Chapter 2

Fundamental Principles

Roy N. Palmer

1. Introduction

Although medicine is an international discipline, practiced in much the same way throughout the English-speaking world, laws vary considerably from country to country. Much of the law applicable in the United States and in the countries of the Commonwealth derives from the English common law, but medical practitioners may not assume that the laws of their own countries or states will necessarily apply in other countries or states even if medical practices are indistinguishable. In this chapter the author attempts to set out principles of general applicability; however, it is written from the perspective of the law applicable in England and Wales and should be read with that in mind.

In recent years in the United Kingdom and elsewhere, a great many statutes relevant to medical practice have been enacted. Ignorance of the law is no defense, and today's doctors are at risk of prosecution for breaches of the law as no previous generation has been. Yet the teaching at the undergraduate level of forensic (or legal) medicine is now patchy and variable, so today's doctors are seldom well-informed about laws that govern their daily practices. It is hoped that this chapter will go some small way to help redress that position but, in the space available, only a brief outline of some relevant law can be offered. Doctors are advised to continue to subscribe to one of the traditional medical defense organizations (MDU, MPS or MDDUS in the United Kingdom, CMPA in Canada, or one of the Australian defense bodies), to an equiva-

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lent organization elsewhere, or to take out adequate insurance to ensure that they have access to advice and legal representation for medicolegal problems arising from their professional work—and, of course, indemnity for any adverse awards of costs and damages for professional negligence.

1.1. Ethical Principles

Doctors who practice as forensic medical examiners (FMEs, sometimes referred to as "police surgeons") have a very special responsibility toward detainees, subjects whose liberty is already infringed and who are at serious risk of future curtailment of their liberty. Although enactments in Europe, such as the Human Rights Act 1998, will afford better protection of the rights and liberties of citizens, the FME has a real part to play in acting honorably, by ensuring that the rights of the detainee are upheld in accordance with medical professional codes of ethics. An FME who believes that the rights of the detainee are being ignored or abused may have a duty to report the concern to a person or body in authority.

It is not always appreciated that forensic medical examiners (FMEs) have two roles. First, they are independent medical assessors of victims and/or perpetrators of crimes and, as such, no conventional therapeutic relationship exists. It is most important that this be made clear to the victims or detainees by the FME, so that properly informed consent is secured for the proposed examination. Second, a therapeutic relationship may arise when advice or treatment or other therapeutic intervention is offered, but the nature of the therapeutic relationship will be constrained by the circumstances and by the FME's duty to pass information to police officers who will be responsible for observing the detainee or victim. Great care is necessary over issues of consent and confidentiality in such circumstances.

Some ethical codes are national, drawn up by such bodies as national medical associations and medical boards or councils set up by the state (such as the British Medical Association [BMA] and the General Medical Council [GMC] in the United Kingdom). Other codes of ethics are regional (for example, the European Convention on Human Rights), whereas still others are international, such as the many codes and declarations prepared and published by the World Medical Association (WMA) (*see* Appendix 1).

Most of the ethical principles will be familiar to doctors who practice in countries that derive their laws from the Anglo-American common law system, but the detail of local rules and regulations will vary from nation to nation, state to state.

2. *Consent*

"Even when his or her life depends on receiving medical treatment, an adult of sound mind is entitled to refuse it. This reflects the autonomy of each individual and the right of self-determination. Lest reiteration may diminish the impact of this principle, it is valuable to recognise the force of the language used when the right of self determination was most recently considered in the House Of Lords." (1)

"It is well established English law that it is unlawful, so as to constitute both a tort (a civil wrong) and the crime of battery, to administer medical treatment to an adult who is conscious and of sound mind without his consent. Such a person is completely at liberty to decline to undergo treatment even if the result of his doing so will be that he will die." (2)

"The principle of self-determination requires that respect must be given to the wishes of the patient, so that if an adult patient of sound mind refuses, however unreasonably, to consent to treatment or to care by which his life would or might be prolonged, the doctors responsible for his care must give effect to his wishes, even though they do not consider it to be in his best interests to do so . . . To this extent, the principle of the sanctity of human life must yield to the principle of self-determination . . . and, for present purposes perhaps more important, the doctor's duty to act in the best interests of his patient must likewise be qualified." (3)

"Any treatment given by a doctor to a patient which involves any interference with the physical integrity of the patient is unlawful unless done with the consent of the patient: it constitutes the crime of battery and the tort of trespass to the person." (4)

"A doctor has no right to proceed in the face of objection, even if it is plain to all, including the patient, that adverse consequences and even death will or may ensue." (5)

The author can do no better than to open a discussion of the topic of consent by quoting the powerful and unambiguous language of the law lords in a recent leading case. The underlying reason for this position

"is that English law goes to great lengths to protect a person of full age and capacity from interference with his personal liberty. We have too often seen freedom disappear in other countries not only by coups d'etat

but by gradual erosion; and often it is the first step that counts. So it would be unwise to make even minor concessions." (6)

The foregoing applies to all mentally competent adults; where a patient lacks the capacity to make decisions about whether to consent to treatment (e.g., when he or she is unconscious or suffering from mental disability) the medical practitioners responsible for his or her treatment must act in the patient's best interests and, if appropriate, may carry out major invasive treatments without express consent *(7)*.

2.1. Requisites for Consent

To intervene without consent may give rise to criminal proceedings (for alleged trespass to the person) and may also give rise to tortious liability (a civil claim for damages). To protect against such proceedings the medical practitioner should ensure that the patient is capable of giving consent, has been sufficiently well informed to understand and therefore to give a true consent, and has then expressly and voluntarily consented to the proposed investigation, procedure, or treatment. In the United Kingdom the GMC has produced a booklet *(8)* setting out guidance for doctors about seeking patients' consent with which any doctor who practices in the United Kingdom must comply.

2.1.1. Capacity

If there is serious doubt about the capacity of the patient (to give consent) it should be assessed as a matter of priority. The patient's general practitioner (GP) or other responsible doctor may be sufficiently qualified to make the assessment, but in serious or complex cases involving difficult issues about the future health and well-being, or even the life, of the patient, the issue of capacity to consent should be assessed by an independent psychiatrist (in England, ideally, but not necessarily, one approved under s.12 of the Mental Health Act, 1983) *(9)*. If, following assessment, serious doubts remain about the patient's competence (e.g., the patient is incapable by reason of mental disorder of managing his or her property or affairs), it may be necessary to seek the involvement of the courts.

2.1.2. Understanding; Risks and Warnings

A signature on a form is not, of itself, a valid consent. For a valid, or true, or real consent in law the patient must be sufficiently well informed to understand that to which he or she is asked to give consent. The doctor must be satisfied that the patient

1. Can comprehend and retain the relevant information;
2. Believes the information; and
3. Can weigh in the balance the *pros and cons* in order to arrive at a choice *(10)*.

To defend a doctor against a civil claim alleging lack of consent based on a failure adequately to warn, it is necessary to have more than a signature on a standard consent form. Increasingly in medical negligence actions it is alleged that risks were not explained nor warnings given about possible adverse outcomes. It is therefore essential for the doctor (or any other healthcare professional) to spend adequate time explaining the nature and purpose of the intended investigation, procedure, or treatment in terms that the patient can understand. Risks and adverse outcomes should be discussed. The patient's direct questions must be answered frankly and truthfully (as was made clear in the Sidaway case *[11]*) and thus the discussions should be undertaken by those with adequate knowledge and experience to deal with them; ideally the clinician who is to perform the operation or procedure.

English law differs from the law in other common-law jurisdictions (e.g., Australia, Canada, the United States) regarding the nature of the information that must be imparted in order for the consent to be "informed" and, therefore, valid. Increasingly, world-wide, the courts will decide what the doctor should warn a patient about—applying objective tests, such as what a "prudent patient" would wish to know before agreeing. For example, in the leading Australian case *(12)* the court imposed a duty to warn about risks of very remote (1 in 14,000) but serious complications of elective eye surgery, even though professional opinion in Australia at the time gave evidence that they would not have warned of so remote a risk.

In the United States and Canada, the law about the duty to warn of risks and adverse outcomes has long been much more stringent. Many (but not all) US courts recognize a duty on a doctor to warn a patient of the risks inherent in the treatment proposed. In the leading case *(13)* the District of Columbia appeals court imposed an objective "prudent patient" test and enunciated four principles:

1. Every human being of adult years and sound mind has a right to determine what shall happen to his or her body.
2. Consent is the informed exercise of choice, and that entails an opportunity to evaluate knowledgeably the options available and their attendant risks.
3. The doctor must therefore disclose all "material risks."
4. The doctor must retain a "therapeutic privilege."

A "material risk" was held to be one that a reasonable person, in what the doctor knows or should know to be the patient's position, would likely attach

significance to in deciding whether to forego the proposed treatment—this test is known as the "prudent patient test." However, the court held that a doctor has a therapeutic privilege by which he or she is entitled to withhold from the patient information about risk if full disclosure would pose a serious threat of psychological detriment to the patient. In the Canadian leading case *(14)* broad agreement was expressed with the propositions expressed in the American case.

English law continues to allow the doctor discretion in deciding what information is to be imparted to the particular patient being advised. The practitioner is not required to make an assessment based on the information to be given to an abstract "prudent patient;" rather the actual patient being consulted must be assessed to determine what that patient should be told. However, the Sidaway and Bolitho *(15)* cases make clear that doctors must be supported by a body of professional opinion that is not only responsible, but also scientifically and soundly based as determined by the court.

The message for the medical and allied health-care professions is that medical paternalism has no place where consent to treatment is concerned; patients' rights to self determination and personal autonomy based on full disclosure of relevant information is the legal requirement for consent.

2.1.3. Voluntary Agreement

Consent obtained by fraud or duress is not valid. A doctor must be satisfied that the patient is giving a free, voluntary agreement to the proposed investigation, procedure, or treatment.

Consent may then be given expressly or by implication. Express consent is given when the patient agrees in clear terms, verbally or in writing. A verbal consent is legitimate, but because disputes may arise about the nature and extent of the explanation and warnings about risks, often months or years after the event, it is strongly recommended that, except for minor matters, consent be recorded in written form. In the absence of a contemporaneous note of the discussions leading to the giving of consent, any disputed recollections will fall to be decided by a lengthy, expensive legal process. The matter then becomes one of evidence, with the likelihood that the patient's claimed perfect recall will be persuasive to the court in circumstances in which the doctor's truthful concession is that he or she has no clear recollection of what was said to this particular patient, one of hundreds of consultations undertaken.

A contemporaneous note should be made by the doctor of the explanation given to the patient and of warnings about risks and possible adverse outcomes. It is helpful to supplement (but not to substitute) the verbal explanation with a printed information leaflet or booklet about the procedure or treatment. The explanation should be given by the clinician who is to undertake the proce-

dure—it is not acceptable to "send the nurse or junior hospital doctor" to "consent the patient."

For more complex and elective procedures, it is wise to give the patient some time to reflect on the advice and on the choices, offering to meet him or her again, later, before a final decision is made and to respond to any interim questions that the patient might wish to pose. For simple procedures (e.g., taking blood pressure, performing a venepuncture) it may be sufficient for consent to be implied—by the patient proffering an arm for the purpose. However, in circumstances in which the procedure has a forensic rather than a therapeutic content and the doctor is not the patient's usual medical attendant but may be carrying out tasks that affect the liberty of the individual (e.g., as a FME or as an assessor in a civil claim), it is prudent to err on the side of caution. If no assumptions are made by the doctor and express agreement is invariably sought from the patient—and documented contemporaneously—there is less chance of misunderstandings and allegations of duress or of misleading the individual.

2.2. Incompetent Adult Patients

Since the implementation of the 1983 Mental Health Act in England and Wales (and the equivalent in Scotland) no parent, relative, guardian, or court can give consent to the treatment of a mentally incompetent adult patient *(16)*. The House of Lords had to consider a request to sterilize a 36-year-old woman with permanent mental incapacity and a mental age of 5 years who had formed a sexual relationship with a fellow patient. The court held that no one, not even the courts, could give consent on behalf of an incompetent adult. (This is because the 1983 act removed the *parens patriae* jurisdiction of the courts in England and Wales; those jurisdictions in which courts retain *parens patriae* powers will retain the ability to provide consent in such circumstances.) However, the House of Lords made clear that doctors could act in the best interests of their adult, incompetent patients by treating them in accordance with a responsible body of professional opinion (i.e., in accord with the Bolam *[17]* principle).

2.3. Age of Consent

In England, section 8 of the Family Law Reform Act 1969 provides that any person (of sound mind) who has attained 16 years of age may give a valid consent to surgical, medical, or dental treatments. The consent of a parent or guardian is not required. For those under 16 years of age the House of Lords decided *(18)* that valid consent could be given by minors provided that they understood the issues. The case concerned the provision of contraceptive advice

to girls under 16 in circumstances in which a parent objected. The House of Lords held that parental rights to determine whether a child under 16 years received treatment terminated if and when the child achieved a sufficient understanding and intelligence to enable him or her to comprehend the issues involved. It is the capacity to understand, regardless of age or of status, that is the determinant factor.

2.4. Intimate Samples; Intimate Searches

Section 62 of the Police and Criminal Evidence Act 1984 (and the equivalent statute in Scotland) provides that intimate samples can only be taken from an individual if authorized by a police superintendent (or higher ranking police officer) and if consent is obtained. For this purpose the age of consent is 17 (not 16) years. For those between 14 and 17 years of age the consents of both the detainee and of the parent or guardian is required and for those under 14 years of age only the consent of the parent or guardian is statutorily required.

Section 55 of the Police and Criminal Evidence Act (and an equivalent provision in Scotland) provides that an intimate search of an individual may be conducted on the authority of a police officer of at least the rank of superintendent only if there are grounds for suspecting that an individual has secreted about him or her either an object that might be used to cause physical injury while he is detained or a class A controlled drug. A doctor called upon to conduct an intimate search will be wise to consider carefully whether a detainee is likely to be able to give a free and voluntary consent in such circumstances; an intimate search should not be conducted unless the doctor is thoroughly satisfied that the individual has given valid consent. An intimate search might, exceptionally, be conducted by a doctor if he or she believes it necessary to remove a concealed object that is of immediate danger to the life or personal safety of those responsible for the detainee's supervision.

2.5. Video and Audio Recordings

The GMC issued guidance in 1997 *(19)* requiring doctors to inform patients before making a video or audio recording and (except in situations in which consent may be understood from a patient's co-operation with a procedure, e.g., radiographic investigation) to obtain their explicit consent. Doctors may make recordings without consent in exceptional circumstances, such as when it is believed that a child has been the victim of abuse.

If a recording has been made in the course of investigation or treatment of a patient but the doctor now wishes to use it for another purpose, the patient's consent must first be obtained. Recordings are not to be published or broadcast

in any form without the explicit, written consent of the patient. Consent is required before recordings are published in textbooks or journals or before the public is allowed access to them.

The GMC states that if patients can be identified from recordings a doctor must ensure that the interests and well-being of the patient takes precedence over all other considerations. This is especially so for the mentally ill or disabled, the seriously ill, children, or other vulnerable people. When disability prevents patients from giving informed consent, the GMC advises the doctor to get agreement from a close relative or caregiver; where children lack the understanding to consent, the permission of the parent or guardian is recommended.

2.6. Recording Telephone Calls

Many countries have laws or regulations designed to protect the rights of individuals that govern the electronic recording of telephone conversations. Commonly, a provision will be included stating that persons whose telephone calls are being recorded must be informed of the fact—the details vary from country to country. In the United Kingdom, for example, the Telecommunications Act 1984 requires that the person making a recording shall make "every reasonable effort to inform the parties" of doing so. "Every reasonable effort" is not defined statutorily but the Office of Telecommunications ("Oftel"—a government-appointed regulatory body) has issued guidance. Reasonable effort may be achieved by the use of warning tones, by pre-recorded messages, by warnings spoken by a telephone operator, or by written warnings in publicity material.

A recording may be an invaluable aid for forensic evidence or to help to refute a complaint or claim for compensation, but practitioners who make electronic recordings of telephone calls must ensure that they comply with local laws and codes of practice.

2.7. Emergencies

Before leaving the topic of consent it is necessary to state clearly that in a medical emergency in which a patient is unconscious and thus unable to give or withhold consent, and there is no clear instruction to the contrary in the form of a valid, extant advance directive made by the patient, treatment may—indeed should—be given that is clearly essential to save life or prevent serious harm. However, nonurgent treatment should be deferred until the patient is able to give consent.

3. Confidentiality

". . . And whatsoever I shall see or hear in the course of my profession, as well as outside my profession in my intercourse with men, if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets . . ." (20)

". . . I will respect the secrets which are confided in me, even after the patient has died . . ." (21)

". . . A physician shall preserve absolute confidentiality on all he knows about his patient even after the patient has died . . ." (22)

Information acquired by a medical practitioner from or about a patient in the course of his or her professional work is confidential and must never be disclosed to others without either the consent of the patient or other proper justification.

Confidentiality is primarily a professional conduct matter for the medical practitioner but patients also have a legal right to confidentiality, protected by law. The GMC in the United Kingdom and other medical councils and medical boards world-wide have published guidance to doctors making it clear that a breach of confidentiality is a serious professional offense. The GMC's current guidance *(23)* requires doctors to

"treat information about patients as confidential. If in exceptional circumstances you feel you should pass on information without a patient's consent, or against a patient's wishes, you should follow our guidance on confidentiality and be prepared to justify your decision".

A separate GMC booklet *(24)* sets out more detailed guidance, including the principles of confidentiality and exceptions to the general rule.

Doctors are responsible for the safekeeping of confidential information against improper disclosure when it is stored, transmitted to others, or disposed of. If a doctor plans to disclose information about a patient to others, he or she must first inform the patient of that intention and make clear that the patient has an opportunity to withhold permission for its disclosure. Patients' requests for confidentiality must be respected, except for exceptional circumstances (such as where the health or safety of others would otherwise be at serious risk).

If confidential information is disclosed the doctor should release only as much as is necessary for the purpose and must always be ready and willing to justify the disclosure—e.g., to the relevant medical council or board, or to the

courts. Where confidential information is to be shared with healthcare workers or others, the doctor must ensure that they, too, respect confidentiality.

3.1. Death and Confidentiality

The duty of confidentiality extends beyond the death of the patient. The extent to which information may properly be disclosed after the death of a patient will depend on the circumstances. In general it is prudent to seek the permission of all the personal representatives of the estate of the deceased patient (such as the executors or administrators) before any information is disclosed. They, in turn, should be advised of the foreseeable consequences of disclosure. A doctor in any doubt should take advice from the appropriate protection or defense organization.

3.2. Detention and Confidentiality

An FME or police surgeon (or equivalent) should exercise particular care over confidentiality when examining persons who are detained in custody. When taking the medical history and when examining the detainee it is common for a police or other detaining official to be in attendance, as a "chaperone" or simply as a person in attendance, in close proximity to be able to overhear the conversation. Such officials will not owe to the detainee the same duty of confidentiality that is owed by a medical or nurse practitioner, nor be subject to similar professional sanctions for a breach of confidentiality.

The doctor called upon to examine a detainee must take great care to ensure that those being examined understand clearly the role of the FME/police surgeon and the implications for confidentiality. The detainee must understand and agree to the terms of the consultation before any medical information is gathered, preferably giving written consent.

The examining doctor should do everything possible to maintain the confidentiality of the consultation. An accused's right of silence, the presumption of innocence, rights under Human Rights legislation and so forth may produce areas of conflicting principle. The doctor's code of professional conduct may conflict with statutory codes binding upon custody officials (e.g., the duty on a police officer to record events). It may be essential to take the medical history in strict confidence, commensurate with adequate safeguards against violent behavior by the prisoner and to insist on a neutral chaperone for a physical examination. In the space available in this chapter it is possible only to highlight the issues; their resolution will vary according to local rules and circum-

stances. In the United Kingdom guidance for FMEs is available from their professional bodies *(25)*.

3.3. Exceptions to the General Duty of Confidentiality

Under several circumstances the doctor may legitimately disclose information gained about a patient during his or her professional work. For a full consideration the reader is referred to the GMC guidance or equivalent locally relevant guidance. In summary, the main exceptions are listed in Sections 3.3.1. to 3.3.5.

3.3.1. The Patient's Permission

The confidences are those of the patient, not those of the doctor, so if a patient requests or consents to their disclosure the information may perfectly properly be disclosed, within the terms of the patient's permissions.

Consent to disclose confidential information may be given by the patient in a wide range of circumstances. These include employment and insurance purposes; housing and welfare; testimonials and references; or legal proceedings (whether civil or criminal or family law matters, and so on). However, care must be taken to ensure that disclosure is limited strictly to the terms of the patient's permission and that there is no disclosure to parties with whom the patient may be in contention unless the patient expressly agrees to it. (The classic pitfalls are disclosure to the advisers of the other spouse or other party in contested divorce, child custody, or personal injury cases).

3.3.2. The Patient's Best Interests

In circumstances in which a patient is incapable of giving consent because of incapacity, immaturity, and so forth, and has refused to allow the doctor to speak to other appropriate persons, a doctor may disclose information to other appropriate persons if convinced that it is in the patient's best medical interests. If a doctor believes that a patient is the victim of physical or sexual abuse or of neglect, he or she may disclose relevant information to an appropriate person or statutory agency in an attempt to prevent further harm to the patient.

Another example of this exception is when a doctor believes that seeking permission for the disclosure would be damaging to the patient but that a close relative should know about the patient's condition—e.g., terminal or some psychiatric illnesses.

The doctor must always act in the patient's best medical interests and be prepared to justify his or her decision. Advice may be taken from appropriate colleagues and/or from a protection or defense organization.

3.3.3. The Public Interest, Interest of Others, or Violent or Dangerous Patients

Disclosure in the interests of others may be legitimate when they are at risk because a patient refuses to follow medical advice. Examples include patients who continue to drive when unfit to do so and against medical advice or who place others at risk by failing to disclose a serious communicable disease. Each case demands careful consideration and doctors who are in any doubt regarding how best to proceed should not hesitate to seek appropriate counsel.

Doctors may also be approached by the police for information to assist them in apprehending the alleged perpetrator of a serious crime. A balance must be struck between the doctor's duty to preserve the confidences of a patient and his or her duty as a citizen to assist in the solving of serious crime where he or she has information that may be crucial to a police inquiry. In cases of murder, serious assaults, and rape in which the alleged assailant is still at large, the doctor might be persuaded that there is a duty to assist in the apprehension of the assailant by providing information acquired professionally that will be likely to assist the police in identifying and apprehending the prime suspect(s). Where the accused person is already in custody, however, the doctor would be wise not to disclose confidential information without the agreement of the patient or legal advisers, or an order from the court. Each case must be weighed on its own facts and merits and the doctor may wish to seek advice from an appropriate source, such as a protection or defense organization.

The violent or dangerous patient poses particular dilemmas for the doctor. In the course of a consultation a patient may tell a doctor that he or she intends to perpetrate some serious harm on another person—perhaps a close relative or friend or someone with whom there is a perceived need to "settle an old score." Each case must be carefully assessed on its own facts and merits and careful clinical judgement exercised; however, under some circumstances a doctor may feel obligated to override the duty of confidentiality to the individual and to disclose confidential information to the intended victim, the police, or another person in authority with the power to take appropriate action. Indeed, a failure to act in such circumstances has led to adverse judicial rulings, as in the Californian Tarasoff *(26)* case, in which a specialist psychologist failed to give a warning to the girlfriend of a patient who later murdered her. The court decided that although no general common law duty exists to protect or warn third parties, a special relationship might impose such a duty.

In the United Kingdom a psychiatrist was sued because he had released, without the consent of a violent patient, a report prepared at the request of the patient's solicitors in connection with an application for release from detention.

The psychiatrist advised against release and the solicitors decided not to make use of his report. The psychiatrist was so concerned about his findings that he released a copy of the report to the relevant authorities and, as a consequence, the patient's application for release was refused. The patient's subsequent civil claim for compensation was rejected by the courts *(27)*, which held that the psychiatrist was entitled, under the circumstances, to put his duty to the public above the patient's right to confidentiality.

3.3.4. Medical Teaching, Research, and Audit

In general data should be made anonymous. Every reasonable effort must be made to inform the patients concerned and to obtain their permission to disclose or publish case histories, photographs, and other information. Where consent cannot be obtained, the matter should be referred to a research ethics committee for guidance. The GMC and similar bodies give guidance *(8,23)* and reputable medical journals have strict codes of practice, requiring that appropriate consent be obtained before even anonymous data are published, but the topic is not discussed here.

3.3.5. Judicial and Statutory Exceptions

Statutory provisions may require a doctor to disclose information about patients. In the United Kingdom they include, for example, notifications of births, miscarriages, and deaths, notifications of infectious diseases, notifications of industrial diseases and poisonings, and notifications under the provisions of the Abortion Act 1967.

A doctor may be required to attend court and to answer questions if ordered to do so by the presiding judge, magistrate, or sheriff. When in the witness box the doctor may explain that he or she does not have the consent of the patient to disclose the information (or indeed that the patient has expressly forbidden the doctor to disclose it) but the court may rule that the interests of justice require that the information held by the doctor about the patient be disclosed to the court. The doctor must then answer or risk being charged with contempt of court.

However, disclosure should only be made in judicial proceedings in one of two situations; first, when the presiding judge directs the doctor to answer, or second, when the patient has given free and informed consent. A request by any other person (whether police officer, court official, or lawyer) should be politely but firmly declined. As always, the doctor's protection or defense organization will be pleased to advise in any case of doubt.

Other statutory provisions of forensic relevance exist, but they are peculiar to individual countries or states and are not included here.

4. Notekeeping

All doctors should keep objective, factual records of their consultations with patients and of other professional work. Not only is this desirable *per se*, it is now also a professional requirement. Current GMC guidance *(23)* states that in providing care doctors must keep clear, accurate, and contemporaneous patient records that record the relevant findings, the decisions made, the information given to the patient, and any drugs or other treatment provided.

Good notes assist in the care of the patient, especially when doctors work in teams or partnership and share the care of patients with colleagues. Notes then help to keep colleagues well informed. Good notes are invaluable for forensic purposes, when the doctor faces a complaint, a claim for compensation, or an allegation of serious professional misconduct or poor performance. The medical protection and defense organizations have long explained that an absence of notes may render indefensible that which might otherwise have been defensible. The existence of good notes is often the key factor in preparing and mounting a successful defense to allegations against a doctor or the institution in which he or she works.

Notes should record facts objectively and dispassionately; they must be devoid of pejorative comment, wit, invective, or defamatory comments. Patients and their advisers now have increasing rights of access to their records and rights to request corrections of inaccurate or inappropriate information.

5. Access to Health Records

Access to medical and other health records, which is provided for by statute law, varies considerably from one jurisdiction to another. In English law patients have enjoyed some rights of access to their medical records since the passage of the Administration of Justice Act 1970. Those provisions are now contained in sections 33 and 34 of the Supreme Court Act 1981 and allow for access to medical records in cases of anticipated civil proceedings for personal injury or death. Since then, however, a number of other statutory provisions have made further provision for access to medical records. These include the Data Protection Act 1984, the Access to Medical Reports Act 1988, the Access to Health Records Act 1990, the Data Protection Act 1998, and the Human Rights Act 1998. Space here does not permit consideration of the detailed statu-

tory provisions and readers are respectfully referred to local legal provisions in their country of practice. A more detailed review of the rules applicable in the United Kingdom is set out in Appendix 2.

6. Preparation of Reports

Doctors are frequently asked to prepare reports for medicolegal reasons. It is very important to understand the nature of the request and what is required—a simple report of fact, a report on present condition and prognosis following a medical examination, an expert opinion, or a combination of these. The fact that a doctor possesses expertise does not necessarily make him or her an expert witness every time a report is requested.

A report may be required for a variety of reasons, and its nature and content must be directed to the purpose for which it is sought. Is it a report of the history and findings on examination some time previously because there is now a criminal prosecution or civil claim? Is an expert opinion being requested based on the clinical notes made by others? Is it a request to examine the patient and to prepare a report on present condition and prognosis? Is it a request for an expert opinion on the management of another practitioner for the purposes of a medical negligence claim?

The request should be studied carefully to ascertain what is required and clarification sought where necessary in the case of any ambiguity. The fee to be paid or at least the basis on which it is to be set should also be agreed in advance of the preparation of the report. If necessary, the appropriate consents should be obtained and issues of confidentiality addressed.

Care must be taken in the preparation of any report. A medicolegal report may affect the liberty of an individual in a criminal case or compensation in a personal injury or negligence action. A condemnatory report about a professional colleague may cause great distress and a loss of reputation; it may even be relied upon by the prosecuting authorities to decide whether to bring homicide charges, for murder ("euthanasia") or manslaughter (by gross negligence). Reports must be fair and balanced; the doctor is not an advocate for a cause but should see his or her role as providing assistance to the lawyers and to the court in their attempt to do justice to the parties. It must always be borne in mind that a report may be disclosed in the course of legal proceedings and that the author may be crossexamined about its content.

A negligently prepared report may lead to proceedings against the author, and perhaps even criminal proceedings in exceptional cases. Certainly a civil claim can be sought if a plaintiff's action is settled on disadvantageous terms

as a result of a poorly prepared opinion. There is also the attendant risk of adverse judicial comment and press publicity.

The form and content of the report will vary according to circumstances, but it should always be well presented on professional notepaper with relevant dates and details carefully documented in objective terms. Care should be taken to address the questions posed in the letter of instructions from those who commissioned it. If necessary, the report may be submitted in draft before it is finalized but the doctor must always ensure that the final text represents his or her own professional views and must avoid being persuaded by counsel or solicitors to make amendments with which he or she is not content: it is the doctor who will have to answer questions in the witness box and this may be a most harrowing experience if he or she makes claims outside the area of expertise or in any way fails to "come up to proof" (i.e., departs from the original statement).

7. *Attendance at Court*

Courts are, broadly, of two types—criminal and civil. Additionally, the doctor will encounter the Coroners Courts (or the Procurators Fiscal and Sheriffs in Scotland), which is, exceptionally, inquisitorial and not adversarial in its proceedings. A wide range of other special courts and tribunals exists, from ecclesiastical courts to social security tribunals; these will not be described here.

A doctor may be called to any court to give evidence. The type of court to which he or she is called is likely to depend on the doctor's practice, specialty, and seniority. The doctor may be called to give purely factual evidence of the findings when he or she examined a patient (in which case the doctor is simply a professional witness of fact) or to give an opinion on some matter (in which case the doctor is an expert witness). Sometimes a doctor will be called to give both factual and expert evidence.

Usually the doctor will receive fair warning that attendance in court is required and he or she may be able to negotiate with those calling him or her over suitable dates and times. Many requests to attend court will be made relatively informally, but more commonly a witness summons will be served. A doctor who shows any marked reluctance to attend court may well receive a formal *subpoena ad testificandum*, which compels him or her to attend or to face arrest and proceedings for contempt of court if he or she refuses.

If the doctor adopts a reasonable and responsible attitude he or she will usually receive the sympathetic understanding and co-operation of the lawyers and the court in arranging a time to give evidence that least disrupts his or her practice. However, any exhibition of belligerence by the doctor can induce a

rigid inflexibility in lawyers and court officials—who always have the ability to "trump" the doctor by the issuance of a subpoena. So, be warned and be reasonable!

Evidence in court is given on oath or affirmation. A doctor will usually be allowed to refer to any notes made contemporaneously in order to "refresh his memory", although it is courteous to seek the court's agreement.

7.1. Demeanor in Court

In the space available it is not possible to do more than to outline good practice when giving evidence. Court appearances are serious matters; an individual's liberty may be at risk or large awards of damages and costs may turn upon the evidence given. The doctor's dress and demeanor should be appropriate to the occasion and he or she should speak clearly and audibly.

As with an oral examination for medical finals, or the defense of a written thesis, listen carefully to the questions posed. Think carefully about the reply before opening your mouth and allowing words to pour forth. Answer the question asked (not the one you would like it to have been) concisely and carefully and then wait for the next question. There is no need to fill all silences with words; the judge and others will be making notes and it is as well to keep an eye on the judge's pen and adjust the speed of your words accordingly. Pauses between questions allow the judge to finish writing or counsel to think up his or her next question. If anything you have said is unclear or more is wanted from you, be assured that you will be asked more questions.

Be calm and patient and never show a loss of temper or control, however provoking counsel may be. An angry or flustered witness is a gift to any competent and experienced counsel, as is a garrulous or evasive witness.

Try to use simple language devoid of jargon, abbreviations, and acronyms. Stay well within your area of skill and expertise and do not be slow to admit that you do not know the answer. Your frankness will be appreciated, whereas an attempt to bluff or obfuscate or overreach yourself will almost certainly be detrimental to your position.

Doctors usually seek consensus and try to avoid confrontation (at least in a clinical setting). They should remember that lawyers thrive on the adversarial process and are out to win their case, not to engage upon a search for truth. Thus lawyers will wish to extract from witnesses answers that best support the case of the party by whom they are retained. The medical witness, however, is not in court to "take sides" but rather to assist the court, to the best of the expert witness' ability, to do justice in the case. The witness should therefore adhere to his or her evidence where it is right to do so but must be prepared to be

flexible and to make concessions if appropriate—for example, because further evidence has emerged since the original statement was prepared, making it appropriate to cede points. The doctor should also recall the terms of the oath or affirmation—to tell the truth, whole truth and nothing but—and give evidence accordingly.

8. *The Duties of Expert Witnesses*

Some medical practitioners have made a career from giving expert opinions, and a few have brought the profession into disrepute by being demonstrably partisan or by giving opinion evidence that is scientifically unsupportable. The courts have now laid down guidance *(28)* for expert witnesses and the UK Expert Witness Institute has prepared a code of practice *(29)* for experts.

The essential requirements for experts are these:

- Expert evidence presented to the court should be and should be seen to be the independent product of the expert, uninfluenced regarding form or content by the exigencies of litigation *(30)*.
- Independent assistance should be provided to the court by way of objective unbiased opinion regarding matters within the expertise of the expert witness *(31)*. An expert witness in the court should never assume the role of advocate.
- Facts or assumptions upon which the opinion was based should be stated together with material facts that could detract from the concluded opinion.
- An expert witness should make clear when a question or issue falls outside his or her expertise.
- If the opinion was not properly researched because it was considered that insufficient data were available, that should be stated with an indication that the opinion is provisional. If the expert cannot assert that the report contains the truth, the whole truth, and nothing but the truth, that qualification should be stated on the report *(32)*.
- If, after an exchange of reports, an expert witness changes an opinion the change of view/opinion should be communicated to the other parties through legal representatives without delay and, when appropriate, to the court.

The Expert Witness Institute *(33)* has also produced an expert's declaration for use by experts that follows the form recommended by Lord Woolf MR in his review of civil justice procedures and that incorporates the legal principles set out above.

In England and Wales, new Civil Procedure Rules for all courts came into force on April 16, 1999 *(34)* and Part 35 sets out rules governing experts. The expert has an overriding duty to the court, overriding any obligation to the person who calls or pays him or her. An expert report in a civil case must end with a statement that the expert understands and has complied with the expert's

duty to the court. The expert must answer questions of clarification at the request of the other party and now has a right to ask the court for directions to assist him in carrying out the function as an expert. The new rules make radical changes to the previous use of expert opinion in civil actions.

9. *Pitfalls*

The potential pitfalls of forensic medical practice are many. Most pitfalls may be avoided by an understanding of the legal principles and forensic processes—a topic of postgraduate rather than undergraduate education now. The normal "doctor–patient" relationship does not apply; the FME/detained person relationship requires that the latter understands the role of the former and that the former takes time to explain it to the latter.

Meticulous attention to detail and a careful documentation of facts is required at all times. You will never know when a major trial will turn on a small detail that you once recorded (or, regrettably, failed to record). Your work will have a real and immediate impact on the liberty of the individual and may well be highly influential in assisting the prosecuting authorities to decide whether to charge the detained person with a criminal offense.

You may well be the only person who can retrieve a medical emergency in the cells—picking up a subdural hematoma, diabetic ketoacidosis, or coronary thrombosis that the detaining authority has misinterpreted as drunkenness, indigestion, or simply "obstructive behavior." Get it right and you will assist in the proper administration of the judicial process, with proper regard for human rights and the liberty of the individual. Get it wrong and you may not only fail to prevent an avoidable death but may lay yourself open to criminal, civil, and disciplinary proceedings.

You clearly owe a duty of care to those who engage your services, for that is well-established law. A question arose recently regarding whether an FME owes a wider duty to the victims of alleged crime and the point was decided in the English Court of Appeal during 1999 *(35)*. An FME examined the victim of an alleged offense of rape and buggery. The trial of the man accused of the offenses was fixed and all prosecution witnesses were warned and fully bound, including the FME.

The trial was scheduled to begin on December 7th and on December 6th the FME was warned that she would not be required to attend on the first day of trial but would be needed some time after that. The trial commenced on December 7th and the accused pleaded not guilty. On December 8th, a Friday, the FME was told that she would not be needed that day but would be required the following week. She did not state that this would cause any problem. How-

ever, on December 11th the FME left the country for a prearranged vacation. On December 14th the police officer in charge of the case spoke by telephone with the FME. She said she could not return to give evidence before December 19th. The remainder of the prosecution case was finished on December 14th. The trial judge refused to adjourn the case until December 19th. On December 20th the judge accepted a defense submission of no case to answer and directed the jury to return a verdict of not guilty. A few weeks later the FME was convicted of contempt of court for failing to attend court to give evidence, and she was fined.

The female victim commenced civil proceedings against the FME, alleging negligent conduct in failing to attend, as warned, to give evidence. In her claim she asserted that if the FME had given evidence (presumably in accordance with her witness statement) the trial judge would have refused the defense submission of no case to answer. The claimant also contended that, on the balance of probability, the accused would have been convicted since the FME's evidence would have undermined the credibility of the accused's defense that no anal interference had occurred. The claimant claimed that the FME owed her a duty of care to take all reasonable steps to provide evidence of the FME's examination in furtherance of the contemplated prosecution and to attend the trial of the accused as a prosecution witness when required. She claimed to suffer persistent stress and other psychological sequelae from failing to secure the conviction of her alleged assailant and knowing that he is still at large in the vicinity.

The claimant did not contend that there was any general duty of care on the part of a witness actionable in damages at the suit of another witness who may suffer loss and damage through the failure of the first witness to attend and give evidence in accordance with his or her witness statement.

When the case came before the Court of Appeal Lord Justice Stuart-Smith stated that the attempt to formulate a duty of care as pleaded "is wholly misconceived. If a duty of care exists at all, it is a duty to prevent the plaintiff from suffering injury, loss or damage of the type in question, in this case psychiatric injury. A failure to attend to give evidence could be a breach of such duty, but it is not the duty itself." Later, Stuart-Smith LJ stated "it is quite plain in my judgment that the defendant, in carrying out an examination at the behest of the police of Crown Prosecution Service, did not assume any responsibility for the plaintiff's psychiatric welfare; the doctor/patient relationship did not arise." He concluded his judgment "it is of no assistance to the plaintiff here in trying to construct a duty of care to attend court to give evidence which, as I have already pointed out, could amount to breach of a wider duty which is not alleged and could not be supported." The other two Lords Justice of Appeal agreed.

The plaintiff's claim against the FME for damages was dismissed and it was confirmed that there was no duty of care owed by the FME to the victim to attend the trial as a prosecution witness when required.

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