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Developing Britain's police surgeon service

Needs better legal and forensic training

Police surgeons, also known as forensic medical examiners, are doctors who have agreed to make themselves readily available to respond to calls by the police.¹ Their work entails examining detainees and police officers who have sustained injuries or who have other medical problems. They also decide whether individuals are fit to be detained or interviewed.

The role of police surgeons in the criminal justice process has been highlighted, not always positively, in a series of reports and court cases over recent years. Although the vast majority of them discharge their duties well, police surgeons have been implicated in several high profile cases of injustice in the British courts. Carole Richardson, one of the "Guildford four," was convicted of an IRA bombing substantially on the basis of a statement made after having been given a sedative for drug withdrawal.² Enghin Raghup's admissions of involvement in the murder of police constable Keith Blakelock during the Broadwater Farm riots in London were made after 10 days of interviews during which he was physically sick but certified fit to be detained.³ Partly in response to these high profile cases, police surgeons were included in the remit of the 1993 Royal Commission on Criminal Justice,⁴ which also commissioned a special research study on the role of the police surgeon.⁵ The commission's recommendations were closely linked to the findings of the study and were, owing to time constraints, based on limited evidence drawn from the custody records of only a few police stations in a few areas. The commission recommended that universities should create centres of excellence for training police surgeons; the fee structures should be revised; the use of nursing staff in some roles should be explored; and, crucially, that training standards and guidelines should be developed. Similar concerns were later echoed in a joint report by the BMA and the Association of Police Surgeons on health care for people detained in police stations.⁶

Implementing these recommendations is, however, problematic, largely because police surgeons operate at both a forensic and a therapeutic level.⁷ Their forensic role entails gathering and preserving evidence; the therapeutic role involves treatment and care. While both the Royal Commission⁵ and the *Lancet*⁸ have argued that a clear distinction exists between these roles, their separation is by no means simple. A police surgeon's forensic and medical actions can have an important impact on the outcome of a criminal case, as the high profile cases mentioned above have shown. Furthermore, seemingly unimportant observations can later assume forensic significance, and the doctor-patient relationship can be threatened by the legal and safety requirements of police work.

Police surgeons need to be equipped to face the challenges of working in an increasingly complex medical and legal environment. The vast majority of police surgeons are general practitioners, paid on a fee plus retainer basis by individual

police services. Their education and experience will be in family medicine, and they are unlikely to have encountered legal or forensic medicine in their undergraduate medical curriculum.⁹ Less than 8% of police surgeons nationally (16% in London) have specialist postgraduate qualifications in legal medicine, such as the Diploma or Mastership in Medical Jurisprudence (Clinical).^{10,11} Proficiency is thus often founded on experience and practice rather than formal academic courses.

Enhanced training opportunities for newly recruited police surgeons and refresher courses for established surgeons are now developing to fill these gaps. Most areas of Britain now have access to courses run by the police. Some courses, such as the one run by the Metropolitan Police in London and the FAGIN course in north west England, have a high reputation, but across the country the content and quality of the courses vary widely. Some police services pay for doctors to attend, others do not; in some areas attendance is mandatory, but more often it is not, particularly if recruiting doctors to the service has been difficult. In an important recent initiative the Association of Police Surgeons and the Association of Chief Police Officers have jointly established a training course covering basic knowledge. Last year they also piloted a refresher course for updating core competencies, which is now being adopted by several forces across England and Wales.

Links with universities and a more formalised training programme are seen as vital elements in the development of the police surgeon specialism.¹² This internal recognition of need, when allied to the external prescriptions of the Royal Commission, must constitute a potent force for change. Otherwise, this small area of specialism will become ever more isolated, uncoordinated, and likely to fail on basic quality assurance.

GRAHAM MOON

Professor of health services research

KATH KELLY

Research associate

STEPHEN P SAVAGE

Professor of criminology

YVONNE BRADSHAW

Lecturer

School of Social and Historical Studies,
University of Portsmouth,
Portsmouth PO1 3AS

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