PRACTICE OBSERVED

Law and the General Practitioner

Assisting the police

STUART CARNE

When the police require medical assistance, either to obtain evidence or because a person in custody is ill or injured, they seek the services of a police surgeon. The more specialised work of these doctors will not be considered here, but occasionally their help may not be available and another doctor will be asked to assist the police. Furthermore, general practitioners may come in contact with the police in connection with a patient or, more likely, a dead body they have seen.

Unexpected death

Until this century death was no stranger in most households; families coped with death as they did with birth. Today when a patient dies at home the family may panic and call the police, even though the death may have been anticipated. The police will always attempt to contact the deceased's own general practitioner but, regrettably, this may not always be possible, especially in the inner urban areas, and another doctor, usually a police surgeon, will be called to pronounce the person dead. Only a registered medical practitioner may certify death, however obvious the death may be; even where death has occurred days or weeks before and decomposition has begun, a doctor will have to make the formal pronouncement that life is extinct.

If it is his own patient, and one whose death had been anticipated, the general practitioner will have no problems in issuing a death certificate. Should there be any doubt about the cause of death, however, or in cases where the doctor had not seen the patient within 14 days of death the Coroner must be notified, usually through the Coroner's Officer.

The criteria on which death is confirmed (before the appearance of lividity and rigor mortis) are:

Goldsmith's Road, London W15 8EJ
STUART CARNE, *onc, recop, general practitioner and police surgeon*

—absent heart sounds—more reliable than an absent pulse; —absent respiration—ideally observed for five minutes; —fixed dilated pupils and ophthalmoscopic changes of trucking. ECG and EEG changes are not normally needed to determine death except when patients have been on a life-support machine in hospital or when the patient is suffering from severe hypothermia.

SUSPICION OF FOUL PLAY

If there is any suspicion, however remote, that there may have been foul play the police should be notified as well as the Coroner. It is essential that as little as possible is touched or moved at the scene of the possible crime. However, if there is any chance that the person may still be alive, then every resuscitative measure needed must be carried out, including transferring the patient to hospital even though this may necessitate moving objects in the room.

Should the doctor be called by the police to certify that life is extinct in circumstances that indicate possible foul play, he may well find CID officers already on the scene. Sometimes in these cases it is beyond doubt that life is extinct: lividity and even more advanced stages of death will be present. In these circumstances there is no need to touch the body; even moving the bedsheet or turning the body over can interfere with the collection of evidence that might be vital. Police photographers will have been called. Only when the preliminary photographs have been taken, and only after the permission of the police officer in charge of the investigation has been given, should the doctor move the body. At this stage he might be asked to record rectal temperature and determine what injuries are present in the previously unexposed parts. It is essential that the doctor records all his observations, including the time of arrival, the names of those to whom the information was given, the state of the body, and any other peculiar circumstances in the room or house.

times their medical condition will tip the scales in favour of being granted bail. If sent to hospital they must be accompanied by a police officer—or two if possibly dangerous or likely to run away: this can be an expensive use of relatively scarce police manpower.

MENTAL ILLNESS AND DRUGS

Prisoners with a severe mental illness can be "deemed" by a police officer under Section 136 of the Mental Health Act and sent to a mental hospital. A number of arrested persons are on drugs, often tranquillisers (in quite enormous quantities in some cases) or hard drugs. Those on tranquillisers will usually be given further doses by the police surgeon while in police custody: it would not be appropriate to stop such treatment suddenly. Those on hard drugs could, if necessary, be given methadone. Though many prisoners like to have intravenous methadone there is rarely an indication for this while they are in custody, and tablets give a longer, though albeit "less lifting," action. Alternatively a tranquilliser—for example, diazepam or chlorpromazine—will often ease many of the pangs of the withdrawal symptoms. Barbiturate habits and alcoholics may have fits as they withdraw from their drug. Many "epileptics" in custody admit that they only get convulsions when they are unable to get alcohol or "barbs." If necessary, I give them phenobarbitone 60 mg every 12 hours to reduce the risk of their convulsing.

CASES THAT ARE NOT CLEAR-CUT

In the majority of cases of physical illness the doctor has no difficulty in deciding whether the prisoner is fit or unfit to remain in custody, but some problems may arise:

(1) The prisoner who has an injury. Is there any possibility of a fracture? In ordinary practice when a patient has, say, a nose injury one may wait a day or so to allow any swelling to decrease before having an x-ray examination. If a prisoner has such an injury it is desirable to establish the full extent of the injury while he is still in police custody, as this may later become a matter for inquiry.

(2) A drunken prisoner who is semiconscious. A police cell is not a safe place to leave a semiconscious patient: he might have a head injury; he might choke on his vomit. Even if a drunk or drugged prisoner is reasonable, the doctor must decide whether or not it is safe to leave him alone in a cell: if not, he must be sent to hospital.

(3) A pregnant woman who is bleeding, however early in the pregnancy. A police cell is not an appropriate place in which to have a miscarriage.

(4) A prisoner with a feverish respiratory infection may need only antibiotic treatment, but it would not be reasonable to leave a pyrexial patient in a police cell.

The local hospital has no option but to accept these patients for examination in the casualty department. Many require no more than an x-ray examination or repair of wounds too large to have been dealt with at the police station, or both. The prisoner is then returned (after an hour or two) to police custody. A few prisoners have to be admitted to hospital for observation, treatment, or both.

Fitness to stand trial

An accused person may ask his doctor to provide a certificate saying he is unfit to stand trial. Before issuing a certificate the doctor must be sure that he can, if so required, back his opinion on oath in the witness box. The words on the certificate must state that the accused is "unfit to stand trial." "Unfit for work"

is unacceptable wording, and the certificate is likely to be rejected. The accused must be told by his doctor to ensure that his solicitor is aware of the existence of the certificate, and someone must present it to the court at or before the time set for the hearing. The court has the right—which it not infrequently exercises—to send their own doctor (accompanied by police officers) to examine the accused at his home or in hospital. The police surgeon will then report his findings (on oath) to the judge. Regrettably, in my experience as a police surgeon I have seen many cases in which the accused, far from being unfit, merely hoped to postpone the evil day. I have seen allegedly bed-bound patients with so many outdoor clothes under their pyjamas that I can only assume that they jumped into bed when I rang the doorbell.

No definite criteria have been laid down for the determination of such fitness. The doctor who is asked to issue a certificate must remember that it is rarely possible to have a case postponed indefinitely on medical grounds: sooner or later the day of judgment will have to be faced. A few examples will perhaps clarify the picture:

(1) Someone in hospital recovering from a surgical operation could ask for—and expect to receive—an adjournment of a month or so to allow for recovery.

(2) An acute myocardial infarction might warrant an adjournment for, say, six weeks, at the end of which time the risks of a trial bringing on a further attack would be assessed.

(3) A person with a feverish cold is probably unfit to stand trial and it would be reasonable to ask for, say, a week's adjournment.

(4) Peptic ulceration would normally not be satisfactory grounds for requesting an adjournment.

(5) Backache, with or without symptoms of sciatica, would be likely to succeed on medical grounds only if it were essential for the accused to stay in bed. A request that the accused be allowed to sit throughout the trial would almost certainly be granted.

(6) Anxiety or depression are commonly offered as medical reasons for seeking a postponement, but such applications are unlikely to succeed. Should the accused be so mentally ill that he could not be expected to follow what was happening at the trial, the court would expect a psychiatric report to be submitted and would, in addition, seek the opinion of a psychiatrist if nominated.

(7) Illness in another member of the family is not a medical reason for seeking an adjournment.

Fitness to give evidence

The same criteria that apply to fitness to stand trial apply to fitness to give evidence. If necessary, however, the court may visit a sick person at home or in hospital to obtain his evidence.

Fitness for jury service

A number of people find jury service inconvenient—either for domestic or business reasons, or because they fear they are not capable emotionally of giving such an important decision affecting the life of another citizen. Deafness, poor eyesight (after correction with glasses), mental ill health, pregnancy, and unstable diabetes are examples of illnesses which would be reasonable grounds on which the doctor could support a patient's request to be exempt from jury service.

Reference

1 McLay WDS. *The new police surgeon*. London: Hutchinson, 1978:338.

TIME OF DEATH

Assuming a full examination is permitted, some idea of the time of death may be gauged from the presence and degree of rigor mortis and the body temperature, but only a very approximate timing can be given; the number of variables is endless. Lividity due to hypostasis is first detectable about 30 minutes after death and is maximal six to 10 hours later. It usually becomes fixed about 24 hours after death. Look for its position. Unless the body has been moved after death the colour changes will be maximal over the most dependent parts. Carbon monoxide poisoning is not commonly seen these days, but look for the cherry red colour; other colour differences in the lividity are the pink of cyanide and the bronze of sodium chlorate poisoning. Rigor mortis sets in about six hours after death and is no longer detectable after 48 hours. But both these times are variable—for example, the ingestion of large quantities of barbiturates (suicide or death in an addict) will accelerate the onset and spread of rigor.

Contrary to the mythology of the detective novel, accurate determination of the time of death by measuring the rectal temperature is not possible even by directly recording the internal body temperature through a stab wound into the liver (a technique used by many forensic pathologists, but not one recommended for the novice). Nevertheless some guidance can be given. The formula usually used is: (99 F - rectal temp F) / 1.5 = hours since death. A low-reading thermometer should be used; be sure to shake it right down before inserting it. Note the time at which the temperature was recorded and also the room temperature and the presence of heaters or a draught. Ideally a second reading should be taken 30 minutes later.

INJURIES

All injuries should be noted. Avoid making dogmatic remarks about their cause unless you are absolutely sure about your facts. You can be challenged in court, and many a doctor has been made to look foolish by a barrister in cross-examination. It does no harm to say to the police: "I'm not sure. You'd better ask one of your experts."

Often, especially in a possible suicide, the police will require assistance in the identification of tablets: could they be associated with the death? An open, empty or half-full bottle of tranquilliser—perhaps with a few scattered tablets on the floor—suggests suicide, especially if there is a bottle or glass of alcohol nearby. Bottles (open or closed) of trinitrin or beta-blockers, or both, suggest coronary artery disease—and thus the probability (but no more than a probability) of natural causes.

Suspected rape

In cases of rape, buggery, or any other sexual offence the police, whenever possible, like to have the victim and any suspect examined by an expert, for much in these cases depends on the clinical findings and their interpretation. The general practitioner may, however, be involved if he or she is consulted by a patient who alleges she has been raped or by a mother alleging her child has been sexually assaulted. It is helpful in such cases if the doctor can get the patient's permission to notify the police so that arrangements can be made for a doctor experienced in such examinations to make the necessary tests. What the general practitioner must always do—and this of course applies equally to the police surgeon examining a victim on behalf of the police—is firstly to ensure that facilities for rape counselling are offered, and secondly that advice is given about possible medical complications (pregnancy and sexually transmitted diseases). Both these services require enormous tact and understanding: rape victims have sometimes complained that the subsequent inquiries are an even greater outrage than the assault itself.

EXAMINATION OF THE VICTIM

Should an ordinary doctor be called upon to carry out such an examination because no one else is available, he will be expected to look for injury to the sex organs, including the anal area, breasts, and mouth; all signs of injury anywhere else on the body. The presence or absence of an intact hymen is of only limited forensic value, except when it can be seen that the hymen has recently been ruptured. The presence of recent vaginal or anal tears and bruising is important and must be carefully looked for with the help of an adequate light and proper instruments. Glaister Keene rods are often used by those who frequently examine victims of rape, but few other doctors have this equipment.

Specimen for examination in a forensic laboratory will also be needed. Training in the collection of some of these specimens is very desirable if the evidence is to be used in court. Most police stations have "rape kits" which have the specimen containers for collecting

—blood for grouping and (if appropriate) blood for alcohol content; —urine for drug and alcohol content; —sputum for grouping; —vaginal, vaginal, penile (preferably coronal sulcus), anal, and rectal swabs; —containers for fingernail scrapings, which should be taken if there has been a struggle (cuticle sticks or orange sticks to collect the specimens are not usually available and experienced police surgeons carry their own supply); —head and pubic hair.

Items of clothing, especially underwear, that might be contaminated with semen, blood, hair, or other particles—for example, paint—should also be sent to the laboratory, but these specimens are usually collected by a police officer. In the rape kit is a large sheet of brown paper to place on the floor while the person being examined undresses; this paper is also sent to the laboratory to be examined for "droppings."

Fitness to be detained in police custody

An arrested person must be kept in police custody or granted bail until he appears before a court. Once charged he will normally go to court the following morning (or on Monday if arrested on a Saturday): thus a normal period of detention is less than 48 hours, but it is possible for a person to stay at a police station for a longer period "assisting the police" while they make their inquiries.

There are no facilities in police stations for nursing or observation of sick prisoners, except at a very superficial level. Once they have appeared before the court they will, if not granted bail, be taken to a prison where hospital facilities are available. If they are taken ill while still in police custody, however serious or minor the illness a doctor will be called. (In a major emergency an ambulance might be called to transfer the prisoner immediately to hospital and expedite the matter.) The main task of the doctor called to the police station—usually a police surgeon—will be to determine whether or not the person is fit to remain in custody. In the majority of cases the medical problem is relatively minor, and there are no medical reasons why the prisoner should not remain in custody. If necessary, medication must be given. Strict instructions must be left by the doctor giving the times at which further doses should be given. Prisoners are not allowed any medicines with them in their cells—certainly not if any harm could follow from misuse of the drug or, in particular, misuse of the container. An exception might be made in the case of, say, a dyspeptic prisoner, who could be given three or four antacid tablets to keep with him in the cell; not liquid, for he might break the container and either swallow it or use it as a weapon.

Those who are unfit to remain in custody have to be taken to hospital. They cannot be sent home unless granted bail. Some-

Emergencies in the Home

Role of ambulance services

R A SLEET

Prehospital management of the critically ill or injured patient has recently changed considerably. Emphasis has been placed on the value of competent first aid by lay members of the public supported by trained medical or paramedical teams who are skilled in resuscitation.¹ Such systems of immediate care are not universally available in Britain. The general public's standards of first-aid knowledge are poor and basic ambulance training is often inadequate to provide all the necessary care for the ill or injured patient.

Despite this, doctors not uncommonly drive past an accident without stopping and later justify their action with the comment that there appeared to be sufficient people at the scene of the accident or that the ambulance had arrived. Similarly, despite the known risk of life-threatening arrhythmias during the early hours of a myocardial infarction some family doctors still leave the patient who has suffered a serious heart attack before the ambulance has arrived to take the patient to hospital. These actions are inexcusable. They may reflect the doctor's lack of confidence to cope with the emergency and this may be a consequence of inadequate undergraduate or postgraduate training in basic first aid, resuscitation procedures, and the principles of dealing with accidents.

Medical care

During 1979 the accident and emergency department of Southampton General Hospital received a total of 6272 patients who had been injured or taken ill suddenly. In 701 (11%) of these cases the family doctor had been called. The prehospital care of the remaining 5571 patients was undertaken by the ambulance service with little or no first-aid support and no medical help at all. Under 10% of the ambulancemen dealing with these patients had received any form of advanced training; this raises the question of whether we should be leaving the immediate care of the severely injured or critically ill patient to the ambulance service or whether the doctor should be encouraged to give prehospital treatment.

The doctor has been providing immediate care in Britain for over a decade in areas recognised to have a high risk of accidents. Dr

Kenneth Easton pioneered immediate medical care for the victims of road accidents on the A1 in the early 1960s with considerable success.² Similar schemes have been established to help people who are injured on the road, in the mountains, in caves, and off our shores.³ Over the years these groups of doctors, usually general practitioners, have developed skills in caring for the patient during transportation over difficult terrain and on the long distances to the nearest accident department.

For the family practitioner concerned with such immediate care, a flexible practice organisation is necessary to make doctors available over the 24 hours. Reliable radio communications are essential, and co-operation with the police, fire, and ambulance services must be good. Specialised protective clothing and equipment is essential and medical skills must be of a high order. These skills include management of the obstructed airway, caring for the traumatic pneumothorax, and correcting hypovolaemia; and the doctor must be able to use them in poor light, inclement weather, and cramped conditions. Since 1977 doctors providing such care have been united in the British Association of Immediate Care Schemes (BASICS) and about 1100 members now provide care over one-third of the land mass of the United Kingdom.⁴

Needs of urban areas

These schemes have arisen from a recognisable need in areas where the accident risk is high and the distances from hospitals great. The needs of urban areas in Britain are different. Distances to the local accident and emergency department are relatively short and ambulance response times good. As the Southampton figures have shown, however, the family doctor is available for only about 11% of emergency calls. This may reflect the nature of the family practice in large towns. The average lot size is over 2500 patients, and the doctors are expected to provide all necessary care for those patients. This includes health education, preventive medicine, and supervising the continuing care of the elderly patient or those with long-term illness. Modern treatments have meant that more can be done for many patients but these treatments often carry the risk of iatrogenic disease, requiring the progress of patients to be monitored frequently and carefully. The growing population of elderly people adds to the family doctor's commitments, particularly as many elderly patients are unable to travel to the surgery for assessment or treatment.

Practice organisation

Many family doctors traditionally supplement their income with part-time employment—for example, as clinical assistants, industrial medical officers, or advisers to insurance companies. To cope with

Southeastern General Hospital, Southampton SO9 4XY
R A SLEET, MB, MRCP, consultant, accident and emergency department, formerly general practitioner

Details of injuries and prehospital treatment of 6272 patients attending an accident and emergency department

	Road traffic accidents	Home	Work	Nature of injury Self-inflicted and overdose	Sport	Other	Place of injury not recorded
Family doctor contacted before ambulance service	5	308	25	40	5	120	204
Emergency services contacted immediately	11	89	131	481	145	1076	1474