Many doctors are concerned about the law and the way it relates to their professional life, as was evident from the number of delegates attending the conference on legal aspects of medicine held at the Royal College of Physicians in November 1993. Those taking part came from a diversity of professional backgrounds—junior and career grade hospital staff working in various specialties, general medical and dental practitioners, prison medical officers and police surgeons, specialists in forensic medicine, lawyers and coroners. The result was a stimulating exploration of the interface between medicine and the law, considering first the doctor’s responsibilities in law and the circumstances which may lead to an appearance in court, and then the doctor as carer of the victims or perpetrators of crime.

Areas of concern

Dr M T Saunders (General Manager, Medical Defence Union) set the scene for the conference with an overview of the size of the problem of negligence claims. Approximately 15,000 ‘untoward incidents’ in hospital clinical care are reported every year in the UK, of which 5,000 progress to formal complaints. The former figure is almost certainly an underestimate, because of fears within the profession of the consequences of reporting such events. The problem is also serious outside hospital—family health service authorities receive approximately 1,200 complaints about principals in general practice each year. Activity on this scale requires a secure risk-management strategy by the providers of health care, which means that accurate data are needed. In the USA some hospitals have sought to improve notification of events which may have legal consequences by making failure to report untoward events a disciplinary offence.

Although we all like to think that such problems only affect other doctors, many of us are likely to be involved in such proceedings at some stage in our professional life. Compensation claims are increasing at a rate of 15% per year (ie doubling every five years). In 1926 the Medical Defence Union was involved in 63 cases, of which seven led to a financial settlement. By 1989 (before the introduction of Crown indemnity) this had risen to 10,000 claims, with 3,500 financial settlements amounting to £37 million. Furthermore, research by review of case notes has shown that for every successful plaintiff in the USA there are seven more who may have a case for compensation, who know this to be so but do not pursue it [1]. It is clear that this problem will not go away.

In the UK the procedures to handle these complaints are notoriously cumbersome, and this is a concern to all involved. The Department of Health currently has three working parties examining the problem:

- to consider the way in which complaints about doctors are handled;
- to assess methods of measuring a doctor’s professional performance; and
- to review the issue of risk management by health providers.

Legislation and the doctor

Mrs M Puxon (QC, London), barrister and former consultant gynaecologist, reviewed legislation which relates to the doctor. She began by reminding us of a few important distinctions:

- The law dictates what we must do, and what we may not do. What we ought and ought not to do is a matter of ethics rather than law.
- Criminal law addresses the relationship between the State and the individual. In a criminal case the Crown prosecutes. The verdict is given by a jury, who have to be sure beyond reasonable doubt of their conclusion. A verdict of guilty may lead to punishment by the State.
- Civil law relates to the relationship between one citizen and another. In a civil action the burden of proof differs from that in a criminal case: to find for the plaintiff, the court has to be satisfied that, on the balance of probabilities, the defendant is guilty of the alleged tort (such as negligence). Such a finding may lead to compensation for the plaintiff.

The legislation which affects the doctor as a professional relates almost entirely to criminal offences. The current Medical Act 1983 governs the registration of doctors and legislates on matters relating to their education, discipline and health. The Act also provides the terms of reference for the General Medical Council which is responsible for the regulation of the profession and answerable to the Privy Council. Numerous statutory instruments are contained within the Act, such as that relating to the constitution of an appointments advisory committee for the appointment of a consultant in the National Health Service. Two other important Acts that have recently passed into law are the Access to Medical Reports Act 1988, which enables patients to see reports made on their behalf for certain purposes, and the Access to Medical Records Act 1990, which gives patients certain rights of access to medical records written about them since the Act came into force in November 1991.
Consent

The law on consent to treatment rests almost entirely on case law rather than statute. However, the Family Law Reform Act 1969 affirmed that a child of 16–18 years, although in law still a minor, has the same capacity to consent as an adult. A further important development in the law of consent is the Gillick ruling by the House of Lords: a child under the age of 16 may be capable of giving consent to treatment if he or she understands the significance of the consent, and if the doctor attending is satisfied that the child has sufficient understanding [2]. Although this ruling has established a child’s ability to give consent, the ability to withhold consent (ie to refuse treatment) remains the sole responsibility of an adult.

Medical ethics

Mrs D Brahams (Barrister, Lincoln’s Inn, London) discussed medical ethics in the context of the law. Although ethical matters are essentially distinct from legal argument, they overlap when a court determines whether a particular act by a doctor was reasonable.

The sanctity of human life is one area in which moral and legal considerations meet. Until the Suicide Act 1961 it was a criminal offence in England and Wales to commit suicide, to attempt to do so, or to aid or abet another in suicide. The Act removed the offences of suicide and attempted suicide; however, it retains the offence of aiding or abetting suicide, even though the action which is so aided is not in itself a crime—probably a phenomenon unique in English law. The ethical and legal issues relating to the sanctity of life were brought together in the case of Tony Bland, a victim of the Hillsborough disaster who was left in a persistent vegetative state. The House of Lords ruled that to withdraw supportive treatment would not, in that specific instance, be unlawful [3]. However, the court indicated that the decision should not be regarded as setting a precedent, and in so doing effectively required that any future case of this nature would require further ruling by the courts. A Practice Note has since been issued, giving guidance about the withdrawal of support in persistent vegetative state [4].

Death

Professor B Knight (Home Office Pathologist, Wales Institute of Forensic Medicine) reviewed a doctor’s legal and professional obligations when faced with the death of a patient. Death has no specific definition in law other than the absence of life, but is widely regarded as the irreversible cessation of all cardiac and respiratory activity. The fact of death is not in itself certified—the law infers that death has occurred from the subsequent issuing of a certificate of the cause of death. In the UK and the Irish Republic the doctor issuing the certificate does not have to have seen the body to confirm that death has taken place, although this is a requirement in the rest of Europe.

A doctor has a statutory duty to issue a certificate of the cause of death if he was in attendance during the last illness unless there is a reason to report the death to the coroner. Attendance by the doctor issuing the death certificate during the last 14 days is a general rule of registrars for guidance, but it is not a legal requirement. If there is reason to suspect that death was not due to natural causes, for example, where violence, accident or industrial activity may have contributed, the doctor should not issue a certificate but must report the death to the coroner. A doctor is not permitted to withhold a certificate in order to secure an autopsy for his own interest—a hospital autopsy is entirely at the discretion of the next of kin.

Dr J D K Burton (Coroner, Greater London Western District) described the work of the coroner in the investigation of the cause of death. In 1991 approximately 180,000 deaths were reported to the coroner in England and Wales (31% of all deaths), of which 128,000 required a coroner’s autopsy and 21,000 an inquest. The purpose of the autopsy is to determine whether or not death was a natural event: determination of the medical cause of death is the responsibility of the coroner, and an inquest is held where unnatural causes are thought to have played a part. In contrast to the adversarial procedures of the criminal and civil courts, an inquest is essentially an inquiry: the coroner has to establish the facts, and to do so, he himself summons and examines witnesses. Unlike other courts, the coroner’s court may also propose remedies to prevent a future recurrence of the events that have taken place.

Appearing in court

Dr N Davis (Police Surgeon) considered the position of the doctor who is required either to appear in court (as a witness or a defendant) or to make a statement for use in court. He gave guidance on how to ensure that medical notes are useful to the doctor or the court. A logical and legible contemporaneous record will be of value both to the doctor and the court, but many entries in medical records do not fulfil these minimum standards. A doctor examining a patient who has presented because of illness may justifiably assume the patient’s consent, but when the patient is in custody no such assumption of consent to examination can be made, and it should be explicitly sought and recorded in the notes.

The professional witness

A doctor summoned as a professional witness is required to give evidence on matters of fact relating to the case. This role should not be confused with that of the expert witness, who is called to guide the court with his expert opinion on the professional issues in question.
The expert witness

Mr R V Clements (Obstetrician, North Middlesex Hospital) spoke from his experience as an expert witness in civil cases. The expert witness is called upon to provide a specialist’s insight to assist the court. Three distinct questions may need to be addressed:

- Has there been failure of care (negligence)?
- If so, has that failure led to the alleged harm (causation)?
- How serious is the consequence (quantum)?

Negligence, in English law, refers to failure to exercise the care which should have been shown in a particular circumstance, thereby causing harm to another in person or property. The law presumes that a duty of care exists between doctor and patient when their professional relationship begins. The standard of that care is set by the profession. In an allegation of negligence, the court will generally apply the Bolam test: a doctor is not negligent if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that art [5].

It is important that an expert opinion takes into account the clinical setting of the case, and represents a view which would have been held at the time in question. For example, in a case alleging negligence in intrapartum care in a district general hospital (DGH) some years ago, the view of the expert witness should reflect the practice accepted as appropriate in a DGH at the time of the delivery. In contrast, an expert on causation in such a case might be a specialist in developmental pediatrics whose opinion should reflect the current professional view as to whether the events which took place might have caused the alleged harm. Similarly, an expert on quantum, who in such a case might be a specialist in disability or an educational psychologist, would give an opinion on the current assessment of the consequences of the harm done.

In preparing an opinion, an expert has an opportunity to review the medical records and meet the plaintiff before preparing a report. The report should contain:

- an analysis of the facts;
- an explanation of the technical aspects of the case;
- an opinion on the standard of care provided.

The report is usually sufficient, and only rarely is an appearance in court necessary. If an expert witness is called to appear, he or she may be permitted to remain in court for the whole hearing—unlike a professional witness who is present in court only when giving evidence.

The expert witness is in a unique and privileged position in being allowed to express an opinion in court. The responsibility of this position was stressed by a number of speakers. The purpose of the opinion is to assist the court and, as such, it must be balanced and represent a view which is genuinely held. An expert is required to make disinterested and objective observations, and the opinion should be such as would have been supported by other authorities in the field at the time of the event(s) in question. It should not mislead by omission of material facts. A report may sometimes be adverse to the party calling the expert: the temptation to bias the opinion in favour of the side paying the fee must be resisted. The particular responsibility of giving an expert opinion in a case involving children was later stressed by Mr Justice Thorpe. Quoting from a judgment in the Family Division, he commented that: a misleading opinion from an expert may well inhibit a proper assessment of a particular case: an absence of objectivity may result in a child being wrongly placed and thereby unnecessarily put at risk [6]. Ultimately, the court will only be guided by the expert, not directed, and will draw its own conclusion from the evidence offered.

Alcohol, drug abuse and the law

Dr A Maden (Senior Lecturer in Forensic Psychiatry, Institute of Psychiatry, London) discussed the influence of drugs on crime. Crime is statistically associated with the prevalence of substance abuse. Possible mechanisms for this include direct effects of alcohol or drugs as a precipitant of a crime, or as an indirect facilitator of crime in a given situation (for example, heroin dealers usually carry guns). Substance abuse may also give rise to organic brain damage, it requires a steady supply of money to maintain the habit, and often arises in the context of poverty, unemployment and social deprivation—all further possible reasons for the association with crime.

Can the effects of drugs be cited as mitigation for criminal behaviour? Different approaches to this argument have been made over the years but they have in general been unsuccessful in the courts, and self-induced intoxication is not a viable defence in criminal proceedings. Actions committed while under the influence of therapeutic drugs are similarly treated. A truly unpredictable side-effect of a drug may influence the mind in such a way as to diminish an individual’s responsibility for those actions, but such effects are hard to prove. A person who behaves irresponsibly while suffering a predictable effect of a drug will be held to have acted recklessly.

Two recent developments in this area of the law are noteworthy. First, it is now recognised that a suspect detained by the police should be in a fit state to answer before being questioned—drug withdrawal is not a good time for an interview. Where there is doubt, a medical opinion may be sought to guide the police.
For example, a suspect who would fail a breathalyser is likely to be unfit for interview. Second, the Criminal Justice Act 1991 introduced a wider range of non-custodial sentences for offenders with drug- or alcohol-related problems. The courts may direct a convict to receive appropriate treatment for such conditions. The patient’s consent to treatment is still required, and it is arguable whether such consent is given as freely as is generally the case in medicine, as the court may be exerting a degree of coercion to accept treatment.

Mental illness and the law

Dr J J Bradley (Chairman of Council, Medical Protection Society) explored the relationship between mental illness and the law. The law does not define mental illness: the Mental Health Act 1983 merely provides for its management. The power to deprive a citizen of his or her liberty, perhaps the most widely recognised effect of the Act, requires that the rights of the individual should be adequately safeguarded. The provisions for this in the Act are more extensive than in the former Act (1959). Section 57 of the current Act contains an important new principle in medicine in that it prohibits the administration of certain forms of treatment without a second opinion—even to patients who give consent and who are not detained under the Act. At present, only two forms of treatment come into this category: psychosurgery and implantation of hormones to reduce libido. In either case, treatment can proceed only if another doctor appointed by the Mental Health Act Commission and two lay persons appointed by the Secretary of State are satisfied that the patient understands the nature of the treatment and is able to give consent. Other than for termination of pregnancy (where a second medical opinion is also required) this limitation of an adult’s ability to receive treatment is a novel principle in English Law.

Under common law a patient who declines treatment for a mental or physical illness may be treated against his or her will in cases of necessity. Although the concept of necessity is not strictly defined in law, it is regarded as including more than immediate life-saving procedures, such as the administration of a sedative to calm a patient during a violent episode. Such treatment would have to be reasonable and sufficient only to bring the emergency to an end.

An important development in the approach of the courts to mental distress has been the recognition of post-traumatic stress disorder (PTSD). Now defined in ICD10, this condition may be a consequence of exposure to an event of an exceptionally threatening or catastrophic nature. Typical features include repeated reliving of the event in dreams, emotional numbness, social detachment, unresponsiveness and incapacity for enjoyment. Anxiety and depression are commonly associated, and suicidal ideas may also be found. PTSD may be the basis of a civil claim for damages following an act of negligence. For example, the wife of a victim of a road traffic accident sued the perpetrator of the accident for compensation for the long-term psychiatric sequelae of the accident. Although her claim was not upheld at the original hearing or in the Court of Appeal, the House of Lords ultimately ruled in her favour [7].

Caring for criminals and their victims

Violence

Professor J Shepherd (University of Wales College of Medicine, Cardiff) presented a maxillofacial surgeon’s view of injuries from acts of violence. The rising incidence of violent crime is well recognised and such events are almost certainly underreported—a publican who repeatedly reports violent incidents on licensed premises will risk losing his licence. Between 3,400 and 5,400 violent offences involving a glass weapon are recorded annually by the police in England and Wales [8], and the compensation awarded by the Criminal Injuries Board to the victims of these offences alone amounts to over £1 million each year [9].

Surveys in hospital accident departments have shown that broken bar glasses are the most commonly used sharp weapons and that they are usually thrown or thrust intact, only breaking on impact. The face and upper limb are the commonest sites of violent wounding, and injuries of this kind usually leave significant disfigurement. Analysis of the physical properties of different bar glasses has revealed that those made of tempered (toughened) glass have a much higher impact resistance than those of annealed glass and are less likely to break—moreover, when they do break, they shatter into small cuboidal fragments rather than the larger jagged pieces which can do more harm [10]. Thus, a move towards tempered glass (which costs no more than annealed glass) for bar glasses is likely to reduce the number of serious injuries caused in bar fights [11].

In addition to causing physical injury, violent crime is a significant cause of psychiatric morbidity. Depression and stress are commoner in the months after an assault than after a road traffic accident or a fall. Pre-existing psychiatric disease in the victims of assault may contribute to this, but it is still a concern that 75% of victims of assault leave hospital accident departments without the involvement of either the police or victim support services. Moreover, the majority of assault victims continue to have a relationship with their assailant after the event.

Children

The Rt Hon Lord Justice Butler-Sloss (a Judge in the Court of Appeal) reviewed the difficult area of child abuse, which may arise in the context of either a
criminal case or a civil action. Child abuse can take the form of physical, social, emotional or sexual abuse, and more than one component may be present in any individual case. Interviewing children in the course of criminal proceedings is notoriously difficult. The government has recently produced guidelines on this [12], and the Royal College of Psychiatrists currently has a working party considering the subject. It is essential to distinguish between interview for investigation of a suspected crime and interview for clinical assessment or therapy: they are different procedures with different aims and problems.

Dame Butler-Sloss recalled the anxieties which arose as a result of the Cleveland and Orkney inquiries, and stressed the importance of keeping an open mind during such proceedings. She concluded during the inquiry that physical signs are rarely diagnostic of sexual abuse. In a civil case, the interests of the child are usually the principal concern. In contrast, in criminal proceedings the child is usually a victim or a witness, but is not the main concern of the court. Thus, a conflict of interest may arise in which the child may not be well treated by the legal process. Furthermore, the child may not wish any outcome from the proceedings other than that the abuse should stop: to seem to have been responsible for the ultimate break-up of the family may add an unbearable strain.

The Hon Mr Justice Thorpe (a Judge in the Family Division of the High Court) gave a detailed exposition of the Children Act 1989. The Act was conceived out of a desire to replace the ‘ragbag of old statutes’ with a single legal code relating to the care of children, and a need to reform areas of the law and practice recently found wanting, such as the events described in the Cleveland inquiry.

The Act establishes in law the importance of safeguarding the welfare of the child, and defines parental responsibility and who should exercise it. It provides for the initiation of legal proceedings by a child himself. Section 31 lays down an important threshold for courts making a care order: that the child is suffering, or is likely to suffer, significant harm from within the family. Section 100 introduces new limitations on the ability of the courts to resort to making a child a ward of court. Administrative changes accompanying the Act introduce reforms in all three tiers of civil jurisdiction involved in the care of children: the Family Division of the High Court, the county courts and the magistrates courts. It provides for the institution of 50 designated regional care centres, each the responsibility of a circuit judge specialising in family justice, and for the institution of a national committee to supervise the implementation of the Act, chaired by a judge of the Family Division of the High Court.

The status of an expert medical report in cases relating to children or the family differs from that in other fields of litigation. In general such a report is provided in confidence to the side commissioning the report, and neither the court nor the other side can require its disclosure. In cases concerning child welfare, however, this principle is now overridden, and disclosure can be required if it is thought that its contents would assist the court to assess the risk of harm to children [13].

Sexual assault

Dr R Roberts (Clinical Director, Sexual Assault Referral Centre, St Mary’s Hospital, Manchester) reviewed the difficulties surrounding the assessment of those who report being the victim of a sexual assault. The common perception of rape is that it is usually committed outdoors, by a stranger, that it leads to obvious physical injury, and that the victim goes straight to the police. In practice, this is rarely true. In the great majority of cases the assailant and the victim already know each other (indeed, half of all reported rapes are committed by a friend), the physical signs are not obvious, and the victim worries that she will not be believed if she reports the crime. The physician attending a rape victim has two distinct areas of responsibility which may conflict: to obtain forensic evidence (and to present it to a court if necessary), and to offer medical care—treat ing injuries, offering contraceptive advice, looking for sexually transmitted disease and offering counselling and aftercare. Where possible, the alleged perpetrator should also undergo a full forensic medical examination, always remembering that he should be regarded as innocent until proved otherwise in court.

Special considerations apply to the assessment of children who may be victims of sexual abuse. In such cases the attitudes and responses of society are often confused, and the strength of public feeling aroused by the case may lead to clouding of judgement. Despite the best precautions, the account of a child suspected of being abused can be misleading because he or she may genuinely misunderstand the meaning of the questions. Furthermore, an insensitive inquiry may harm the child it is designed to help. A forensic medical assessment of a child may itself be regarded as a form of child abuse if the child perceives it as an assault, if important evidence is missed, or if abuse is wrongly diagnosed.

Concern has been expressed about the absence of any independent validation of medical evidence presented in court, particularly in respect of the interpretation of physical signs of child sex abuse. In other fields of expertise, expert opinion is more extensively supported by peer review. Dr Roberts suggested that a scheme for critical scrutiny of such evidence might be considered—for example, independent review by other experts of photographic or video evidence. This would be a major departure from the current conduct of legal proceedings, but it might add an important safeguard against courts giving undue weight to the opinion of an inexperienced witness whose evidence may, because of the emotive nature of the case, have
come to lack impartiality. The consequences of a miscarriage of justice are particularly serious where children and family life are involved.

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Health care: international comparisons

A conference held at the College in July 1994 examined the wide range of health care systems employed around the world and their varying responses to the combined pressures of demographic change and increasing patient expectations in the face of anticipated unsustainable increases in financial demand. The meeting, which was planned by Professor Roger Williams, was jointly sponsored by the College, the NHS Management Executive, Glaxo Holdings plc, the Nuffield Provincial Hospitals Trust and the Kohn Foundation.

The conference was opened by Professor Sir Leslie Turnberg (PRCP) who pointed to the rapidly and disproportionately rising costs of health care in all countries and the tendency towards overt or covert rationing in its delivery to patients. The purpose of the meeting was to examine the different ways in which the medical, ethical and financial challenges are being tackled, and to learn from the positive and negative experiences of others.

Professor C Ham (Director, Health Services Management Centre, University of Birmingham) contrasted the traditions of managed control of health care in the UK and Scandinavia with the free market approach of the USA, but pointed to the very public ‘needs’ for reform exemplified by the 1986 Dekker report in the Netherlands, through the UK reforms introduced since 1989, to the current Clinton proposals in North America. A common theme has been a move towards ‘managed competition’, with considerable differences in the meaning of this term according to the previously prevailing system. The changes in the UK appear among the most radical, but in no case yet have changes been adequately evaluated to judge their success or failure. The provider/purchaser split, with increasing influence vested in the latter, has been accomplished, possibly at the cost of equity. The transition itself has borne considerable financial and personal costs, and as yet funds are not always seen to ‘follow the patient’.

Dr P D Martin (Vice President, Royal Australasian College of Physicians) reviewed the changes enacted in New Zealand since 1991 in response to increasing surgical waiting lists, increasing costs and patient dissatisfaction, in a managed service with many parallels to the British NHS. Discussion illustrated that, although in several countries the waiting list issue is

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