

# Chapter 2

## Fundamental Principles

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### Introduction

From the time of Hippocrates, doctors have undertaken to practice medicine in accordance with ethical and professional codes of conduct. In addition, as with any other citizen, they are required to comply with the laws of the country in which they reside and practice and must understand the constraints and obligations these may impose on them. Laws will vary from one jurisdiction to another, although there may be some commonality, for example, secondary legislation deriving from European Union law and the influence of English common law on countries of the old Commonwealth. This chapter is written from the perspective of the law in England and Wales and should be read with that in mind.

Recently, in the United Kingdom and elsewhere, many new laws have come into effect that are relevant to medical practice. Ignorance of the law is no defense, and today's doctors are at risk of prosecution for breaches of the law and professional codes of conduct as no previous generation has ever been. With the advent of the internet, patients have become increasingly well informed, have much higher expectations, and are more willing to challenge doctors than their predecessors. Today's doctors are under considerable pressure to keep up to date, not only with advancements in medical practice, but also with changes in the laws governing that practice. It is hoped that this chapter will help to highlight key areas of law doctors should be familiar with, but this can only be an outline. For advice on individual cases or more detailed legal and ethical guidance, doctors are encouraged to approach their Defence Organisation (e.g., MPS, MDU, MDDUS in the UK. Similar arrangements operate in other jurisdictions, e.g., Avant in Australia, MPS in South East Asia, CMPA in Canada) or to refer to guidance from other sources such as the British

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Medical Association and the General Medical Council. For those doctors wishing to pursue a career in Forensic Medicine, the Faculty of Forensic and Legal Medicine (FFLM) offers a higher professional examination (MFFLM) which addresses all the key areas of law relevant to the practice of forensic medicine.

Doctors have a professional obligation to ensure they hold appropriate indemnity. In England and Wales, doctors employed by the NHS are indemnified by the Crown in respect of any claims for negligence arising out of their NHS work. Doctors generally are individually responsible for ensuring they hold appropriate professional negligence indemnity for any work they undertake outside their NHS employment. They should also be aware that individual advice in relation to complaints handling, inquests, disciplinary action (whether by their employer or their regulatory body), and general ethical and professional matters do not fall within the scope of NHS indemnity. All doctors are therefore advised to join an appropriate Defence Organisation to ensure they have access to medicolegal advice and representation whether or not their practice is confined to the NHS.

## *Ethical Principles*

Doctors who practice as forensic physicians (FPs, forensic medical examiners FMEs, forensic medical officers FMOs, or police surgeons) have a special responsibility towards detainees, who, having been deprived of their liberty, are potentially vulnerable and unable to protect their own interests. Although human rights legislation is designed to protect those interests, the FP is in a position to act as advocate on behalf of a detainee and ensure that his or her rights are upheld in accordance with the doctor's professional and ethical codes of conduct. If a doctor has reason to believe these rights are being ignored or abused, he/she may have a duty to raise these concerns with the appropriate authorities.

It is not always appreciated that FPs have two separate roles. In the first instance, they are independent medical assessors of the victims and/or alleged perpetrators of crime, and as such, no conventional therapeutic relationship exists. It is important, therefore, that detainees or victims understand this and the potential ramifications, in order that valid, informed consent can be obtained prior to any examination, being conducted. Second, a therapeutic relationship may arise where advice or treatment is offered to a detainee or victim, but the nature of this relationship will be constrained by the circumstances and the doctor's obligation to pass on relevant information to the police officers responsible for the care and supervision of that individual. This dual accountability has certain parallels with that of occupational health physicians, their employers, and any employees they may be asked to examine or report on. Great care should be exercised when considering issues of consent and confidentiality in such circumstances.

The FP is an integral member of a multidisciplinary team involved in the assessment and care of the victims of crime as well as potential offenders. He/she has a professional requirement to work effectively as part of that team. The elements of

effective team working are set out by the GMC in *Good Medical Practice* and include the following: effective communication within and outside the team, a respect for the skills and contributions of others, and an awareness of individual roles and responsibilities and lines of accountability. Doctors also have a professional obligation to participate in audit and team performance reviews and to take steps to remedy any deficiencies identified.

The GMC states that doctors should be willing to participate in the teaching and training of other doctors and students. As with any other professional duty, doctors who take on a teaching commitment are responsible for ensuring they develop the appropriate skills and competencies for the task. They must also ensure that all staff for whom they are responsible are properly supervised and any appraisal or assessments made are honest and objective.

Most of the ethical principles embodied in codes of professional conduct will be familiar to doctors the world over, although they may vary in the detail from one jurisdiction to another. This is the case in relation to guidance produced by regulatory bodies, medical associations, and boards, whereas other codes, for example the European Convention on Human Rights or declarations produced by the World Medical Association, by definition, transcend these geographical boundaries. Doctors should be familiar with the codes of conduct pertaining to the country in which they practice and should expect to abide by them. A breach of professional ethics may lead to disciplinary action against the medical practitioner and may call into question his or her medical registration and hence ability to practice.

## Consent

It is a long established principle that an individual of sound mind has the right to determine what will be done with his own body, even if as a consequence of exercising that autonomy his life may be put at risk. This is often referred to as the principle of self-determination and was encapsulated by The House of Lords in its consideration of the seminal case of *Airedale NHS Trust v Bland* [1]. Lord Keith stated “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.”

This principle applies to mentally competent adults, but what of minors or the mentally incompetent adult? How does the law ensure their interests are protected? Case law has established that in these circumstances it is the doctor’s duty to act in the best interests of his/her patient. Determining what constitutes a patient’s best interests involves a holistic assessment of the individual’s needs in the context of his/her circumstances, values, and beliefs. This can be particularly challenging when dealing with patients who have never had the capacity to express their own views.

In circumstances in which an individual is temporarily incapacitated, for example, as a result of a road traffic accident, the doctor may do what is necessary in these circumstances to preserve life and prevent deterioration of the patient's condition without the express consent of the individual concerned. He/she may, however, do no more, and other less pressing decisions relating to medical care must be deferred until the patient has regained capacity to participate in the decision-making process. The Mental Capacity Act 2005 embodies in statute these common law principles and lays down the framework in which mental capacity is assessed. It goes beyond the common law in that it also makes provision to protect the interests of those without others to speak for them, through the appointment of Independent Mental Capacity Advocates (IMCAs).

### ***Requisites for Consent***

It has been established above that any intervention without consent may give rise to criminal and/or civil proceedings against the doctor. The minimum requirement in order to protect against a criminal charge is that the patient should understand in broad terms, the nature, purpose, and effect of the proposed treatment. Any failure to provide sufficient information in relation to the risks or benefits of the proposed treatment would render the doctor potentially vulnerable to a civil claim in negligence. For consent to be deemed valid, the medical practitioner should ensure that he is satisfied that the patient is capable of giving consent, has been sufficiently well informed about what is proposed and therefore able to give a true consent, and has then expressly and voluntarily consented to the proposed course of action. The GMC guidance "Consent: patients and doctors making decisions together" [2] sets out in some detail the professional obligations and good practice considerations with which all UK practicing doctors should be familiar and comply.

### **Capacity**

All doctors must understand the requisites for consent and be capable of determining where this may be in question. In such cases, a formal assessment of capacity should then be conducted as a priority, before any medical intervention is contemplated. This is a situation the doctor is likely to face on a regular basis as a FP. In many cases, you will have the requisite skills to make an assessment of capacity, but in more complex cases you should be prepared to refer your patient for a formal assessment by an independent psychiatrist. In England, this would ideally be a psychiatrist approved under Section 12 of the Mental Health Act 1983 [3]. In a few cases, capacity may still remain in doubt, and in these circumstances, it may be necessary to refer the matter to the courts. The courts will hear such matters as applications for Power of Attorney, for example, where an individual is deemed incapable of managing his or her property and financial affairs.

## Understanding Risks and Warnings

There are three separate elements to valid consent, namely, the patient must have capacity, be sufficiently well informed to be capable of understanding that to which he or she is being asked to consent, and give the consent freely and without duress. To satisfy the first of these requirements, the doctor needs to establish that the patient is capable of the following:

1. He or she can comprehend and retain the relevant information.
2. He or she believes that information.
3. He or she can weigh up the information in the balance and arrive at a choice [4].

From this it is clear that valid consent requires more than a signature on a form, and that the latter is of itself, insufficient evidence to mount a successful defense against a civil claim in negligence alleging lack of consent based on a failure to warn adequately. Such claims alleging that risks were not explained or adequate warnings given are arising more and more frequently in medical litigation. It is therefore essential for those seeking consent to spend adequate time explaining the nature and purpose of the proposed investigation or treatment and discussing any risks or adverse outcomes, as well as alternative treatment options available. The standard consent forms produced by the Department of Health provide a useful prompt to those completing them to help ensure that all these issues are considered. The patient's questions about the proposed intervention should be answered frankly and truthfully as was made clear by the courts in the case of *Sidaway* [5]. The discussions should be undertaken by those with the appropriate knowledge and experience to deal with them, and ideally, the individual who will be performing the procedure.

English law has been slow to follow other common law jurisdictions (e.g., Canada, Australia, and the United States) regarding the nature of the information that must be imparted for consent to be deemed valid. The law has shifted from a paternalistic approach, applying the "reasonable doctor" test based on the *Bolam* principle of what a reasonable doctor in the circumstances would have told the patient, to a much more patient-focused approach, applying the "prudent patient" test, i.e., what a reasonable patient in those circumstances would want to know. For example, in the leading Australian case [6], the courts imposed a duty to warn of 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 has long been much more stringent. Many US courts recognize a duty on a doctor to warn a patient of the risks inherent in a proposed treatment. In the leading case [7], the District of Columbia appeals court imposed an objective "prudent patient" test and enunciated the following 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 (the principle of self-determination).
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 "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 what is known as the “prudent patient test.” However, the court held that a doctor must retain therapeutic privilege by which he or she is entitled to withhold from the patient information about risk, which, if disclosed, would pose a serious threat of psychological harm to the patient. In the leading Canadian case [8], broad agreement was expressed with these propositions.

Until recently, English law continued to allow doctors’ discretion in deciding what information should be imparted to the particular patient being advised. The cases of *Sidaway* and *Bolitho* [9] set the constraints under which this discretion was exercised, namely that the doctors must be supported by a body of medical opinion that is not only responsible, but also stands up to logical and scientific analysis and scrutiny as applied by the courts. In English law, the pendulum has now swung fully in the direction of the “prudent patient,” in line with other common law jurisdictions. Furthermore, in *Chester v Afshar* [10], the House of Lords effectively removed the requirement to prove a causal link between an alleged breach of duty (in this case, a failure to warn of a material risk) and the injury sustained. Hence, if a practitioner fails to warn of such a risk, and that risk eventuates, the practitioner is liable, regardless of whether or not the treatment is carried out negligently. The message for medical and allied healthcare professionals is clear. Medical paternalism no longer has any 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.

## **Voluntary Agreement**

Consent given under duress, or where the patient’s free choice may be influenced by others or by the circumstances in which the consent is obtained, is not valid. A doctor must be satisfied that a patient’s consent is given of his own volition and as an expression of his personal autonomy to exercise his free choice about whether or not to undergo the proposed investigation, procedure, or treatment.

Consent may be implicit or explicit, verbal or written, the validity of each depending upon the circumstances and what is being proposed. Implied consent may be sufficient for some purposes, but not others: for example, a patient holding out her arm in response to a doctor’s request to take a blood sample, or measure blood pressure. Where a more complex intervention is proposed, express consent will usually be necessary: for example, consent to undergo surgery. Express consent can be verbal or written. Again, a decision as to what is appropriate will depend upon the circumstances. Although verbal consent is legitimate, the advantage of written consent is evidential. Disputes may arise in the future about the nature and extent of the consent obtained, information given in relation to warnings of side effects or risks, and alternative treatment options. In the absence of a contemporaneous note, the courts will need to decide whose version of events is to be believed, often preferring

the patient's recall of a significant life event over and above that of the doctor's recollection of a discussion that took place with one patient among many. Ideally, consent should be taken by the doctor who will be performing the procedure, but at the very least, must be someone with the appropriate level of knowledge and skills to be able to respond appropriately and knowledgeably to any questions the patient may have about what is proposed.

The contemporaneous note should record details of the nature, purpose, and effect of what is proposed, together with information about the relative risks and benefits of treatment, likely success rate and alternative treatment options. For more complex interventions, it may be helpful to supplement these discussions with a printed information booklet or other resource, for example, a CD-ROM which the patient can take away and consider at leisure. Patients should be given time to reflect and discuss what they have been told with loved ones, should they wish to do so. This should be followed up with a further opportunity for the patient to ask questions before finally committing to the procedure.

Particular care should be taken when consent is being obtained in circumstances where the procedure has a forensic rather than a therapeutic purpose, and the doctor is not the patient's usual medical attendant, but may be carrying out tasks that may have a wider implication for the patient, for example, impacting on the liberty of that individual (as a FP), or on his future financial security (in making an assessment for the purposes of a civil claim).

### ***Adult Patients Who Are Incompetent***

Until the implementation of the Mental Capacity Act 2005 in England and Wales and the Adults with Incapacity (Scotland) Act 2000, no relative, parent, or guardian had the power to consent to treatment on behalf of an incapacitated adult. No similar power was vested in the courts, either. In 1990, the House of Lords considered a request to sterilize a 36-year-old woman with a permanent mental incapacity and a mental age of 5 years who had formed a sexual relationship with a fellow patient [11]. It was held that no one, not even the courts, could give consent on behalf of an adult who was incompetent. (This followed on from provisions within the Mental Health Act, 1983, removing the *parens patriae* jurisdiction of the courts in England and Wales. Those jurisdictions in which the courts retain *parens patriae* still therefore hold the power to provide consent in such circumstances). The House of Lords made it clear that in terms of providing treatment to an adult without capacity, doctors were entitled to act in what they considered the best interests of the patient. In determining the patient's best interests, the doctors were required to act in accordance with a responsible body of medical opinion, i.e., the Bolam principle [12].

The Mental Capacity Act 2005, which came into effect in 2007 in England and Wales, gave statutory effect to these common law principles and to advance directives, or "living wills" as they were more popularly known. Furthermore, the Act introduced a new Power of Attorney, the Lasting Power of Attorney (LPA) to replace

the earlier Enduring Power of Attorney (EPA), allowing donors to elect a named representative to make decisions in relation to healthcare matters on their behalf in the event the donor lost capacity to make decisions for himself. The Act also made provision for the appointment of IMCAs to represent the interests of incapacitated adults who have no other friends or relatives to act as an advocate on their behalf.

### ***Minors and Consent***

In 1969, the Family Law Reform Act gave minors who had reached the age of 16 years or over the statutory right to consent to treatment without the requirement for the consent of a parent or guardian. The legal position relating to minors less than 16 years was established in the case of Gillick [13]. The House of Lords decided that valid consent could be given by minors under 16 years, provided they understood the issues involved. The particular case in question concerned the provision of contraceptive advice to girls less than 16 years in circumstances in which a parent objected. The House of Lords held that parental rights to determine whether a child under 16 years old received treatment terminated if and when the child achieved a sufficient understanding and intelligence to be able to comprehend the issues involved. The determinant factor is therefore the capacity to understand, rather than the age or status of the individual concerned.

The right of a minor to refuse treatment is much more complex. In order for treatment of a minor under the age of 18 years to be lawful, the consent is required of either the child concerned (if competent) or anyone with parental responsibility (including the courts). When a minor refuses treatment, it may still be lawful to proceed if the doctor has the requisite consent from any other person with authority to give it. Clearly there are practical as well as ethical issues in relation to compelling a minor to undergo treatment against their wishes. The doctor will need to make a judgment as to the relative seriousness of the issue in question and the potential consequences of proceeding or not proceeding with the treatment. In complex cases or where there is disagreement about what is the preferred course of action, it may be necessary to make an application to the courts to resolve this. Case law has shown that, in general, the courts are reluctant to allow a minor to refuse a course of treatment, in consequence of which, his life may be put at serious risk, preferring to err on the side of preserving life, at least until the child in question has attained adulthood at which point he may exercise his right to autonomy to refuse treatment.

### ***Intimate Samples and Intimate Searches***

Section 62 of the Police and Criminal Evidence Act (PACE) 1984 provides that intimate samples can only be taken from an individual if authorized by a police inspector (or higher ranking police officer) and if the requisite consent is obtained.



For this purpose, the age of consent is 17 (not 16) years. For young persons between the ages of 14 and 17 years, the consent of both the detainee and the parent or guardian is required, and for those younger than 14 years of age, only the consent of the parent or guardian is statutorily required.

Section 55 of PACE provides that an intimate search of an individual may be conducted on the authority of a police officer of at least the rank of inspector only if there are grounds for suspecting that an individual is hiding on himself or herself 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 may, exceptionally, be conducted by a doctor if he believes it is necessary to remove a concealed object that is an immediate danger to the life or personal safety of those responsible for the detainee's supervision.

PACE does not apply to Scotland. Where an intimate search is considered necessary in Scotland in the interests of justice and in order to obtain evidence, this may lawfully be carried out under the authority of a sheriff's warrant. As with searches authorized under PACE, however, the BMA and FFLM consider that such searches should be carried out by a doctor only when the individual has given consent [14]. If consent is not given, the doctor should refuse to participate and have no further involvement in the search.

## ***Video and Audio Recordings***

The GMC [15] and BMA have issued guidance [16] requiring doctors to inform patients before making a video or audio recording and, except in situations in which consent may be understood by the patient's cooperation with a procedure (e.g., radiographic investigation), to obtain his or her explicit consent. Doctors may make recordings without consent in exceptional circumstances, such as when it is believed 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, for example as a teaching or training aid or in research, the patient's consent must be obtained. Recordings may not 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 they enter the public domain. Consent is required whether or not the patient can be identified from the recording. This is especially so for patients who are mentally ill or disabled, otherwise seriously ill, or children or other vulnerable people. When disability prevents patients from giving informed consent, the GMC advises the doctor to obtain agreement from a close relative or carer; where children lack the capacity to consent, the consent of a parent or guardian is required.

Specific care has to be taken with the recording, storage, and use of intimate images where the FFLM has produced joint guidance with RCPCH on the procedure to be followed in this respect [17].

### ***Recording Telephone Calls***

Many countries have laws or regulations that govern the electronic recording of telephone conversations, which are designed to protect individuals' rights. Commonly, a provision will include stating that persons whose telephone calls are being recorded must be informed of that fact – the details of the provision varying from country to country. In the United Kingdom, for example, the Telecommunications Act 1984 requires that the person making the recording shall make “every reasonable effort to inform the parties” of doing so. What constitutes “every reasonable effort” is not defined in the Act, but guidance issued by Ofcom (<http://www.ofcom.org.uk>) states that reasonable effort may be achieved by the use of warning tones, prerecorded messages, verbal warnings given by telephone operators, or written warnings in publicity material.

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

### ***Emergencies***

In a medical emergency in which a patient is unable to give or withhold consent as a result of their medical condition at the time (e.g., unconscious patients), and there is no known clear written instruction to the contrary in terms of a valid, extant advance directive made by the patient, treatment that is clearly essential to save life or to prevent serious harm may and indeed should be given. However, non urgent treatment should be deferred until the patient is able to give consent. Patients with longstanding mental incapacity should be given treatment deemed to be in their best interests. Again, in an emergency situation, this should be limited to immediately necessary treatment and nonurgent interventions postponed until a more comprehensive assessment of the patient's best interests can be undertaken.

### ***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...” [18].

Information acquired by a medical practitioner from or about a patient in the course of his professional work is confidential and should not be released to any third party without the consent of the patient or without proper justification in accordance with professional guidance. This duty of confidence to a patient continues even after the patient's death.

The processing of personal information about an individual is governed by statute. In addition to complying with the law, doctors should also be aware of and follow professional codes of conduct and ethical guidance which may impose additional professional duties on the doctor not required by law. In the UK, the Data Protection Act 1998 makes provision for the handling of personal data about a living individual, including processing, disclosure, storage, and destruction of personal data. Medical information about an individual is classified as sensitive personal data and as such is subject to more rigorous controls. The General Medical Council has recently issued updated guidance entitled "Confidentiality" [19] and "Confidentiality: supplementary guidance" which sets out the professional obligations of a doctor with reference to the statutory framework and gives examples of how and in what specific circumstances breaching a patient's confidence may be justified.

Doctors are responsible for the safekeeping of confidential information obtained in a professional capacity. Information thus obtained from a patient should not generally be disclosed to others without the patient's consent, except in certain specific circumstances. These include where there is a legal duty to do so or where there is an overriding public interest in disclosure, for example, where a failure to disclose the information could put others at serious risk. Most patients would expect information about them to be shared with other healthcare professionals involved in their care, and consent in these circumstances may be implied. Patients may not, however, be aware that information may be shared for other purposes, for example, service planning and financial audit. As a registered medical practitioner, you must be satisfied that patients have access to information about how their details may be used and their right to object. If patient identifiable data are to be disclosed, express consent should be sought and a patient's right to withhold consent should be respected unless disclosure without consent can be justified.

As a general rule, when making a disclosure of confidential information to a third party, only the minimum information necessary to achieve the objective should be disclosed. The doctor should be satisfied that the person(s) to whom the disclosure is made understands and respects that confidentiality.

## ***Death and Confidentiality***

The doctor's duty of confidentiality extends beyond the death of the patient. The extent to which information can properly be disclosed after death depends on the circumstances. In general, the consent of the deceased's personal representatives

should be obtained before making any disclosure. They should be advised of the purpose of the proposed disclosure and any potential consequences. If in doubt about the appropriateness of making a disclosure relating to a deceased patient, the doctor should contact his defence organisation for further advice. If the doctor is aware of any information held about the deceased that the deceased had previously expressly indicated should not be shared after his death, then these wishes should be respected. Information may also be withheld, if in the opinion of the holder of the record, disclosure would cause serious harm to the mental or physical welfare of another person.

### ***Detention and Confidentiality***

A FP should exercise particular care over confidentiality when examining persons who are detained in custody. When taking a medical history and examining a detainee, it is common for a police officer or other detaining official to be in attendance, sometimes in the role of a “chaperone,” or possibly simply posted nearby where they can overhear the conversation. Such officials will not owe the detainee a duty of confidence in the same way a healthcare professional does, nor will they be subject to professional sanctions for breaching that confidence.

The doctor called upon to examine a detainee must take great care to ensure that the person being examined understands the role of the FP and the implications for confidentiality. The detainee must understand and agree to the terms of the consultation before any medical information is obtained, preferably by giving written consent.

The examining doctor should do everything possible to maintain the confidentiality of the consultation. It is essential to take the medical history in conditions of strict confidence, commensurate with adequate safeguards against violent behavior by the detainee, and to insist on a neutral chaperone for a physical examination. A police officer who has his own professional duty to record information and events may not be in a position to take on this role.

In the rest of this chapter, only the central issues can be highlighted; local rules and circumstances dictate how these may be resolved in individual circumstances. FPs are advised to refer to the specific guidance available from their professional bodies [20].

### ***Exceptions to the General Duty of Confidentiality***

Under certain circumstances, a doctor may disclose confidential information obtained about a patient. For a full consideration of these, please refer to the GMC guidance or equivalent locally relevant guidance. In summary, the main exceptions are set out below in subheadings 3.3.1 to 3.3.5.

## **With the Patient's Consent**

The patient may agree to confidential information about him being shared with others in a number of situations. The most usual of these is where information is shared with other healthcare professionals involved in the care and treatment of the patient. Consent to disclosure in these circumstances may be implied. All doctors in clinical practice have a duty to participate in local clinical audit and in National Confidential Inquiries. Patients should be made aware that their information may be used in this way and that they have the right to object. A patient may also consent to the release of information for employment or insurance purposes, housing and welfare benefits, and references and legal proceedings. In these circumstances, care should be taken to ensure that the patient is aware of the nature and extent of the proposed disclosure and to whom the disclosure will be made and agrees to it. Information may not normally be released to these parties without the patient express consent.

## **Disclosures Required by Law**

You must disclose information about a patient where this is specifically required by law, for example, notification of communicable diseases, industrial diseases and poisoning, and notifications under the provisions of the Abortion Act 1967. As a matter of good practice, wherever practicable, you should inform patients of your obligations and advise them what information will be disclosed and to whom, unless this would undermine the purpose of the disclosure.

There are a number of statutory bodies that have powers to access patients' records as part of their duty to investigate complaints, criminal activities (e.g., fraud), or healthcare professionals' fitness to practice. You should comply with such requests provided you are satisfied that the disclosure is required by law or that it can otherwise be justified. You may wish to ask the relevant body to provide you with details of the statutory requirement on which they are relying and seek advice from your defence organisation if in doubt. Most such statutory bodies will have Codes of Practice which set out how they will access and use personal information. You need to be clear that where information is requested but not required by law, for example, as is the usual case where the GMC are investigating a doctor's fitness to practice, you should seek the patient's consent before disclosure unless you consider the disclosure can be justified in the public interest.

Disclosure of confidential information during the course of judicial proceedings should only be made either with the express consent of the patient, or if the presiding judge directs the doctor to do so. If you are called to give evidence in court and you do not have the patient's consent to release information about them, you should explain this to the judge or presiding officer of the court. The judge will then decide whether the interests of justice in making the disclosure outweigh the patient's interests in keeping the information confidential. You must comply with a direction from a judge to disclose confidential information. Failure to do so may otherwise put you at risk of being held in contempt of court, the penalties for which

may include a fine and/or a custodial sentence. Requests for information from the police or solicitors acting on behalf of the patient or a third party normally require the patient's consent, unless the disclosure can be justified in the public interest (see below).

### **Medical Teaching, Research, and Audit**

As a general rule, where possible, patient data used for teaching, audit, or research purposes should be anonymized and express consent should be obtained before identifiable patient data are used in this way. For the purposes of local clinical audit, it is sufficient that patients are made aware their data may be used in this way and of their right to object. Where the purpose of the audit is financial or administrative, express consent should be sought for the disclosure of patient identifiable data. Identifiable information may be disclosed without consent if it is required by law, if it is approved by the Ethics and Confidentiality Committee of the National Information Governance Board under Section 251 of the NHS Act 2006, or if it can be justified in the public interest, and it is either necessary to use identifiable data or it is not practicable to anonymize the information and in either case, it is not practicable to seek consent or efforts to seek consent have been unsuccessful.

### **Disclosures in the Public Interest**

The GMC define the public interest test as follows:

"Personal information may be disclosed in the public interest, without patients' consent, and in exceptional cases where patients have withheld consent, if the benefits to an individual or society of the disclosure outweigh both the public and the patient's interest in keeping the information confidential." [19]

As with all disclosures made without consent of the patient, the doctor should consider whether the proposed disclosure is necessary for the intended purpose and whether this could be achieved if the information were to be disclosed in anonymized or coded form. Disclosure of identifiable patient information may be justified where a failure to do so could put individuals other than the patient at risk of death or serious harm. Examples would include a disclosure to the DVLA about a patient who continues to drive against medical advice, or who places others at risk by failing to disclose a serious communicable disease. Each case must be judged on its individual merits, and if in doubt, doctors should seek specialist advice from their defence organisation.

Another circumstance in which a disclosure without consent may be justified is to assist the police in the investigation, prevention, or prosecution of a serious crime. Police Officers will often rely on Section 29 of the Data Protection Act to support their request for information. Doctors should be aware that this provision simply protects the person making the disclosure from prosecution for breach of the Act and does not remove the doctor's professional obligation to keep information about

patients confidential. The doctor must still be prepared to justify any disclosure made without consent. There is no agreed definition of what constitutes “serious crime,” although it is generally accepted that these usually refer to crimes against the person (such as murder, rape, assault) and serious harm to the state or to public order. Crimes against property (with the exception of arson where there may be a risk to life) and financial crimes, unless substantial, are not usually considered to fall into this category. Doctors should also consider the circumstances in which the request is being made. For example, a doctor may be persuaded to release information to assist the police in apprehending a murder suspect who is still at large, and hence, where there is still a risk to the public, but not to release information about a suspect who is already in custody without either the patient’s consent or an order from the court.

A patient who is violent or dangerous 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. Each case must be assessed on its own facts; however, under some circumstances, the doctor may be sufficiently concerned for the welfare of the third party to disclose information to the intended victim or to the police or other person in authority with the power to take appropriate action. Indeed a failure to act in such circumstances could lead to criticism by the court, as happened in the case of *Tarasoff* [21] in California, in which a specialist psychologist failed to warn the girlfriend of a patient who threatened to kill her, and subsequently carried out the threat. The court determined that while there was no general duty to protect or warn third parties, a special relationship may impose such a duty. In the United Kingdom, a psychiatrist was sued by a patient with a history of violence, for releasing a report about him, prepared at the request of his solicitors in connection with an application for release from detention, without his consent [22]. The psychiatrist advised against release and the patient’s solicitors therefore decided not to use the report. The doctor, however, was so concerned about his findings that he released a copy of the report to the relevant authorities, as a consequence of which, the patient’s application for release was refused. The patient subsequently filed a civil claim for compensation but this failed, the court holding that the psychiatrist was entitled, under the circumstances, to put his duty to the public above the patient’s right to confidentiality.

### **Duty to Report Gunshot and Knife Wounds**

The GMC’s recently updated guidance on confidentiality contains supplementary guidance [23] which gives special consideration to dealing with patients presenting with gunshot and knife wounds. It describes a two-stage process in which the police should be informed whenever a patient presents with a gunshot wound or a wound that may have been inflicted by a knife or other sharp instrument, other than self-inflicted wounds or those sustained by accident. Personal information should not be disclosed to the police at this stage. On the attendance of the police, if the patient’s clinical condition permits, consent should be sought from the patient for interview. The consequences of

a refusal of consent should be clearly explained to the patient, but the patient's decision should nevertheless be respected. Any subsequent decision to disclose information without consent must be justified by the doctor in the usual way, for example, to assist the police in the investigation of a serious crime. The information disclosed should be the minimum necessary to achieve the objective of the disclosure.

### **Disclosures to Protect the Patient**

If a doctor considers disclosure of confidential information is necessary for the protection of the patient, he should explain his reasons for this and encourage the patient to consent to the disclosure. However, a doctor should normally abide by a competent patient's refusal to consent, even if the disclosure leave him or her, but no one else, at risk of serious harm. Disclosure may be justified if it is not practicable to seek consent, for example, where doing so would prejudice the purpose of the disclosure.

### **Disclosures to Protect Others**

Disclosure of identifiable confidential patient information may be justified without consent if in the doctor's judgement, a failure to make the disclosure could put others at risk of serious harm. In these cases, the doctor must weigh the patient's interest in keeping the information confidential against the public interest, or the interests of another individual, in releasing it. This is dealt with more fully in the section on Public Interest disclosures above.

### **Disclosures About Patients Who Lack the Capacity to Consent**

Where a patient is incapable of consenting to disclosure of information about him, either because of a disorder or arrested development of the mind, or because of temporary incapacity for example, unconscious patients, or because the patient is a minor and lacks the maturity to reach a decision, a doctor must either obtain consent from someone with the authority to act on the patient's behalf, or if this is not possible, do what he considers necessary and in the best interests of his patient. For a fuller discussion of those with authority to consent on behalf of minors and incapacitated adults, see the section on consent above. In making an assessment of best interests, the doctor should take into consideration the views of relatives and carers and any previously known wishes of the patient including the existence of a valid advance directive.

Where there are potential child protection/safeguarding concerns, doctors should be aware of their statutory duties under relevant legislation including, for example, the Children Act 1989 and 2004, to make the best interests of the child their paramount consideration and to share relevant information with other agencies. In situations involving vulnerable adults, for example where the doctor is concerned the patient may be the victim of neglect or abuse, and the doctor believes the disclosure is in the



patient's best interests and or is necessary to protect others from risk of serious harm, he should pass relevant information promptly to an appropriate authority.

## Record Keeping

All doctors should keep objective, factual records of their consultations with patients and of other professional work where the information recorded should be relevant to the purpose for which the note was made. Not only is this desirable per se, but it is also now a professional requirement. Current GMC guidance [24] states that, in providing care, doctors should keep clear, accurate, and legible records, reporting the relevant clinical findings, the decisions made, the information given to patients, and any drugs prescribed or other investigation or treatment. Further, the records should be made at the same time as the events being recorded or as soon as possible thereafter. These standards apply to both paper and electronic records. Where retrospective entries need to be added to the record, these should be clearly recorded as such and dated and timed accordingly. Audit trails allow the exact time an amendment is made in electronic records to be identified and a failure to flag an entry as retrospective could call into question the motivation of the maker of the record.

When handling patient identifiable information there are six fundamental principles (the Caldicott principles) to bear in mind: justification of the purpose of every proposed use, don't use information unless absolutely necessary, use the minimum necessary information, access on a strict need to know basis, all those with access should be aware of their responsibilities and must understand and comply with the law. Particular care must be taken to ensure appropriate measures are in place to ensure confidentiality of electronic records, for example having restricted access levels for different users according to need, password protection, and encryption of portable data, for example, memory sticks. Doctors are encouraged to seek advice on specific issues relating to record keeping from their defence organisation or local Caldicott guardian.

Comprehensive 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; there may be a substantial delay in requests for statements or court appearances. When the doctor faces a complaint, a claim for compensation or an allegation of serious professional misconduct or poor performance, comprehensive notes are invaluable when defending such cases. The medical defence organisations have long explained that an absence of adequate notes may render indefensible which may otherwise have been defensible. The existence of full and accurate contemporaneous notes is often the key to 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 defamation. Patients and their advisers now have increasing rights of access to their records and rights to request corrections of inaccurate or inappropriate information.

## **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. Since the passage of the Administration of Justice Act of 1970, English patients have enjoyed certain rights of access to their medical records for the purposes of a personal injuries claim. The relevant legislation is now contained in the Data Protection Act of 1998, which repealed previous statutory provisions relating to living individuals, governing access to health data, such as the Data Protection Act of 1984 and the Access to Health Records Act of 1990 albeit the 1990 Act remains in force in respect to deceased persons where an individual may have a claim arising out of their death. The Access to Medical Reports Act of 1988 remains fully in force. Unfortunately, space considerations do not permit an explanation of the detailed statutory provisions; readers are respectfully referred to local legal provisions in their country of practice.

The Data Protection Act of 1998 implements the requirements of the European Union Data Protection Directive, designed to protect people's privacy by preventing unauthorized or inappropriate use of their personal details. The Act, which is wide ranging, extended data protection controls to manual and computerized records and provided for more stringent conditions on processing personal data. The law applies to medical records, regardless of whether they are part of a relevant filing system. Besides the primary legislation (the Act itself), secondary or subordinate legislation has been enacted, such as the Data Protection (Subject Access Modification) (Health) Order of 2000, which allows information to be withheld if it is likely to cause serious harm to the mental or physical health of any person, although the normal expectation is disclosure even if the content might be unpalatable to that person.

Guidance notes about the operation of the legislation are available from professional bodies, such as the medical defence organisations. In the United Kingdom, compliance with the requirements of the data protection legislation requires that the practitioner adhere to the following:

- Is properly registered as a data controller.
- Holds no more information about patients than is needed for their medical care and uses it only for that purpose.
- Stores records securely and restricts access to authorized personnel only.
- Complies with patients' legitimate subject access requests access respect to their health records.

## **Preparation of Reports**

Doctors regularly receive requests to produce reports for medicolegal reasons. They should understand the basis for this and what is required – a simple report of fact based on their professional involvement in a case, a condition and prognosis report after a medical examination, an expert opinion, or a combination of these. Although

a doctor may possess certain expertise, this does not necessarily mean the court will designate him an expert on every occasion.

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 previous examination 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 necessary and clarification sought where necessary in the case of any ambiguity. The fee 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 up-to-date consents should be obtained and issues of confidentiality addressed.

Reasonable care must be taken in the preparation of any report. A medicolegal report may affect an individual's liberty 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; prosecuting authorities may even rely on it to decide whether to bring homicide charges for murder ("euthanasia") or manslaughter (by gross negligence). Reports must be fair and balanced. Any expert should be independent and impartial. The doctor is not an advocate for a cause, but should see his or her role as assisting the court in determining the outcome of a case by clarifying the relevant medical issues. It must always be considered that a report may be disclosed in the course of legal proceedings and that the author may be cross-examined about its content, on oath, in court, and in public.

A negligently prepared report may lead to proceedings against the author, perhaps even referral to the regulatory body and criminal proceedings in exceptional cases. Certainly, a civil claim can be brought 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 which may significantly affect that doctor's status in respect to any future instruction.

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. It is acceptable for the report to be submitted in draft form 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 believes cannot be justified: it is the doctor who will have to answer questions in the witness box which may be felt as the loneliest place in the world 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).

In civil proceedings in England and Wales, matters have been governed by the Civil Procedure Rules and by a Code of Practice approved by the head of civil justice since 1999. Any practitioner who provides a report in civil proceedings must make a declaration of truth and ensure that his or her report complies with the rules which emphasize his duty to the court.

## **Attendance at Court**

Generally, courts consist of two types: criminal and civil. Additionally, the doctor will encounter the Coroners Court (or the Fatal Accident Inquiry at the Sheriff Court in Scotland), which is, exceptionally, inquisitorial and not adversarial in its proceedings. A range of other special courts and tribunals exists, from ecclesiastical courts to social security tribunals; these are not described here.

It is possible for a doctor to 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 made in the course of his practice, 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.

Normally, a doctor will receive adequate notice that attendance in court is required and he or she may be able to negotiate with those calling him or her concerning 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 summons, 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 cooperation 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 summons, 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 to “refresh his memory,” although it is courteous to seek the court's agreement.

## ***Demeanor in Court***

The limited space available does not permit more than to outline good practice when giving evidence. Court appearances should be taken seriously as an individual's

liberty may be at risk or significant damages and costs may rely on the evidence given. The doctor's dress and demeanor should be appropriately professional, and he or she should speak clearly and audibly.

Whether it be evidence in chief or cross-examination, it is worth listening attentively to the questions posed. Consider carefully the proposed response prior to putting one's mouth into gear. Answer the question asked (not the one you think it should have been) concisely and carefully, and then wait for the next question. The role of the doctor is not to fill a gap in the conversation; the judge and others will be making notes, and it is wise 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. If there is a straightforward answer, then give it unless the outcome would mislead the court. Brevity has much to commend it, although answering in monosyllables is unlikely to help the court.

Be calm and patient, and never show a loss of temper or control regardless of how 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.

It is perfectly permissible to ask for a question to be repeated as long as this strategy is not repeated ad nauseam.

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 on 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. However, the medical witness 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. Therefore, the witness should 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, the whole truth, and nothing but the truth – and give evidence accordingly.

## **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 [25] for expert witnesses; the Academy of Experts and the UK Expert Witness Institute (EWI) have issued a joint code of practice [26] for experts and the General Medical Council issued specific separate guidance entitled Acting as an Expert Witness – guidance for doctors [27].

It is unclear how long after retirement from a specialty a doctor may proffer expert opinions but the GMC document does now stipulate a requirement to keep up to date in that doctor's specialist area of practice and it would seem the longer the time that elapses, the more difficult it will be to maintain credibility in the eyes of the court.

The essential requirements for experts are as follows:

- Expert evidence presented to the court should be seen as the independent product of the expert, uninfluenced regarding form or content by the exigencies of litigation [28].
- Independent assistance should be provided to the court by way of objective unbiased opinion regarding matters within the expertise of the expert witness [29]. An expert witness in the court should never assume the role of advocate.
- Facts or assumptions on 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 believed 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 [30].
- 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 EWI [31] has also produced a declaration for use by experts that follows the form recommended by Lord Woolf, the Chief Justice of England and Wales, in his review of civil justice procedures and that incorporates the legal principles just set out. The EWI Website (<http://www.ewi.org.uk>) provides an easy route to access several important documents.

In England and Wales, new Civil Procedure Rules for all courts came into force on April 16, 1999 [32], and Part 35 establishes 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 conducting the function as an expert. The new rules make radical changes to the previous use of expert opinion in civil actions.

The GMC guidance explicitly advises on bringing any potential conflict of interest to the attention of the court and specifies that the doctor may continue to act as an expert only if the court decides the conflict is not material to the case.

## Pitfalls

There are many potential pitfalls in forensic medical practice and while most may be avoided by an understanding of the legal principles and forensic processes, this is now a topic of postgraduate rather than undergraduate education. The typical “doctor–patient” relationship does not apply; the detainee needs to understand the role of the FP and the relevant explanation provided to ensure any consent is informed in nature.

Meticulous attention to detail and a careful documentation of facts are 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 effect on the liberty of the individual and may be highly influential in assisting the prosecuting authorities to decide whether to charge the detained person with a criminal offense.

Although a degree of reassurance is provided with the increasing use of custody nurses and paramedics, the doctor may 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.” Making the correct decision will assist in the proper administration of the judicial process, with the desired regard for human rights and individual’s liberty. Getting it wrong may not only fail to prevent an avoidable death, but also may lay the practitioner 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. The issue of whether a forensic physician (FP/FME) owes a wider duty to the victims of alleged crime was decided in the English Court of Appeal during 1999 [33]. A doctor working as an FME examined the victim of an alleged offense of rape and buggery (sodomy). The trial of the accused offender was fixed, and all prosecution witnesses were warned and fully bound, including the FME.

The trial was scheduled to begin on December 7, and on December 6, 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 7, and the accused pleaded not guilty. On Friday, December 8, 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. However, on December 11, the FME left the country for a vacation. On December 14, 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 19. The remainder of the prosecution case was finished on December 14. The trial judge refused to adjourn the case until December 19. On December 20, 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, the claimant 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 because 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, Lord Justice Stuart-Smith stated:

"it is quite plain in my judgment that the defendant, in carrying out an examination at the behest of the police or 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. Lord Justice Clarke observed that:

"In (the circumstances of the case) any duty of care owed (by the FME) must be very restricted. It seems to me that she must have owed a duty of care to carry out any examination with reasonable care, and thus, for example, not to make matters worse by causing injury to the plaintiff. It also seems to me to be at least arguable that where an FME carries out an examination and discovers that the person being examined has, say, a serious condition which needs immediate treatment, he or she owes a duty to that person to inform him or her of the position."

The claimant's action 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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