How to do it

Give evidence

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The witness box is commonly held to be the place which most doctors shun with distaste and even trepidation. Even so, an appearance in court as a medical witness need not be an ordeal if the doctor observes a few simple rules. This applies equally well to both criminal and civil cases in the crown courts and to a lesser extent in magistrate's courts and coroner's inquests, the latter having been dealt with in a previous article. Certain doctors, such as police surgeons and forensic pathologists, make such frequent visits to the witness box that it might be thought that they become immune to the tensions and pitfalls of the courts; nevertheless, they can just as easily come to grief if they ignore the basic precautions.

There has long been a facetious saying that the doctor in court should "dress up, stand up, speak up, and shut up," and there is considerable merit in this advice. The doctor in the witness box should dress like a professional person and not like a disc-jockey or lumberjack. Not only is a fairly sober suit more appropriate to the many cases in which there was a fatal outcome, but an opinion uttered by someone who at least looks like a medical expert will carry that much more conviction.

Similarly, as long as it falls well short of condescension or arrogance, a confident demeanour will add weight to the substance of the evidence. As to speaking up, if the doctor's evidence is worth hearing, it is pointless to have it mumbled and muttered. This tends to give the impression that the witness is so unsure of the substance of his testimony that he is reluctant to have it heard. Inaudibility will not only lengthen the proceedings but irritate judge and counsel.

As to "shutting up," there is a further well-known saying that "if one opens one's mouth, one puts one's foot in it." Any amplification should be limited to the matter under discussion; the loquacious witness is a delight to opposing counsel, who will encourage the doctor to tie himself in knots with his own tongue.

Importance of original statement

These general matters apart, the most important part of giving evidence takes place not in the court itself but in the original circumstances which generate the evidence. More than any other single factor, it is the original statement given to the police or to a solicitor—sometimes months or even years earlier—that determines whether or not the doctor is to get a rough ride in the witness box. It is vital that this first statement—which is a formal declaration of the facts known to the witness and, where appropriate, his opinion on those facts—should be

exactly what the doctor is prepared to say orally when he stands before the court.

Therefore, the doctor must decide at the outset what are the limits to which he is willing to testify. He must consider all aspects of the case and decide on the factual demarcation beyond which he is not prepared to step. He must be prepared to "put his mouth where his pen was" when the time of trial arrives. So often, in the security of his consulting room, a doctor will dash off a sweeping statement, drawing unwise and perhaps unwarranted conclusions and opinions. Then, when he is on his feet before a crowded court, the previous literary bravado tends to drain away and he fails to "come up to proof," as his legal colleagues would term it. In these circumstances not only will he do the court and justice a disservice, but he will almost certainly have a very uncomfortable time from opposing counsel and possibly the judge or magistrate. So often one has seen a barrister waving a sheaf of papers at the discomfited medical witness as he says, "But doctor, let me read what you said last February."

It cannot be overemphasised that the medical witness should never commit himself to opinions that he is not willing to maintain. This is not to say that he should never admit to being wrong in the face of new facts or interpretations from elsewhere, but he should not back off at the time of trial from his own earlier opinions.

Preparing the facts

The second necessity is the preparation of the facts. Whether he is attending as a witness-to-fact or as an expert witness with opinions, the medical witness should have done his homework sufficiently to be seen in the witness box to have at least an adequate grasp of the matters under discussion. Too often, the sorry sight is seen of a doctor standing sheepishly in the witness box, giving the impression that he has never heard of the person about whom he is being questioned and has no idea of any medical facts relating to the case. Under such circumstances, counsel becomes sarcastic and the judge himself incensed to the point of apoplexy. The doctor should bring all records relating to the patient; he should have read them beforehand; and he should refer to them when questioned, rather than mutter and stammer in a vain attempt to remember the relevant details. Such records must be originals, such as actual case notes or the contemporary reports made by the witness himself.

The use of such records in the witness box may have to be approved by the judge, who may wish to see them, to check that they are originals. He will always allow the doctor to refer to them for the purpose of "refreshing his memory," so that it is as well if the medical witness avoids shuffling them and searching as if this was the first time he had ever set eyes upon them.

Thirdly, the doctor should never trespass beyond the bounds of his own skill or competence. A junior house officer is not expected to give opinions which might tax the capabilities of a senior consultant—if he does so, he is likely to be destroyed by opposing counsel. Similarly, a senior specialist is equally

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vulnerable when he transgresses the boundaries of his own specialty. The classical example was the comment of Mr Alec Bourne, the well-known gynaecologist, when Sir Bernard Spilsbury unwisely gave an opinion about clinical obstetrics. Mr Bourne said that, however eminent Sir Bernard was as a forensic pathologist, when he spoke of childbirth his evidence should be treated with contempt. The doctor who is pressed to answer questions which he considers to be beyond his sphere of skill should draw a firm line and indicate to the court—by appeal to the judge if necessary—that he feels unable to give a useful opinion.

Courtesy and consideration

The days of blood-and-thunder advocacy are thankfully past and counsel today are almost invariably courteous and considerate, especially to witnesses in a sister profession. Nevertheless, this does not detract from the penetrating intellect and piercing questions with which they can nail the medical witness to the court-room wall. When the doctor has allowed himself to stray on to the thin ice of doubtful fact or the swampy ground of unwise opinion, the best course is to cut his losses and regain terra firma as gracefully as possible, by admitting that he does not know some fact or that he allows that a contrary opinion may be correct.

Whatever happens, embarrassment and loss of face should not tempt the doctor into anger, sarcasm, or even impertinence. Not only will this earn a rebuke from the judge, but it delights opposing counsel, who can run rings round an angry witness

like a matador around a bewildered bull. Nevertheless, this state of affairs is rarely likely to happen if the doctor is well prepared, has kept within the perimeter of his original considered opinion, and gives his evidence and responses to questions calmly and responsibly.

There are two last points. Firstly, in the crown courts especially, evidence needs to be given slowly and in short instalments, as the judge will be writing it down longhand. Some doctors have suggested that the barrister who is on his feet suffers from intermittent catalepsy, but in reality he is watching the end of the judge's pen before putting the next question and the experienced medical witness will do the same. Secondly, the doctor should use comprehensible language in court, free from medical jargon. Even though the barristers and the judge may know almost as much about the medical aspects of the case as the doctor, the rest of the court—including the jury, if there is one—may not have the slightest idea of what the witness is talking about. From motives of sheer thoughtlessness, from professional pomposity, or even because a retreat into the familiar terminology is comforting during the uneasy vigil in the witness box, many doctors relapse into the jargon of our mysterious medical language. The good witness will translate his evidence into everyday English. Often the more junior doctors are the worst offenders; two of their classical gems are "periorbital haematomata" for "black eyes" and "biventricular myocardial hypertrophy" for "a big heart."

Eventually this series will be collected into a book and hence no reprints will be available from the authors.

A Modern Epidemic

Road accidents: are drugs other than alcohol a hazard?

BY A SPECIAL CORRESPONDENT

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A car zigzags between a line of bollards and then repeats the process in reverse—not the antics of a mad driver but one of the vehicle-handling exercises devised to test the effects of small doses of drugs on driving.¹ Three tranquillisers (a barbiturate, a benzodiazepine, and a phenothiazine) impaired performance in this series of tests, but the volunteers themselves were unaware of any impairment. A similar study² showed that a tricyclic antidepressant particularly increased risk-taking. This and certain types of laboratory experiment have provided ample evidence that various prescribed drugs could in theory cause accidents; but do they in the real world, where cumulative effects might be different from short-term ones and where the driving task is sometimes more and sometimes less demanding? The only real test of fitness to drive is real driving.

Medicinal drugs

Driving while impaired by drugs has been an explicit offence since the Road Traffic Act of 1930, but the effects of most drugs are much harder to study than those of alcohol, despite recent advances in analytical techniques: their metabolism is more

complex, the blood concentration tends to be less straightforwardly related to their effects, and responses may be more idiosyncratic.³ Moreover, the condition for which the drug is taken may itself impair driving. Thus the types of accident studies needed to provide conclusive evidence are not easily undertaken. Nevertheless, certain pointers have come from surveys.

SURVEYS

In a survey of high-school students in Toronto tranquillisers and stimulants, though numerically posing a much smaller problem than alcohol, appeared to give the greatest accident risk; but this study was based on questionnaires.⁴ Using pharmacological methods, an American study of drugs in living and fatally injured drivers suggested that stimulants increased the risk of fatal accidents 14 times and sedatives and antihistamines five times, but tranquillisers not at all.⁵

The Transport and Road Research Laboratory's survey in Berkshire also looked at drug use.⁶ Eighty-seven of the 2211 drivers at fault were considered to have been impaired by a drug other than alcohol (none admitted to drug abuse). Thirty-one of those who had taken a drug had also been drinking, and in 14 (12%) of those accidents where alcohol was thought to have