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1. Introduction

1.1. This guide is designed to assist Independent Medical Examiners (IMEs) achieve the report writing standards expected by the Victorian WorkCover Authority (VWA) in performing the unique function of independent medical examiner (IME).

1.2. An injured worker can be compelled under Victorian workers compensation legislation (the legislation) to attend an independent medical examination.

1.3. The resulting independent medical opinion is to assist the Scheme to make claims management decisions affecting an injured worker.

1.4. The VWA approves a pool of qualified medical practitioners who have each been assessed for suitability by their peers and signed a standard VWA IME Agreement covering the services they are to provide.

1.5. This Agreement includes Service Standards for the conduct of the examination and the preparation of the report. The VWA requires all reports to meet these standards relating to format, content, accuracy, consistency, and bias.

1.6. Once an IME submits a report to the requestor, it is eligible for quality audit at any time against these standards by peer review. If reports are determined not to meet the standards, an IME's VWA approval to accept referrals may be removed.

1.7. There are three kinds of IME report and fee payable under the Workcover Scheme based on the services required to complete that type of report:

1.7.1. “First Report” (full fee)

- applies if it is first time you have seen the worker for an IME
- applies if it has been more than 12 months since you saw the worker
- requires full occupational and medical histories to be included
- has a fee that reflects these tasks

1.7.2. “Subsequent” Report (partial fee)

- applies only if you have seen the worker within the last 12 months
- does not require full occupational and medical histories to be included but does require an update and a reference to the previous histories taken on last visit
1.7.3.  “Supplementary” Report (nominal fee)

- applies when asked for specific information additional to the initial request
- does not apply where your original report was deemed to be unclear or left out

1.8. It is in the interests of all IMEs to be familiar with the VWA service standards and VWA expectations to ensure the right outcomes for injured workers in Victoria.
2. Format of the Report

2.1. Consistent report format is essential to ensure maximum clarity and usability of the information being provided. This is particularly important if this information is subsequently scrutinised in a medical panel, dispute conciliation, or a court of law.

2.2. Poor format and language can impede communication and lead to oversight of important advice, misinterpretation, or unnecessary follow-up requests.

2.3. To enhance clarity for all potential users of your report it is strongly recommended that it is structured and written in a manner easily understood by non-medical readers. While it may be necessary to use relevant medical terminology in reporting findings and medical conditions, plain English is strongly encouraged for commentary, explanations, conclusions, and summaries.

2.4. Requirements for basic format of an IME report are set out in the Service Standards attached to the IME Agreement (see Appendix 1).

In the introductory section of your report (the "beginning"):

2.5. The purpose of the examination and the identity of the report requestor.

2.6. Specific report reference information about the injured worker, including: name, claim number, the employer, the date of injury, and date of birth. This is usually as provided by the agent requesting the report, but is necessary to be reproduced in your report to ensure accurate matching.

2.7. The date and place of the examination, and any other relevant information about the nature of the consultation. This should include whether any other person/s were present, whether an interpreter was required and present, any unusual event or occurrence during the encounter which could be of relevance to the case, including any difficulties encountered, etc.

2.8. A list of all materials provided to you and sighted by you in preparing your report – investigations, previous reports, letters, certificates, etc.

2.9. While this should have been listed by the agent, the documents provided should also be confirmed by you. This enables anyone reading your report to understand the sources of information you used in reaching your conclusions and making any recommendations.
2. Format of the Report

In the body of the report:

2.10. A concise but comprehensive history of the events leading up to and including the injury/ies, and the subsequent work and medical history.

2.11. Other relevant personal, occupational, and medical history.

2.12. The relevant findings, both positive and negative, from your physical (and/or mental state) examination.

2.13. The results of any relevant investigations provided to you by the agent, or organized by you subsequently after consultation with the requesting agent.

2.14. The nature and significance of any other opinions/reports/assessments made available to you.

2.15. Specific answers to each of the questions asked by the requesting agent.
   Note: A short explanation should be provided if a question is not answered or is considered inappropriate or irrelevant.

In the concluding section:

2.16. A concise summary or concluding comments - highlighting the most important issues in your report, particularly in the case of extensive and/or complex reports.

2.17. Your personal signature - this is essential to verify that you have read and checked your report and certified its veracity.
3. Content of the Report

3.1. This section of the handbook deals with the expected content within the structure of an IME report - the history and the findings from your examination. Further information on consistency of content and answering specific questions asked by the requesting agent are dealt with in later sections of this handbook.

The history:

3.2. The history is available from materials provided by the agent and the injured workers own responses during examination. Where independent corroborating or conflicting information exists or is elicited however this should be reported.

3.3. For most reports the following history is essential:

3.3.1. An occupational history, i.e. pre-injury employment and work capacity.
3.3.2. The events leading up to and causing the reported injury.
3.3.3. The injury itself – mechanism, nature, severity, etc.
3.3.4. Subsequent medical attention, care, investigations, treatment, procedures, complications, etc.
3.3.5. Effects of the injury/ies on capacity for work (current functional status), including current work status.
3.3.6. Current symptoms and/or disabilities.

3.4. Additional history which may be relevant in certain circumstances includes:

3.4.1. Pre- and post-injury personal, work, or medical factors which may have had or may be having an impact on the injury and/or on the consequences of the injury.
3.4.2. Handedness (usually in the event of limb or shoulder girdle injuries).
3.4.3. Level of education, other training, previous work history, etc.

The examination:

3.5. Every independent medical examination report must be based upon an actual medical assessment of the patient conducted.

3.6. In the case of psychiatry, every independent medical examination must include a mental state examination.
3. Content of the Report

3.7. Your physical and/or mental state examination serves a number of purposes:

3.7.1. To document the nature and consequences of the injury;
3.7.2. To determine functional capacity and the nature and magnitude of any impairment/disability;
3.7.3. To corroborate, or to raise questions about, the accuracy and/or completeness of the history;
3.7.4. To assess whether other medical conditions exist and if so to determine in what way they relate to the injury/impairment/disability.

3.8. An examination that forms the basis of your report must have been conducted in accordance with recognised professional standards and applicable laws.

3.9. It should have been of sufficient length to make a fair and comprehensive examination that enables answering of questions asked by the report requestor.

3.10. The nature and extent of the physical and/or mental state examination/s performed should be reported (concisely).

3.11. All abnormal findings and any relevant normal findings should be carefully documented. In addition, document any abnormal, inappropriate or excessive pain, or other relevant behaviour observed during the course of the encounter.
4.1. This section deals with ensuring that the conclusions and any recommendations are evidence-based and consistent with the findings on history and examination.

4.2. Inconsistent report information can mislead the reader, prompt unnecessary supplementary requests, and bring the basic capabilities of the professional into doubt when the report is scrutinised.

4.3. Your conclusions and recommendations are therefore the most important aspect of any independent medical examination, reflecting where your particular expertise is most directly brought to bear on the case.

4.4. You should have elicited a thorough and relevant history, and performed a high-quality, targeted examination. Your role is to use this data to formulate an understanding of the worker, the injury, and its consequences in light of your specialised medical knowledge, experience, and expertise together with your understanding of the workplace.

4.5. You should seek to demonstrate the consistency of your answers with your findings and their basis in evidence by referring specifically to the relevant findings and the appropriate evidence. This will support the conclusions and recommendations contained in your answers:

For example: Compare the following three increasingly higher quality responses to the requesting agent's question “Has the worker sustained an injury?”

Answer 1. Yes.

Answer 2: Yes (history of predisposing activities, typical examination findings, confirmatory ultrasound).

Answer 3: Based on the history of duties at work known to predispose to rotator cuff damage, examination findings typical of this condition, and a confirmatory shoulder ultrasound it is my opinion that this man is suffering from a right rotator cuff tendonitis.
4. Constituent Evidence-Based Findings and conclusions

Insufficient evidence to make a clinical opinion

4.6. Conversely, if you cannot support your conclusions or recommendations by the findings, or if your conclusions or recommendations are not consistent with current medical knowledge and evidence, you should give serious consideration as to whether you should be making those conclusions or recommendations at all. It is better to indicate that you are unable to answer the question, or that there is insufficient information available to provide an answer, rather than venture an opinion which is unsupportable.

Presenting symptoms or signs outside your field

4.7. Sometimes a referral may be made outside of your speciality, or presenting relevant factors on which you are not qualified to provide advice

4.8. If at any time you consider there are symptoms or signs that are beyond your area of expertise, you should not include an opinion in your report on that matter. You should simply note them as another particular factor and that you are unable to provide an independent medical opinion on that matter as it is outside your area of expertise.

4.9. Before submitting your report, confirm for yourself that the key service you have agreed to provide – a sound, independent, evidence-based professional opinion – is not compromised by missing information, unsustainable links between evidence and opinion, or internal inconsistencies

Presenting symptoms or signs not related to the referral

4.10. If, during an examination, you find a condition that does not relate to the request, normal ethical requirements still apply. If the condition clearly does not relate to the worker's claim the matter should be raised with the injured worker, and the injured worker encouraged to raise the matter with their treating health practitioner. If you think you need to discuss the matter with the treating practitioner, obtain the worker's consent in writing to do so.

4.11. You must not, of course, discuss treatment with the injured worker. You should not raise the condition with the report requestor or include it in your report.
5.1. This is the crux of your report – answering, to the best of your ability (with regard to the history you have elicited, your examination findings, your review of any additional information available, and the best available medical knowledge) the specific questions posed by the requesting agent.

5.2. In answering the requesting agent's specific questions best practice is to state the question in your report and then proceed to answer that question, and only that question.

*For Example: Was employment a significant contributing factor to the injury?*

**Answer:** "I consider that this worker's employment has not been a significant contributing factor to her injury. I have reached this conclusion having regard to the sedentary nature of her work, the duration of her symptoms, examination and X-ray findings demonstrating osteoarthritis consistent with her age, and the contents of the workers compensation legislation. That is, it is my considered opinion that the changes are age-related degenerative changes which would have occurred whether or not she had undertaken this employment."

**Providing additional, un-requested answers or opinions**

5.3. Normally you should not need to provide any separate assessment, opinion/s, or conclusions, if you have answered all the questions asked by the requesting agent.

5.4. However, you may feel there are circumstances in which one or more unsolicited responses may be appropriate, indeed necessary, e.g. you consider the questions posed to be insufficient or inadequate in a particular case, i.e. unable to reflect adequately the complexities of the case or the full breadth of the situation.

5.5. Whether you wish to proceed directly to provide unsolicited conclusions or recommendations, or whether you feel it more appropriate to contact the requesting agent to seek direction, will depend to a considerable extent upon your personal approach to your role, your prior experience, logistical realities, etc.
Responding to inappropriate, irrelevant or repetitive questions:

5.6. In some circumstances the requesting agent's questions may seem inappropriate, irrelevant, or repetitive. This is clearly a difficult situation, and one which has the potential for misunderstanding.

5.7. However, attempting to answer questions in which you have little confidence, or which lie outside your area of special expertise can be frustrating, irritating, and pointless. On the other hand, just omitting to answer questions, or re-framing them in a way which you consider makes more sense, is contrary to the implied contract you have with Victorian WorkCover and its requesting agents.

5.8. Ideally it would be better if you were able to clarify the situation with the requesting agent before finalising the report. However, this may not always be possible, and there may be situations where it is reasonable to list the question, explain your concerns regarding that question, and indicate how you have chosen to proceed.
6. Avoiding Bias

6.1. As an IME you are being engaged by the requesting agent not as their agent (even though they are paying you), nor to act as the claimant's personal doctor, but to provide a fully independent professional medical assessment of the case.

6.2. It is very important that an independent medical examination and its associated report are just that, i.e. independent and impartial. Note also that it is not the role of an IME to determine or comment on liability, but to provide a medical opinion to assist others in their determination of liability.

6.3. Bias, either consciously or subconsciously, most commonly arises from one of three sources:

Taking the injured worker's "side"

6.4. This may occur because:

6.4.1. You feel sympathetic to the claimant's circumstances;
6.4.2. Because you accept at face value what the claimant tells you about their workplace, their accident, and the consequences of the accident; or
6.4.3. Because of a professional commitment to "act in the best interests of your patient".

6.5. These factors may be compounded by the usual working presumption doctors quite correctly normally operate within: that their patients tell the truth about their injuries/illnesses – a presumption which may not be justified in circumstances where the patient stands to benefit from being less than forthcoming with the truth.

Taking the requesting agent's "side"

6.6. This may be due to the natural tendency one has to provide a sympathetic service to the person or organisation paying for the service (particularly in a fee-for-service culture), or it may be due to a more or less well informed suspicion of some WorkCover claimants and the nature of some of their injuries and/or claims.

6.7. However, the content of your reports must always be in accordance with the terms of your Agreement, which explicitly requires that the opinions you provide in your report be quite independent of the Authority, authorised agents, or self-insurers.
6. Avoiding Bias

6.8. You have a contractual obligation to protect this independent status and are required to notify the Authority immediately in the event of any real or perceived attempt by an employee of the Authority, a self-insurer, a worker, or worker's representative to influence your report in any way.

Professional bias

6.9. This may be demonstrated through certain diagnoses, models of causation, and/or treatments, either as a result of one's particular specialty training, or arising from a somewhat idiosyncratic view of some aspect/s of medical practice.

6.10. The best defence against unconscious bias is a deliberate, conscious awareness of the issue of bias, its types and its origins, and a determination to minimize its effects on your work.

6.11. The best defence against conscious bias is to write your report and subsequently to read it through, asking yourself the following three questions:

- Could what I have written be biased in any way?
- Could what I have written create a belief or perception of bias in others who might read it, even if no such bias exists?
- If the answer to either of these questions is 'yes', or 'maybe', can I rewrite it in such a way as to remove that bias or perception of bias?
7. Getting the Job Done

7.1. “Getting the job done” includes such organisational issues as timeliness, efficiency, presentation standards, accuracy, etc.

7.2. While there are many ways to deliver a well-written, well presented, accurate report on time, the following are some “tips” to assist those who don’t always find their performance in these matters is up to the standards they, and others, would wish.

**Use a checklist**

7.3. If you are performing independent medical examinations regularly, you might wish to use a report checklist. This would normally include all those components of the report which are more or less standard for each report, such as your usual preamble, section headings, signature, even basic history and examination proformas which can be tailored to each case.

**Ensure the availability of all the provided documentation**

7.4. Letters, results, reports, etc. are available before starting the interview and the examination of the claimant. You may decide to read these documents before starting to enable you to develop an initial understanding of the case – or alternatively choose deliberately to “start fresh”, i.e. with no preconceived ideas, in which case you will need to read the documents after initially seeing the claimant, but before they leave (in case you need to confirm or corroborate any information or findings arising from the documentation).

7.5. Contacting the claimant direct after an examination is not an acceptable avenue for seeking private information.

**Read the requesting agent’s questions**

7.6. Before commencing (and if necessary again during the interview and/or examination) to ensure that you gather the information which will be necessary to answer the specific questions you have been asked.
6. Getting the Job Done

Make concise notes

7.7. Notes should be made of your findings as you go, particularly key positive and negative findings on both history and examination, and any contradictory findings which could influence your assessment and conclusions. This will assist you in writing your report at the end of the clinical encounter with the claimant, and also ensures that if for some reason you are unable to write your report immediately, or if the report is mislaid or lost, you have a contemporaneous record of your key findings for later use.

Decide your own drafting strategy

7.8. Decide your own strategy for how best to prepare first and final drafts of your reports. However it is done, quality results are generally achieved by preparing an initial draft, then revising or editing to a final draft, while ensuring appropriate formatting (and use of some form of ‘spell-check’ to detect spelling errors, typos, etc).

Re-read your opinion

7.9. Ensure the report accurately reflects your findings and conclusions and ask:

7.9.1. Is my report accurate, i.e. containing an accurate medical diagnosis based on appropriate clinical examination presenting an evidence based approach to evaluating symptoms and findings;

7.9.2. Is my report independent, impartial, limited to relevant information and not disclosing personal information except where it bears on the work injury;

7.9.3. Are you satisfied that the medical opinion provided is consistent with and agrees with your clinical findings.

Personally sign the report...

7.10. … and record that you have signed it on your own copy. If the report is forwarded without your signature, record the reason for it not being signed and ensure that a signed copy is forwarded as soon as possible.
Appendix 1

Schedule D of the IME Agreement
Clauses 3, 7.3

Service Standards

Service standards applicable to independent medical examinations are as follows:

1. Appointments:
   1.1 Appointments will be made as soon as practicable after receiving a request for appointment. As a guide, appointments should be made within 3 weeks of a request from the Report Requestor.

   1.2 On date of appointment, injured workers will not be kept waiting for an unreasonable period of time.

2. Conduct of examinations:
   2.1 Injured workers attending Independent Medical Examinations will be interviewed and examined with care, consideration and courtesy.

   2.2 Independent Medical Examinations will be conducted in accordance with recognised professional standards and applicable law.

   2.3 The length of the independent medical examination will be sufficient to make a fair and comprehensive examination of the injured worker with a view to answering the questions asked by the Report Requestor.

   2.4 The Independent Medical Examiner should ask the Report Requestor to contact the injured worker's treating practitioner where clarification of an issue is required. If the Independent Medical Examiner makes direct contact with the injured worker's treating practitioner, the Independent Medical Examiner must obtain the injured worker's consent in writing before contacting the treating practitioner.

   2.5 Additional tests (e.g. radiology, pathology etc) should only be conducted when the findings of an Independent Medical Examination would otherwise be unreliable. Approval from the Report Requestor should be sought before initiating additional tests.
3. Preparation of reports:

3.1 Reports must be:

(a) Timely - that is, provided within 7 business days of examining the injured worker and receiving any additional material reasonably required to complete the report. Any requests for additional information should also be made in a timely manner.

(b) Accurate - that is, an accurate medical diagnosis based on appropriate clinical examination. As far as practicable, reports should present an evidence based approach to evaluating symptoms and clinical findings.

Reports should indicate if there is insufficient clinical information to make a diagnosis.

(c) Unbiased - that is, independent and impartial. Reports should be limited to relevant information and not disclose personal information except where it bears on the work injury.

(d) Consistent - that is, reports should be internally consistent in that the opinion should agree with the findings.

3.2 The beginning of the report should include:

(a) the purpose of the examination and the identity of the Report Requestor; and

(b) the date and place of the examination; and

(c) the material sighted (such as other medical reports, investigation reports) before completing the report; and

(d) whether an interpreter or other person was present at the consultation.

3.3 The body of the report should include:

(a) history of the injury and its treatment; and

(b) relevant general health, personal and social history; and

(c) occupational history; and

(d) current complaints/symptoms a list of the injured worker's complaints/symptoms at the time of examination; and

(e) present restrictions, daily activities and interests; and

(f) details of examination findings; and
(g) results of relevant investigations; and

(h) answers to specific questions asked by the Report Requestor.

3.4 Reports must be signed personally by the Independent Medical Examiner.

3.5 Prior to determining whether or not to provide an Independent Medical Examination report to an injured worker who is the subject of the report and who has requested access to the report, the Independent Medical Examiner must contact the Authority, Authorised Agent or self-insurer who requested the report.

4. Attendance at court:

4.1 Conducting Independent Medical Examinations and providing reports may also involve co-operating with the WorkCover Conciliation Service or attendance at court hearings, including attendance at hearings held in country areas.