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Editorial

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Wither Clinical Forensic Medicine

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Clinical Forensic Medicine (CFM) is facing a crisis of identity and ultimately of existence. Unlike its partners, forensic pathology and forensic psychiatry, clinical forensic medicine has failed so far to establish itself as an independent medical and academic discipline, and in some jurisdictions, has allowed and encouraged a fragmentation and loss of services to other medical and paramedical disciplines.

CFM has existed for very many years and the practitioners have provided their services under a variety of titles including police surgeon, government medical officer, forensic medical examiner and, more recently, forensic physician. The discipline includes custodial medicine, traffic medicine, assessment of assault victims of all ages (both physical and sexual) and alleged offenders, aspects of forensic psychiatry, crime scene examination, and the provision of expert evidence in courts and tribunals. In some cases, practitioners in this field also conduct autopsies to determine causes of death. In the past, much of this work was conducted by general practitioners with a special interest in forensic medicine. A recent survey has shown that generally this situation continues but, in some jurisdictions, adult sexual assault victims are being examined either by female non-forensic general practitioners, gynaecologists or nurses, child abuse cases are being examined by paediatricians, and custodial medical services are provided by non-forensic general practitioners. In some countries, pathologists also conduct clinical forensic examinations. Sadly, in a few regions where the clinical forensic doctor once conducted a full range of forensic duties, these duties have been or are being fragmented and directed to practitioners in other disciplines (eg. paediatricians,

gynaecologists, female non-forensic general practitioners, nurses, etc.) with the subsequent deskilling of the forensic practitioner, a reduction in the scope of the practitioner's field of practice and thus a decreased ability to recruit and retain new practitioners, a reduced level of clinical forensic practical experience and knowledge for both the forensic and other practitioners, and the resultant potential for an increased disservice to both the courts and the parties brought before the courts.

Although the discipline has existed well over a century, formal education has been piecemeal. Many have learnt 'on the job' and without much, if any, knowledgeable supervision. The only basic formal educational qualifications are the Diploma of Medical Jurisprudence from the Society of Apothecaries, London, the Diploma of Forensic Medicine from Glasgow University, and a Diploma in Forensic Medicine from Monash University, Melbourne. But there is no absolute obligation for practitioners of CFM to obtain one of these diplomas or similar qualification prior to or while practicing in the field although the practitioner may be encouraged to do so by their employer. Similarly, there has been no requirement for the practitioner to partake in formal continuing medical education (CME).

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This will have to change due to the implementation of mandatory postgraduate advanced training and CME to obtain ongoing annual medical registration gradually being imposed by medical registration authorities. For the forensic practitioner, this creates a problem as there is neither a peer-group regulating body (eg, a College) nor an accredited, current CME programme. Specialist forensic societies and associations exist which provide varying degrees of educational support but these lack the standing of a learned College.

Added to this are two additional problems that compound the educational dilemma for CFM. One is the absence of academic acceptance of the discipline and the other is the research base on which it is founded. Academic acceptance is essential for the development and progress of any medical discipline. This requires research and teaching staff with suitable clinical and research backgrounds that are able to attract research funding and gain and maintain good standing within the academic community. To the author's knowledge, despite the presence of forensic science, pathology and psychiatry departments within Universities, there isn't one academic clinical forensic medical department. Some quasi-academic units exist but the role of these departments is principally service provision leaving the clinicians inadequate time for academic and research pursuits. The absence of research has led to a not-often-publicised problem. Many of the 'facts' in forensic medicine, be it forensic pathology or CFM, are not based on scientifically proven data. Practitioners have developed theories that have mutated to 'facts' in text books without the appropriate rigour of scientific investigation and experimentation. Some of these 'facts' have proven to be fiction when subjected to appropriate investigation. A classic example is that of the colour evolution of bruises where a few recent research papers have disproven the accepted published dogma.

The absence of co-ordination and quality control has not passed entirely unnoticed. In 1993, a Royal Commission on Criminal Justice reviewed the role of police surgeons in the criminal justice system of the United Kingdom and raised these issues. They made several recommendations including the need to establish centres of excellence at universities and appropriate training and standards for doctors providing these services. Nothing appears to have eventuated despite the passage of nine years.

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It is interesting that the medical and legal profession consider it inappropriate for the various academically recognised disciplines of medicine to practice without appropriate advanced training but appear willing for clinical forensic practitioners to practice and provide expert evidence within the legal system often without the appropriate level of training. Understandably, it is considered inappropriate for an inexperienced, untrained doctor to perform complex surgery on a patient because of the increased potential for adverse outcomes. Why, then, is it acceptable for similarly inexperienced and untrained doctors to provide clinical forensic medical examinations and expert evidence in court? An error in the interpretation of an injury, for example, may make the difference between whether a non-guilty person is convicted of a crime or not. Is it not equally detrimental for a person to suffer at the hands of an inappropriately inexperienced surgeon as for the non-guilty to receive a custodial sentence resulting from erroneous clinical forensic medical evidence?

If CFM is to survive and function as a specialty or sub-specialty and to provide an ongoing professional service, the issues of direction, education and training require urgent attention. This will require:

1. the establishment of academic centres of excellence, staffed by experienced and appropriately qualified forensic practitioners to develop an educational and research base and who can gain and maintain standing within the academic community;
2. the availability of funds from both government and private sources for the conduct of forensic medical research;
3. the establishment of learned societies or colleges to implement and monitor standards for and quality of forensic practitioners, and to conduct CME; and
4. cessation of fragmentation of CFM.

Achievement of these aims will not be easy and will also require a campaign to convince medical colleagues, the legal profession, academics and politicians of the need for CFM as a speciality in itself.

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