact inserts . . . .

RULES ABOUT WHICH TO FORGET
(for your private perusal in case you're interested)

1. *Never end a sentence with a preposition.*
   Both of the following are correct:

   He was a person everyone looked up to.
   He was a person to whom everyone looked up.

2. *Never begin a sentence with And/But/Because.*
   This is folklore, not a rule. But what can we do if editors insist it is indeed a rule? It's hard to fight folklore.

3. *Distinguish between restrictive and non-restrictive clauses with the use of* that *and* which.

   It's interesting that this rule was actually *invented* early in the century by Francis and Henry Fowler *(A Dictionary of Modern English Usage)*. Only editors and school teachers observe it. Even grammarians find that this is a rule which they announce and then immediately break.

   Examples of the "rule":

   Restrictive clause:
   The examination ***that*** *was scheduled for today* had to be cancelled because the patient left town.

   Non-restrictive clause:
   The examination, **which** was not an important one, had to be cancelled because the patient left town.

4. *Never split an infinitive.*
   But educated writers commonly do.

   Example of the "rule" broken:
   The patient intended *to openly display* her distrust of the operation

5. "Use *shall* as the first person simple future, *will* for the second and third person simple future; use *will* to mean strong intention in the first person, *shall* for second and third person."
   Unobserved by almost everybody.

PUNCTUATION AND OTHER MECHANICS

(OR DID YOU PROOFREAD? AND HOW'S YOUR DICTATION?
OR WHAT HANDBOOK DOES YOUR TYPIST OWN?)

COMMON ERRORS:

Failure to use a semicolon before "however" or to use a semicolon before a new sentence:

1. There is some erythema noted on the tonsillar ridge, however, there are no exudates.

2. He has been able to work at his normal postal position, however, he has had limitations intermittently due to his low and upper back problems.

3. The examinee was scheduled to return in one week, no further documentation is available.

Fragment: it occurs in cases such as the following.

4. Mr. Hale was in two accidents. The first accident occurring in June 23, 1979 and consisting of lifting and turning to the left with a sudden pain and discomfort developing in the low back.

Failure to stick with one choice of verb tense or to choose the appropriate tense:

5. She comments that she works in Ithaca, New York, and would drive 50 miles each way from her home in Syracuse, New york.

6. This examinee has reached the maximum degree of medical improvement after I prescribed nautilus rehabilitation program.

7. X-RAYS: Films are taken of the left ankle. These films do not show any fracture or dislocation. There is seen a screw in the medial malleolus. Degenerative changes are seen about the ankle.

Sentence disaster due to lapse of memory during dictation so that the sentence structure shifts halfway through the sentence:

8. Physical therapy notes for 2/19 - 4/9/92 are available with four total visits documented show the examinee received cryotherapy, hydroculator packs, and electrical muscle stem to the low back. *Cure: proofread.*

Articles on writing

George D. Gopen and Judith A. Swan.
"The Science of Scientific Writing"

Los Angeles Times.
"Guidelines on Ethnic and Racial Identification" and
"Applications of the Ethnic and Racial Identification Policy."

Bibliography

1. *AMA Guides to the Evaluation of Permanent Impairment, 4th ed.*, 1993, AMA, Chicago
2. *Disability Evaluation*, 1996, Demeter, Andersson, Smith, ed., , Mosby, AMA, St. Louis
3. *"The Science of Scientific Writing"*, *American Scientist*, Gopen, Swan, Vol 78, p 550-558

COMPREHENSIVE MEDICAL REPORT

WHY BOTHER ?

We are frequently called upon as physicians to trade our role as treating physicians and become evaluators. The final work product involved in this process does not directly lead to the treatment of a pathological entity.

However operationally it can allow appropriate rendering of the medical process to an individual or may substantially alter the course of events in a non-medical setting. This at times may impact far beyond the consequences of a disease process.

It is important for you as evaluators and as physicians to apply and develop this talent which is not dealt with in your formal medical education. This process is learned by trial and error or better through post-graduate courses such as you are presently attending.

It is important that you approach this process with the same diligence that you applied when you took your biochemistry examination. Unlike our Core Curriculum in medical school this process is some what amorphus, not addressed in ordinary text books or journals, and can be as varied as the individuals creating the medical report.

This is probably one of the most difficult exercises you will be required to produce in the neutral, objective, functional and operational way. I hope this syllabus will assist you in formulating your own educational process to address this most difficult task.

William E. Blair, Jr., M.D.

SYLLABUS On

Medical Report Writing

William E. Blair, MD

THE QUALITY MEDICAL REPORT: INTRODUCTION....

Your Medical Report represents the materialistic depiction of your talents as a Medical Evaluator. It is the work product for which you are paid. The quality of this product will determine your share and representation in the market-place. Your report will determine your longevity in a growing and competitive market.

Remain professional and unique, comprehensive, logical, concise, clear and competent. Your conclusions must be irrefutable and structurally based on the data provided in the body of your report. The conclusions must lead to one and only one answer.

Create a professional image specifically orientated to your client base. Present your work product in a graphically appealing way. Use your computer word processing and graphic art programs to develop a unique and pleasing style. Update and integrate your programs frequently. Hire consultants to keep you abreast of new developments. Become knowledgeable in desk top graphics, portfolio creation, advertising layout configurations. Throw away your type writer .. it's old hat.

THE QUALITY MEDICAL REPORT: FORWARD....

The Report must be a narrative that tells a story. It must have an organized structure that introduces fact in a manner that the unknowing reader can understand. Do not speak in "Doctorease". Your subject matter must be presented in such a way that the reader win understand and come to the same reasonable conclusions you have with your trained and experienced background

Your report must include your flow of thoughts. Your reader must be able to follow the strategy of your process. Do not wander from one point to another. Use Segways. Your report must be organized from start to finish.

Your report must bring all of the informational data to a sound and logical conclusion. You must present your examinee as a real-life person and present the claimant in a manner that projects the pertinent influencing factors and altitudes;

- Physical characteristic
- Mental Status
- Historical Data
- Work Attitudes, etc.

Remember, no matter how Comprehensive, Skillful, or sleuthing the medical examination and history taking, if the writing of the Medical Report is inadequate, the entire effort is on no value to the client and may even be damaging to the client and you. Bad news travels much faster than good news. Present a knock-out, irrefutable, eye appealing professional report and you're on your way.

THE DISABILITY CLAIMS EVALUATION REPORT ... IMPORTANT POINTS TO REMEMBER:

A. YOUR REPORT IS WIDELY DISTRIBUTED
B. YOUR REPORT IS KEPT PERMANENTLY
C. YOUR REPORT IS NOT CONFIDENTIAL
D. YOUR REPORT IS A LEGAL DOCUMENT
E. YOUR REPORT IS AVAILABLE TO;
   - LAWYERS
   - JUDGES
   - OTHER PHYSICIANS
   - CASE WORKERS
   - CLAIMS REPRESENTATIVES
   - THE EXAMINEE

WRITE YOUR REPORT IN PLAIN ENGLISH....

KEEP IN MIND THE TECHNICAL KNOWLEDGE OF YOUR READERSHIP....

ACRONYMS AND EPONYMS:

Instead of reporting meaningless proper names of tests identify these tests as to their function and meaning. The "Mc Murray test" is a rotational stress test of the knee to infer integrity of the cartilage of the knee joint. If you use the proper name give an explanation.

(HINT) Set up your transcription program with MACROS that can be addressed by a few key strokes. Instruct your transcriptionist to insert the appropriate macro for the acronym or eponym. Saves time and make you took like a pro.

RULES AND TECHNIQUES:

A. Use many short paragraphs
B. Use an Organized Format
C. Use good grammar and correct spelling

(HINT) Make sure your word processor has an extended Medical Dictionary. Instruct you transcriptionist to constantly up date and add new words. Use a Grammar check program and keep current with its recommendations. This will take time initially but with time it will save you in efficiency and effectiveness.

Use a 386 computer, or better. Upgrade programs when available.

LEARN TO WRITE IN A JOURNALISTIC STYLE:

- Use short paragraphs
- Short paragraphs are effective to divide thought processes
- Short paragraphs allow the Reader to digest your thought processes in a logical order.
- Allow your paragraphs to build to your conclusion. (Crescendo)

(Remember) If an attorney cannot pick apart your Report content he will go after spelling, typo's, and grammar mistakes. This will create a sense of error and may occupy a great deal of deposition time or trial time. The jury may only remember this aspect and not your content. Be correct and concise and present an error free technical report.

YOUR REPORT MUST BE COMPREHENSIVE & DOCUMENTED....

DOCUMENTATION:

- Stipulate your Source
- Beware of stipulating information in a factual manner .. you may cause such information to become factual
- Information stated in the Body of your report will dictate your Conclusions
- Review your report and remove any factual statements made without source information
- Do not depend on a single blanket statement disclaimer to cover the entire content of your report. State the source over & over. Get into the habit of "she said", "he said", the "claimant states." This will protect yourself as well as your client and present information in a way that doesn't convert statements to a factual concept.

DOCUMENTATION OF YOUR CONCLUSION....

SIMPLE....

- Your conclusion can only come from the factual content given in the body of your report.
- The factual content will constitute the logical conclusions
- Every conclusion will be documented
- Replay factual evidence & documentation with conclusion. If you support your conclusion with the Medical Literature use journals that insure Peer Review. Cite your references in the Bibliography or include copies of the Article in the Index.

RULE....

- It is not permissible to make a Conclusion for which there has been no supporting documentation in the Body of your Report.
- Leaving the reader questioning or wondering how you came to your conclusions is not indicative of a "Quality" Medical Report.
- If a clinical Condition has a variable expression, Variable symptomatic cycles (degenerative arthritis) or a controversial treatment protocol, say so... and support your position with the appropriate Medical Literature documentation.

GENERAL ORGANIZATION OF THE MEDICAL REPORT....

I THE INTRODUCTION
II THE BODY
III THE SUMMARY & CONCLUSION

CONTENT OF THE INTRODUCTION:

- List the title of your report
- Indicate to whom your report is to be sent
- indicate who the report is about (identity Designator)
- Where the evaluation took place
- When was the Evaluation done (date)
- What was the purpose of the Examination

(Journalistic process; who? what? where? why?)

"AT YOUR REQUEST".....

This simple phrase identifies the buyer of your report. If your report is acceptable it infers an obligation by the buyer to compensate you for your work product.

THE BODY OF THE REPORT ....

I.
- Contains all points of information
- Refers to all collected data and knowledge of the subject I matter whether established as fact or not.
- This is your "Collection bin"

II.
- Information established within this section must document its source;

  - Previous Medical Records
  - Xrays, scans, Diagnostic Image reports Ergometric Evaluations
  - Previous IMEs
  - Hospital Records
  - Police Reports

II. (cont)
- Surveillance Reports
- V.A. Records or Military Health Records
- Others

III.
- Keep all record sources separate. Document date received, from whom acquired, and include a statement if any data is missing.
- Catalogue these Documents
- Indicate any and all white outs
- Keep track of all received data in case log book
- Do not bundle and intermix these files

IV.
- Accumulate and present all information in a pure form.
- Do not paraphrase
- Do not editorialize
- Present previous opinions, conclusions, diagnoses as found. (your comments and opinions regarding this information will be expressed in your discussion, conclusion and summary)

V.
- Present the factual information in standard format of your choice. There is no specific way to do it. Present it in a chronological order with source documentation and structured to allow ready recall and tracking.

THE PRESENTATION OF THE CLINICAL INTERVIEW....

- Include area topics and discuss revellent to P.I
    - Personal Data
    - Date of Birth
    - Residences
    - Schooling
    - Military Service
    - Family Status
- Work History
    - Job Chronology
        - reason for job change
        - Periods of work foe more than a week
        - Any accidents of injuries
        - any workers compensation
        - exact date of current disability
        - date last worked

Job Chronology (cont)

- date returned to work
- same job
- regular duty
- light duty

- Job Description
  - job title
  - give a narrative of exactly what was going on at the time of the injury. What was he doing.
  - what part of his body did he hurt
  - what are the limiting factors preventing his return to work.
    - mental factors
    - physical factors (strength, flexibility, endurance)
    - essential (critical) job task

- Other impairments
  - Balance
  - Hearing
  - Cognitive
  - Sight
  - Speech
  - Sense of touch
  - Other ongoing medical conditions
  - Other secondary responsibilities (Home Factors)

HISTORY OF THE PRESENT ILLNESS ....

- Date and time of the accident
- Was the accident witnessed
- Was an accident report made (what body parts injured)
- Was medical help obtained immediately
- Did the onset of symptoms occur immediately, later?

DISCUSSION OF PRESENT TREATMENT ....

- List all current and previous treating Medical Providers
- List all current Medications and any other taken for 12 mo.
- List any & all tests, treatments, and rehabilitation care.
- List all Surgeries, invasive procedures, deliveries
- List all hospitalizations, emergency room visits
- List all proposed care or anticipated testing
- List discharged dates from medical providers

DISCUSSION OF PAST MEDICAL HISTORY ....

- Include any and all prior accidents & injuries
- Include causes & circumstances
- Include type & amount of Compensation for previous injuries
- Include past surgeries & hospitalizations
- Include psychiatric Rx, Counselling, Chemical rehab

SOCIAL HISTORY ....

- Habits
- Home
- Autos
- Animals
- Hobbies
- Friends & Family relationships
- Income (all household sources)

REVIEW OF SYSTEMS ....

• Allergies	• Headaches	• Dizziness
• Fainting	• Skin	• Hair
• Vision	• Hearing	• Speech
• Neck	• Shoulders	• Arm
• Hand	• Fingers	• Wrist
• Chest	• Lungs	• Heart
• Vessels	• CVA	• TIA
• Back	• GI	• GU
• Menstrual	• Gyne	• Para / Gravida
• Hips	• Knees	• Ankles
• Legs	• Feet	• Toes

WORK ATTITUDES .... (Very important in terms of outcome & Surgical effectiveness)

- Important concepts to document

  - Will you ever get well
  - Will you be able to work again
  - Will you go back to the same job
  - Could you if you had a different supervisor
  - Who was responsible for the accident
  - Has your employer treated you fairly
  - Has the union been helpful
  - Has the insurance company been sympathetic & helpful
  - Have you been happy with your medical treatment
  - Have you seen a lawyer
  - What has you lawyer told you to do about medical Rx.
  - Has you lawyer referred you for special medical Rx.
  - What are you future Plans

The work attitude section is extremely useful in determining the over all outlook of the patient. It may be quite obvious in this section that the patient needs to escape for his work situation rather than require medical treatment. You recognition of this is extremely important. The medical injury or accident may be the escape vehicle.

Be aware of the of side attitudes when questioning in this area. Many examinees will be very defensive. They feel you will try to return them to a bad situation or attempt to cheat them of what they deserve. Pay attention to their expressions of:

- Hostility
- Paranoia
- Ambition
- Motivation
- Frustration
- Anger
- Interest in Rehabilitation
- Future outlook

The above is very important if you are asked to make recommendations about future medical treatment.

Discuss the above in a separate section and carry over your impressions and recommendations in you summary & conclusion section. Spell out all the facts and documentation in this section.

THE PHYSICAL EXAMINATION....

- The physical examination is a head to toe complete process with a focused and expanded subsection dealing with the site of alleged injuries.
- Spell out your findings in a manner a lay person can understand.
- Present it in a format that is pleasing to the eye and is easy to read. (remember short paragraphs)
- Do not speak "Doctorease" (use macros for explanation)

OTHER INFORMATION ....

- Use any and all test and laboratory data you can get you hands on. Some test results it is also important to get raw scores rather than just the final summary. (MMPI)
- Obtain all previous disability reports. (Entire Report)
- Employer Records
- Previous Compensation Documents
- Previous Insurance injury records and case summaries
- Case Worker Documentation
- SSI applications and examinee statements
- Military health records & V.A. reviews for SCD

THE SUMMARY AND CONCLUSION ....

- This is the most critical part of your Report
- Requires intense Cognition
- This is the most difficult

(HINT) Complete you entire report except for the discussion, summary and conclusion. Make a working copy. Go through and highlight the important and supporting information you feel is most relevant.

In your discussion section go through the medical data section and comment on the finding. In this section you can state on what you feel is important and what is missing in the data you reviewed. Say if what is there makes sense, Be responsibly critical.

The discussion will lay the ground work as to how you will base your summaries and conclusion.

- Include a brief statement regarding all positive findings.
- Reduce previous statements and ideas to the shortest meaningful form. (this is a reduction process)
- All concluding statements must be reference with supporting data.
- All conclusions must be logical and credible and be written and supported in a way that only one interpretation can be concluded.
- Remain neutral; do not be an advocate

THE FINAL RULES OF MEDICAL REPORT WRITING ....

- All items requested by the buyer are to be included in detail in the conclusion of your report.

- If criticisms of medical treatment are requested be professional and gentlemanly in every way. Use careful thought. Do not impugn judgement calls. You may have more information than the treating doctor. Judgement is situation and circumstance based.

- Do not include comments on culpability unless a specific request is made.

- Recommendations for future management are made only when requested.

- Recommendations for future diagnostic testing can be made if necessary to qualify impairment or assist in the determination of impairment. Beware of recommending empirical MRI studies. They are extremely sensitive and not so specific.

- You job is to determine functional impairment, not micro manage medical treatment.

THE CRUX ....

- Are impairments present
  - How extensive
  - What is the prognosis for recovery
- Can the claimant return to work
  - Former position
  - Limitations
  - Job change recommended
- The impairments and limitations must correlate with the diagnosis and associated loss of function.
- The extensiveness of the impairment
  - indicate prognosis
  - Temporary or permanent
  - Maximum Medical Improvement
  - Work-ability
- Remain neutral, objective, positive
- Be the expert
- "Dictated but not read" does not get you off the hook. This does not implicate a quality report. If you don't care enough to read it once it is completed why should I read it? Why should I pay for it?