THE WHOLE TRUTH:

Responsibilities when providing evidence

What you really need to know

Avant riskIQ

an Avant member benefit

Table of contents

Introduction

As a benefit to members, medico-legal expertise is available 24/7 in emergencies through our Medico-legal Advisory Service telephone advice line. One of the most common types of calls we receive is about how to respond to requests for information for use in legal proceedings or for a medico-legal purpose. Many doctors are uncertain about how to respond to these requests. As this handbook will make clear, there are different obligations and requirements for different types of medico-legal information requests.

We have produced this handbook to outline what you need to do in the most common situations you are likely to encounter.

Of course there will always be scenarios that may not fall neatly into any of the categories we cover in this handbook. If in doubt you should always contact Avant for advice.

This handbook covers three topics:

1. Requests for medical records
2. Statements and report writing
3. Giving evidence in court

Chapter 1
Requests for medical records

Solicitors' letters | Subpoenas to produce | Search warrants

Parties involved in legal proceedings are entitled to gather evidence to support their case. Solicitors' letters and subpoenas are usually used by solicitors seeking information to be used in legal proceedings or for other medico-legal purposes. Search warrants are typically used by police in the investigation of a crime.

This chapter outlines how to respond to:

- letters from solicitors (or insurers) seeking information about a patient and/or copies of patient records (requests for reports are dealt with in Chapter 2)
- subpoenas for production, summonses, and notices of non-party disclosure
- search warrants

When can I provide patient medical records?

With the patient's consent	Without the patient's consent
In the form of a signed authority or verbal consent which you carefully document	Use or disclosure required by law: ▶ mandatory legal disclosures such as a subpoena or warrant ▶ public interest exemption such as when a serious crime has been committed or there is a risk of serious harm to the patient or to another person.

Requests for information

A common method of obtaining evidence for medico-legal purposes is through a subpoena to produce or summons. These are all court documents that compel a third party (such as a medical practitioner) to produce documents to the court. A subpoena or summons may also require a third party to attend court to give evidence. In Queensland and the ACT a notice of non-party disclosure compels a third party to produce documents to the requesting party.

Privacy and confidentiality

As a medical practitioner you have a strict duty to keep patient information confidential, as well as obligations under privacy legislation. These obligations can be overridden in certain

circumstances including in legal proceedings or where information is to be used for medico-legal purposes. If you are ever unsure about how to proceed following a request for information you should contact Avant for advice.

Solicitors' letters

A request for information may come as a letter from a solicitor. Letters may include requests for:

- a medico-legal report on a patient (see chapter 2)
- a copy of your medical records relating to a patient
- a meeting to discuss a patient.

Under privacy legislation, you can disclose a patient's records to a third party such as a solicitor, with the patient's consent.

If you receive a letter from a solicitor, consider:

1. Who is the solicitor acting for?

Is it the patient or an appropriate representative, such as an executor or administrator of the patient's estate if they are deceased, or an insurer or other party to litigation? If you have any doubt about who the solicitor is acting for, contact the solicitor and find out. You should always deal with requests from solicitors seriously and with appropriate priority.

2. What is the purpose of the request?

The purpose for the request should be clear. If not, ask the solicitors to clarify why they want the information sought.

3. Is there a signed and dated authority from the patient for you to release the information to the solicitor?

A solicitor's request should include a signed and up to date authority (consent) from the patient.

The patient's authority should be recent and specifically relate to the purpose of the request. Generally if the authority was signed over 12 months ago you should check with the patient if it is still valid or ask the solicitor to provide an up to date authority.

4. Do you have any concerns about releasing all the records to the solicitor?

Often a solicitor will request the complete medical record, but you may have concerns about releasing the entire record, particularly if the record contains sensitive information. Sometimes the patient is not aware that everything in the medical record will be provided.

The solicitor may be acting for an insurer who is relying on a compulsorily acquired authority from the patient. Read these authorities carefully and strictly as they may not necessarily permit the disclosure of records and/or a complete copy of your records.

If you have any concerns about releasing the entire record, you should contact the patient to clarify if they would like their entire medical record released or a limited selection.

Failure to respond to requests for information in a timely manner is often a cause of complaint to regulatory bodies, such as AHPRA.

When receiving a solicitor's request:

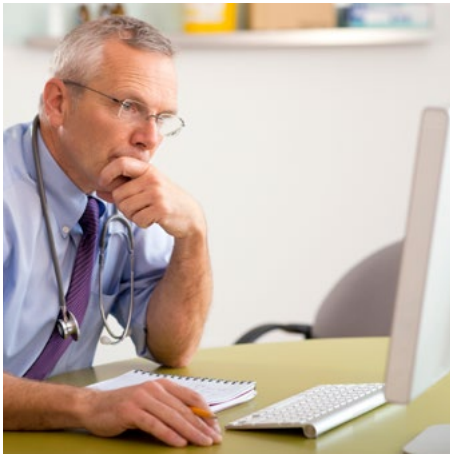
1	2	3	4
ascertain who solicitor is acting for	check purpose is clear	has patient authority (consent)	check scope of request (all or part of record)

Remember!

The following steps are important in managing requests from third parties:

- Check that there is an appropriate authority from the patient or that you are required by law to provide the records.
- Try to obtain some understanding of the reason for the request and what the third party is particularly looking for in the records.
- It is acceptable to provide a copy of all notes you have available including reports and specialist letters that did not originate from your practice.

If in doubt, contact Avant



Patient authority/consent

When you receive a patient's written consent or authority to release medical records you should:

- Read the authority or consent form carefully to ensure that the documents requested are within the scope of the authority or consent provided.
- Ensure the written authority clearly indicates who the records can be released to and which records are covered by the authority.
- Ensure the authority is signed by the patient and is up to date.

If you have any doubt, contact the patient to clarify. If you receive a patient's verbal consent to release records to a third party then you should carefully document this and ensure the verbal authority clearly indicates to whom the records can be released and which records are covered by the authority.

Court orders: subpoenas and summonses

A subpoena or summons is a court order. A subpoena or summons can require you to produce documents to the court, and can also require you to attend court to give evidence. In this section we consider subpoenas and summonses seeking production of documents.

A subpoena or summons is issued at the request of a party involved in legal proceedings. It will be stamped with the court's seal, state when attendance at court is required and/or what documents must be produced to the court.

In Queensland, a notice of non-party disclosure, which is also a court order, is used to compel production of documents in civil proceedings.

In all states a valid subpoena or summons generally overrides your duty of confidentiality to the patient.

A subpoena/summons is valid if:

- it has been properly addressed to you
- conduct money has been provided, if it is so required by the court rules
- it has been served in the required time frame specified in the document.

You should read the subpoena or summons carefully. Any irregularity such as the addressee, time for service and the need to pay conduct money will usually be apparent on the face of the document.

Failure to comply is a serious offence and if you do not comply you may be found guilty of contempt of court. A warrant could potentially be issued for your arrest and you could be ordered to pay any costs caused by your non-compliance.

The schedule to the subpoena/summons

The schedule to the subpoena outlines the documents to be produced. You should read the schedule carefully. The schedule may require originals to be produced or may state that copies are sufficient. You should ensure that documents referred to in the schedule are produced, even if they are kept in different files. "All notes" means both handwritten and computerised notes.

The subpoena may require the production of letters to and from solicitors acting for the patient and also medico-legal reports. It is for the patient through their solicitors to claim legal professional privilege over these documents. If you are a party to the proceedings, then you should obtain legal advice from your solicitor about producing documents passing between you and your solicitor.

You should only produce those documents caught by the schedule to the subpoena and no more.

If you are in any doubt about whether to produce certain documents, you should seek legal advice or contact Avant.

What can you charge for producing records under subpoena or a summons?

Generally, you are entitled to be paid reasonable costs you incur in complying with a subpoena where those costs exceed the conduct money paid. Conduct money is a sum of money paid with the service of the subpoena to allow the documents to be delivered to the court. Reasonable costs over and above this might include the costs of locating archived files, photocopying documents, administration costs and any additional costs to convey the documents to the court. Accounts for these costs should be submitted to the solicitor who served the subpoena or summons.

Notice of non-party disclosure

A notice of non-party disclosure, used in Queensland and ACT, is a court document requiring you to produce records that are directly relevant to an issue in legal proceedings. The records can be produced for inspection by the applicant or their solicitor, at their place of business or the place of business of your solicitor, within ordinary business hours or at another mutually agreed time and place.

A notice of non-party disclosure is valid if the notice:

- has been issued by the court, signed by a clerk on behalf of the registrar of the court and has on it the court stamp or seal
- is an original document, not a photocopy
- has been served upon you within three months of the date of issue set out in the first paragraph on the first page of the notice.

If the notice is not valid, you should advise the applicant within 14 days why you believe the notice is not valid.

If the notice seeks documents relating to a patient who is not a party to the proceedings, the applicant is obliged to serve a copy of the notice on that patient. The patient then has seven days in which to object to disclosure in writing to both you and the applicant. In these circumstances, you should wait seven days before responding to the notice. If the notice seeks documents of a patient who is a party to the proceedings, there is no obligation to advise them that a notice has been issued.

In responding to a notice, you should satisfy yourself that your patient's records are relevant to the proceedings.

The first or second page of the notice should set out the allegations in the pleadings between the parties to which your patient's records relate. Notices which do not identify specific issues but which ask for all records are probably invalid. If you think the notice is invalid or you do not think that the records are relevant to the proceedings, you should seek advice about objecting to or challenging the notice. You have 14 days after service of the notice to object to the notice.

Sometimes the statement of claim or other court documents outlining the plaintiff's case will be served with the notice. If not, you should request copies.

Once you are satisfied that the records relate to particular issues in the case, wait seven days and then provide access. Most solicitors will not want to inspect your original records and will simply request copies.

You are entitled to your reasonable costs and expenses of producing the documents. This ordinarily includes photocopying costs and possibly some administration fee or a component for professional time in reviewing the notice.

If unsure about what to do in response to a notice of non-party disclosure you should seek advice from Avant immediately as the window for objection to producing the records is 14 days after service of the non-party disclosure notice.

Steps to take in providing documents to a court:

1. **Take a copy of the records and the subpoena and place the records in a sealed envelope, labelled:** The confidential medical records of Dr [ ] relating to the patient [ ]/produced in response to a subpoena in (Plaintiff) v (Defendant), Proceeding No [ ].
2. **Place this envelope into another envelope addressed to the court officer**, together with the copy of the subpoena or summons (this is a mandatory requirement in New South Wales).
3. **Arrange for the secure delivery of the envelope to the court** by hand or registered post.
4. **Provide the patient with a copy of the subpoena and inform the patient that their medical records have been forwarded to the court in compliance with the subpoena.** It is then a matter for the patient and their legal representatives to determine whether they wish to raise any issue with the court.

Objections to producing documents

In limited circumstances you can object to producing records in answer to a subpoena, summons or notice of non-party disclosure. The grounds for objection include matters such as:

- the subpoena or notice is oppressive due to the considerable expense and inconvenience in complying with the subpoena or notice, e.g. because the amount of documentation is excessive or if you need to exercise precise judgement as to what documents have to be produced
- lack of relevance of the documents to the issues in the action, a difficult argument to mount when you are not a party to the proceedings
- lack of particularity of the subpoena schedule i.e. the request is too broad to be able to identify exactly what records to produce (not a likely objection in a medical case)
- claim of legal professional privilege (**note:** in respect to this basis you will probably need to seek legal advice. The privilege may be the patient's or yours if the documents record communications created for the purpose of receiving legal advice or for use in legal proceedings)
- the confidential nature of the documents such as a communication that would fall within confidential communications relationship privilege or sexual assault communications privilege under the Evidence Act in NSW
- the effect disclosure would have on any person
- the validity of the subpoena or notice, including whether it has been served on you within the required time frame.

Objecting to production on these grounds is rarely successful in a medical case.

Search warrants

Police generally do not have the power to search premises unless they have a search warrant. Police have the power to search a premises if they have a search warrant. An exception to this would be if the police enter and search a premises for the purpose of arresting a person they believe has committed a serious offence.

If police attend your premises seeking to execute a search warrant you should call Avant for advice.

If a police officer produces a warrant, check that the warrant has been signed by a magistrate or judge and correctly identifies your premises. Check the time and date on the warrant during which the search may be executed. The warrant must list the type and category of items the police have been authorised to find and seize.

If the warrant is in order, you should then cooperate with the police but ensure that you retain, if at all possible, a copy of the documents taken under the warrant. In any event the police should provide you with a list of documents taken during the search process.

Challenging a warrant

It is possible, although uncommon, for a warrant to be challenged in court, for example because it is legally defective in some way. It is for this reason that you should call Avant and seek advice when faced with a search warrant. The police will often extend a medical practitioner the courtesy of allowing them to seek legal advice before they commence their search.

Releasing information to police when they do not have a warrant

Privacy and confidentiality of patients' health information is not absolute. There may be times when it is necessary to balance the public interest in maintaining privacy of health information and the public interest in avoiding danger or harm to the community or individuals.

The Commonwealth *Privacy Act 1988* sets out limited situations when a patient's information can be disclosed without their consent. These include when there is a reasonable belief that the use or disclosure is necessary to lessen or prevent a serious threat to the life, health or safety of an individual; defending or establishing a legal or equitable claim, for example responding to a civil claim for damages or a disciplinary complaint, and for law enforcement activities.

Generally in relation to law enforcement activities, there should be a good reason why the police cannot obtain a search warrant for the information in question.

You should exercise caution if the police ask you to release information to them. You are under no obligation to release patient information to the police if they do not have a warrant or the consent of the patient. You should contact Avant for advice if you are in any doubt about whether to release the information.

If you are accused of an offence

Sometimes, medical practitioners are accused of sexual misconduct or other offences in the conduct of their practice. Often the first you might know of such an allegation is when the police attend with a search warrant or request that you attend the police station for questioning. If you are requested to attend the police station for questioning, it is vital that you immediately contact Avant and seek legal advice. The police should allow this contact to be made.

Limited exceptions to giving access

There are some situations where you might consider not giving a patient or their authorised representative access to their medical records. These reasons are referred to as limited exceptions which include but are not limited to:

- if access would pose a serious threat to the life, health and safety of any individual
- if access would breach someone else's privacy
- or if denying access is permitted/required by law.

You should contact Avant if you have any concerns about providing medical records as requested.

Requests for patient information			
Request from:	**Patient (or authorised person) consent required:**	**Overrules confidentiality:**	**Submit to:**
Solicitor	✓	✗	Solicitor
Police	✓	✗ *(some exceptions ie request from coroner)*	Police
Subpoena summons	✗	✓	Court
NNPD	✗	✓	Solicitor
Patient	✓	✗	Patient or as directed
Insurance or other third party	✓	✗	insurer or third party

Remember!

If you are accused of a criminal offence, seek immediate legal assistance before responding to the allegations.

Key messages

- A subpoena, search warrant or NNPD is an order of the court and should, subject to seeking legal advice as necessary, be complied with.
- Failure to comply with a subpoena, search warrant or NNPD may have serious financial and legal consequences.
- A subpoena must be complied with and documents submitted to the court by the date specified.
- Objections to an NNPD must be made within 14 days. Contact Avant immediately if you have any concerns about the notice.
- When in doubt about whether you should comply with a subpoena, seek timely legal advice from Avant.

Chapter 2
Statements and report writing

Statements to the police | Statements to the coroner | Report writing Treating practitioner | Expert witness

You may be asked to provide a statement to police for the investigation or prosecution of a crime, or for a coronial investigation into a reportable death.

Report writing, whether as a treating doctor or expert witness, is one of the requests for information you might encounter in medical practice. Failing to complete such reports appropriately can result in a complaint to AHPRA and even a finding of unprofessional conduct.

In this chapter we clarify the doctor's legal obligations and provide a model for structuring different types of reports.

Medical practitioners commonly receive requests for reports or statements for a range of medico-legal purposes. These can include:

- a statement for the coroner
- a statement for police for a criminal matter
- a treating doctor's report about a patient
- an independent expert opinion.

Medico-legal statements

Statements for the police for criminal proceedings

It is likely that during your medical career, you will be asked to provide a statement to the police about a consultation or interaction you had with a patient who becomes involved in a criminal investigation or is the victim of a crime.

You do not have any obligation to provide information about your patient to the police (unless they have a warrant), and a police request does not override your duty of confidentiality to your patient or your obligations under privacy legislation.

It is not mandatory to provide a statement to the police when asked, however doing so may decrease the likelihood of involvement in further court proceedings.

Consent

Whenever possible, you should obtain your patient's consent before you provide any information to the police.

In limited circumstances you may be permitted to provide information to the police without your patient's consent.

Supporting you all the way

Avant can advise and support you during the entire process, relieving the pressure by:

- becoming the contact point for the police, coroner's office, or courts
- ensuring you have all the available material to assist in drafting your statement
- assisting and advising you to draft your statement reviewing your statement from a medical and legal perspective.

If the patient does not consent or will very likely not consent, for example because they are the one under police investigation, contact Avant for legal advice as to whether it is appropriate to breach the patient's confidentiality in the circumstances. If the patient was a hospital inpatient at the relevant time you should check with the hospital administration that you are permitted to provide a statement using the hospital records.

Whether or not you provide a statement, you may still be required to attend court to give evidence.

Format

The statement should be provided in a format that means it can be used as evidence if necessary. This will vary between jurisdictions but is usually an affidavit [1], an expert certificate or a sworn statement. The police should provide the correct template. You should notify Avant and we can assist you with the preparation and offer advice about the correct template to use.

Content

It is important to remember that the requirement is for a factual, not an expert, witness statement. Describe what happened but do not stray into providing expert opinion. You should be clear about your specific role in events.

Your statement should be factual and should be based on your records.

Your statement should include:

- your qualifications and experience
- details about your consultation with the patient including:
  - history taken
  - examinations performed and findings on examination
  - impression/differential diagnoses
  - your treatment plan.

The information you provide should also be consistent with the medical records. If you have no access to the records, ask the police to provide a copy.

Do not speculate and do not comment on areas beyond your area of expertise.

Summary

The patient's consent and hospital approval should be obtained before you provide a statement to the police, except in limited circumstances.

The statement should be a factual account of your consultation with the patient.

The statement should outline the extent of your exact role.

Avoid giving your opinion.

[1] An affidavit is a written statement of facts prepared by a party or witness, solemnly sworn to be true, and signed in the presence of an authorised person such as a justice of the peace or lawyer. It is used as evidence in court proceedings.

Statements to the coroner

If you provided medical care to a patient who died as a result of a reportable death, you may be approached by the police to provide a statement. You should not provide a signed statement or enter into detailed conversations with a police officer without first contacting Avant.

You should ask the police officer to request the statement in writing.

Background

Coroners are responsible for investigating suspicious and reportable deaths and fires. The table on page 16 provides a quick guide to the differences between each state and territory.

The coroner's role is to determine the identity of the deceased as well as the date, place, circumstances and cause of death. The preliminary investigation and gathering of evidence for the coroner is generally conducted by the police under instruction of the coroner.

Specific points to note about writing a statement for the coroner

As a treating doctor:

- You do not need to obtain consent from the deceased's family or the executor or administrator of their estate to provide the statement. The coroner's written request is sufficient authority.
- You should be clear about your specific role in events. You should avoid commenting upon the care provided by other medical practitioners in your statement – you should detail your own involvement in the matter.
- The statement should begin with your full name, practice address and formal qualifications.
- If the treatment provided was in your capacity as a public hospital employee you may also need to submit the statement to medical administration.
- We recommend the draft statement is submitted to Avant for review and assistance.

The investigation

Coroners are responsible for investigating suspicious and reportable deaths and fires. The legislation in each state and territory defines a "reportable death" somewhat differently – refer to table on page 16.

The coroner's role is to determine the identity of the deceased as well as the date, place, circumstances and cause of death. The preliminary investigation and gathering of evidence for the coroner is generally conducted by the police under instruction of the coroner.

Once statements have been obtained from the relevant witnesses, those assisting the coroner may obtain an independent expert's report commenting on the role of various individuals in the care and treatment of the deceased.

The coroner will review all of the evidence and determine whether an inquest (a court hearing) is necessary.

In the majority of cases the manner and cause of death is clear, and so the coroner will not usually hold an inquest. If, however at the conclusion of the investigation, the manner and cause of death remain unclear and/or there are important public health issues to be addressed, the coroner will hold an inquest. Coronial investigations can be complex and lengthy. Investigations can take twelve months, or longer.

Coronial inquest

There is a range of circumstances where a coroner can decide to hold an inquest concerning the death or suspected death of a person. In some circumstances, for example a death in custody, the coroner must hold an inquest.

The duration of an inquest can vary from one day to many weeks depending on the complexity of the case and the number of witnesses called to give evidence. Generally, Avant will be notified of the amount of time the inquest is "set down" for. Medical practitioners as witnesses will generally be excused after giving their evidence (which may take a few minutes to hours).

The result of the coronial inquest

After all the evidence has been heard, the coroner will hand down their findings and may make recommendations. Often there will be a period of weeks or months between the end of the evidence, and the coroner handing down their findings. Although the role of the coroner is not to apportion blame, sometimes coroners may be critical of a medical practitioner and refer them to a regulatory authority such as AHPRA or the local health complaints body. After this, a separate assessment or investigation will take place into the practitioner's conduct. Sometimes during the inquest the coroner may form the view that there is a case for criminal charges to be considered against an individual. If so, the coroner will suspend the inquest and forward the documents to the Director of Public Prosecutions. Fortunately, this happens rarely to doctors. If the coroner makes adverse findings, the deceased's family may consider bringing a civil claim for damages against individual practitioners.

Key messages

- Do not provide a signed statement or have detailed conversations with police without first contacting Avant.
- If you receive a summons to give evidence at a coronial inquest you should contact Avant immediately so that steps can be taken to assist you and to protect your interests.
- You may be asked to give evidence at an inquest for a variety of reasons. Often the practitioner's involvement is not contentious. You simply possess one or two pieces of the factual jigsaw puzzle that the coroner needs to assemble.
- Avant will help you appreciate the nature and extent of your involvement as the case progresses.

The table below is an overview only. For full details of your legal obligations you should check the legislation in your state or territory.

Quick reference guide for when to report a death to the coroner

Circumstances	ACT	NSW	NT	QLD	SA	TAS	VIC	WA
Violent or unnatural death (e.g. by drowning, suspected killing etc.)	✓	✓	✓	✓	✓	✓	✓	✓
Sudden death, unexpected death, cause unknown	✓	✓	✓	✓	✓	✓	✓	✓
Death in suspicious circumstances (that require investigating)	✓	✓	✓	✓	✓	✓	✓	✓
Unable to determine cause of death and certificate is not issued	✓	✓	✓	✓	✓	✓	✓	✓
Deceased not attended by a medical practitioner within a period of time immediately preceding death (6 months)	✓	✓						
Identity not known	✓	✓	✓	✓	✓	✓	✓	✓
Death while under, or as a result of, or within a period of time of administration of anaesthetic			✓		✓ 24 hours	✓		✓
Death during a medical procedure	✓				✓		✓	
Death following a medical procedure where the death was not the reasonably expected outcome of the procedure. (Health care-related death in QLD)	✓ 72 hours	✓		✓	✓ 24 hours		✓	
Following an accident that may have caused the death (in Tasmania this includes work-related death)	✓		✓	✓		✓	✓	✓
While "held in care" or temporarily absent from an establishment, such as a hospital within the meaning of the Mental Health Act, a facility or a residential centre for persons with disability, and while the person was a resident at the establishment for the purpose of receiving care, treatment or assistance	✓	✓	✓	✓	✓	✓	✓	✓
While in custody or escaping from the custody of a police officer or other lawful custody	✓	✓	✓	✓	✓	✓	✓	✓

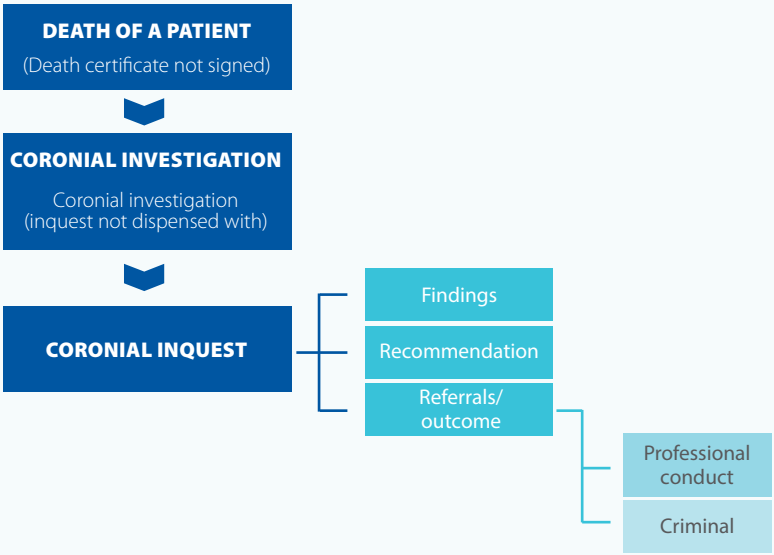
Reportable deaths generally include:

- deaths when the identity of the person is unknown
- unexpected, unnatural or violent deaths, including deaths in suspicious circumstances or deaths resulting directly or indirectly from an accident or injury
- the death of a person held in care or custody
- unexpected healthcare related deaths
- the death of a person where the cause is unknown.

If the manner and cause of death are clear, the coroner will usually dispense with an inquest. Many coronial investigations do not proceed to inquest and the file is closed by the coroner at an early stage.

Do not issue a cause of death certificate if the death is reportable to the coroner.

The coronial process



Writing medico-legal reports

A medico-legal report is a medical report prepared for legal purposes, such as coronial inquests, disciplinary complaints, civil/common law claims for damages, third party motor vehicle accident cases, workers compensation and determining testamentary capacity. You may be asked to prepare a medico-legal report as the "treating doctor" or as an independent medical expert.

Most of the reports you will be asked to write are treating doctor's reports, i.e. factual reports regarding your involvement with the patient's treatment and management.

However, you may also be asked to provide your expert opinion on a case. This may include:

- opinion, either in relation to one of your patients or an unknown person
- examining a patient and providing an expert opinion on their condition and prognosis
- providing an opinion on liability, causation or standard of care.

If you are the treating doctor you are not obliged to provide an expert opinion. You can offer to provide a treating doctor's report instead. You need to carefully consider whether you wish to take on the role of 'expert' in the patient's case. You will not be independent and you will be bound by the Expert Code of Conduct.

You should be asked to provide a medico-legal report in a letter of instruction, which sets out who is requesting the report, provides any applicable court code of conduct and sets out what you should address in your report.

General principles

Medico-legal reports should, where possible, be typed on your letterhead or you should ensure that you provide details such as your full name, practice address and qualifications in full (i.e. Bachelor of Medicine rather than MB). Include any training or experience that is relevant to the report content.

Some suggestions for things to include:

- Reference to the party requesting the report e.g. lawyer, police, coroner or coroner's assistant (e.g. police officer).
- The patient or other person in the report should be referred to by their title and name e.g. Mr George Thomas.

- The persons present at the consultation/ examination, e.g. mother, spouse, police officer, nurse etc.
- The nature of contact with the patient e.g. insurance examination and report, patient for x number of years, motor accident case etc.
- The history of the patient, examination, treatment and prognosis, if deceased – time, date, mode of death, etc. Where appropriate it may be necessary to enclose a photocopy of the clinical notes and depending on legibility, a typewritten transcript with abbreviations written out in full.
- State not only what was found on examination but also what was looked for but not found. If the report is challenged in the legal process, it may be on the basis that the doctor failed to make an adequate assessment.
- Write in the first person and active voice e.g. "I saw the patient on" rather than "the patient was seen on".
- List all documents relied on in writing the report, e.g. X-ray reports.
- Answer, where possible, any specific questions in the request for the report.
- Do not stray and provide opinion if it has not been requested, for example if asked to comment on a medical practitioner's standard of care do not also provide an opinion on what caused the injuries unless asked to do so.

You may be required, in the future, to give evidence under oath based on the content of your assessment or report. Accordingly you should be careful to ensure that the conclusions and opinions are in fact drawn from the patient's history, the clinical examination and any other pertinent information.

Report writing as a treating doctor

A treating doctor's report should deal only with the patient's condition and treatment and not with issues of liability relating to the claim (i.e. who may be responsible for the injury or illness and have a liability to compensate the patient). In some cases, you may be uncomfortable about the information to be disclosed in the report. Contact Avant to discuss your concerns.

In the case of treating practitioners, when you agree to write a report for medico-legal purposes on request by the patient or their solicitor, you should do this as promptly as is reasonably possible. It may be necessary to review the patient to assess their injury or illness properly or review the patient's entire record. If a report is not an accurate record of a patient's medical history it may jeopardize your credibility. Inaccuracies, errors or incomplete information in a report have resulted in complaints against practitioners.

In the absence of a subpoena or other court authority, such as a request from the coroner, as a treating doctor you must not provide a medical report without a patient's consent. Ideally, an authority signed by the patient should be an original document, should be contemporaneous with the request for the report, addressed specifically to the medical practitioner and identify the injury or illness for which information is sought. You must only disclose information that the patient has consented to being disclosed.

Report writing as an independent expert witness

Court rules define an "expert" as a person who has specialised knowledge based on training, study or experience, or who is qualified to give evidence as an expert. The overriding duty of a medical expert is to assist the court, impartially, on matters relevant to their area of expertise. An expert witness is not an advocate for a party, so it is imperative you remain impartial. It is also an imperative that as an expert witness you remain within the scope of your competence.

To be accepted by a court, expert evidence must satisfy two criteria:

- the expert witness must have "specialised knowledge based on the person's training, study or experience"
- the opinion expressed in evidence by the witness "is wholly or substantially based on that knowledge".

Before agreeing to provide an independent expert's opinion you should therefore be satisfied that you have:

- relevant academic and professional qualifications
- relevant clinical experience in the area at the time the medical issue in dispute arose
- specialised knowledge of the medical issue in dispute
- an active practice in the relevant area of expertise.

Retired practitioners, or those no longer practising in the area of expertise addressed in the expert report, should only give opinions about an incident that occurred when they were in active practice.

Examination for the purposes of an independent expert's report

If asked to examine a person to provide an expert's report, you should:

- explain to the person your area of medical practice, your role, purpose, nature and extent of the assessment to be conducted
- anticipate and correct any misunderstandings that the person may have about the nature and purpose of your assessment and report
- recognise that, if you discover an unrecognised, serious medical problem during your assessment, you have a duty of care to inform the patient or their treating doctor.

When writing the report following the examination:

- Provide an impartial report.
- Make clear the limits of your knowledge and do not give an opinion beyond those limits when providing evidence.

Time commitment

Preparing expert reports can be time consuming. A key consideration at all times for you is whether you can make the necessary time commitment required, if not you can say no. Consider:

- the volume of material to review – ask how many pages or volumes there are to read
- meetings that may be required – when, where and for how long?
- whether there is likely to be a need to attend an experts' conclave, at which experts confer to produce a joint report that articulates points of agreement and contention, or court hearing and, if so, when and where.

It is a requirement of the court's Expert Witness Code of Conduct that experts agree to comply with court directions, including the date for service of expert reports. Always find out when an expert's report is required and if there is a court-ordered date for service of the report. In these circumstances, you owe a duty to the court when you agree to provide an expert's report.

Before commencing an independent expert's report you should ensure:

- you have clear, unambiguous instructions
- you have all relevant documentation
- you are aware of specific questions to answer
- you know what areas are to be covered.

An expert witness may be engaged to:

- consider the available papers and provide an opinion on liability. i.e. breach of duty of care (standard of care) and/or cause of the person's injuries/ illness
- examine a person and report on their current condition and prognosis
- undertake both of the above.

Format for an expert's report

There is no set format for an expert's report but a good guide is to cover the following items:

- your qualifications and experience (short CV)
- acknowledgement of the Code of Conduct
- documents provided to the expert, including the solicitor's briefing letter
- the facts and assumptions on which you base your opinion
- examinations, tests or other investigations undertaken
- your opinions and detailed reasons for each opinion
- any issue that falls outside your field of expertise
- qualifications to your opinion or changes of opinion
- literature or other materials relied upon to reach your opinion
- executive summary (for a lengthy report, you could provide a summary of your opinion).

In relation to expert witnesses:

- You may discuss a draft report with the instructing lawyers.
- Lawyers may suggest areas requiring clarification or expansion.
- Lawyers may advise where the content is not relevant to the issues.
- Lawyers cannot require you to change your opinion or ask that relevant material be excluded.

The Expert Witness Code of Conduct is the court document which guides an expert's role in the provision of the expert opinion. The code of conduct varies between states and territories yet will usually include the following core elements:

- The expert has a paramount duty to the court and must assist the court impartially.
- The expert is not to be an advocate for one party or another.
- The report or testimony must contain the qualifications of the expert, the facts and assumptions relied upon by the expert, reasons given for opinions expressed, what issues fall outside the expert's field of expertise, and the research or literature relied upon by the expert.
- The expert must indicate if the report or testimony is incomplete or requires qualification by an additional expert in the field.
- Where the expert subsequently changes their opinion they must supply a supplementary statement to the engaging party.
- An expert may be required to confer with other expert witnesses and must exercise their independent professional judgement.

Reasonable care

When giving an expert opinion you may be asked to comment on whether care given during the events in question was "reasonable". This can be difficult to identify for several reasons.

A natural instinct is to push towards perfection, or even what you may have done in the same situation, rather than to say if the care given was "reasonable" given what was known at the time.

When evaluating this, consider the advantage you have with knowing the outcome from the decisions made at the time, and the range of acceptable practices at the time. Hindsight bias can make this a challenge but it is important to consider the decisions only on the information known at the time.

In practice as we know, decisions need to be made under less than ideal circumstances, and often quickly. It is far easier to make decisions when you know all the facts and have plenty of time to consider your options. Consider these issues when reviewing the facts of the case and forming an opinion about what would constitute reasonable care.

It is not your role as an expert to give an opinion on whether or how the claim or litigation should resolve. This is a matter for the courts and the lawyers representing the parties.

You provide your medical opinion solely upon an independent assessment of the person's injuries or a review of documents which are provided. You should make no comment to the person about the conduct of the litigation, the likelihood of settlement or the amount of damages they are likely to recover as a consequence of their injuries or illness. You are not in a position to know all the considerations, legal and otherwise, that will impact on the resolution of a claim.

You should also be careful not to make derogatory remarks about patients, parties to litigation or your colleagues, either verbally when examining the patient, or in written reports. You should confine yourself to medical facts and your professional opinion alone.

Remember!

Understand and abide by the relevant rules and requirements for writing an expert's report take very seriously the responsibilities imposed under the Expert Witness Code of Conduct.

Setting and collecting fees

A fee for a medico-legal report is usually a matter for negotiation between the you and the party requesting the report.

As far as practicable, the fee for a report should reflect the effort, skills and resources associated with the provision of that report, and the following factors should be considered:

- In preparing the report, what amount of your income is foregone?
- Are other employees involved in the preparation and at what cost are their services to be provided?
- Are there other costs directly associated with the service (e.g. photocopying, telephone calls, etc.)?

In some states and territories, experts' fees are capped by court rules. In NSW, the AMA (NSW) and the New South Wales Law Society agree annually on a schedule of fees for medico-legal examinations and reports. Some organisations such as motor vehicle accident and workers compensation authorities have prescribed limits for fees paid for medical and expert reports. It is important to be able to justify the fee charged. We recommend that you should arrange to receive payment of the fee before providing the report.

Remember that if you provide a report as an independent expert you may be called upon to give evidence in court. An independent expert will ideally have the ability to communicate complex issues to a lay audience. Judges or the jury are very unlikely to be clinicians and their experience in understanding technical evidence will vary. They will have difficulty accepting a proposition if they cannot understand it. In the adversarial context of the courtroom, you need the skills to support your expert opinion in challenging circumstances.

Remember!

Ensure you are familiar with the appropriate code of conduct.

Key messages

- Ensure you have access to the patient's medical records as required and wait until you have reviewed them before providing a statement or report.
- Be clear about your role, when recounting events don't speculate on what others may have done.
- If providing an expert opinion be clear about your limitations

Chapter 3
Giving evidence in court

Witness of fact | Expert witness

For many doctors, this is the least familiar, and possibly the most stressful form of involvement with the legal system. In this chapter, we provide practical tips about giving evidence in court.

You may be required to give evidence in court as a witness, either as a participant in events or treatment (a factual witness) or as an independent expert who has provided an expert's report (an expert witness). It is important to be clear about your specific role and the purpose of your contribution to the court process.

If you are required to give evidence in a court hearing, you will usually receive a summons or subpoena. These are court orders that compel you to attend court. If you do not comply with a valid summons or subpoena, you may be found to be in contempt of court and a warrant may be issued for your arrest.

Responding to a subpoena or summons

The summons or subpoena contains the date on which you are required to attend court. Usually this date is the first day of the hearing, and this is not necessarily the day you will be called to give evidence.

If attendance is difficult because the court is interstate or overseas, you may ask if it is possible to give evidence by video link. You should discuss this with the solicitor who arranged for the subpoena to be issued as soon as possible, as courts require arrangements to be made in advance.

What can you charge for attending court in response to a subpoena?

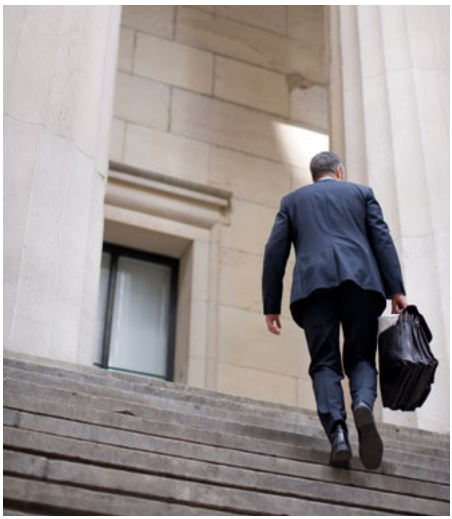
If you attend court in response to a subpoena you may be entitled to be paid reasonable fees and expenses. If you receive a subpoena but are later told that you need not attend, you may be entitled to charge a cancellation fee. Some courts provide a scale of fees but the fee is usually a matter for agreement between the witness and the solicitor who issued the subpoena. If there is no agreement the fees may be determined by the court. If you are served with a subpoena, you should agree on a fee structure (including cancellation fees) before the trial commences.

Watch

avant.org.au/Resources/Public/20140903-evidence-in-criminal-court

Standby arrangements when attending to give evidence

Unfortunately, the progress of court proceedings can be unpredictable and at the discretion of the judge or presiding officer. Courts are conscious of the commitments of professional witnesses and try to minimise inconvenience, but sometimes inconvenience is unavoidable. A witness may be requested to attend, for example, at 10 a.m., but in fact they will not be required until much later. Bear in mind that because it is not clear how long the evidence of each witness will last, the next witness may be required to be present or able to attend at very short notice. This is known as being "on standby", and can be a source of frustration for a person called to give evidence.



The process

Attendance

Unless you are told otherwise by the solicitor who issued the subpoena, you should attend court at least 15 minutes prior to the time you have been asked to attend and wait outside the courtroom to be called in.

Do not enter the court until called. As a witness you are not allowed to hear the evidence of other witnesses before giving your evidence.

It is advisable not to discuss evidence with other witnesses prior to giving your evidence to ensure that your recollection is not influenced by the recollection of any other person.

Oath or affirmation

Witnesses will be called into court to give evidence and escorted to the witness box. Do not take any documents into the witness box unless directed to do so.

Once in the witness box you will be asked to swear an oath or make an affirmation to tell the truth. This can vary, but a court official or the judge will generally ask whether you would prefer to swear on a the Bible, Koran or other religious book, or give an affirmation. If you elect to swear on the Bible, you will be requested to take the Bible in your right hand and asked "Do you swear that the evidence that you will give will be the truth, the whole truth, and nothing but the truth, so help you God?" If you agree with the question, you should say "So help me God". Alternatively, you may be asked by the judge to read the oath from a card in the witness box.

If you elect to give an affirmation the process is essentially the same but you do not need to swear on a Bible to tell the truth.

Persons in attendance

The judge or magistrate will be sitting on the bench. If you need to address the judge, they are referred to as "Your Honour".

The barrister or solicitor for the party who is relying on your evidence will ask questions first. This is known as "evidence in chief".

The questioning generally is as follows:

State your name, occupation and address.

If you provided a statement or report, you will be handed this from the bundle of exhibits, asked to confirm it as your statement or report, and asked to confirm that you agree that its contents are true. You will then be taken to parts of the statement or report for discussion, but additional questions outside the statement or report may also be asked. The legal representative for the other parties may ask questions after the first barrister/solicitor has finished. This is known as "cross-examination".

After cross-examination, the barrister/solicitor who started has the opportunity to ask more questions to clarify anything you said in cross-examination. This is known as "re-examination".

The judge may interject at any time to ask questions.

Concurrent evidence

In some courts, the usual process is for independent experts to give evidence concurrently. This means that all of the experts on a particular issue will be invited into the witness box at the same time and will be asked the same questions, a process sometimes referred to as "hot-tubbing". In this situation the questioning is often directed by the presiding judge.

When giving evidence:

1. **enter court only when asked**
2. **take the oath or affirmation**
3. **state your name, occupation and address**
4. **confirm your statement or report as previously submitted**
5. **answer questions succinctly when asked**
6. **refer to documentation if needed (such as patient records)**

Tips for giving evidence

Giving evidence can be a stressful experience. It is important to take your time and remain calm. Do not be rushed by the person asking the questions or feel pressure to fill any silences between questions.

- Listen carefully to each question and ensure you fully understand it before answering; if in any doubt, ask for the question to be repeated. Think about your answer and then answer the question accurately. Be responsive but as succinct and to the point as reasonably possible.
- If the question is capable of a "yes" or "no" answer, then it is appropriate to just answer "yes" or "no".
- If the question requires more than a yes or no answer, then answer the question as fully as you can. Do not volunteer any additional information outside the scope of the question asked unless it is relevant. It is up to the person asking the question to clarify or request additional information.
- Your answers to the questions should be confined to issues of fact, not opinion, unless you are specifically asked to provide your opinion or if you are called to the hearing as an expert.
- There may be an objection to the questions asked. As soon as an objection is made, you should stop answering the question until a ruling is made by the judge. You will then be directed by the judge as to whether you need to answer the question.
- If you are giving evidence as a witness to an event and you do not recall something, you should respond "I do not recall". You should not try to reconstruct what you believe may have happened or what you have been told by somebody else they believe happened. Your evidence should only be based upon what you actually recall happening.
- If you are uncertain about something, you should say this in your answer.
- If you feel you need to provide a more detailed answer than the barrister allows before the next question, say that you wish to further answer the previous question and continue providing the answer.
- If you need to look at the medical records or another document, it is entirely appropriate to ask to look at the medical records or other document in order to refresh your memory. Your evidence to a question may be that "I cannot now recall, but I made a note at the time and this is what my note says ...".

- If you realise you have made a mistake in the answer you have just given or any previous answer, say so and give the correct answer.
- Do not try to anticipate what the questioner is getting at or their subsequent line of questioning.
- Remain polite and civil even if provoked by the questioner.
- Do not argue with the questioner.
- Do not volunteer information that is not necessary to respond to the question.
- Do volunteer information that is necessary to understand your response, for example "Can I explain?"

Additional tips for independent experts

If you are called upon to give evidence in court as an expert, these tips may also be helpful:

- Remember your role and closely guard your independence. This may involve making concessions or agreeing with experts for the opposing side(s).
- Listen to the question. If you don't understand it, say so.
- Always answer the question. Do not be evasive.
- Where experts are giving evidence concurrently, do not be afraid to ask questions of other experts or engage in dialogue.
- Be courteous, polite and professional, but if you disagree with another expert's view, you should say so.
- Remember that the judge is not medically qualified, so where possible express your opinion in a way that can be understood by people who are non-medically trained.
- Don't stray beyond your expertise. Before giving evidence:
  - Prepare adequately: review all records, the reports or briefs prior to the hearing
  - Be aware of the latest research in the area. The lawyers will be aware of any research that may help their case. Listen to other opinions and consider your position. Don't be unduly pliable or rigid under pressure.
  - Be impartial and avoid any observable bias.

Giving evidence at a coronial inquest

A coronial inquest is a court hearing where the coroner considers evidence to determine the identity of the deceased and the date, place, manner and cause of death of the deceased. The coroner often calls witnesses to give evidence.

If you have provided a statement to the coroner and an inquest is held, it is likely that you will be summonsed to give evidence at the inquest. Occasionally, you may be asked to attend to give evidence at short notice. Sometimes it is not until the inquest commences that it becomes clear that your evidence is needed. For more information refer to page 14 of this handbook.

You should request assistance from Avant, early - such as when you are first asked to provide a statement. We can advise you on your position and whether you need to have legal representation at the inquest. If necessary, we will appoint a lawyer to represent you. The lawyer will contact the coroner's court to advise that they will be seeking leave to appear at the inquest on your behalf.

The investigating officer will compile a coronial brief for the coroner. The brief contains all relevant statements, medical records, autopsy reports and expert reports obtained for the coroner in relation to the investigation. Avant or the lawyer will obtain a copy of the coronial brief and review it to identify possible areas where the coroner may make adverse comments.

During the inquest, the coroner is usually assisted by counsel.

If you are called to give evidence, you will be asked to adopt or confirm the accuracy of the statement you have previously provided. Those who have a sufficient interest are then entitled to ask questions in cross-examination. Generally, at the end of cross-examination, you will be asked questions by your lawyer to clear up any ambiguities or issues that may have arisen.

It is important to remember that a coronial inquest is an inquisitorial process, a fact-finding exercise, and not a method of apportioning blame. The rules of evidence do not apply in the coroner's court and those called to give evidence are either factual or expert witnesses. In other words, unlike civil and criminal courts, coronial proceedings are not adversarial and there are no parties.

Dealing with the stress of the legal process

Dealing with the legal process, whether providing a statement, responding to a subpoena or giving evidence in a court can be stressful. This is particularly true if you are responding to charges or a complaint made against you. Facing a complaint, litigation or a disciplinary hearing is one of the most stressful events a doctor will face and it can have significant professional and personal impacts.

The legal process can be unpredictable and Avant is here to support you when you need to respond to a legal request. We suggest you familiarise yourself with the process so you know what to expect. Examine how you respond to stress and if you feel yourself getting stressed act proactively and address it early. Re-examine your life and restructure it as necessary - this can be an opportunity to put life in perspective and reprioritise.

There are many support systems available to you, Avant included. Identify those with whom you feel most comfortable to share your reactions and recognise that most practitioners need to share their reactions to the experience with someone. For you it may be another practitioner, a spouse, a family member, friend, office staff, medico-legal adviser, claims manager or solicitor.

If you need more information than provided in this handbook please contact Avant through the support services listed on the last page.

Remember!

Always be well prepared before entering the court room in any capacity.

Key messages

- Be familiar with the patient's medical record
- Answer questions without unnecessary elaboration
- If you don't know the answer it is okay to say so. Take time to consider your responses.

Further reading

Australian Medical Association. *Ethical Guidelines for Doctors Acting as Medical Witnesses* 2011; Canberra: AMA, 2011. Available at https://ama.com.au/position-statement/ethical-guidelines-doctors-acting-medical-witnesses-2011

Australian Health Practitioner Regulatory Agency. Medical Board of Australia. *Good Medical Practice: A Code of Conduct for Doctors in Australia*, Section 8.8. Canberra: AHPRA, 2014. Available at
http://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx

Cambridge Medicine. *How to write a good medico-legal report*, Cambridge: 2013 Feb 3. Available at http://www.cambridgemedicine.org.uk/how-to-write-a-good-medico-legal-report/

Nash L et al. Factors associated with psychiatric morbidity and hazardous alcohol use in Australian doctors. 2010 MJA 193; 3: 161- 6 at 164

Beyond Blue. *National Mental Health Survey of Doctors and Medical Students*, 2013, https://www.beyondblue.org.au/docs/default-source/research-project-files/bl1132-report---nmhdmss-full-report_web

Support

At Avant we have supported many of our members through stressful and time-consuming court appearances. We are aware of the toll it may take on our members both personally and professionally.

Our support includes:
Avant Medico-legal Advisory Service:

Call **1800 128 268**
Visit **avant.org.au/mlas**
Email **nca@avant.org.au**
Fax **1800 228 268**

Avant Health and Wellbeing website:
Visit **avant.org.au/health-and-wellbeing**

Avant Risk IQ:
Visit **avant.org.au/risk/iq**

Avant riskIQ

an Avant member benefit

Avant Risk IQ, a market-leading risk education program committed to educating the medical profession.

Avant members, log on to **avant.org.au/riskiq/handbooks** where you may be eligible for CPD/CME points for reading this handbook and completing the associated questions.

If you are reading this online and would like a hard copy please email **riskiq@avant.org.au** with your member ID and postal address.

New South Wales

Level 28, HSBC Centre, 580 George Street
Sydney NSW 2000
PO Box 746 Queen Victoria Building NSW 1230
Telephone 02 9260 9000 Fax 02 9261 2921

Queensland

Level 11, 100 Wickham Street
Fortitude Valley QLD 4006
GPO Box 5252 Brisbane QLD 4001
Telephone 07 3309 6800 Fax 07 3309 6850

South Australia

Level 1, 195 Melbourne Street
North Adelaide SA 5006
GPO Box 1263 Adelaide SA 5001
Telephone 08 7071 9800 Fax 08 7071 5250

Tasmania

Suite 4, 147 Davey Street
Hobart TAS 7000
PO Box 895 Hobart TAS 7001
Telephone 03 6223 5400 Fax 1800 228 268

Victoria

Level 2, 543 Bridge Road
Richmond VIC 3121
PO Box 1019 Richmond North VIC 3121
Telephone 03 9026 5900 Fax 03 8673 5015

Western Australia

Level 1, 91 Havelock Street
West Perth WA 6005
PO Box 950 West Perth WA 6872
Telephone 08 6189 5700 Fax 08 6189 5713

1800 128 268 **avant.org.au**

3717 03/16 (0254)

Avant mutual group