Legal and Forensic Medicine: UK and Australia

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Abstract

Forensic and Legal Medicine is an evolving area of medical practice, and there are a number of organizations that have been developed to support doctors working in these fields in the UK and Australia. Initial training and continuing professional development are essential to ensure that practitioners have the core competencies to perform the roles required and remain up to date in this rapidly changing area. These disciplines of medicine need full specialist recognition.

Introduction

This chapter will discuss legal and forensic medicine, outlining the professional organizations in Australia and the UK available to support these areas of medical practice. What standards are required in this area of medicine, which is not currently seen as a major specialization? The importance of initial training, with the attainment of higher qualifications and ongoing professional development, is discussed. There is a fundamental need for the practice of forensic and legal medicine to be recognized as a speciality.

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The Terms "Legal" and "Forensic" Medicine

Legal and Forensic Medicine has been defined by the European Council of Legal Medicine (ECLM) [1] as a medical speciality in the European Union with a speciality profile given as

> The application of medical knowledge and methodology for the resolution of legal questions and problems for individuals and society.

The ECLM promotes the teaching of legal medicine to undergraduates outlined in the "Perugia document" as modified in Cologne in July 1992 [1]. The major topics to be highlighted include the following: thanatology and forensic pathology, clinical forensic medicine, and medical law and related jurisprudence.

In Europe, clinical forensic medicine (CFM) and forensic pathology fall under this definition, although other areas of practice such as forensic toxicology, forensic psychiatry, forensic genetics, and forensic anthropology may be involved. Many of these areas are well developed when compared to clinical forensic medicine. In many jurisdictions, there are no specialized health-care professionals to provide this pivotal role. Forensic pathology and forensic psychiatry do have well-established and respected profiles with speciality training pathways in both Australia and the UK.

Beran has defined Legal Medicine as the interface between medicine and the law in health care [2]. There has been debate regarding whether legal medicine and forensic medicine are equivalent [3] with such a wide definition encompassing multiple medical specialties being criticized [4]. Recognition of the need for new specialities of Forensic Medicine and Legal Medicine was certainly behind the development of the Faculty of Forensic and Legal Medicine of the Royal College of Physicians of London (FFLM) which was established in 2005. The Royal College of Physicians, the parent College, was clear that the new Faculty was set up for three *specific* groups of doctors – forensic physicians (FPs), medico-legal advisors, and medically qualified coroners – and was not, and should not be seen as, a Faculty of Expert Witnesses validating those working "medico-legally" in multiple medical specialities.

One of the original aims of the FFLM was to achieve this specialty recognition for Forensic Medicine and Legal Medicine, and a first stage application for speciality status was sent to the Department of Health in May 2007[1]. The application was rejected, with a formal response received from the Department on 30 June 2008 informing the Faculty that[2]:

> the areas of practice that the faculty had defined in its application represent a distinct field that requires a discrete knowledge, set of skills and level of expertise. It was also acknowledged that there is an increasing demand for such practitioners.

A letter from the Parliamentary Undersecretary of State in March 2012 to President George Fernie, the FFLM President, confirms that this view will not change until 2013.

Previously the Department of Health (DH) and the Postgraduate Medical Education and Training Board (PMETB) suggested that the expertise should be recognized as a subspeciality with a recognized curriculum, training, and qualification in

Forensic Medicine and Legal Medicine. There were problems with finding suitable parent colleges to support this initiative[3], and a proposal was made to consider modular credentialing[4].

In Australia, clinical forensic medicine (CFM) is not recognized as a speciality. For specialist status to occur, the Australian Medical Council (AMC) process requires that there are deliverable benefits to the Medicare system and CFM is practiced uniquely outside the Medicare system. In Queensland, there is a process to recognize clinical forensic medicine as an area of advanced credentialed practice[5] using the requirements of the Australasian College of Legal Medicine. The process required is equivalent to that required by other medical specialties. In interstate jurisdictions, such as NSW and WA, Fellows of the ACLM are eligible for appointment as staff specialists and senior staff specialists and have been appointed as such.

Relevant Organizations Involved in Forensic and Legal Medicine in the UK and Australia

Association of Police Surgeons (APS)/Association of Forensic Physicians (AFP)

Payne-James and Stark have recently outlined the history of forensic medicine and, in particular, clinical forensic medicine [5]. In the UK, the APS was founded as a London Metropolitan Association in 1888 [6]. The APS became a National organization in 1951 and eventually also had international members. This was, in part, because the only recognized international qualification in clinical forensic medicine and forensic pathology was in London. Many international doctors came to the UK to study and obtain the Diploma in Medical Jurisprudence run by The Worshipful Society of Apothecaries. The APS became the AFP in May 2003 [7] and was one of the founding organizations for the Faculty of Forensic and Legal Medicine at the Royal College of Physicians of London.

In 1995, the Council of the APS set up an education and research subcommittee [8] which worked tirelessly to develop educational material for doctors practicing in the field of clinical forensic medicine producing guidelines, recommendations, fact sheets, policy statements, and training packages. This was extremely important when representations were made to the Royal College of Physicians, regarding the establishment of a Faculty, and it showed the need for specialist recognition by starting to define the standards required in a number of areas, such as for doctors, allied health-care professionals, police, lawyers, judiciary, or social workers. The education and research committee set the foundations for the academic committee of the FFLM which took over this role in 2006.

In 2000, the Council of the APS recommended to the Annual General Meeting (AGM), using a significant amount of the capital reserves in an attempt, to form a College of Clinical Forensic Medicine [9]. The matter was debated at the AGM, and unanimous support was given to the establishment of a working group, led by Dr Stephen Robinson. From the start, the College was seen as an academic body.

Discussions were held with the Society of Apothecaries in 2001 who had previously been involved in a similar initiative with general practitioners [10], but this came to nothing.

In 2003, the AFP President, Dr Margaret Stark, wrote to the Home Secretary, David Blunkett, asking him to support the development of a College of Forensic Medicine. Further letters of support for this initiative had been obtained from Lord Justice Auld (Lord Justice of Appeal in the Court of Appeal, England and Wales), Chief Constable Martin Richards (Wiltshire Police and ACPO Liaison with the AFP), and Baroness Molly Meacher (the former Deputy Chair of the Police Complaints Authority and Chair of the East London and City Mental Health Trust). Hazel Blears, Minister of State, gave support in principle for the College, and the AFP then had to prepare the business case to ensure the Home Office funding.

In 2004, the AFP went back to the RCP of London and asked about the possibility of the development of a Faculty. That year, the medically qualified coroners and the medico-legal advisors also approached the RCP, and on 9 March 2005, the Council of the RCP approved the formation of the Faculty in principle. Over that summer, the standing orders were developed, and it was on 14 September 2005 that the full Council of the RCP endorsed the Faculty's standing orders and elected the Foundation Fellows. The inaugural meeting of the Faculty of Forensic and Legal Medicine of the Royal College of Physicians of London was held in London on 13 April 2006.

Australasian Association of Forensic Physicians (AAFP) (www.forensicphysicians.org)

In Australia and New Zealand, the lack of specialist recognition led to the formation of the Australasian Association of Forensic Physicians in an attempt to address this important issue. The AAFP was established in 2009 by physicians in Australia and New Zealand with the aim of "unifying the practice of Clinical Forensic Medicine, developing a training and career path, defining and setting standards for the discipline and moving towards specialist recognition."

The AAFP produced a training curriculum in 2009 with three domains: clinical process, medical expertise, and ethics and the law. This curriculum has learning objectives with core and noncore competencies outlining the knowledge and skills required [11].

The AAFP has started to draft policy documents, standards, and guidelines and holds regular web-based professional development training sessions.

Australasian College of Legal Medicine (ACLM) (www.legalmedicine.com.au)

The ACLM was established in November 1995 by doctors and dentists who are duly qualified in the law and medicine or dentistry. The ACLM has a number of

membership categories including affiliate, associate, member, and fellow. Doctors and dentists who are practicing legal medicine at a specialist level, having completed appropriate training with a degree, such as an LLB or LLM, in a relevant subject or equivalent, may be awarded membership or fellowship. Since its formation, there was also an avenue, toward full Fellowship of the ACLM, dependent upon holding suitably recognized qualifications in forensic medicine, demonstrating two alternative methods of achieving College recognition. The ACLM has a Maintenance of Professional Skills/Continuing Professional Development (MOPS/CPD) form to assist members with documenting their continuing medical education. The College also offers an annual conference, a regular newsletter, and expert witness training.

The Australia and New Zealand Police Medical Officers Forensic Medical Society formally merged with the ACLM in 2004.

Australian Academy of Forensic Sciences (www.forensicacademy.org)

The Australian Academy of Forensic Sciences is a multidisciplinary organization whose foundation meeting took place in Sydney in 1967. In recent years, its activities have expanded to other Australian States and Territories, beyond New South Wales. The Academy has members from the professions of law and medicine, as well as leading scientists, sociologists, police officers, and government officials. The Academy publishes the *Australian Journal of Forensic Sciences*.

Australian Health Practitioner Regulation Agency (APHRA) (www.ahpra.gov.au)

In Australia, APHRA was established on 1 July 2010 by the Council of Australian Governments (COAG) as the single National Registration and Accreditation Scheme for ten health professions including medical practitioners. A National Board, the Medical Board of Australia (www.medicalboard.gov.au), has established registration standards that set out the requirements for continuing professional development and for recency of practice under the National Law[6]. The Australian Medical Council (AMC) (www.amc.org.au) is the national standard body for medical education and training in Australia. Functions include accrediting programs of specialist medical training.

British Academy of Forensic Sciences (BAFS) (www.bafs.org.uk)

The BAFS is an information and educational charity, working to encourage the study, improve the practice, and advance knowledge in Forensic Science and Medicine, as well as promote better cooperation between lawyers and expert witnesses. The Academy held its first meeting in 1960 and continues to have regular meetings in London as well as publishes the journal *Medicine, Science and the Law*.

Faculty of Forensic and Legal Medicine of the Royal College of Physicians of London (FFLM)

The Faculty of Forensic and Legal Medicine (FFLM) of the Royal College of Physicians of London (RCP) was established in 2005 following direct representation from three groups of medical practitioners in the UK [12]. The inaugural annual general meeting was held in London at the RCP in April 2006. The FFLM is a registered charity, managed by a board of trustees financially independent from the RCP. The objectives of the Faculty are set out in the standing orders [13]:

- *To promote for the public benefit the advancement of education and knowledge in the field of forensic and legal medicine*;
- *To develop and maintain for the public benefit the good practice of forensic and legal medicine by ensuring the highest professional standards of competence and ethical integrity*.

From the beginning, the FFLM aimed to set the required standards to ensure that those working in the field have the necessary expertise to perform the role [14]. The three specific groups included the following: forensic practitioners working in general forensic medicine, sexual offense medicine, and forensic pathology; medico-legal advisors working for the three defense unions (the Medical Protection Society, the Medical Defence Union, and the Medical and Dental Defence Union of Scotland); and medically qualified coroners.

Medically qualified practitioners who were judged, by the Fellowship Committee, to hold a relevant postgraduate qualification and who had made a notable contribution to Forensic and Legal Medicine through practice, research, or training were elected to Foundation Membership or Fellowship. This route to membership closed after three and a half years, when the Membership examination was established for doctors working in the field. Fellowship continues by self-nomination now.

The grandfather clause that allowed medically qualified coroners and forensic pathologists to be members has recently reopened. Individuals need to have a relevant postgraduate qualification and have made a notable contribution to Forensic and Legal Medicine through practice, research, or training. It is hoped that forensic psychiatrists may be added to this list in the future.

Affiliation with the Faculty is open to doctors who are working in the field, as trainees either full time or part time, or other individuals, such as the growing number of custody nurses or paramedics, who are working in the field of clinical forensic medicine, both general and sexual offense medicine, and those working as Medical Examiners (or Medical Reviewers in Scotland).

The FFLM has a number of committees including the main "Board," which oversees the running of the FFLM. The Academic Committee chaired by the Academic Dean oversees the Chief Examiner's Committee, the Research Subcommittee, the Conference Subcommittee, the Forensic Science Committee, the Training and Education Subcommittee and the Sexual Offences Forum; the Fellowship

Committee, the IT Steering Group, and the Revalidation Committee which oversees the Continuing Professional Development (CPD) Subcommittee.

Perceived benefits for the organization are increasingly important. The FFLM offers an annual flagship conference; the *Journal of Forensic and Legal Medicine* in hard copy and online; development training days; a wealth of information/documentation on the website covering guidelines, recommendations, facts sheets, pro formas, and policy statements; frequently asked questions; and newsletters. The FFLM has also produced core competencies for each discipline[7] and appraisal documentation to assist doctors in the proposed GMC revalidations. For doctors working outside the NHS, without an obvious designated body and responsible officer, this has been essential.

Setting up the membership examination was essential but a costly exercise, both in terms of time and money. The training requirement for examiners was onerous, and the commitment from each examiner to provide the necessary examination materials is time consuming and intellectually challenging and stimulating. The Membership examination is an important step to ensuring that forensic physicians have the appropriate knowledge and skills, as assessment is a key component of learning in the clinical environment.

Forensic And Medical Sexual Assault Clinicians Australia (FAMSACA) (www.famsacaustralia.org.au)

FAMSACA was established in 2003 from the National Adult Sexual Assault Medical Committee which had been formed in 1998. The organization has a number of aims and objectives, including to be the recognized body for those providing medical and nursing sexual assault care (including forensic management) in Australia. This includes an advisory, educational, and professional development role and provides professional standards for Australian doctors providing sexual assault care, particularly in forensic management. The website contains useful resources for forensic practitioners working in this field, including a newsletter and list of references on relevant topics for sexual assault practitioners.

General Medical Council

The General Medical Council (GMC)[8] and the publication *Good Medical Practice* outline the standards for doctors working in the UK[9]. Postgraduate training in the UK has, until recently, been regulated by the Postgraduate Medical Education and Training Board (PMETB), an independent statutory body covering all specialities and subspecialities. On 1 April 2010, the PMETB merged with the General Medical Council (GMC), which is now responsible for all stages of medical education and training. The standards and

requirements for all organizations, whether NHS, other service providers, or the independent sector, are outlined in three GMC documents [15].

The Medico-Legal Society (MLS) (www.medico-legalsociety.org.uk)

The aim of the MLS is to promote Medico-Legal knowledge, in all its aspects, and meetings are held in London where lectures are given with a forum for discussion. The presentations are then published in the *Medico-Legal Journal*. There are a number of other Medico-Legal Societies in the UK, for example, the Bristol Medico-Legal Society (www.bmls.org.uk), the Manchester and District Medico-Legal Society (www.mdmls.org.uk), and the Birmingham Medico-Legal Society founded in 1987 (www.bmlsinfo.org.uk).

In Australia in Victoria, a Medico-Legal Society was established in the 1930s by doctors and lawyers interested in mutual professional issues (www.mlsv.org.au). There are other medico-legal societies, for example, in NSW since the 1947 (www.medicolegal.org.au) and Queensland (www.medico-legal.com.au) since 1952.

Royal Society of Medicine (RSM) (www.rsm.ac.uk)

The Royal Society of Medicine was founded over 200 years ago, and its main function is to provide continuing medical education. The RSM has a Clinical Forensic and Legal Medicine Section which has meetings three times a year in London.

Royal College of Pathologists

Forensic pathologists focus on the legal medicine investigations of sudden or unexpected death. There are Colleges in the UK (www.rcpath.org) and Australia (www.rcpa.edu.au), and both offer a training program in Forensic Pathology. Many pathologists have a Diploma in Medical Jurisprudence (Path) from The Worshipful Society of Apothecaries of London. The UK College offers a Diploma in Forensic Pathology for those who have full training in histopathology and then wish to specialize in forensic pathology.

The Royal College of Psychiatrists (www.rcpsych.ac.uk) and the Royal Australian and New Zealand College of Psychiatrists (www.ranzcp.org)

Forensic psychiatry is a specialty which helps mentally disordered people who are a risk to the public. Psychiatrists working in this area liaise closely with police, prosecution services, the courts, and prisons. There are specialist training programs in the UK and Australia.

How Important Are Standards?

In 1993, a Royal Commission on Criminal Justice in the UK [16] voiced concerns about the lack of quality control of doctors working as police surgeons (forensic medical examiners, forensic medical officers, government medical officers, and forensic physicians) in the criminal justice system in the early 1990s. The role of doctors working in this field had changed since the introduction of the *Police and Criminal Evidence Act* 1984 [17]. Since the Royal Commission's report, there have been repeated calls for a high-quality professional forensic medical service to be established throughout the UK [18, 19, 20].

The role of the forensic physician has been well defined in the UK since 1996 [21], with regular reviews and revisions updating the role over the years, most recently in 2010 [22]. The Australasian Association of Forensic Physicians National Advisory Committee has (in 2009) defined Clinical Forensic Medicine and outlined the specific areas of expertise [23]. As other health-care professionals, nurses, and paramedics became involved in the provision of clinical forensic medical services, their function has also been detailed [24].

With regard to setting the standards, the FFLM, after a full consultation, issued Quality Standards in Forensic Medicine covering General Forensic and Sexual Offence Medicine [25]. These standards cover recruitment, initial training, work-based supervision, continuing professional development, and service-level standards. Subsequently, interim standards have been issued for health-care professionals – nurses and paramedics who are working in this field[10].

The importance of well-trained practitioners working in this area cannot be underestimated. There is a need for a specific skill set, and this is often not recognized until a disaster happens. There has been a paucity of research regarding the health-care needs of those detained for short periods in police custody, but recent research [26] has shown that many detainees have chaotic lifestyles, and major health-care demands will often be identified in police custody that have previously been unrecognized or are not being treated appropriately. This increases the risk for those with a duty of care, such as the police.

In Australia, there also is little information on short-term custody in the "Watch house." Sturgiss et al. [27] have found that the majority of the workload, involving suspects detained in the watch house in Canberra, was the medical review of detainees and not forensic procedures. A significant number of these detainees had mental health and/or drug and alcohol problems. The importance of screening, access to appropriate medical services, supervision, and monitoring in these high-risk individuals was highlighted repeatedly in the Royal Commission into Aboriginal Deaths in Custody [28].

In 2012, a "police doctor" was cleared of manslaughter but criticized as "negligent" by the trial judge [29]. Dr El-Baroudy was not guilty of gross negligence manslaughter over the death of Andrzej Rymarzak who had been detained by the Metropolitan Police Service in a cell at Chelsea police station in January 2009.

That the population is a risky one, where mistakes may result in a death in custody or a "near miss," with resultant criminal or civil liability as well as

disciplinary procedures, needs to be recognized [30]. Payne-James [31] obtained information from the GMC in the UK regarding examples of proven findings related to forensic medical practice which highlighted concerns regarding failure to take an adequate history, failure to perform a physical examination, failure to conduct an adequate assessment, failure to record findings, and failure to take adequate forensic intimate samples.

For forensic practitioners practicing in a field of medicine overlapping with the law, much of the work is driven by legal requirements. Doctors involved in this type of work need robust training to deal with the pressures that may be exerted by law enforcement agencies. It is also essential that practitioners in the field are independent, nonjudgmental, and professional, as well as advocates for vulnerable groups [22].

Wood, in 1997, identified a particular problem in relation to Medical Officers employed in the Clinical Forensic Medicine Section (now the Clinical Forensic Medicine Unit (CFMU)) of the NSW Police Force [32, 33], stating that:

> the nature of their work, and their professional and ethical responsibilities, requires them to have independence in their clinical activities. However, under the existing management structure, they are directly responsible to sworn officers who may have conflicting operational responsibilities or requirements.

Wood recommended transferring the Section from the control of the Police Service to the Institute of Forensic Medicine as this would overcome this problem in part and ensure that advice obtained by the Service, in this area, was not only objective and independent but seen to be so. Fifteen years have elapsed since Wood made this recommendation, but no transfer from NSW Police Force to NSW Health or another body has occurred in NSW.

The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) was set up in 1987 by the Council of Europe Convention and set standards for law enforcement agencies (www.cpt.coe.int). These state that people in police custody should have a formally recognized right of access to a doctor. All medical examinations of people in police custody must be conducted out of the hearing of law enforcement officials and, unless the doctor concerned requests otherwise in a particular case, out of the sight of such officials.

The Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment ("SPT") started its work in 2007 in the United Nations human rights system[11]. The SPT was established to fulfill the Optional Protocol of the Convention against Torture ("OPCAT") which was adopted in December 2002 by the General Assembly of the United Nations and entered into force in June 2006.

Australia is a party to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT), and the Government signed the OPCAT on 19 May 2009 but has not yet ratified the agreement[12].

Currently, there is no national program of inspections of places of detention, such as police custody facilities, but a National Preventive Mechanism will need to be established once the Australian Government ratifies OPCAT. In the UK, there are a number of independent organizations that oversee the detention of individuals

and any complaints, such as Her Majesty's Inspectorate of Constabularies (HMIC)[13]; Her Majesty's Inspectorate of Prisons for England and Wales (HMIP)[14]; and the Independent Police Complaints Commission (IPCC)[15]. Independent review of police and other authorities that deprive individuals of their liberty is essential.

Under the *Police and Criminal Evidence Act* in England and Wales, intimate searches are allowed for both weapons and drugs[16]. In 1997, the APS issued guidance regarding the role of doctors in these examinations [34]. Over the years, this has been updated to ensure that the fundamental ethical principle guiding medical practice, that no examination, diagnosis, or treatment of a competent adult should be undertaken without the person's consent, is maintained[17].

In NSW, the *Crimes (Forensic Procedures) Act* 2000 outlines the mechanism by which forensic procedures may be carried out, with informed consent of the suspect or by order of Magistrate or other authorized officer, if necessary with reasonable force. This includes the taking of intimate and non-intimate forensic samples and photographs of external genitalia. Under section 108, no medical practitioner, nurse, dentist, dental prosthetist, or appropriately qualified police officer or person is *required* (author's emphasis) to carry out a forensic procedure. On occasions, the law allows certain procedures, but physicians will not be party to such procedures due to ethical obligations.

Training: Courses and Examinations

The FFLM has published a fact sheet outlining how to obtain qualifications in clinical forensic medicine in the UK [35]. A National Training course for forensic physicians was established in 2005, in conjunction with the National Police Improvement Agency (NPIA). The syllabus for this course had previously been devised by the Education and Research Committee of the Association of Forensic Physicians in 2003. From 2009, the University of Teesside offered a Certificate in Postgraduate Professional Development – Forensic Medicine – following successful completion of the course which included assessed coursework[18]. Wall [36] has previously suggested that those doctors who did not attend an approved introductory training course in custodial medicine were significantly more at risk of failing to recognize adverse events in relation to patient safety and of missing forensic evidence.

In 2009, the FFLM's Revalidation Committee developed core competencies for revalidation, as part of the development of continuing professional development and appraisal documentation for members[19]. There are also practical training documents, in relation to general forensic medicine[20] and sexual offense medicine[21], that are recommended for use for initial training of forensic physicians. Such initial training documentation has been available since 1996.

Doctors working as Principal Forensic Physicians (PFPs) in London were surveyed in 2008/2009 [37]. The PFP in London had, at that time, a contractual managerial and educational supervisory role, including supervision of the

development training of all FPs in their group and the induction (or initial) training of assistant FPs. A clear training need was identified for educational supervisors, especially with regard to appraisal. Further research, looking at the experience of assistant forensic physicians throughout their induction training, found an overwhelming need for a more formal structure to the process [38].

As forensic medicine is not recognized as a speciality, there are no nationally agreed mandatory standards for training forensic physicians in either general forensic or sexual offense medicine. In the UK, the current situation has recently been evaluated [39] with doctors (trainees) who had recently (within the last 2 years) started working in the field of clinical forensic medicine trainees and trainers with responsibility for clinical and educational supervision of new trainees, surveyed by a questionnaire to gather their views on how the relevant GMC standards are being met in initial on-the-job training. Telephone interviews were also performed with 11 doctors working as clinical/medical directors to determine their views.

The results of this research showed that the quality of training in CFM is substandard and inconsistent and that the PMETB-published standards in 2008, as to the minimum requirement for training that must be met by postgraduate medical and training providers at all levels, are not being met.

Stark and Norfolk recommended that the FFLM set explicit quality standards which will comply with the regulator [39]. The DH proposed that the FFLM work with PMETB, now the GMC, to explore piloting the development of a national credential to recognize the skills and expertise of doctors practicing in forensic and legal medicine. Modular credentialing provides a formal process of accrediting competencies in a defined area of practice, so ensuring that an individual doctor would be fit to practice at the credentialed level [40].

The FFLM is currently running a credentialing pilot [41] using a range of service provisions for forensic medicine over the four nations of the UK. To credential by practitioner competence, the entry requirement would be based on the Quality standards [25], a knowledge assessment – the Membership examination, work-based assessments along with the FFLM proposal for appraisal and revalidation [42]. Work-based assessments would include direct observation of procedural skills (DOPS), mini-clinical evaluation exercise (mini-CEX), case-based discussion (CbD), 380° colleague feedback, and statement writing. This approach will satisfy the GMC's requirements of learning and assessment in the clinical environment using Supervised Learning Events (SLEs – formally formative assessment – feedback on progress) and Assessment of Performance (AoP – summative assessment – assessment to determine progress) [43].

Recommendations for the appropriate training for forensic physicians working in regional sexual assault referral centers have also been outlined[22] but not yet implemented nationwide. This lack of national standards for the training of forensic physicians has been highlighted[23] and should be addressed by the implementation of the 2009 Bradley review[24] with the feasibility of transferring commissioning and budgetary responsibility for health-care services in police custody suites currently being assessed[25].

The Diploma in Medical Jurisprudence (DMJ) had been administered by The Worshipful Society of Apothecaries of London (www.apothecaries.org.uk) since 1962, in clinical and pathological formats. International candidates would travel to England to take the exam, which was seen as the "gold standard" qualification in the field. The exam comprised two parts, each with two written papers and an oral (structured viva), and for the second part, the production of a bound casebook with ten varied cases presented with a detailed discussion of the relevant literature. With the development of the Faculty Membership examination, the clinical part of the DMJ was discontinued in 2011.

The Apothecaries also run a Diploma in Forensic Medical Sciences (DipFMS), established in 1998 (www.apothecaries.org.uk). This diploma requires attendance on a taught course, either in London or Glasgow, with a written examination and submission of a dissertation on a specified subject. This examination is open to nondoctors – lawyers, police officers, and other HCPs – with a professional qualification but not necessarily holding a previous degree, and there is a pathological bias to the course content.

The University of Central Lancashire, in conjunction with the Lancashire Law School, established a Postgraduate Diploma in Forensic Medicine and Bioethics (DFMB) in 2003, specifically for medical practitioners with at least 3 years post registration. The course was held over 2 years with three modules a year of two and a half days duration. Assessment was by various written assignments, including case studies and a written exam paper at the end of each year, with an option for an MSc in Forensic Medicine over a third year which could be completed at a distance. There are plans to restructure the course so as to prepare trainees for the new Faculty exam with the option of an MA or LLM in the third year (www.fflm.ac.uk).

A Postgraduate Diploma and MSc Forensic and Legal Medicine are also run by the Faculty of Life and Health Sciences at the University of Ulster (www.campusone.ulster.ac.uk). Students complete six modules over 2 years with assessment taking the form of problem-based coursework, case studies, essays, online discussion assessments, poster presentations, and written examinations. Those wishing to obtain the MSc need to submit a research project in the third year.

The University College Dublin has also been running a graduate diploma course, since 2004, over one year with the option to progress to an MSc in the second year (http://www.ucd.ie/medicine/graduate/taughtprogrammes/mscinforensicmedicine/). A graduate certificate in sexual assault forensic examination, with theoretical and practical modules, has also been proposed.

The Department of Health has sponsored a new Diploma in the Forensic and Clinical Aspects of Sexual Assault, provided by the Society of Apothecaries (2010). This diploma purports to

> set national quality standards for the professional care that medical professionals provide for victims of sexual abuse and violence.

The examination is open to doctors and nurses who have achieved a basic level of experience in the care of complainants of sexual assault (adults and/or children)

and is based on a knowledge-based part I (single best answer) and competency-based part II. A curriculum has been published, setting out the knowledge criteria, generic professional skills and attitudes, competencies, and evidence required for the objectives in each of the six modules: Initial Contact, History, Examination, Aftercare, Statement, and Court.

For part II, each candidate has to present a Compendium of Validated Evidence (COVE) which must be signed by "Clinical Validators" to confirm that the candidate has completed the modules satisfactorily. The Validators must not sign off a competency until they are sure that the required standard has been reached. The candidate has to identify and obtain the cooperation of one or more clinical validators. Candidates also need an educational supervisor whose role is to certify the completion of all the components of the modules. These doctors should have significant experience in the examination of complainants of sexual assault, have experience in the field of education and training, have some experience as an educational supervisor, and adhere to the PMETB standards. This evidence is submitted for part II with a record of 10–13 anonymized case reports for assessment, with marks awarded for the construction and presentation of the case, the assembly of ideas, and reflective analysis. There is also an OSCE with 12 stations of 7–10 min each. Dr Lucy Love has written about her experience of the DFCASA with recommendations for any doctors or nurses who are thinking about sitting the examination [44].

The Faculty membership examination was established three and a half years after the formation of the FFLM with the first full exam being completed in April 2010[26]. The overall aim of the new examination was to ensure that those who passed had the professional knowledge, skills, and attitudes to practice in the discipline as independent practitioners [45].

Starting in October 2009, the exam was set up for Forensic Physicians of both disciplines – General Forensic Medicine and Sexual Offence Medicine, and Medico-Legal Advisors. It is hoped that the exam will become compulsory for those who wish to pursue a career in forensic and legal medicine in the UK at a consultant level. Doctors who pass the exam will have the professional knowledge, skills, and attitudes to practice as independent practitioners within the speciality of forensic and legal medicine. To be eligible to sit the exam, candidates must have been working in the speciality for 3 years (within the past 5 years). Part I is a knowledge-based test, covering medical law and ethics, testing factual knowledge. The part II written exam will test the application of knowledge to problems, in modified short answers and more practical skills on the OSCEs/OSPEs. A detailed syllabus has been published, outlining the areas of knowledge and understanding required for both parts of the exam; the part II syllabus is different for each of the three disciplines. Feedback regarding the examination has been positive from both examinees [46] and examiners.

In Australia, Monash University (http://www.monash.edu/study/coursefinder/course/3412/) in Melbourne runs a Master of Forensic Medicine (students may exit with a Graduate Certificate or Diploma en route) which aims "to develop academic standards in clinical forensic medical practice and produce graduates

who have a sound knowledge of medico-legal principles." There are three core units – medical evidence; injury interpretation; ethics, medicine, and the law – and a number of elective units – elements of forensic science, adolescent sexual abuse, non-accidental injury in childhood, adult sexual assault, traffic medicine, elements of forensic toxicology, custodial medicine, and research project in forensic medicine. The assessments for the course include coursework and workshop participation, formal assignments, casebooks, and a minor thesis (the latter perhaps unusually for a Masters program).

Since 2012 a Unit of Study is available from the University of Sydney (http://sydney.edu.au/courses/uos/SEXH5409/adult-sexual-assault). The course is designed to cover the medical examination required, both therapeutic and forensic aspects including evidence-based sampling, and to be able to complete an expert certificate and provide evidence in court.

Conclusion

Forensic and legal medicine should be a feature of the undergraduate curriculum. The arguments have been well made for specialist recognition of the disciplines of forensic and legal medicine. There is a lack of political will to ensure that resources are made available to establish a full training pathway and specialist status in either the UK or Australia. Credentialing may provide an interim solution. It is hoped that, in the future, with more research in this area, there will be an evidence base to show that highly skilled specialists are required and of benefit to society as a whole.

Ready Reckoner

Legal and Forensic Medicine

Legal and forensic medicine has been defined by the European Council of Legal Medicine as the application of medical knowledge and methodology for the resolution of legal questions and problems for individuals and society.

Faculty of Forensic and Legal Medicine of the Royal College of Physicians of London (FFLM)

The FFLM of the Royal College of Physicians of London (RCP) was established in 2005 and includes forensic practitioners working in general forensic medicine, sexual offense medicine, and forensic pathology; medico-legal advisors working for the three defense unions (the Medical Protection Society, the Medical Defence Union, and the Medical and Dental Defence Union of Scotland); and medically qualified coroners.

Australasian College of Legal Medicine (ACLM) (www.legalmedicine.com.au)

The ACLM was established in November 1995 by doctors and dentists who are duly qualified in the law and medicine or dentistry.

Standards for Training

Practitioners in the field need to undergo initial training, to include practical on-the-job training, ensuring core competencies are achieved. This training should be overseen by an appropriately trained educational/clinical supervisor. Ongoing professional development training is also required to ensure that specialists have the knowledge and skills to continually perform the role required in the jurisdiction in which they practice. A number of examinations are available to test knowledge, and there is a need for the knowledge-based assessment to be combined with work-based placed assessments. These areas of training should be standardized.

Cross-References

- ▶ Driving Fitness and Legal Medicine in Australia
- ▶ Explaining Causation of Injury – An Australian Case Study
- ▶ Giving Expert Evidence: A Guide
- ▶ Law and the Medical-Man: The Challenges of an Expanding Interface
- ▶ Law of Evidence: Main Principles
- ▶ Legal Medicine Report Preparation in Australia
- ▶ Legal Medicine and Medical Law
- ▶ Providing Expert Evidence in an Australian Court: A Lawyer's View

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