PRACTICE

Nova Scotia College of Physiotherapists

GUIDELINE

MEDICAL LEGAL REPORTING

Preamble

These Guidelines are presented with the intention of directing physiotherapists in the preparation and presentation of legal reports. The relationship between a patient and a physiotherapist is fundamental to the delivery of safe, quality and effective physiotherapy care. However, when writing legal reports, the physiotherapist should refrain from acting as an advocate for either party and should confine the contents of the report to objective observations only.

Scope:

These guidelines shall apply to all civil, criminal, quasi-judicial and administrative proceedings at which the attendance of a physiotherapist, and/or their medical report, may be compelled by subpoena.

When a Report is Requested:

1. The lawyer should provide the physiotherapist with clear and simple instructions, in writing, as to the matters to be addressed by the physiotherapists in the report. The letter of request should follow the guidelines of attached Appendix A.

2. The physiotherapist must be fully informed by the lawyer of all available medical information concerning the injuries.

3. The physiotherapist should ensure the medical-legal report answers all the questions posed by the lawyer, and is written to be easily understood by non-physiotherapists. The physiotherapist should confine the contents of the report to objective observations only.

4. The medical-legal report should be typewritten.

5. The form of the medical-legal report can follow the guidelines in attached Appendix B.

Confidentiality: The lawyer should provide the physiotherapist with adequate written consent from the patient, spouse, parent, guardian, or next of kin as is appropriate.

Promptness: A report requested by a patient or their authorized agent, in respect of any examination or treatment performed by the physiotherapist, should be provided by the physiotherapist within 30 days of the receipt of the request. If it is not possible to provide the report within that timeline of 30 days you should, within that time period, advise the requesting party of that fact and the reason(s) therefore.

Fees:

1. The lawyer should pay the physiotherapist's fee within 30 days of the receipt of the report unless the lawyer indicates, in writing , at the time the request is made that he or she is not prepared to meet this obligation personally in which case the physiotherapist is not obligated to prepare the report.

2. It is not appropriate for a lawyer, as a matter of course, to disclaim responsibility for payment of the physiotherapist's fee or to make payment contingent on the litigation. It is for the lawyer to make necessary arrangements with the client/patient.

3. It is not appropriate for a physiotherapist to demand his or her fee in advance.

4. It is not appropriate for a physiotherapist to charge a fee for a copy of file material other than a reasonable charge for the photocopying and retrieval of the material. *(Ref Sec 14-17 of the Personal Health Information Regulations pursuant to Sec. 110 of the PHIA Chap.41 of 2010)*

<u>Report Fees:</u>

The factors to be taken into account in establishing an appropriate fee for a medical-legal report are:

(a) The amount of time spent;
(b) The expertise and experience of the particular physiotherapist;
(c) The complexity of the case;
(d) Whether an examination was done;
(e) Whether the report is a repetition of previous work already done or a follow-up on an earlier report;
(f) Whether the report discloses relatively routine attendance and observations;
(g) The number of documents reviewed.

The physiotherapist must, on request, disclose the basis for the fee charged.

A physiotherapist should not charge for a follow-up request to a medical-legal report where the information was requested in the first instance and not included.

<u>Attendance:</u>

A physiotherapist who attends, on request by a lawyer *(by agreement pursuant to Civil Procedure Rule 18.03 or Rule 55.11), by Discovery Subpoena pursuant to Civil Procedure Rule 18.05 or by Court Order*), an interview, hearing, trial or discovery examination, is entitled to expect the lawyer to pay the physiotherapist's fee within 30 days of the attendance. The factors to be taken into account in establishing an appropriate fee for an attendance are:

(a) The amount of time spent;
(b) The expertise and experience of the particular physiotherapist;
(c) The complexity of the case;
(d) Preparation involved;
(e) Earnings lost during time spent.

1. It is not appropriate for a physiotherapist to demand his/her fee in advance.

2. The lawyer must inform the physiotherapist as soon as possible concerning attendance, adjournments, and cancellations and should inquire as to any cancellation fees.

3. The physiotherapist is entitled to charge a reasonable cancellation fee based on income lost.

4. The physiotherapist must, on request, disclose the method of calculation of a cancellation fee to be charged if one is to be charged.

5. The lawyer should meet with a physiotherapist to prepare his/her evidence for discovery or trial on behalf of the patient.

(NOTE – Civil Procedure Rule 18.05(2) prescribes a witness attendance fee of $35 per hour plus transportation, accommodation, and meal cost for attendance at a Discovery by Discovery Subpoena. The Physiotherapist should obtain prior agreement of the legal counsel requesting discovery attendance to pay increased attendance fees in accordance with normal hourly rates prior to the discovery);

(Note-If the Physiotherapist is providing an expert Medical/Legal opinion report in compliance Rule 55.04, then he or she cannot be compelled to attend at a Discovery Examination unless they agree.)

Resources:

- *http://www.courts.ns.ca/Civil_Procedure_Rules/cpr_rules_and_forms_index.htm*
- *http://www.courts.ns.ca/Civil_Procedure_Rules/CPRs_in_html/Rule_55.htm*
- *Sec 14-17 of the Personal Health Information Regulations pursuant to Sec. 110 of the PHIA Chap.41 of 2010*

These Guidelines were revised in March 2018 and replaces the 1999 MedLegal Guidelines

Appendix A

LAWYER REQUEST GUIDELINES

1. Identification of the client the lawyer represents and nature of matter, e.g. car accident, work injury;
2. Enclose authorization;
3. Brief relevant history of events surrounding treatment;
4. Nature of request; if physiotherapist is not treating, attach all relevant prior medical reports;
5. Request that the physiotherapist respond to attached outline and/or answer the following specific questions;
6. Request compliance with Civil Procedure Rule 55.04 (Rule 55.04 set out in full below in Appendix "C") including provision of a copy of CV or summary of relevant qualifications in the body of the report; Schedule "B" includes the required Expert Representations needed to comply with Rule 55.04)
7. Undertake to pay fees for report within 30 days of receipt or advise of alternate payment proposal (failure to agree otherwise will obligate lawyer to pay within 30 days).

Appendix B

REPORTING GUIDELINES

These are the things to consider when preparing your reports:

1. *Civil Procedure Rule 55.04 Expert Opinion Representations*

    (a) *I am providing an objective expert opinion for the assistance of the court, even though I have been retained by a party;*

    (b) *I am prepared to testify at the trial or hearing, comply with directions of the court, and apply independent judgment when assisting the court;*

    (c) *This expert report includes everything that I regard as relevant to the expressed opinion and it draws attention to anything that could reasonably lead to a different conclusion;*

    (d) *I will answer written questions put by parties as soon as possible after the questions are delivered to me;*

    (e) *I will notify each party in writing of a change in the opinion, or of a material fact that was not considered when the report was prepared and could reasonably affect the opinion, as soon as possible after arriving at the changed opinion or becoming aware of the material fact.*

    (f) *I have included my relevant expert qualifications, as provided in an attached resumé contained in Appendix "A";*

    (g) *I have included reference to any documents, electronic information, and other things provided to, or acquired by, me to prepare the opinion, and I have included reference to any of my publications on the relevant subject matter or to any literature and other authoritative material consulted by me to arrive at and prepare the opinion, all as provided in an attached list in Appendix "B";*

    (h) *I have included in my report relevant information on a test or experiment performed to formulate or confirm the opinion, as contained in Appendix "C" Statement of test results that includes identification and qualifications of another person if the test or experiment is not performed by myself;*

2. The patient's name (preferably as stated in the pleading's).
3. Date, place and reason for the examination.
4. History as related by the patient:

    (a) The patient's version of what he believes caused his condition (i.e. the mechanics of the injury - how it was caused, not who was at fault).

    (b) A complete list of the injuries or conditions complained of by the patient (whether these seem significant and relevant or not and whether the patient has recovered or not). If consulted as specialist, confine yourself, if you think it appropriate, to matters relevant to the topic to be reported on.

5. Your findings which do (or do not) corroborate each of these items of complaint, or which indicate the results of an injury which have not been noticed.

(a) Presence of physical corroboration (spasm, limitation of movement, etc.) of complaint A, of complaint B, etc.

(b) Degree of diagnostic corroboration (spasm, limitation of movement, etc.) of complaint A, of complaint B, etc.

6. Physiotherapy Diagnosis:

   (a) A description of diagnostic procedures undertaken by you or by others with respect to each symptom or condition.

   (b) Your conclusions.

7. Causal connection with the accident - consider and give your professional opinion of the precipitating factor or "cause' of the patient's condition. The court must know if the injury or condition for which damages are claimed was probably caused, aggravated or accelerated by the accidents or events complained of.

8. Treatment:

   (a) The treatment you recommend for symptom A, for symptom B, etc.

   (b) Whether or not your recommended treatment has been followed; If not, why not, and the probable result.

9. Degree of disability:

   (a) The extent of impairment of function at the time of your examination which (1) should be treated , (2) cannot be treated (this is most important if it exists) , (3) is unlikely to improve spontaneously and (4) will probably improve spontaneously.

   (b) The pain, suffering, inconvenience and discomfort which you would expect (1) the patient has suffered and (2) will probably suffer (or not) in the future.

10. Prognosis:

    (a) Your opinion as to the probability of future recovery.

    (b) Your opinion as to the probable nature of permanent impairment.

    (c) The probable time within which maximum recovery can be expected.

    (d) Having regard to the individual and his personal activities, the extent to which his activities should or will be curtailed.

11. DEGREE OF CERTAINTY OF OPINION – the expert opinions I express in this report are based on reasonable medical probability (more probable than not) unless otherwise stated and are independent of the referral source.

    (NOTE: Opinions do not need to be held to a degree of medical certainty (normally 100% certain). The applicable legal standard required is proof on a balance of probabilities – i.e. that something is more probable than not. For many legal issues (such as causation, diagnosis etc.) the court must be persuaded on a balance of probabilities – i.e. that it is more probable than not that the collision was the cause of the injury or condition).

Avoid using vague expressions such as "it is possible that". When predicting future events (i.e. chance of developing arthritis; need for further treatment; deterioration of condition; future disability etc.) try to express the matter in terms of percentages if you can (e.g. "there is a 10% chance of recurrence within five years").

NOTE: Throughout, use technical medical terms for the sake of precision and then follow these by a description couched in ordinary lay language.

(Signature of the reporting physiotherapist)

Appendix C

CIVIL PROCEDURE RULE 55.04

NOTE - In order for a Physiotherapist to provide admissible expert opinion evidence in a civil proceeding in Nova Scotia, an Expert Medical/Legal report must be submitted that complies with Rule 55.04 as set out below. Note also that pursuant to Rule 55.11(1) a physiotherapist (or other expert) who files an expert report cannot be compelled to attend at discovery examination unless he or she agrees.

“Content of expert’s report

55.04(1) An expert’s report must be signed by the expert and state all of the following as representations by the expert to the court:

(a) the expert is providing an objective opinion for the assistance of the court, even if the expert is retained by a party;

(b) the witness is prepared to testify at the trial or hearing, comply with directions of the court, and apply independent judgment when assisting the court;

(c) the report includes everything the expert regards as relevant to the expressed opinion and it draws attention to anything that could reasonably lead to a different conclusion;

(d) the expert will answer written questions put by parties as soon as possible after the questions are delivered to the expert;

(e) the expert will notify each party in writing of a change in the opinion, or of a material fact that was not considered when the report was prepared and could reasonably affect the opinion, as soon as possible after arriving at the changed opinion or becoming aware of the material fact.

(2) The report must give a concise statement of each of the expert’s opinions and contain all of the following information in support of each opinion:

(a) details of the steps taken by the expert in formulating or confirming the opinion;

(b) a full explanation of the reasons for the opinion including the material facts assumed to be true, material facts found by the expert, theoretical bases for the opinion, theoretical explanations excluded, relevant theory the expert rejects, and issues outside the expertise of the expert and the name of the person the expert relies on for determination of those issues;

(c) the degree of certainty with which the expert holds the opinion;

(d) a qualification the expert puts on the opinion because of the need for further investigation, the expert’s deference to the expertise of others, or any other reason.

(3) The report must contain information needed for assessing the weight to be given to each opinion, including all of the following information:

(a) the expert's relevant qualifications, which may be provided in an attached re sumé;

(b) reference to all the literature and other authoritative material consulted by the expert to arrive at and prepare the opinion, which may be provided in an attached list;

(c) reference to all publications of the expert on the subject of the opinion;

(d) information on a test or experiment performed to formulate or confirm the opinion, which information may be provided by attaching a statement of test results that includes sufficient information on the identity and qualification of another person if the test or experiment is not performed by the expert;

(e) a statement of the documents, electronic information, and other things provided to, or acquired by, the expert to prepare the opinion.

Appendix D

Personal Health Information Regulations made under Section 110 of the *Personal Health Information Act* S.N.S. 2010, c. 41, Sec.13-17.

Fees prescribed do not include applicable tax

13 The fees prescribed in these regulations do not include any applicable tax.

General fee for access to record

14 A custodian who makes a record, or part of a record, of personal health information available to an individual or provides a copy of it to an individual may charge a general fee, not to exceed $30.00 per request, as compensation for all of the following:

(a) receiving and clarifying the request;

(b) locating and retrieving the record, including any record held electronically;

(c) providing an estimate of the access fee to the requester as required by subsection 82(1) of the Act;

(d) review of the record for no longer than 15 minutes by the custodian or an agent of the custodian to determine whether the record contains personal health information to which access may be refused under subsection 72(1) of the Act;

(e) severing of the record if access to part of the record is refused under subsection 72(1) of the Act;

(f) preparing the record for photocopying, printing or electronic transmission for no longer than 30 minutes;

(g) preparing a response letter to the requester;

(h) supervising an individual's examination of original records for no longer than 30 minutes;

(i) the cost of mailing a record by regular mail to an address in Canada.

Specific fees

15 In addition to the general fee provided for in Section 14 and any direct costs provided for in Section 16, a custodian may charge up to the maximum fee set out in the following table for the activity specified:

Activity	Maximum Fee
Making photocopies of a record	$.20 per page
Preparing a record for photocopying, printing or electronic transmission	$12.00 for every 30 minutes after the initial 30 minutes covered by the general fee under clause 14(f)
Faxing a record	$.20 per page
Making a compact disk containing a copy of a record stored in electronic form	$10.00 per request
Making a microfiche copy of a record stored on microfiche	$.50 per sheet
Making a paper copy of a record from microfilm or microfiche	$.50 per page
Making a copy of an audio cassette recording	$5.00 per cassette
Making and providing a copy of a ¼″, ½″ or 8 mm video cassette recording that is - 1 hour long or less - more than 1 hour long	 $20.00 $25.00
Making and providing a copy of a ¾″ video cassette recording that is - 1 hour long or less - more than 1 hour long	 $18.00 $23.00
Producing a record stored on medical film, including x-ray, CT and MRI films	$5.00 per film
Printing a photograph from a negative or from a photograph stored in electronic form, - per 4″ × 6″ print - per 5″ × 7″ print - per 8″ × 10″ print - per 11″ × 14″ print - per 18″ × 20″ print	 $10.00 $13.00 $19.00 $26.00 $32.00
Review of the record by a custodian or an agent of the custodian to determine whether the record contains personal health information to which access may be refused under subsection 72(1) of the Act	$25.00 for every 15 minutes after the first 15 minutes covered by the general fee under clause 14(d)

Supervising an individual's examination of original records	$6.00 for every 30 minutes after the first 30 minutes covered by the general fee under clause 14(h)

Direct costs

16 In addition to the general fee provided for in Section 14 and the specific fees provided for in Section 15, a custodian may charge for the following direct costs incurred by the custodian, including any applicable tax:

(a) charges to retrieve a record from and return the record to off-site storage, if an individual requests expedited access to a record for which additional retrieval costs are charged to the custodian;

(b) courier costs, if courier delivery is requested by the individual;

(c) the cost of mailing a record to an address outside Canada;

(d) taxes payable on the services provided.

Visit history

17 (1) In this Section, "visit history" means a record that

(a) can be produced by a custodian's administrative staff from the custodian's health records; and

(b) consists of a computerized printout of an individual's visits.

(2) If a custodian has the ability to produce a visit history for an individual, the custodian may provide a copy of the visit history to the individual at the individual's request.

(3) A custodian may charge a fee of no more than $10.00 to produce a visit history and may not charge the general fee provided for in Section 14 or a specific fee provided for in Section 15 to an individual who requests only a visit history.