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METHODOLOGY OF MEDICAL EXAMINATION FOR ASSESSMENT PURPOSES

BY

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Abstract

Alongside prevention, diagnosis, and treatment, adjudication is one of the core areas of medical activity. At the same time, it is an underestimated field. Adjudication may concern the assessment of the ability to work or perform a specific profession; obtaining permission to obtain a driving licence (establishing the absence of medical contraindications); in some countries, obtaining a weapons licence; determining the amount of damage to health as a result of an accident suffered (and thus the corresponding financial benefit from an insurance company); or establishing the right to receive sickness benefits or allowances resulting from the state of incapacity to live independently. A patient who comes to the doctor as an ill person expects his or her condition to improve and cooperates with the doctor in the diagnostic and treatment process. A petitioner who comes to a doctor to have his or her state of health assessed for the purpose of receiving financial benefits is primarily interested in receiving a ruling that will allow him or her to receive those payments. Therefore, he will not always cooperate with the doctor, which may lead him astray. For these reasons, the medical examination for adjudication purposes is different, which not all doctors and not always remember.

Keywords: *medical examination, jurisprudence, health impairment.*

INTRODUCTION

Every medical examination begins with a patient background check. The person we come into contact with in the outpatient clinic or examination room may not necessarily be a patient or supplicant. It may be a person who has come on behalf of someone else - so we need to be sure who we are dealing with before taking the appropriate medical action. Once we have verified the identity of the person being examined, the next data we will be interested in is their employment, occupation, marital status, and number of children. This is all information that allows us to place the subject in his or her environment and to identify possible occupational or environmental exposure factors.

The examination should be carried out under appropriate conditions. The room must be large, well lit, and equipped with the basic instruments – a scale, an apparatus for measuring blood pressure, a stethoscope, a neurological hammer, a centimetre (for measuring muscular atrophy or oedema), a torch, and a needle and swab for testing surface sensation.

During the examination, the doctor should pay attention to his or her appearance, facial expression, voice intonation, gesticulation, the way of speaking, sitting or moving around the room, and the style of conducting the examination, which should be done without undue haste, carefully, methodically and in such a way that the patient feels that he or she has been treated competently. In addition, you should avoid entering into a discussion with the opinionated person, tactfully pointing out to the opinionated person who is conducting the examination here.

The clinical examination consists of two main parts: the subject examination and the physical examination. If necessary, these elements are supplemented by an analysis of the results of additional examinations. In the assessment room, the person examined is not a patient, but a supplicant. The medical examination for the purpose of the assessment is exclusively for assessment purposes, therefore the examiner is not allowed to give advice, write prescriptions, recommend certain treatments or specific doctors, etc. during the examination. He or she may not refer to the assessed person or use the word "sick" in the documentation, as a healthy person may take part in the assessment. The medical examiner must also bear in mind that the sole criterion for assessing the state of health is factual. Therefore, he/she cannot take into account non-substantive factors (e.g. age of the person examined, number of children, whether the person assessed is

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unemployed or not, etc.). Making the granting of a benefit dependent on the above factors will show that the adjudicator is acting as a social welfare officer and not as a doctor. The adjudicator cannot in his/her actions "practice philanthropy out of his/her own pocket". When assessing the adjudicator, the principle should be that it is the petitioner of the insurance institution, and not vice versa, who has to prove that he or she is a sick person and should be entitled to a benefit (incapacity, pension, attendance allowance, health impairment).

Obviously, this cannot be done by the claimant himself, so he uses the assistance of the treating physician who carries out a full diagnostic examination, undertakes the treatment, and then, with the appropriate documentation, refers the claimant for a certificate of competence. The task of the medical examiner is to analyse the medical documentation provided, without - as far as possible – deferring a decision because, for example, basic test results are missing.

Under no circumstances may the medical examiner examine anyone he or she is treating, is related to or is a close friend of, or has a business relationship with.

Medical history

When a doctor examines a patient in need of treatment, diagnosis is most often made 'by similarity' of symptoms or in the form of differential diagnosis. Hence, the questions asked may direct the patient, show him alternatives, or suggest a range of symptoms. The situation is different in the case of the adjudicatory examination. Here, the applicant faces an examiner with an already established diagnosis; the role of the examiner should only be to substantively critique the medical documentation provided. It is also necessary to be critical of the diagnoses written on the forms with which the applicants appear at the assessment and to always seek confirmation of these diagnoses in the source documentation. The questions asked must not suggest symptoms (instead of asking: "do you have dyspnoea", one should say: "please describe how you breathe").

When taking the history, special attention should be paid to the duration of the disease, its dynamics, the rate of progression of symptoms, the duration of periods of stabilisation. In this way, both morphological (name) functional (anatomical effects or loss of function of organs or systems) and aetiological (as to the cause) diagnoses can be established.

The personal examination includes a history of the patient's main complaints, previous illnesses and their treatment, addictions, lifestyle, inclinations, occupation, past illnesses, and operations, heredity in the immediate family and diagnostic tests performed, hospitalisations, etc. The interview should be carried out in three stages: first of all it is necessary to establish contact with the patient and gain his/her trust; then the patient should be allowed to freely express his/her comments, complaints, and conclusions about his/her state of health; and only at the end should questions be asked to verify what the patient has just told us. This approach to the supplicant avoids attitudes of entitlement, even despite the denial of benefits. For these reasons, the jurisprudential work must not be carried out in a hurry, in a way that does not allow the examined person to express his or her own opinion. An inappropriate attitude on the part of the doctor triggers or exacerbates claim attitudes. Taking an interview for adjudicative purposes differs from taking an interview for therapeutic purposes. The questions asked to the sick person (for therapeutic purposes) are intended to guide the doctor in the simplest possible way to establish the diagnosis and thus to implement adequate treatment. Therefore, the doctor, as it were, "leads the sick person by the hand", inquiring in detail about many important things and details.

When taking the medical history, the doctor already has the diagnosis of the disease on the prescription form. Therefore, the task of the medical examiner is not so much to verify the validity of this diagnosis, as to check (by taking an interview with the patient) to what extent the condition limits the patient's ability to work on the farm or to live independently. Thus, the questions posed to petitioners must be formulated in an appropriate manner - they must not suggest answers. Therefore, questions such as "how many metres will you walk before you get a burning sensation behind your sternum?" cannot be asked. - The necessary information can be obtained from the patient by asking, for example: "Do you go out of the house? Where? How far? Why not?" or: "How did you arrive for today's examination? By bus? By train? Alone or with care?", etc.

It is not uncommon, when taking the history, for patients to mention the names of diseases and organs instead of speaking in their own words about their complaints. The patient should then be corrected by saying, for example: "please speak in your own words about what you feel without calling it diabetes" or: "how do you know that the cause of these complaints is coronary heart disease? Did the doctor say? And if he didn't say, how would you know?", etc. It is also important to be critical of diagnoses made by patients themselves unless they are verified by qualified doctors in the relevant medical records.

The physical examination includes an examination of the general state of health and an examination of individual organs and systems. The clinical examination begins with the patient's first visual contact with the doctor. On the one hand, the patient assesses the doctor, who must give the patient the impression of being competent and interested in carrying out the examination properly and impartially. On the other hand, for the doctor, the first moments of the patient's stay in the examination room are an opportunity to observe the general impression made by the supplicant: whether he or she is independent, how he or she walks, his or her facial expression, facial expression, body build, etc. Each petitioner examined for assessment purposes should initially strip down to his/her underwear. It is compulsory to weigh the person being examined, as well as to measure height, blood pressure, and pulse rate. The body weight should be related to normal values. Changes in body weight, especially over the past three months, should also be asked. The patient should then be instructed to walk around the room with a slow step, then on

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their toes and heels. During this time, assess the physique, the state of muscle development and any atrophy, the mobility of peripheral joints, the distribution of body fat, and any neurological disorders.

Stripping the examinee down to their underwear also allows us to assess the skin and subcutaneous tissue, the presence (or not) of scarring, varicose veins, sores, swellings, and fistulas, as well as assessing peripheral lymph nodes. We can also assess in this way the way in which the examinee is independent in undressing and then dressing (it happens that some examinees are better at dressing than undressing because they are already past the examination and no longer on guard). The clinical examination of the various systems and organs should begin with those that are most severely expressed (judging from the clinical diagnoses on the form filled in by the attending physician). If we are to assess a symmetrical organ (e.g. one of the limbs), the examination should be started from the healthy side, in order to then relate the result of the examination of the sick side to the norm of the healthy side. The detailed scope of examination of individual systems and organs has been described in numerous medical textbooks and will not be recalled here. However, it is necessary to mention here the critical approach to the symptoms demonstrated by the supplicants, which is indispensable in the adjudicatory examination.

Therefore, methods of clinical examination should be developed and practised to reveal individuals faking a symptom or condition. If, for example, we have doubts about the result of the Romberg test, we can (in addition to performing the classic Romberg test) instruct the patient to perform a modification of this test: stand on one leg while bending the other at the knee; then close the eyes and stretch the arms out in front of the patient; at the same time, the patient should be informed that it is very important to which side he starts to wobble. Such a simple modification makes it possible to exclude false-positive Romberg test results. In addition, non-objective or low-objective parameters (mainly in geriatric patients) should be taken into account in the adjudication, such as lower biological reserve; lower organ and systemic capacity (mainly renal – expressed as eGFR) and bone marrow; chronic malnutrition; mental and organic changes of the psyche in particular, or frailty syndrome. It is also important to assess the degree of adaptation to the loss of function or the anatomical loss suffered.

Two international scales may be of some help in determining the degree of functional impairment of the subjects: Zubrod's and Karnofsky's, which give a score of the subject's fitness:

Karnofsky	Scale		Zubrod
No complaints or symptoms of disease, full activity	100	0	Completely fit, no care required
Slightly worse life activity and physical performance	90	1	Patient with moderate functional limitation, complaints of slight intensity, patient does not need to be in bed
Maintaining an active life requires effort, physical capacity limited	80		
Inability to be fully active, ability to self-care	70	2	Patient incapable of self-care, constant assistance required, spends more than 50% of day in bed
The need for periodic assistance	60		
Need for constant care and frequent medical assistance	50	3	Patient incapable of self-care, constant assistance required, spends more than 50% of day in bed
Lying patient, need for specialist assistance	40		
Bedridden patient, need for continuous specialised care	30	2	Patient completely incapacitated, permanently in bed
Severe condition, need for hospitalisation and maintenance treatment	20		
Dying patient	10		
Death	0	5	Death

The results of additional examinations should be assessed not as isolated results, but in combination with the entire medical records. This is because it can happen that a patient presents two test results (e.g. ECHO of the heart), performed 2 months apart and presenting divergent conclusions. Therefore, it is useful to have your own tables of the most common standards for laboratory, radiological, stress tests, etc. Always look at the original results and not at copies, paying attention to the dates on which they were performed (the validity of the result) and the quality of the equipment on which the determination was performed, and the details of the centre where it was performed. As the name suggests, "additional tests" are "additive" to the physical examination and subjective examination, which indirectly indicate the existence or otherwise of certain symptoms and clinical syndromes, but do not always resolve "zero-one" their presence.

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Formulation of diagnoses

The medical examiner should also pay attention to the formulation of diagnoses in his/her work, as the medical examiner should remember that the process of assessment does not begin and end with him/her. There is the possibility of further referral to another doctor or court. Therefore, apart from the fact that all documentation must be legible (preferably in computerised writing), the clinical diagnosis must be objective, unambiguous, simple, and comprehensive. The clinical diagnosis must be objective, unambiguous, simple, and comprehensive and must describe those conditions that are of importance from the point of view of the decision-making (for this reason, tooth decay or flat feet, for example, may be omitted from an epicure). When formulating the diagnosis, it is necessary to state:

(1) the name of the disease,
(2) the date it was diagnosed,
(3) its progression,
(4) the methods of treatment used, if applicable with dates,
(5) the consequences of the disease and treatment (in the case of the locomotor system, the extent of loss of joint movement in degrees or the degree of muscle atrophy in centimetres; in the case of the visual system, the loss of field or visual acuity; etc.).

Examples of such diagnoses are as follows:

Wrong	Normal
Arterial hypertension	Arterial hypertension of the third period with retinoaptation and cardiac involvement
Status post-myocardial infarction	Myocardial infarction of the inferior wall and interventricular septum suffered in February 2019 with subsequent current aneurysm of the heart wall
Carcinoma of the cervix	Pre-invasive carcinoma of the cervix after surgical removal of the reproductive organ 02.03.2000. – healing
Fracture of the right forearm bone in a typical location	Fracture of the right forearm bone in a typical location sustained in January 1999 with subsequent formation of a pseudarthrosis and limitation of mobility of the right wrist to a high degree
Bronchial asthma	Moderate bronchial asthma (FEV1 72%) - grade 3 (history for 8 years)
Bi-ocular large degree of visual impairment due to cataract	Cataracts in both eyes (vision after correction: Vod=0.1; Vos=0.08) in a patient scheduled for surgery in 6 months' time
Condition after injury to the left elbow joint with limitation of joint function	Dislocation of the left elbow joint suffered on 04.02.2022 with subsequent positioning of the joint in a functionally unfavourable position

Always put the name of the disease first in the diagnosis, followed by a detailed description (as in the table above). Leave a self-certified copy of the relevant medical records (dated, signed, and stamped on each page) in the case file.

Applications

A properly organised, conducted, and described medical examination for assessment purposes, taking into account the specificity and methodology of this examination, allows for an impartial and objective assessment of the state of health in order to determine the ability (or not) to work, to assess the degree of damage to health or to establish the right to allowances for incapacity for self-care

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