Writing a medicolegal report: the psychological consequences of accidents

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Your patient was injured in an industrial accident. His solicitors have asked for a medical report and he has authorised you to reply. You have a clear understanding of his physical injuries but you do not feel confident in describing the psychological sequelae. You imagine a horde of psychiatrists, all equipped with the DSM-IV, waiting to pounce on you for using the wrong labels. Here is why you do not need to worry.

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Before putting pen to paper remember the advice given in my previous article on writing a report.[1] The more objective your report, the more it will help your patient achieve justice. Make a clear distinction between what you have observed yourself and what you have been told. Use plain English, and everyone will understand what you are trying to say.

Some problems with diagnostic categories

You may wonder whether some disorders are diseases. When Professor Scadding first described pulmonary sarcoidosis he asked himself whether or not it was a disease.[2] Being a wise man he realised that he could not answer the question unless he could define a 'disease'; being honest as well, he realised that he could not do so.

What is a disease is a matter of convention, not of definition. Thus all would agree that fractured femur and pulmonary tuberculosis are reasonably regarded as diseases, but what about alcoholism? And excessive gambling?

There have been many attempts at a definition. For example, one is diseased if in a condition which threatens to shorten life or to diminish the ability to procreate. A wit pointed out that a Catholic priest who rode a motor bike was in this category. There is a large literature; the search for a definition continues.

Since there are no criteria of what is a disease, the boundary between what is normal and what is a reasonable response to a situation, and what is a 'disease' is sometimes no more than a matter of opinion. Thus, some years ago, the socially disadvantaged people from Detroit rioted, and caused a lot of trouble. The then existing diagnosis 'Episodic Dyscontrol Syndrome' was applied to them. Since it was supposed to be due to cerebral dysfunction, certain academics suggested that the rioters should be treated with cerebral surgery. Fortunately wisdom prevailed and no-one was harmed. This diagnosis no longer exists.

To put it shortly, some diagnoses reflect objective criteria. Others do not, but are useful. Others are manifestations of the cultural, temporal and social backgrounds of those constructing them. It is almost half a century since the first Diagnostic and Statistical Manual of mental Disorders appeared – there have been many changes in that time and no doubt there are more to come.

Similarly there are patients who have symptoms which you feel are genuine enough but which you do not understand. It is better to own up and say that the patient has a backache of uncertain causation than to use a term like 'Regional Pain Syndrome' or 'Somatisation Syndrome'.

There are many resounding diagnoses like repetitive strain injury, fibromyalgia and myalgic encephalitis. Unless you are very expert in the area, stay away from them.

If your patient has symptoms like this and all the somatic

tests and experts can find nothing, then rather than search the nomenclature why not have a psychiatric assessment? There may perhaps be a DSM-IV classification which fits the patient exactly. One does not arrive at a psychiatric diagnosis by exclusion.

Diagnosis and disability

It is important to understand that a diagnosis does not necessarily indicate disability. It may – if your patient had both legs amputated, much follows logically. However, consider 'A' who has a phobia of giraffes. A phobia is a recognised psychiatric disorder. If she lives in Sydney, and stays away from the zoo, she will have no disability.

'B' is bereaved, suffering greatly and for the time being quite disabled. Bereavement is not a psychiatric disorder; it is a normal reaction to a common event. It may be very disabling indeed.

Put your diagnosis aside for the moment and spell out the disability your patient has in all the roles that he or she has in life.

What is normal? 'Z' has been involved in an air crash. Everyone survived, but – understandably – he was scared stiff. Now, a year later, if he has to travel by air he is much more anxious than he used to be. Since his occupation involves frequent air travel, this is quite a burden.

It is neither surprising nor abnormal that 'Z' should be anxious in this way. The important point is that 'Z' can be much helped by appropriate behaviour therapy. Here we have someone suffering from a normal reaction who will benefit from treatment.

Where we are

Diagnostic categories can be very useful; they can also be confusing, misleading, transient or even dangerous. Disability and diagnosis do not necessarily go together. The boundary between normality and disease is by no means clear and cannot be until there is a satisfactory definition of 'disease'.

Therefore, if you feel insecure about using technical terms in this area do not be too concerned. Reflect upon those who use this year's terminology as if it were carved on tablets of stone.

In case you think that these remarks are heretical, note that those who put DSM-IV together were well aware of this problem. On page xxiii they stated:

'The specific diagnostic criteria included in DSM-IV are meant to serve as guidelines to be informed by clinical judgment and are not meant to be used in a cookbook fashion.'

Further down on the same page a section headed 'Use of DSM-IV in forensic settings' makes it clear that its use in that context carries significant risks and that undoubtedly future editions will contain new disorders and lack some of those in the present edition.

Conclusion

Doctors who understand their patients need not be too troubled by the complexities of nomenclature, particularly when it comes to describing the psychological consequences of accidents and other misadventures.

Write in plain English about how your patients feel, how they are coping, how they behave in the different aspects of their lives and how they see the future. Comment on whether their present condition is a reasonable consequence of what happened to them. If you can give some indication about the future, do your best to do so.

Remember that the important readers of your report will be members of the legal profession who wish to come to a well-founded understanding of how things are and that a dazzling display of psychiatric nomenclature may not give them the most assistance, particularly if DSM-V comes out after you write your report. MT

References

1. Ellard J. On writing a report. Mod Med Aust 1999; 42(1): 61-62.
2. Scadding JG. Diagnosis: the clinician and the computer. Lancet 1967; 319: 877-882.