Responding to a request for a report: a guide for foundation year doctors

Introduction

A 46-year-old man is admitted to the accident and emergency (A&E) department, following a serious road traffic accident. He had multiple injuries and signs of internal haemorrhage. Despite all attempts at resuscitation and transfusion he dies from internal blood loss within 3 hours of admission. It subsequently transpires that the last unit of blood was intended for another patient in A&E with the same surname.

As the duty doctor in A&E you may be involved in producing reports for:

1. Police, investigating the road traffic accident and circumstances of the death
2. Coroner
3. The trust – who will need a serious untoward incident report in relation to the transfusion error
4. Complaint from the family who have been told of the error, but that it was of no consequence to the outcome.

Consider your response with reference to the general guidance below

Doctors and all staff working in the NHS and other health-care settings are involved from time to time in circumstances where things have gone wrong. This may be for many reasons: errors by one or more individuals, problems with the systems in place within the organization or lack of resources.

It can be a worrying time. Frequently staff will be asked to provide written reports in such cases. These are often a source of further anxiety. This article gives guidance on how to approach the situation if something goes wrong, and how to produce a report if you are asked to do so.

Steps to take when things go wrong

Try to keep calm, and work your way through the following steps.

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- Take any necessary steps to rectify the situation, if possible, or seek help if you are unable to do so
- Make careful notes of what has happened, and the steps that you have taken after discovering the problem
- Inform someone else as soon as possible – your consultant or other appropriate senior should normally be the first person to approach
- The patient should be informed as soon as possible – although a full explanation may need to wait until after the matter has been properly looked into. Speaking to the patient should normally be left to the most senior person available
- Seek advice from your protection organization sooner rather than later.

Preliminary issues to consider

Before starting your report you should ask yourself a number of questions:

- Who has asked for the report?
- Who will see the report?
- Do you have access to the notes?
- Will you need consent?
- Is there a deadline for the report?

Who has asked for the report, and who will see it will help you decide how to phrase your report. An adverse incident report requested by the trust and intended for internal use may be phrased in more technical terms. A report requested by the complaints manager, and which is likely to be seen by the patient or relatives, will need to explain matters in lay language. Tailor your report for the average, sensible lay person.

Normally, if a case involves patient care or treatment, you will have made entries in the clinical records – if so it is essential that you have access to the records, or at least a copy of the relevant sections, to refer to when compiling your report. If there is difficulty gaining access to the records, make sure you seek advice from your protection organization.

Finally, you will need to consider whether consent is needed. This will be necessary where the report may be seen by third parties. For example if a relative wishes to complain on behalf of a competent adult patient, then that patient's consent will be required before a response can be sent to the relative.

Reports for the following will not usually need consent:

- The coroner
- Trust internal procedures such as adverse incident reports
- The trust solicitors to help investigate a potential claim
- A confidential report for your protection organization.

Establish whether there is a deadline for producing the report. You should try to meet it, but if this is not possible (for example, you will have to first review the records), then tell the person requesting the report and give an indication of when the report will be available.

Structure of a report

Once you have dealt with the preliminary issues, you can proceed to draft the report. In doing so, you should try to adopt a style that is clear for the reader to follow:

- Use white paper headed with your contact address, telephone number and email details
- Always have your report typed or printed in black ink. If this is impossible, ensure that your writing is legible – if necessary use block capitals
- Preface the report with a heading, making it clear what the report is about, and the purpose – for example 'Report for HM Coroner re Mrs Jane Doe deceased'
- Use a suitable font size and spacing so as to make the report easily readable
- Break the report up into easily digestible paragraphs
- Number paragraphs and pages
- Write your report in the first person. For example 'I reviewed the patient at 23.00 hours', not 'The patient was reviewed at 23.00 hours'
- Ensure that your report is accurate, and contains all the relevant information, so as not to be misleading.

Content of a report

Start your report with a brief summary of your training, qualifications and experience. Explain your current position, the one you held at the time of the incident (if different), and how you became involved.

Next, explain what your report is based on – where you have referred to your notes, whether you have any recollection of the events in question, and where you rely on your knowledge of your normal clinical practice.

Set out in detail each contact with the patient in chronological order. Make sure you give the date and time (by 24-hour clock) clearly for each event.

Transcribe your notes directly into the report, indicating this clearly (for example with italics and quotation marks) before going on to expand on them.

Make it clear where other parties become involved in the case, giving their full details. For example 'The specialist registrar, Dr Rodney Houghton, arrived on the ward at 10.52 hours and reassessed the patient'.

With team working and current work patterns, you will often be relying on information passed to you by colleagues and other professionals, either in person, or recorded in the notes. Make the source of any such information clear in your report. For example 'I reviewed the patient on Monday at 09.00 hours. I saw from the notes that he had been seen with a further episode of pain at 17.50 hours on Sunday by the duty senior house officer, Dr Ahmed…'.

Your opinion about the patient's condition at the time is an important piece of factual information and should be recorded (i.e. your diagnosis or differential diagnosis). For example 'My initial diagnosis was musculoskeletal pain, but in order to exclude a cardiac cause I arranged…'.

What to avoid

Remember that you should not:

- Speculate
- Comment on, or criticize, the actions of others, save in a purely factual way
- Present an assumption or guess as a fact – if your memory of events is unclear, say so
- Allow yourself to become angry – even if you are responding to a complaint phrased in angry terms
- Venture an opinion – unless specifically asked to do so – if you are make sure you stay within the bounds of your knowledge and expertise.

And finally

Once you have completed your report, make sure you read it through carefully to check that the meaning is clear (as well as for the usual typos).

When you are happy with your report, it should be signed and dated before submission. It would be sensible for you to keep a copy for your own file whenever possible.

Sometimes (for example, where formal legal proceedings are involved) your report will need to be put into the form of a formal statement – this will normally be done by a solicitor on your behalf. When you receive the statement, ensure you check it thoroughly before signing it. Solicitors can make mistakes, and your report may have been misinterpreted – so make sure you are happy with the statement before signing and dating it.

If you believe you may be criticized as part of the process for which the report is prepared, then make sure you seek advice earlier rather than later – it is better to spend a little longer finalizing the report with the assistance of your protection organization, than to submit a poorly drafted or inaccurate report in haste. If you need extra time in order to seek advice before finalizing your report, inform your employer – they will usually be understanding.

Writing a report is an important responsibility. Prepare carefully, and write anticipating that you may be questioned about it at some point in the future. Factual accuracy, clarity of expression and attention to detail are indicators of a professional and responsible approach. BJHM

Conflict of interest: none.

Further reading

General Medical Council (2001) *Good Medical Practice.* General Medical Council, London

General Medical Council (2004) *Confidentiality: Protecting and Providing Information.* General Medical Council, London

Medical Protection Society (2002) *Writing Reports and Giving Evidence in Court, a complete guide for juniors.* Medical Protection Society, London

KEY POINTS

- When writing a report, be aware of whether or not you need consent to disclose any information.
- Remember your audience: a report for the trust may use more technical language than one which will be seen by patients and/or relatives.
- Keep it factual: do not speculate or make assumptions.
- Seek advice early if there is anything you are unsure about.