CROSSROADS: WHERE MEDICINE AND THE HUMANITIES MEET

The medico-legal expertise: Solid medicine, sufficient legal and a measure of common sense

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All through medical school, aspiring medical practitioners spend most of their time learning about the inner workings of the human body and study to pass their exams so that one day they may be in the position to accomplish that ever-daunting task, already pursued by their predecessors , to serve mankind, to restore normal health, to stamp out disease, to prevent its occurrence, explain sicknesses to patients and stay out of jail. Once in practice however, the physician may be called upon one day to assess medico-legal aspects of a case in his practice or that of a colleague, something he may never have been shown how to do while in medical school.

Has the point of Maximal Medical Improvement been reached, is there an impairment? A functional limitation? A temporary or permanent disability? A handicap? Did the incident cause the injury and the sequelae? Is there an apportionment? An aggravation of a pre-existing condition? Is there evidence of malpractice? Is the individual employable? Part-time or full-time? Are there other investigations or treatments to come? Would you be willing to testify in court?

Answers to these questions are equally important in the overall helping of mankind, particularly for the great multitude toiling in the manual working class who are most often subjects involved in the medico-legal process. Because such people seldom have the capabilities of changing careers in mid-stream, they require some form of support should they become unable through misadventure to continue in their chosen pre-injury line of work.

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THE EXPERT

The physician who feels drawn to get involved in medico-legal matters is usually a specialist in practice for at least 10 years (orthopaedics and psychiatry are the most common) and begins to take on cases (expertises) from publicly-funded agencies such as the Workmen's Compensation Board, Provincial Automobile Insurance, Pensions Board, the Military. In time, depending on his performance and reputation, other agencies may come calling: Insurance Companies, individual legal firms, medical protective agencies, unions. Although the various mandators want the same answers, each one words their questions differently to suit their ends and each produces different guides for the evaluation of permanent disability. The old adage of "caveat emptor" for the employee, perhaps thinly veiled, can still be seen to be present.

The physician who does "expertises" becomes known as an "expert" not so much because he holds every discernable award or has performed brilliantly on the medical stage in his speciality, but rather because he has the required training and experience and is expected to know everything there is to know about the medical side of things in the case at hand, is expected to be available, willing and able to explain the issues on paper and, if required, as a witness in court. While in court, he must also be prepared to debate certain controversial issues arising from the case while addressing members of the legal profession and defend his opinion if such is contradicted by equivalent "experts" for the opposition. At all times, he must remain focused and informative and refrain from allowing personal feelings from intruding into his deliberations. He is there at the behest of the court and must remember to address his words to the judge who ultimately will make the final decision. His main purpose is not necessarily to beat down the

opposition but to adequately represent the medical interests of his client.

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To become an efficient expert, the physician can gain knowledge of the process by following degree-bearing university courses, attending refresher courses, reading journals and books on the subject or belonging to societies of like-minded practitioners, while all the while learning the language of the court and finding out what is expected of an "expert" in medical matters.

Before entering into an agreement to act as an expert witness, the physician must assure himself and his mandatary (requester of a mandate) that there exists no conflict of interest between himself and the case at hand. Otherwise, he should disqualify himself. The mandate (the actual request, specified questions asked and expected to be fully answered and reasons given for the answers) should be clearly enunciated in writing, authorised by the client, accompanied by all required medical documents concerning the case. Discussion of fees for the expertise, the cost of going to court, should be discussed and agreed to before proceeding. The claimant must be made aware that the physician chosen for an expertise is acting as an evaluator, and not as a treating physician. An expert gains more credibility when he chooses to diversify his allegiance as evaluator between plaintiff and defendant. Some experts occasionally referred to as "hired-guns" who remain on call solely to one or the other party, refusing to deal with either side of the picture, have an unsavoury reputation in the field of medico-legal expertise. Their views may be stilted preventing an unbiased appraisal of the facts.

THE REPORT

THE PHYSICIAN MUST ASSURE HIMSELF AND HIS MANDATORY THAT THERE IS NO CONFLICT OF INTEREST BETWEEN HIMSELF AND THE CASE AT HAND.

For the expert to have respect for the claimant goes without saying. No matter the circumstances of the claim, the expert listens to the story that is given and attempts to know as much of the details as is possible, somewhat in the manner of a detective , uncovering the truth in a methodical way. He records and lists all documentation received either from the mandatary or the client. He must try to keep the story in line and proceed chronologically through the events. He uses simple clear, language and takes great pains to ensure that he will not be misunderstood. His impartiality and transparency must be displayed at all times. Past and present history is important especially if the claimant already has suffered an injury at the same site. Habits such as smoking and taking medication should be recorded as well as past and present surgeries and hospitalisations.

Physical examination must be thorough and painstaking, known objective tests mentioned, measurements recorded, manoeuvres performed and fully described to verify the presence of a physical ailment in cases where "illness behaviour" is suspected. If such is difficult or impossible to ascertain (the client refusing to cooperate), the expert must explain why in his report, while never straying from the preset confines of his own speciality. In orthopaedics, when a certain part of the body is clearly the part to be studied (a broken ankle), all pertinent tests are required to be done so that as much information as possible is available for review. In dealing with the appendicular skeleton, as opposed to the axial skeleton, comparison with the opposite normal side is usually useful. A problem at times arises when the condition straddles the border between the axial and the appendicular skeleton (pain in the neck and the arm, pain in the back and the leg). In such cases, there may be more than one pathology to explain the symptomatology and signs. Similarly, for pain and dysfunction in an arm or leg, all parts must be carefully examined to include all probable pathologies, some being dominant, others subordinate. In rare situations, the "expert" is asked to determine if injury to one part of the body may have contributed to signs and symptoms arising in another part (shortened leg causing problems in the opposite leg or in the back). Injuries to parts of the skeleton carry sequelae that may take a while to show up (avascular necrosis of the head of the femur after a hip fracture). Referral to specific research data as found in the literature may be helpful to the expert, while dictating his summation, in explaining the general principles involved and how they may or not pertain to the case at hand. Recent publications are preferred and references always given.

The court will usually be satisfied with simple answers that get quickly to the point. Elongated, tortuous arguments will be difficult for non-medical participants to follow and can more likely serve to open the door to conflicting and burdensome counterinterogation. The "expert" speaks to the court and not to colleagues at a medical meeting.

As to the correct medical diagnosis, the expert is expected to be clear and concise and if required, because of the debatable nature of a condition, give all

the appropriate reasons for his choice. He must state the reasons as to why he feels that a certain diagnosis exists and another does not. In some cases of course, a clear and concise diagnosis may not be possible. The expert must then rely on the "balance of probabilities" in producing the best diagnosis possible and elaborate on his reasoning. In deciding whether the claimant has reached a point beyond which no further investigation or treatment is indicated, known as the consolidation point or point of maximal improvement, a study of the evolution of the condition and the response to treatment is carried out. If no further improvement is noted during the post-op visits, if the physio reports indicate an unchangeable level of return of function, strength, range of motion, and pain, if repeated xrays and other tests are unchanged, the expert, by all rights, declares that the condition is now medically stabilised and nothing further can or need be done.

THE REASON WHY THINGS HAVE PROGRESSED TO A LEGAL DEBATE IS BECAUSE THE ISSUES ARE CONTENTIOUS (MORE GREY THAN BLACK OR WHITE).

In explaining possible cause and effect relationships, the expert is guided by the nature and intensity of the trauma, the elapsed time between event and the complaint, related events both prior and following, the coherence of impact-anatomical site-and type of injury sustained, the quantity and quality of the symtomatology, the pre-morbid state of claimant, the natural history of the condition, and all other associated diagnoses and treatments. He includes medical opinions by specialists solicited by the treating physician during the course of medical treatment. He reports results of the laboratory tests and xrays. He wraps things up with a summary and conclusions and then goes on to answer the questions asked by the mandator. He does not venture into areas that are not solicited although he should make a mental note of these and be prepared, should the opposition wish to bring them up, to face those issues with compelling arguments.

He gives reasons for his answers which he knows he can uphold in a court of law. In citing from the medical literature, it is always safer to quote articles dealing with basic principles already agreed upon and the natural course of the condition including known complications rather than with gratuitously expressed personal assertions and opinions which can easily be countered by the opposition. It is important to give a reference when citing a percentage disability. Published guidelines are usually available. There are rare instances where the actual medical diagnosis defies categorization (pain syndrome, partial nerve injury). In such cases, the expert may need to revert to analysis by analogy to a similar condition occurring in a different body system.

At other times, an expert is asked to produce a counter-expertise to one already submitted by the opposition. Such cases may be more demanding on the part of the expert and require more experience. The process to follow however is the same although more specific on certain points of contention.

THE LEGAL SIDE

The purpose of being engaged in a medico-legal dispute is to be able to convince the judge that you have a better argument than the opposition, in short, to win the argument based on the presentation of more credible evidence. The reason why things have progressed to a legal debate is because the issues are contentious (grey rather than black or white).

Although the main duty of the physician is to clearly explain the medical side of things, that of the lawyer is to argue and win the argument on points for his client. The lawyer relies on the physician to provide him with the necessary medical information which he will weave into legal dissertation which he hopes will convince the adjudicating body of the correctness of his proof on behalf of his client. The idea is that neither the physician nor the lawyer should see themselves as individuals but rather as members of a team of fact finders and expositors, working in tandem, bringing to light the true nature of the dispute, enabling the judge to be well informed, weigh the arguments, see the truth, and find for their side. Hard honest work and common sense will usually provide the necessary tools for the construction of a winning case. Teamwork is essential, neither doctor nor lawyer ever trying to outdo each other. Winning for the client is key. The preset rules of the legal system already established and improved over the years will, when well fed and properly oiled, provide the energy to see the case through and allow for an orderly and compelling presentation of the facts. However good the arguments are, the ultimate decision will always reside with the judge or jury. If a side feels it has been denied justice, there is always the appeal process to fall back upon.

In his report, the physician must clearly state and distinguish what is said by the claimant, by the consultant, by the therapist, by the nurse and under what circumstances. He must keep the narrative in order and record the train of events in a consecutive manner. If there are long unexplained gaps where very little happened medically - "un silence medical" -he must explain the reason. He must refrain from giving a personal opinion as he discusses the facts, even though

he may not be in agreement with the medical decisions taken in the case. A factual, objective and non-judgemental exposé of the case is always called for. The physician will find this tack much easier to defend when called upon to explain his written report orally in court. When interrogated by counsel for the opposition, the medical expert can expect to be protected by his counsel should the questioning become off-base. There is no need to become argumentative with opposing counsel.

THE PHYSICIAN'S REPORT MUST BE SUFFICIENTLY FACTUAL AND APPROPRIATELY WORDED TO DISPEL ANY THOUGHTS AS TO THE HIGH STANDARD OF HIS PROFESSIONALISM AND CREDIBILITY

The physician must remember that a great probability exists that a host of others will most likely read his report and make comment and that no one is ever neutral in debate. His report must be sufficiently factual and appropriately worded to dispel any thoughts as to the high standard of his professionalism and credibility.

To determine whether an aggravation of a previous condition at the same site has occurred is not an easy task and may become a much debated point. One point of view that has merit in my view is that if the previous condition was entirely dormant and only reappeared as a result of the sustained injury (e.g. latent osteomyelitis reappearing after an injury to the same site), then grounds for an aggravation can be entertained. On the other hand, if the previous condition had already been noticed to be causing symptoms and signs by the patient or his treating physician, then a second injury at the same site would not be seen as being responsible for the aggravation.

The same is true for the establishing of functional limitations following an injury which has left a degree of permanent injury. There is no tried and tested way of doing this and one relies on a number of factors, not the least of which is a good measure of common sense. First of all, we all know of individuals who are handicapped but in no way disabled for doing the same work they did before the injury. The body and the mind have a great way of compensating in the willing subject. The employer as a rule wants to hire able bodied individuals capable of doing the tasks that go with the job. You can either do it or you can't. If Mother Teresa was the boss of a private enterprise, she would probably act the same way. If the individual clearly cannot do the job (the job requires two good legs and he only has one), then clearly professional reorientation is called for. But if the claimant has two good legs, but one is shorter than the other by 0.5 inches, normally this would not present a functional deficit. Again, if the claimant has two good legs and one hurts but has good strength and a normal range of motion, this would also not normally constitute a functional impairment. While taking into account the claimant's sequelae after injury and the listed demands of the targeted job, the expert usually allocates as few functional limitations as possible in keeping with the described disability, only those that will impact directly on his pre-injury job. Too many limitations would disqualify the claimant from returning to work either with the same employer or a competitor.

A good and trusted worker will also find it easier to return to work. A worker with a bad reputation will likely not be so fortunate. Goodwill must exist on all sides. In syndicated workers, the union representative will often wish to be part of the medico-legal proceedings. At times they have tried to influence medical decisions and be present at the actual medical examination of the worker. It is my belief that there is no rule that says they should be present and the expert, while accepting the fact that the union is there to protect the workers' rights, has every right to deny the union's presence in the examining room. The union however has the right to contest the report if it feels their justice standards have been denied. In general, a third party is inadmissible during a medico-legal examination unless that party is present as a designated expert (translator, deaf-mute sign specialist).

THE ASSESSMENT OF PAIN ON ITS OWN MERITS, IN THER FACE OF NORMAL SENSORY AND MOTOR FINDINGS OF A PART, REQUIRES A FAIR BIT OF KNOWLEDGE AND EXPERIENCE.

The assessment of pain on its own merits, in the face of normal sensory and motor function of a part, requires a fair bit of knowledge and experience. A great number of contested cases hinge around this very subject. Some pains are tolerable by the claimant and are covered by the disability process and the resulting functional limitations. Some pains are all encompassing and of themselves prevent the worker from carrying out the regular activities of daily life, let alone work-related tasks. Published criteria (AMA Guidelines to the Assessment of Functional Disabilities, 2001) exist for the establishing of disability in such cases. It remains for the expert however to adequately categorize those pains which the claimant alleges keep him from performing his regular pre-injury job despite the lack of objective evidence of motor or sensory dysfunction. In some mandates, without objective clinical (not merely

radiological) evidence, the expert cannot establish a defensible percentage disability. In other mandates however (Société d'Assurance Automobile du Québec) there is allowance for the inclusion of certain pain modalities as such in the granting of disability (préjudice non-pecuniaire). This area, so often debated and still shadowy, clearly requires further defining and will need time to do so.

The world of the medico-legal expertise can be both medically beneficial to the claimant and a compelling and interesting medical exercise for the expert. A well done expertise containing accurate medical information and providing objective and clear answers to the questions asked will usually determine the correct path for an injured worker to follow post injury and by so doing, can serve as a liberating and even a therapeutic force. The art and science of medicine combine to shed light in the arena of social justice.

As to aspiring physicians still in medical school, although their curriculum is already overcharged, some of the aspects of this type of medicine included in their curriculum would, in my opinion, teach them the reach and application medical science can have in the lives of a sizable group of workers at large, beyond the more protected confines of the hospital, the library, the operating room and the office.

James D. Sullivan graduated from McGill University Medical School in 1962 and has been associated as an active member in the Department of Orthopedic Surgery at St. Mary's Hospital since 1969. Throughout his career, he has been interested in treating sports injuries. He is a consultant with the Canadian Olympic Association as well as to the professional teams in Montreal. He maintains a busy orthopedic practice and is a lecturer in orthopedics at McGill University. Dr. Sullivan has authored a number of medical expertise reports for a variety of groups and associations. He is also author of over fifty published articles relating to different aspects of orthopedic surgery.