PRACTICE OBSERVED

Law and the General Practitioner

Appearing in court

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A general practitioner may be called upon to give evidence in a variety of courts for a variety of reasons, but the basic principles are the same. In this article we assume that the doctor's evidence is in relation to his professional activities and not to some non-medical happening such as witnessing a road accident, where his standing in court will be the same as any other member of the public.

In his professional capacity the general practitioner, unless a police surgeon, will seldom act as an expert witness. This is usually the role of the consultant pathologist or surgeon who appears in court to interpret and give opinions on postmortem findings or the prognosis of a disabled patient. Most of the legal pronouncements of family doctors will concern matters of medical fact arising out of their practice, though there is a somewhat indistinct zone between this aspect and an opinion upon those same facts, which then merges into the purview of the expert witness.

Appearing as a professional witness

Let us concentrate for the moment, however, on the most common activity when the doctor appears as a "professional witness." This term distinguishes him both from the lay citizen who is giving purely eye-witness accounts of what he saw and from the expert who often pontificates upon cases that he has never seen in the flesh. The distinction is important, not least financially, as the rate of fees and expenses are appreciably different in the three classes. In criminal cases and in the coroner's courts fees are rigidly laid down and the "going rate" can be found in the publications of the British Medical Association, which assiduously looks after the doctor's remuneration.

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by negotiating updated increases at frequent intervals. When a doctor acts either for the defence in a criminal case or for either party in a civil case, fees are not nearly so clear-cut, but again some general guidance can be obtained from the BMA.

Whatever type of court or case is concerned there are some general features common to all medical evidence. Firstly, there is the mechanism by which the doctor becomes embroiled in the whole affair, often reluctantly. The first approach may be made by a police officer, when the case is to be heard before either a coroner or a criminal court. This may escalate from quite innocuous beginnings, the policeman initially asking merely for a statement about the doctor's dealings with a patient. When the coroner is concerned no ethical dilemma exists, as there is a statutory duty on all citizens, doctors included, not to hamper the coroner in his investigation. No problems about medical confidentiality exist when the patient is dead, and indeed it is often the doctor who initiates the whole affair by first reporting the case to the coroner.

In any event the police officer or coroner's officer will ask for a statement about the medical history and the events of the death and if an inquest is held, the doctor may well be required to attend and give evidence. In the coroner's court the proceedings are informal, and though lawyers may be present the strict rules of evidence seen in other courts do not apply so that the tenor of the proceedings is usually more relaxed.

After either reading his statement or being led through it by the coroner, the doctor may be asked questions by the relatives, their legal representatives, or the coroner himself. Most coroners are keenly aware of the demands on a general practitioner's time and will usually either call the doctor early in the case and release him immediately after he has given evidence or arrange for him to attend at some predetermined time. Compared with the formality of the Crown Courts, giving evidence at an inquest is no ordeal at all, if the doctor has taken the trouble to provide a coherent statement and has read it over before stepping into the witness-box.

When the matter concerns a live patient and is to go before the magistrates or Crown Court, then the doctor needs to be more

the side who called him, either prosecution or defence. The witness should confine himself in this evidence-in-chief to what is being asked, without launching into voluble asides and irrelevances, unless it seems that a short answer might misrepresent what he wishes to convey. Then cross-examination from the opposing lawyer will follow, when courteous replies should be given to what these days are almost invariably polite questions—though the good manners of the counsel may well disguise a penetrating ability to lead the unwary doctor into many traps. If, however, the groundwork of good preliminary statements has been laid and the practitioner sticks unwaveringly to the facts and opinions as stated, then he should not come to grief. Once again, he should answer only what is asked and beware of unnecessary amplification, as nothing delights a lawyer more than a loquacious witness who can be led by the nose into all sorts of embarrassments.

NO BOMBHELLS OR JARGON

The doctor is there to help the court and to assist in arriving at the truth, whatever that may be. He should therefore not be overtly partisan on behalf of "his side" and not reply evasively, beligerently, or reluctantly when questioned by the adversary lawyer. He has an ethical duty not to conceal any facts which may be advantageous to the other side, though he should not volunteer facts not brought out by his own counsel unless it is apparent that a definite miscarriage of justice might occur. This is uncommon, but if it did arise the doctor should invariably discuss it out-of-court with the solicitor or barrister and not

drop it like a bombshell in his evidence before an unprepared counsel.

As I have mentioned the atmosphere at the coroner's inquest is much lower keyed and in all but the most controversial cases questions are few and usually simple. Relatives are entitled to inquire of the doctor, and the coroner often invites them to do so. These should be answered as sympathetically as possible, even if they seem trivial or obvious—and as in all court appearances the replies should be couched in a language that is easily understood by non-medical people. Medical jargon—especially abbreviations—should be avoided at all costs, even when the barristers and judge may be well acquainted with the terminology. Other people are present in court, such as the jury, relatives, and the press, and they have the right to understand what the medical witness is talking about. "Periorbital haematomas" means little to them when a black eye is being talked about, and a "DVT" or an "SGOT" is quite incomprehensible. Sheer thoughtlessness, professional pomposity, or retreating into comfortable familiar jargon may cause uneasy medical witnesses to relapse into the mysterious vocabulary of medicine, something which must be consciously resisted.

Conclusions

The doctor will have little reason to view a court appearance with distaste if he gives an accurate and restrained first statement, if he gives his evidence in a calm and professional manner, if he confines himself to the content of that first statement, and if he uses straightforward commonplace language in his delivery.

Sex Problems in Practice

Referring patients to a gynaecologist or psychiatrist and to a marriage guidance counsellor

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Consultant gynaecologist or psychiatrist

The pattern of referral for sexual problems varies from place to place, depending on the services available and the skills and interests of individuals, who may belong to one or several disciplines. Referral to a hospital clinic will usually be to either a gynaecologist or a psychiatrist. These specialists are perceived by the patient as having very different roles, and they usually function within different frameworks. To simplify, the gynaecologist's skills include intimate touching, which is professionalised partly by not focusing upon sexuality, whereas the

psychiatrist is open to talk about sexual attitudes and emotions, but generally avoids physical touching. To handle sexual problems adequately, each has to broaden his competence and become professionally "comfortable" with both the talking and the touching.

In deciding when to refer problems to one or the other, the general practitioner will obviously be influenced by his local knowledge of an individual's skills. The following guidelines indicate the type of case that is best referred to one or the other.

PATIENTS SUITABLE FOR GYNAECOLOGICAL REFERRAL

Patients with dyspareunia as a primary problem should always undergo a careful and skilled examination to identify local causes—for example, vaginitis, tender scars or caruncles, urethritis, or pelvic inflammatory disease. Indeed, all women who find intercourse painful should, in my view, have a pelvic examination, even if this is only to reassure them that they are physically normal, before embarking on behavioural therapy.

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circumpect in revealing confidential details of a patient's history. Much depends on the circumstances and it is both mendacious and futile to stand too much on medical dignity when it is patently obvious that the truth will inevitably have to be aired. Too ready a willingness to divulge intimate details, however, may well damage the doctor-patient relationship, both with that particular patient and potentially among the rest of the practice.

When a doctor has treated the victim of an assault, however, then in almost every case the victim will be only too willing to have details of his injuries given to the court when his assailant is brought to trial. But when the injured person himself is to be charged or where intrafamily disputes have required medical intervention, the doctor must be more cautious. The police have no absolute right to demand a statement, and the doctor can refuse. The official remedy would usually be to serve a witness summons upon the doctor, who may then be hauled before the court, where he has no privilege in respect of medical confidentiality and either has to answer the questions or risk a penalty for contempt of court. In addition, recent changes in the legal procedures to obtain medical records have made it easier for lawyers to see the medical facts before the cases come to trial, so an unreasonable stubbornness in resisting a request for medical details seldom succeeds. There may be occasions, however, when a doctor genuinely thinks that he should make a show of reluctance—when he thinks the medical aspects are trivial or irrelevant or when delicate issues, often concerning a pregnancy or venereal disease, may damage his relationship with his patients.

CIVIL MATTERS

In civil matters, particularly those concerning compensation for disability after accidents and industrial injuries, the practitioner must be wary of requests from solicitors for a report on the patient's condition and prognosis. He should first identify the lawyer to find out whether he is acting for the patient or "the other side," as occasionally the legal gentlemen seem purposely vague about their true allegiance. The safest procedure is to delay giving a report until the lawyer has provided written assurances that he is either acting on behalf of the patient or, if not, that he has permission in writing from the patient to learn medical facts.

When the doctor is satisfied that he is able to give the statement, this should be accurate, concise, and confined to matters of medical fact, free from any conjecture or opinions unless these have been specifically requested. The accuracy so often depends on the doctor's own records, but unfortunately practice records often leave much to be desired. Judges and magistrates have many times waxed caustic over the apparent medical amnesia of a medical witness in the court. Though more easily said than done, any case which may have potential medicolegal aspects should be recorded with special care. Unfortunately some of the apparently most humdrum events lead to weighty forensic consequences and, as these may occur months or even years later, the memory of the doctor for the details may be as blank as his record card.

In the witness-box

The foundations of a good and untroubled appearance in the witness-box are laid at the time of giving the initial statement or report—this is probably the most important piece of advice that can be offered. What is said in the first deposition is what the court depends on when the matter comes to trial. The doctor should put nothing in that first report that he is not prepared to stick to through thick and thin. It matters even more in expert evidence where opinions are offered, but even in factual professional evidence the doctor should be firmly prepared to "put his mouth where his pen was" when it comes to giving evidence.

It is all too easy to give way to expansive descriptions, even to flights of fancy, when writing a report with no immediate prospect of court appearance, but many doctors get cold feet when the day of the hearing approaches and they try to back out from what they had put their signatures to some months previously. This fault of "not coming up to proof," as the lawyers call it, is one of the most common flaws in medical evidence and can lead to the doctor getting a rough ride in the witness-box.

Conversely the doctor should not go overboard when giving his evidence, so that he makes sweeping statements and introduces new facts that he never mentioned in his statement. He risks being tied in knots by the opposing lawyers, who are adept at digging large verbal holes into which the garrulous witness readily falls. There must be overemphasised that the serenity or otherwise of the appearance in court depends largely on the foundation laid by the original statement.

FACTS AND OPINIONS

As mentioned earlier, most family doctors will go to court to give factual accounts of their dealings with a patient rather than for the more expert task of drawing conclusions from those facts. It is often impossible, however, to draw a strict line of demarcation between the two functions. For instance, a doctor may describe how he sutured a wound on a person's scalp, which is a matter of fact. But then he may reasonably be asked whether the wound was serious and whether he considered that it constituted any risk to life. This then becomes a matter of opinion, based on clinical experience and judgment. Similarly a doctor may relate facts of a patient's dermatitis in respect of the diagnosis and treatment, but then be asked if he thought it could be the result of some industrial exposure. The answer would be an opinion, and the doctor should accept these minor excursions into such marginal areas of expertise. If the questioning goes more deeply into matters of opinion, however, he should either resist the trend by stating plainly that he does not feel competent enough to hazard expert opinions or point out to the magistrate or judge that he is now being asked to act as an expert witness—with a consequent increase in his fee. He should only do this if he feels on sure ground that his opinion is justified. He might be far better qualified, for instance, to give an obstetrical opinion than a most eminent forensic pathologist who has not attended a birth for 30 years, but a general practitioner would be ill-advised to trespass far into fields such as orthopaedics or surgery. In fact he might well be challenged pretty smartly by the opposing lawyer as to his competence in such fields.

AIR OF QUIET AUTHORITY

As to actual courtroom technique, nothing can surpass a cool and reasoned statement of the facts, given in a professional manner by someone who resembles the public's idea of a doctor. The old adage, "Dress up, stand up, speak up, and shake up," still has much to commend it. A doctor's evidence will carry much more weight if it comes from a witness with an air of quiet authority—the general demeanour and appearance certainly help in establishing this image. Even in the witness-box, where the informality, court eyebrows will be raised if the medical witness appears in a hairy pullover, faded jeans, and no tie. I remember a coroner of the old school becoming almost apoplectic when confronted with a house-officer witness at an inquest, who was dressed in a Stronson and a loud, plaid lumberjacket. The discomfited doctor was dismissed from the court to return in something more appropriate and informed that his fee would be forfeited. If the evidence is worth giving it is worth hearing, so a clear and audible delivery is desirable, though it should fall short of a pedantic, lecturing style, which unmarks of professional condescension.

In courts other than the coroner's, the doctor will usually be led through his evidence by the barrister or solicitor acting for

Couples who are infertile and have sexual difficulties as well often present considerable problems of management. Rarely is it easy to decide which problem should be tackled first, or whether an attempt should be made to deal with both at the same time. Certainly there should be the closest intercommunication between those handling the two aspects of the case, with (preferably) a single person acting as "co-ordinator."

Couples who also have a contraceptive problem, which the general practitioner does not feel able to handle.

Couples who are unwilling to attend a psychiatric hospital or clinic.

With two other groups the choice of referral is less clear-cut. Patients with vaginitis (non-consummation) have problems that may present a great range of difficulty. They are likely to be helped in either treatment setting, though the woman may be reluctant to attend a gynaecological clinic because of a clinical pelvic examination unless she can be reassured that this will not be imposed.

There is a large group of women whose sexual problems date from the post-partum period. Their recent contact with the obstetrician, if found helpful, would be a reason for referring them back to the same person. If, however, their obstetric care has not gone smoothly and satisfactorily, they may prefer referral elsewhere.

PATIENTS SUITABLE FOR PSYCHIATRIC REFERRAL

Patients who also have a problem of sexual orientation (homosexuality, bisexuality) or of sexual identity (transsexuality). Patients with other paraphilias.

Patients whose pattern of general behaviour is so abnormal as to suggest a personality disorder.

Patients whose sexual difficulties are accompanied by morbid depression or sustained anxiety.

Patients whose sexual problems are complicated by alcohol or other drug abuse.

Finally there are couples whose sexual difficulties are only a part of a broader problem within the whole marital relationship. The marital counselling needed will generally be available in a psychiatric clinic, although other agencies, such as the Marriage Counselling Service and social workers, may be available to provide this type of treatment.

London Marriage Guidance Council

In 1974 the Department of Health gave a grant to the National Marriage Guidance Council (NMGC) to train a few counsellors in the use of behavioural therapy methods to treat sexual problems as pioneered by Masters and Johnson and developed by Helen Singer Kaplan. The skills of these experienced counsellors—who had completed the two-year basic training and counselling in the NMGC—were to be used to train other counsellors who would be an excellent foundation on which to graft the further expertise of using directive, time-limited behavioural methods for specific sexual dysfunction. Counselling is concerned with helping a couple to understand their interaction and to recognise that there are choices either for change or for acceptance, while in the treatment of sexual dysfunctions the therapist is primarily an educator and permission-giver and takes responsibility for change in this treatment which is highly goal-oriented.

Six counsellors were trained in these methods in the Midlands

and the results of this three-year experiment encouraged the DHSS to give a further grant so that the training could be spread throughout the country. There are now about 30 clinics. Addresses of clinics may be obtained from NMGC, Herbert Gray College, 1 Little Church Street, Rugby, or from the London MGC. The first one and a half years are spent working with a trainer, attending training courses at NMGC at Rugby, and attending regular case discussion groups. The second year and a half is spent in co-therapy with a peer, or in training another counsellor with continuing training at Rugby and support from case discussion groups.

The London MGC's Sexual Function Clinic (76a New Cavendish St, London W1, tel: 580-1087) was started in 1977 and now offers 14 sessions a week, run by six trained therapists and one training session run by one therapist with two trainees. LMGC asks for a contribution of £10 per session, when there is real hardship we are always willing to discuss this. Clients come from many different sources—referred by general practitioners, marriage guidance counsellors and other counsellors, Family Planning Association clinics, and many are self-referred, having heard of the clinic through the media. Treatment is offered only to couples in a committed relationship, and, due to the experimental nature of the treatment, cannot be offered to individuals.

TREATMENT

In the first interview the therapist determines whether the presenting problem is primarily a sexual one or is the presenting symptom of deep underlying conflicts in the psychopathology of the individuals or of their relationship. When it seems that the latter may interfere with treatment the couple are usually advised to seek counselling first. A retrospective analysis of couples who were assessed and treated during the first two years of the clinic showed that "success" is very strongly linked to a correct assessment made at this stage of the balance between the "psycho" and the "sexual" components of the problem, the former carrying the poorer prognosis. This seems also to be the experience of other clinics both here and in the United States. If the relationship seems strong enough to support treatment, the psychosexual histories of each partner are taken next. This is followed by a "round table" session when a contract is built between therapist and clients based on mutually agreed aims. The treatment is explained in further detail and the first semate focus exercises are set. The treatment then becomes tailor-made to the individual's and couple's needs, and is supplemented and supported throughout by the therapist seeking and giving information, at times using visual aids, by the permission they give to the clients to be sexual and, above all, by the therapist's feeling comfortable in the area of sexuality. Deeper problems that sometimes surface during treatment respond to brief, active confrontation of the problem using the psychotherapeutic approach of counselling to challenge or sidestep the resistance to the purely behavioural methods. A balance and flexibility between these two methods is essential in each case. Treatment lasts on average between 8 and 14 weekly sessions.

Success measured in terms of couples walking off happily into the sunset is rare, but it does happen, and success in terms of a much improved sexual relationship is generally accompanied by a greatly improved relationship in general.

The following dysfunctions are treated in the clinic: *Men*: primary and secondary impotence; premature and retarded ejaculation. *Women*: vaginismus; total anorgasmia; situational anorgasmia. *Men and women*: low libido (or desire-phase dysfunction); dyspareunia.