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## **The Ugly Stepchild of Personal Injury**

By Arthur Croft, DC, MS, MPH, FACO

In many offices, personal injury narrative reports have become the mothers of procrastination. They are reviled, loathed, and continually relegated to the bottom half of the work pile. But, as I discovered to my chagrin many years ago, they are such an integral part of personal injury case management, procrastination can cost you a lot of referrals. And, needless to say, poor construction often carries similar penalty.

Conversely, well written reports will bring in more business than you might think. A few months ago I got a nice letter from Dr. Arlene Roncin of Point Pleasant, NJ, who told me that she'd received a letter from an attorney telling her that hers was the best narrative report he'd ever seen, and that he had forwarded a copy of it to the orthopaedic surgeon, suggesting that he use it as an example!

This editorial is about contemporary issues and problems related to narrative reports. Solutions to most are suggested. The three things I'll discuss here are:

1. some common serious problems with narrative reports;
2. shortcuts to narrative construction;
3. computer graphics: charts, images, and radiographs.

To avoid seeming pedantic, I must first request amnesty. My name is Art, and I am a narrative procrastinator. Well, not now, mind you, but once a procrastinator, always a procrastinator. In truth, just about every mistake I mention in regard to narrative report construction is a personal hard earned lesson or reformed bad habit.

### **Some Common Serious Problems**

1. Procrastination. You should appreciate that tardy reports may delay or even sabotage settlement negotiations. Believe me, attorneys are unlikely to forgive you more than a couple of times. So get in

the habit of accepting the duty of generating timely reports: usually within a week of the request. Have your office manager keep you current on this.

2. Typographical, spelling, and grammatical errors. Remember that you are generally known in medicolegal circles only for how you appear on paper. Fair or not, such errors suggest a poor education, lack of intelligence, or sloppy habits; they detract seriously from the credibility and professionalism of the report.

In addition to software spell checkers and manual proofreading, you can also use grammar checking software to pinpoint problems in writing style. I also suggest keeping a little book on grammar and punctuation handy. When questions arise as to the correct use of the colon, for example, look it up. Eventually, you will have relearned that indispensable art of communication -- English!

3. Disorganization. This is one of the big ones. Subject headings are frequently unclear or missing. The doctor frequently goes off on tangents, providing extraneous, and frequently gratuitous and long-winded discussions of pathophysiology. These excursions are rarely helpful and more often make the doctor appear to be a patient advocate rather than an objective care provider interested only in getting the patient well. Remember, your reader has precious little time to read your report. Padding and fluff serve only to obscure key issues and send the reader looking for a more concise report; that other report might be written by an IME doctor who doesn't share your opinions.

The solution is to organize the report into separate and easy to find headings: Chief Complaints; Past Medical History; History of Injury; Diagnostic Impressions; Review of Records, etc. Look for redundancy and eliminate it. Simplify your writing. "Based on my extensive review of the available medical documents in this case, my considered opinion is that the patient is suffering from a mild type of myofascial disorder ..." becomes, "The patient has a mild myofascial disorder."

And stick to the topic. Continually ask yourself these questions: a) If I didn't know anything about this patient, would the report make sense to me? b) Does the report sound as though it was written by an objective observer? c) If the reader is only interested in selected topics, can he/she navigate the report easily? d) Have I strayed from the topic or said more than was necessary? e) Is the history consistent/compatible with the physical examination and the diagnosis?

4. Excessive use of citation. Many clinicians believe it necessary to fortify their conclusions with citations

to the literature. Although this is generally acceptable, excessive use of citation can be a problem. It suggests that the clinician expects to be questioned; in most cases they are not. This is particularly true when discussing commonly accepted notions of causation (e.g., rear impact collisions resulting in cervical spine injuries). Likewise, Gray's Anatomy need not be cited in discussions of generally agreed upon facts of anatomy. The narrative report should be viewed as an objective assessment of the patient's injuries, treatment, current condition, and future need for care, not an instrument of persuasion.

Clinicians should, however, carefully consider the reference cited. If the author of the citation expresses opinions within that citation that contradict the clinician's opinions or conflict with the method of management, it could easily be used against the clinician later (with embarrassing effectiveness) in arbitration or trial. Some lecturers have actually provided their students with selected quotations from the existing literature to use for such purposes. Unfortunately, without reading the entire paper, the clinician will never know whether these quotations are taken out of context or whether other parts of the citation would be problematic. My general recommendation is merely to state that such and such notion is "generally well accepted (or recognized) in medical and chiropractic circles."

Some attorneys have recommended to treating clinicians that they do include specific citations in the report so that it will be easier at a later time to introduce these papers into evidence. This is based on the argument that they would then satisfy the rules of evidentiary admissibility based on the fact that the clinician relied upon them in arriving at his/her opinions. In some cases this may work. However, similar groundwork can often be set down during direct examination in an arbitration or trial. And while an objection might be raised by the opposing attorney, these papers and books generally are not required to satisfy the requirements of admissibility. Federal rules of evidence state that, in general, if a concept is sufficiently difficult to explain verbally, an expert can make use of illustrative material (charts, videos, drawings, etc.) which need not satisfy the more stringent requirements of admissibility.

5. Hyperbole. Most strains and sprains experienced by the victims of automobile accidents are either minimal, slight, or moderate by definition. Likewise, most of the subjective complaints follow accordingly, with severe pain being mercifully less common. It is surprising how many reports I read describing "severe strain/sprain" and "severe pain" in these patients. It is sometimes advisable to revisit operative definitions of the grades of severity of these injuries and the resulting subjective complaints. Overstatement suggests a lack of objectivity and detracts from the credibility of the clinician.
6. Anachronism. When we read a report in November of an injury that occurred in January, and the diagnosis tendered is "acute cervical strain/sprain," it's natural to wonder whether: a) that was merely the

appropriate diagnosis in January; or b) that is the current diagnosis. If a) is the case, then we have no information about the patient's current condition in November. If b) is the case, it is certainly incorrect, since such injuries do not remain acute for 10 or more months.

This common ambiguity also invades other critical sections of the narrative report. This is due, for the most part, to the tendency to collect the most comprehensive history and physical examination findings in the initial stages of patient care. When the narrative report is dictated months later, it is this more comprehensive information that is used. Yet, in many cases, the reader is unable to determine whether the limited ranges of motion and other findings mentioned are current difficulties, or whether these were merely the initial findings.

The solution to this common error is to describe findings by date, such as "original chief complaints" (January 7, 1996) and "current chief complaints" (November 12, 1996). This way, there's be no room for confusion or ambiguity, and it is much more likely that your report will be relied upon.

7. Failing to make your point. Generally, the major topics that should be discussed include social history, past medical history, history of the injury, chief complaints, physical examination, radiographic examination, review of other reports/consultations, discussion of disability scores (when indicated), diagnostic impressions, a general discussion/summary section, and a section on prognosis and the need for future care. Once you've ridden the report of the padding and fluff, ask yourself if you've effectively made your point(s). Is it clear what your conclusions are? I frequently find that clinicians contradict themselves throughout their report -- almost as though they had trouble making up their minds about key issues. If I can't make sense of my own report, I certainly wouldn't expect someone else to.

## **Shortcuts to Narrative Construction**

It's not difficult to streamline the process of narrative report construction so that it can be dictated quickly. This begins with an effective history form that prompts the clinician to ask the right questions in the proper order. When the report is later dictated, much of it will come directly from this document. Knowing the standard medical shorthand will allow efficient SOAP notation, with the added benefit of being able to read the notes of nurses, medical doctors, PTs, and paramedics.

The best boilerplate is homemade, using the macro function of your word processor. For a small investment in time, you can save yourself hundreds of hours later on. Canned report writing packages still lack the

sophistication for serious personal injury work and, in my experience, offer no advantage in time savings for the organized clinician who is comfortable with dictation. On the down side, canned reports come out jerky, disjointed, and barely passable as being written by someone who speaks English as a first language. High-level artificial intelligence has simply not yet been adapted to this endeavor.

If you want to invest some time, you might be interested in the new voice recognition programs that will actually take direct dictation from you and turn it into a narrative report. I've played around with a program called Dragon Dictate and it performs as advertised, although I find the training that is necessary (the computer continually learns from your voice) and the precision needed in verbal commands taxing on my dyslexic mind. Computer Graphics: Charts, Images, and Radiographs

A slew of common questions arise. Here, in a very brief nutshell, are some answers:

Q: Can I scan radiographs into my computer for use in narrative reports?

A: Yes. A number of solutions are available, with quality running in lock step with price. At the less expensive end, you can buy a video capture board for the computer for a few hundred dollars, shoot the radiograph on the viewbox with your camcorder, and then dump the image into your computer. The pros are the price. The cons are poor resolution when using cameras with lesser resolution than Hi-8 or digital video format. Even with high end camcorders, the results are only barely acceptable.

Another solution is to shoot the radiographs with standard 35 mm film and then send it to Kodak to be made into a photo CD. This can then be downloaded and manipulated in various paint programs (e.g., Photoshop) and then imported to documents, prints, etc. The pro is the cost. The con is the longer turnaround time.

The best (and most expensive) method, which I recommend for IME doctors, is to purchase a 35mm slide scanner. Shoot the images using a quality 35mm camera with a 50mm macro lens and tripod. Use daylight film with an FL-day filter. Scan at the desired resolution. These scanners will scan at near-optical resolution, so this is a reasonable system for archival purposes as well. The cost will range from \$700 to \$2000 for a scanner. I use a Nikon, but several are available. The pros are the very high quality images and archival capability. The only con is the cost.

Q: What about charts and diagrams?

A: Several companies have charting software and, as is often repeated, a picture is worth a thousand words. Ranges-of-motion, progress with disability instruments (e.g., Oswestry or Neck Disability Index), and other data can be presented more understandably with histograms and bar charts. They have the added benefit of being eye-catching. Line drawings also help you to convey key points, although they should be used sparingly. Several companies specialize in medical and anatomical clip art. Conversely, you can simply scan drawings from anatomy texts and import them to your document.

Finally, a word about printers. When printing reports containing gray-scale images (radiographs, MRI scans, etc.), you should use a high-quality laser printer. For color images or charts, the current crop of inkjet color printers will provide excellent resolution for under \$400 and are definitely worth looking into.

*Arthur C. Croft, DC, MS, FACO*

*San Diego, California*

*E-mail: [dr\\_croft@4dcomm.com](mailto:dr_croft@4dcomm.com)*

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