

CHAPTER 5

Medical records, reports and evidence in court



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- 5.1 Medical records
- 5.2 Writing a medico-legal report
- 5.3 Going to court in a civil case
- 5.4 Going to court in a criminal case
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Outcomes

At the end of this chapter you will be able to:

- Understand medical records and why they are kept
- Know how to write a medical report
- Understand the difference between a criminal and civil trial
- Know how evidence is presented in a criminal or civil trial.

5.1

Medical records

Medical records consist of information kept by doctors, health care centres, community health clinics or local hospitals detailing what the doctors or other bodies know about the medical condition and history of patients. The information is usually about medical examinations, treatment or operations, and should be recorded at the time of the consultation or immediately afterwards. Medical records should reflect objective information and comments about patients and should not include derogatory or unsubstantiated observations or opinions. In summary, medical records should be accurate, objective and contain information recorded at the time the treatment is given or the observations are made.

5.1.1

Reasons for keeping medical records

Medical records provide:

- a) Information for planning patient care
- b) A means of communicating information between the attending doctor and other doctors and health care workers dealing with the patient
- c) Documentary evidence of the patient's illness, treatment and response to treatment
- d) Information for review, study, and evaluation of care given to patients
- e) Protection of the legal interests of patients, hospitals and health care workers, and
- f) A database for medical education and research.



MEDICAL RECORDS

Medical records consist of information detailing what is known about the medical condition and history of patients.



Sources of information for medical records

5.1.2

Sources of information for medical records

Information held in medical records of patients may come from:

- a) Notes taken by the attending doctor or health care worker at the time
- b) Notes and histories taken by previous attending doctors or health care workers
- c) Laboratory file cards or other records of test results
- d) Histology sections
- e) Cytology slides
- f) Photographs
- g) X-rays
- h) Working records and research data, and
- i) Clinical trial data.



KEEPING RECORDS

Most legal actions are begun within ten years, and it makes good sense to keep general medical records and medical specimens for at least ten years.

How long should medical records be held?

5.1.3

As a general rule, most legal actions are begun within ten years, and it makes good sense to keep general medical records and medical specimens for at least ten years. The South African Medical Association recommends that medical records are kept from six to nine years.

Access to medical records

5.1.4

Technically doctors or health care institutions in the public or private sector own the patients' records held by them. However, such ownership is really a form of custody of medical records because the rights of such persons or bodies to use patients' records are limited by the confidentiality rule. [See pgs 91-93] The use of such records is further limited because they may not be destroyed or defaced or made inaccessible to patients. The modern trend in most countries, including South Africa, is to allow patients to have access to their records. Special safeguards are necessary, however, to make sure that only patients and authorised people have access to such information.



ACCESS TO RECORDS

The modern trend in most countries, including South Africa, is to allow patients to have access to their records.

Special safeguards are necessary to make sure that only patients and authorised people have access to medical records.



The Constitution provides that every person has the right of access to information held by the state.

The right of access to information

The 1996 Constitution provides that every person has the right of access to information held by the state (as of right), and the right of access to information held by private bodies (where he or she can show that such information is required in order to exercise or protect his or her rights) [Section 31(1)]. The Access to Information Act 2 of 2000 was passed to implement the provisions of the Constitution. It specifically defines a 'health practitioner' as a person 'who carries on, and is registered in terms of legislation to carry on, an occupation which involves the provision of care or treatment for the physical or mental health or for the well-being of individuals'. These would include medical practitioners, psychiatrists, psychologists, nurses and social workers.

In terms of the Access to Information Act the information officer of a governmental body must provide a patient access to his or her medical records. This may be refused however if the information officer has consulted with the health practitioner who provided the record, or was nominated by the requester, and such practitioner is of the reasonable opinion that the disclosure is likely to cause serious harm to the patient's physical or mental health or well-being. Similar provisions apply to heads of private bodies in cases where the patient needs the information in the medical records to exercise or protect a right.

Patients also have a Common law and Constitutional right to privacy [Section 14]. Therefore, disclosures of information in breach of the confidentiality rule may result in the wrongdoer being sued for invasion of privacy, defamation or breach of contract

Keeping accurate and relevant records

Medical records should be accurate and relevant in order to supply sufficient information to justify the diagnosis and the treatment given to a patient. They also provide a full picture of the patient's record from the time of the first treatment until further treatment is no longer necessary. Records should be signed by the doctors or health care workers responsible for the medical care of the patient.

Special care should be taken when altering medical records. They should only be altered in order to change inaccurate information. Changes should be made in such a way as to leave the original information still legible. New information added should be initialled and dated. The reasons for the change should also be explained on the record.

Standardised protocols and checklists

Standardised protocols and checklists are useful for ensuring that accurate medical records are kept.

A useful protocol and checklist for appropriate medical records should include the following:

- a) Identification information
- b) Evidence of appropriate informed consent (e.g. signed form)
- c) Patient's medical history
- d) Report on patient's physical examination
- e) Diagnosis information (e.g. reports of diagnostic tests, pathology reports, record of consultations, provisional and final diagnosis)
- f) Therapeutic information (e.g. treatment, medication, surgery, anaesthesia, progress and health care reports)
- g) Discharge information, and
- h) Follow-up care reports.

Problems and pitfalls of improper records

With the moves towards greater access to medical records by patients problems occur when doctors and health care professionals include too much sensitive and non-essential information which might be harmful. For example, it would be unwise to include personal criticisms such as 'she is dressed like a slut' or comments such as 'her perfume smells nice'. The subsequent disclosure of such comments is likely to cause embarrassment to both the doctor and the patient and may damage their relationship. Such comments are also likely to make doctors and health care workers reluctant to allow access to medical records which include embarrassing information.

5.1.5



LEGIBLE CHANGES

Changes to medical records should be made in such a way as to leave the original material still legible.

5.1.6



ACCURATE RECORDS

Standardised protocols and checklists are useful for ensuring that accurate medical records are kept.

5.1.7



IMPROPER RECORDS

Problems occur when doctors and health care professionals include too much sensitive and non-essential information which might be harmful.

The main pitfalls of improper or incomplete medical records are that they may undermine attempts by doctors and health care workers to protect themselves against charges of medical negligence or malpractice (see above). When medical records are placed before the courts judges and magistrates evaluate their reliability and draw conclusions from their appearance. If vital information is missing it may be evidence of negligence on the part of the doctor or health care worker. However, if complete and accurate records are produced the court is more likely to regard the doctor's or health care worker's evidence as reliable.



TALKING POINT

The second opinion

A patient is given a second opinion by a private doctor which indicates that the first doctor, who was employed by a provincial hospital, had treated her negligently. She asks both doctors to hand over copies of their medical records to her so that she can consult a lawyer.



1. Is she entitled to copies of her medical records? Why or why not?
2. What would she have to show in terms of the the Promotion of Access to Information Act in order to have access to the records held by:
 - a) The provincial doctor
 - b) The private doctor?
3. What can she do if access to her records is refused?



TALKING POINT

The suicidal patient

The information officer of a provincial hospital releases a patient's medical records to her without consulting the health professional who provided the record because he is away on holiday. The patient has been suffering from chronic depression for several years but has only recently been treated at the hospital's psychiatric ward. After reading her records the patient becomes so depressed that she commits suicide. Her children wish to know whether they can sue the hospital for negligence.



1. If you were the lawyer for the hospital what arguments could you make to justify the conduct of the information officer?
2. If you were the lawyer for the family what arguments could you make to show that the hospital was negligent?
3. If you were the judge in this case what decision would you make?

5.2

Writing a medico-legal report

A medico-legal report is a report on the condition of a patient or deceased body, solicited for legal purposes, which gives the medical expert's findings, diagnosis, prognosis and opinion.

A medical record is any record made by a medical or other health practitioner concerning a patient during or after a consultation, examination or the conducting of a medical or surgical procedure.

Writing a medico-legal report is a technical exercise, which, if done correctly, will limit the number of unnecessary court appearances for the practitioner, besides serving the cause of justice.

It is important also to emphasise that any medical document regarding a patient may potentially be required in court as medical evidence. This underscores the importance of well-kept records. [See pg 112]

Reasons for writing a medico-legal report

Medico-legal reports are written for the following reasons:

1. To provide a complete record of the medical examination of a patient (or deceased) for legal purposes (i.e. describing the person's condition and appearance, recording injuries or pathology and providing a medical interpretation of the findings).
2. To ascertain the physical and mental condition of the patient at the time of examination, and the nature and extent of injury suffered, in order to enable a court to determine the probable cause and mechanism of the injury.
3. For use in court as direct evidence in litigation and for associated purposes – not for clinical management, clinical audit, teaching or research, or for administrative purposes.

In order to fulfil the above purposes all medico-legal reports should be legible, simply presented, concise, factual and relevant.

Medico-legal reports in affidavit form

Medico-legal reports are prepared largely in the form of an affidavit when presented in criminal cases. Affidavits are sworn statements. Such medico-legal reports are handed in as written evidence during

Definition

MEDICO-LEGAL REPORT

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5.2.1

Definition

MEDICAL RECORDS

A medical record is any record made by a medical or other health practitioner concerning a patient during or after a consultation, examination or the conducting of a medical or surgical procedure.

5.2.2

the court hearing. All affidavits are written in black ink and signed in presence of a commissioner of oaths. The report must be accurate and correct in all respects such as the dates of examination, death, post-mortem, special examinations, signing, etc.

5.2.2

Contents of a medico-legal report

A report should consist of at least the following four parts:



GOOD HISTORY

A good history is one of the best guides to a good examination.

MEDICO-LEGAL REPORT

A. INVESTIGATION DETAILS

The following investigation details are required:

1. Name and details of the examiner
2. Name and other details of the patient's or deceased's identity
3. A police case reference number (CAS no.) where appropriate, if already reported
4. Other persons present at the examination
5. Time and date, and address of the institution (including, where appropriate, the section) where the examination is being carried out.

B. RECORD OF THE HISTORY

The following aspects of the history should be recorded:

1. The date and time when the injury is alleged to have occurred, as well as details of the nature and circumstances of the injury (e.g. if any force was involved, if there were any alternative causes, or if there were any contributing factors by the injured person). These should be recorded in chronological order from the patient, accompanying persons or the police, with the source of information identified
2. The history and nature of treatment to date, the current extent of disability, the present prognosis and the likelihood of future complications (e.g. hospital records, other medical records, other experts' reports, X-rays and laboratory reports).

A good history is one of the best guides to a good examination, and for the taking of the appropriate specimens.

C. SCHEDULE OF FINDINGS AT PHYSICAL EXAMINATION

The schedule of findings should include the following:

- A factual record of all abnormal physical and psychological findings on clinical examination, excluding any subjective and non-essential information
- Diagrams and colour photographs of all injuries – these are not obligatory, but highly recommended. Diagrams should be handed

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MEDICO-LEGAL REPORT CONT.

in as annexures, dated and signed, with neat text and numbering of the wounds that correspond with the text of the report. Annotations should be concise and should not repeat the text

- An evaluation of the patient's mental state. This is often an important aspect of the examination
- A prescribed form such as the J88 form [Appendix D] should be used or one that contains similar information.

D. SPECIAL INVESTIGATIONS

Special investigations supplement a forensic examination, as do special or laboratory investigations in ordinary medical examinations. The prescribed form J88 has provision for these to be recorded on the form. Critically important in the taking of specimens and exhibits is the maintenance of the chain of custody of physical evidence.

Unless a laboratory investigation is critical to the forensic findings, the report should not be withheld until the result of the test is available. The initial or provisional report should be made available immediately. A subsequent amended report may always be requested, in affidavit form, once the special investigation results become available.

E. INTERPRETATION, OPINIONS, CONCLUSIONS AND DIAGNOSIS

An interpretation and diagnosis as to the possible cause of all abnormal symptoms and findings is expected. The medico-legal report should be factual, and only express conclusions or opinions in relation to the medical details of the case. When the findings of the report are being interpreted it is necessary to consider them in the context of the history and examination results and the nature of the subject's allegations.

Details of the prescribed treatment for the patient as well as his or her management and any arrangements for referral should be noted. Where the practitioner is unable to finalise the report (e.g. because of the unavailability of further examination or test results) this should be stated. The report should always be signed by the practitioner to authenticate it and should reflect his or her contact details in legible writing.



PHYSICAL EVIDENCE

Critically important in the taking of specimens and exhibits is the maintenance of the chain of custody of physical evidence.

Guidelines for medico-legal reports

1. Good notes imply good practice. They should be complete but concise, and consistent.
2. Use a standardised format: notes should contain in order the history, physical findings, investigations, diagnosis, treatment and outcome or disposal.
3. Avoid complicated medical/technical jargon where possible; if the use of technical or medical terms are unavoidable, give the interpretation or lay meaning in brackets.



1. Good notes
2. Standardised format
3. Avoid jargon

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4. Avoid comments
5. Do not alter initial entry
6. Label documents
7. Take consent before photography
8. Respect confidentiality

4. Avoid unsolicited comments as far as possible, describe the facts, and make conclusions only essential for patient care or that which relates to confident medical diagnosis. Avoid self-serving or disapproving comments.
5. If the record needs alteration, e.g. in the interest of patient care or for genuine correction – then show no intent to hide by lining out items, initialising and dating the changes and, when possible, entering a new note that refers to the correction without altering the initial entry.
6. Always label attached documents such as diagrams, laboratory results, photographs, diagrams, charts, etc. Never rely on sheets of paper remaining identifiable by being bound or stapled together.
7. Be sure to take consent before photography. To ensure validity, photographs should only be taken with the use of a small card with the case number/reference number and a scale also in the viewfinder/field of photography; for this purpose a small 15cm ruler with a stick-on label usually suffices.
8. The confidentiality of information is to be respected. Only release copies of records after receiving proper authorisation.

Pitfalls of the medico-legal examination

1. Not being aware of the objectives of the examination
2. Failure to take an informed consent
3. Failure to do an adequate examination and describe the body or person externally
4. Not taking adequate specimens for special investigations and maintaining the chain of custody of the evidence
5. Not making proper written documentation of the examination and aids such as photographs and diagrams
6. Making a subjective diagnosis that that is not scientifically acceptable
7. Failing to refer for second opinion, especially in cases of child abuse.

5.3

Going to court in a civil case

There are special procedures that have to be followed if a person wishes to go to court to sue somebody for damages, to prevent them from doing something or to force them to do something. The best way of explaining the procedures to be followed is to give a case study example.

Mrs Kala goes to court

Mrs Kala goes to a KwaZulu-Natal provincial hospital for an appendicectomy and gall bladder operation. For several months after the operation the wound oozes pus and she suffers severe discomfort. Eventually, some gauze comes out of the wound and it is found that a swab was left inside her during the operation. She sues the hospital for R50 000 and brings an action in the magistrate's court.

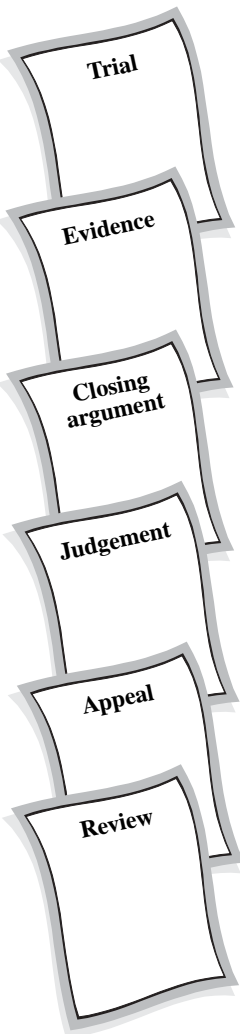
Steps in a civil case

The following steps will be followed:

1. Mrs Kala who is called 'the *plaintiff*' will approach a lawyer to sue the hospital for R50 000. If she cannot afford a lawyer she may go to the local legal aid office which may provide her with a lawyer. The lawyer takes a statement and then writes a letter to the KwaZulu-Natal Minister Health who is responsible for the hospital, setting out the claim and demanding payment of the money within a certain number of days. This is called a *letter of demand*.
2. If there is no reply to the letter of demand the lawyer draws up a *summons*. The summons is a document issued by the court setting out the details of Mrs Kala's (the plaintiff's) claim. It also tells the Minister of Health (the 'defendant') that she must defend the case within a certain number of days or judgment will be given in favour of Mrs Kala. (If the Minister does not reply a judgment will be given against her even though she was not present in court. This is called a *default judgment*).
3. When she receives the summons the Minister will refer it to her lawyers for them to recommend that she do one of the following:
 - a) Defend the claim
 - b) Admit that the money is owed and agree to pay
 - c) Try to settle the case after discussing it with Mrs Kala's lawyer.
4. The Minister can defend the claim by completing a form called a, '*Notice of Intention to Defend*' which is on the back of the summons. Mrs Kala's lawyers will take copies of the notice to court for stamping and send a copy to the Minister's lawyers.
5. After the Notice of Intention to Defend has been sent Mrs Kala's and the Minister's lawyers set out the facts in dispute in a number of documents called '*pleadings*' which have to be drawn up according to the rules of the court. The purpose of the pleadings is to clarify the issues in dispute for the parties and the court.



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6. At any time during the pleadings, (or even during the court case), the Minister of Health can still decide to *settle* the case out of court. She does this by agreeing to pay the amount claimed or by persuading Mrs Kala to accept less.
7. If Mrs Kala and the Minister do not settle the dispute, there will be a *trial* (a court case). At the trial the parties will present their cases to the court. This is done by giving their evidence and calling witnesses. Each side may cross-examine the other side's witnesses so that the court can decide whether they are telling the truth.
8. When they think they have led sufficient evidence, the attorneys for Mrs Kala and the Minister will close their clients' cases. They will then make a closing argument to the court to persuade it that their clients should win.
9. The magistrate will then decide whether or not Mrs Kala has proved her case against the Minister. If she has proved her case 'on a balance of probabilities' (i.e. that her version of the facts is more likely than that of the Minister), judgment will be given in her favour. If Mrs Kala does not prove her claim judgment will be given in favour of the Minister.
10. If Mrs Kala or the Minister of Health thinks that the magistrate made a mistake when interpreting the facts or applying the law, they can take the case on appeal. [See pg 41]
11. If the loser feels that the magistrate was biased or prevented them from presenting the case properly, it may be taken on review. [See pg 41]

5.4

Going to court in a criminal case

Special procedures have to be followed when the state wishes to prosecute a person for committing a crime. The Constitution provides arrested or detained people with certain rights after they are arrested or detained and when they appear in court.

5.4.1

Rights of arrested or detained persons before trial

Arrested or detained persons are entitled to the following rights:

Rights of arrested or detained persons

Lawyer

1. They are entitled to consult a lawyer from the moment of their arrest or detention. If they cannot afford a lawyer and a substantial injustice will occur if they are not given a lawyer they must be provided with one by the state.

Reasons

2. They must be informed of the reasons for their arrest or detention in a language that they can understand and told that they do not have to say anything if they do not wish to do so.

Bail

3. They may apply for bail and should be released unless it is not in the interests of justice to do so (e.g. they may disappear, interfere with witnesses or commit further crimes).

Charge

4. They must be charged and brought to court as soon as is reasonably possible but not later than 48 hours after their arrest or detention.

Visitors

5. They may contact and be visited by their spouse or partner, relatives, religious counsellor or doctor.

Pleading

6. Before the case goes to trial the accused person will be asked to *plead* by the magistrate. This means that they must say whether they think they are guilty or not guilty. The accused person has the right to have a lawyer present during this procedure.

Guilty as charged

7. If the accused decides to plead guilty the magistrate must satisfy himself or herself that the accused is indeed guilty by asking the accused person questions. If the magistrate is satisfied that the person is guilty of the crime the magistrate will formally find the accused guilty as charged and there will be no need for a trial.

Change of plea

8. If the accused pleads guilty but the magistrate is not satisfied that the person is guilty the magistrate will enter a plea of not guilty.

Statement

9. If the accused pleads not guilty the magistrate may ask the person if he or she wishes to make a statement. The accused is not obliged to do so as he or she has a right to silence.

Demand for lawyer

10. An unrepresented accused may inform the magistrate that he or she is not prepared to plead until he or she has consulted with a lawyer.

Steps in a criminal trial

5.4.2

In a criminal trial the following steps are followed:

The criminal trial

Witnesses

Evidence

Cross-examination

Re-examination

State's case closed

Evidence for the defence

Cross-examination of defence witnesses

Defence's case closed

Prosecutor's summing up

Defence's summing up

1. Where the accused pleads not guilty the prosecutor will begin by calling witnesses for the state to show that the accused committed the crime.
2. The prosecutor will ask each witness to tell the court what he or she knows about the case (i.e. to give evidence).
3. After each prosecution witness' evidence the accused (or the defence lawyer) will have a chance to ask each witness questions (called cross-examination). The aim of cross-examination is to obtain evidence from the witness to support the accused's case, or to show that the witness is not telling the truth. [See pgs 128-129]
4. After cross-examination of each of the state's witnesses by the accused (or defence lawyer) the prosecutor may ask the witnesses further questions (called re-examination). The aim of re-examination is to clear up or explain answers that were made to look untrue or unreliable in cross-examination by the accused or the defence lawyer. The court may also ask questions to clear up evidence which is not clear, but may not cross-examine witnesses.
5. After the prosecutor has called all the state witnesses and each has been cross-examined and re-examined, the prosecutor closes the state's case. This means that the prosecutor thinks that he or she has proved the state's case and it is the turn of the accused to present his or her case.
6. The accused (or the defence lawyer) then calls witnesses to give evidence for the defence. The first witness to be called will be the accused – if he or she is going to give evidence. This is so that the accused will tell the truth and not change his or her story to agree with what the defence witnesses say. The accused can decide not to give evidence.
7. The prosecutor may cross-examine the accused and each defence witness and then the accused (or the defence lawyer) may re-examine each witness (and the accused in the case of a defence lawyer). The court may also ask questions but may not cross-examine the accused or any witnesses.
8. After the defence witnesses have all been called, cross-examined and re-examined, the accused (or the defence lawyer) closes the case for the defence. This means that the defence does not intend to call any more witnesses.
9. The prosecutor sums up the state's case and gives reasons why the accused should be found guilty.
10. The accused (or the defence lawyer) then argue and gives reasons why the accused should be found not guilty.
11. The judge or magistrate then gives a judgment. If the accused is

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found not guilty he or she will be acquitted. If the accused is found guilty he or she will be sentenced.

12. Before an accused who is found guilty is sentenced he or she (or their defence lawyer) must be given an opportunity to address the court on why the sentence should be reduced. The prosecutor can then argue why it should be increased.
13. If the accused is unhappy about the conviction and/or sentence he or she can appeal to a higher court to have them changed. [See pg 41]
14. If the accused believes that the proceedings were not conducted fairly or that the judge or magistrate was biased he or she can take the case on review to a higher court to have it set aside. [See pg 41]

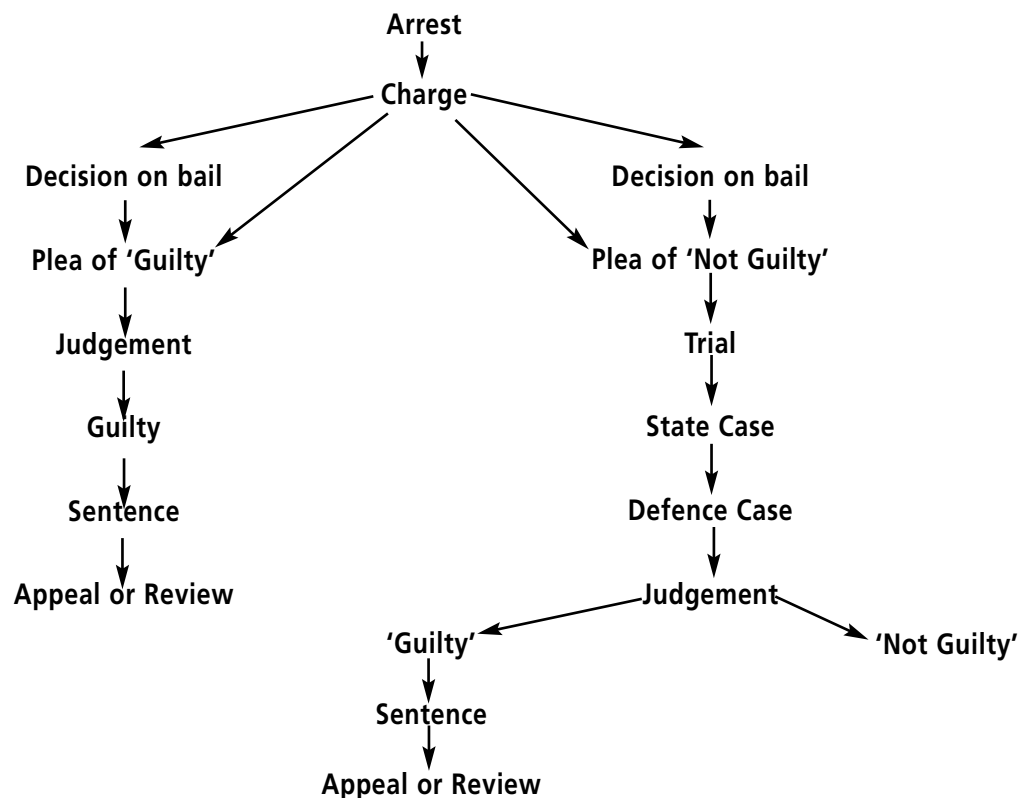
Judgement

Accused's address

Appeal

Review

Steps in a criminal case



[Source: Street Law Book 7 Criminal law and Juvenile Justice]

5.5

Health care workers in court



CROSS-EXAMINATION

Each witness will be subjected to cross-examination in court by the opposing advocate.

The court system in South Africa is an adversarial one. Both sides may call witnesses and instruct experts to provide reports and give evidence in court. Each witness will be subjected to cross-examination in court by the opposing advocate. In civil cases, (where a plaintiff is suing for damages), the judge or magistrate will decide the case on a 'balance of probabilities'. In other words, the burden is on the plaintiff to prove that his or her case is more probable than not (i.e. over 50% likely). In criminal cases, where the state prosecutes the accused for the alleged commission of a crime, the burden is on the state to prove that the accused is guilty 'beyond reasonable doubt'. In other words the judge or magistrate may only convict the accused if he or she is sure that the accused is guilty. This is a much higher standard of proof than that required in civil cases. [See pgs 40-41]



Evidence given by doctors or health care workers may play a crucial role in assisting the court.

Medical evidence

Medical evidence may be used in both civil and criminal trials. Evidence given by doctors or health care workers may play a crucial role in assisting the court in deciding whether a person should be liable or not in civil cases, and whether accused persons should be found guilty or not guilty in criminal cases. Medical practitioners or health care workers may find themselves giving evidence as:

1. a defendant in a civil or an accused in a criminal action (e.g. in the case of the negligent death of a prisoner or patient)
2. a witness of fact (e.g. as a witness to a motor vehicle accident)
3. as a professional witness, or
4. or as an expert witness.

5.5.1

Court room etiquette

A medical or health care witness should look professional and dress accordingly. He or she should also speak clearly, slowly and loud enough for everyone to hear. The following list provides some tips for giving evidence in the court room.



LOOK PROFESSIONAL

A medical or health care witness should look professional and dress accordingly.

Tips for giving evidence in court

1. Use plain language and avoid jargon wherever possible
2. Only use jargon when unavoidable and explain the jargon when necessary
3. Do not volunteer information beyond what is asked in the mistaken belief that you are being helpful
4. Treat the legal practitioners with respect even though you may not agree with their views or tactics
5. Do not venture outside your area of expertise or experience
6. Try to separate factual statements from opinions
7. Do not be afraid to use the phrase: "I do not know"
8. Do not lose your objectivity or become over-enthusiastic about the cause of the party who called you
9. Do not give away concessions under cross-examination due to fear or a desire to be helpful
10. If you are asked to comment on whether a hypothetical scenario is possible you should also give your opinion as to the chance of that possibility having occurred in this case, (i.e. whether such a possibility should be taken into account in this particular case, or whether it is so unlikely as to be of no significance).

Difference between expert and opinion evidence

Opinion evidence is evidence of the opinion or belief of a witness who has drawn certain conclusions from the facts. Traditionally the courts have said that the opinions or beliefs of witnesses concerning facts are irrelevant because witnesses should give evidence as to the facts and the court should form an opinion based on the facts presented by the witness. Generally therefore the witness' opinions concerning the facts were regarded as irrelevant, except in the case of expert witnesses. The more modern approach, however, is that opinion evidence should be regarded as relevant if it can assist the court, e.g. where the witness is better qualified to form an opinion than the court.

Expert evidence includes the expressing of opinions by experts. The latter may express opinions because their qualifications make their evidence relevant. Their opinion evidence is relevant because they are usually better qualified to give an opinion than the court. Therefore an expert's qualifications will be measured in relation to the evidence that the expert will give to determine whether the evidence is significant and relevant to the case.

The role of the expert witness

An expert witness may be defined as one who through education, training and experience possesses knowledge outside that of lay persons. The function of an expert witness is to make complex scientific

5.5.2

Definition

OPINION EVIDENCE

Opinion evidence is evidence of the opinion or belief of a witness who has drawn certain conclusions from the facts.

5.5.3

Definition

EXPERT WITNESS

An expert witness may be defined as one who through education, training and experience possesses knowledge outside that of lay persons.

principles understandable to lay people – the lawyers, judges and magistrates.

The role of an expert witness is not to support the cause of a particular party, but to assist the court in coming to a proper decision on technical and scientific matters. An expert witness, who supports the cause of a client to such an extent that he or she loses objectivity, will in fact undermine the client's case. The expert's credibility will end up being questioned. In some cases, experts from the opposing parties can meet prior to the trial to narrow and define the areas where they agree and disagree. Such co-operation between experts on opposing sides generally results in savings in time and costs.



The expert witness is an unbiased expert.

Summary of the expert witness' role

1. To review objectively all the relevant evidence. It is important to know the records and reports of other experts. Failure to do so may open up discrediting lines of cross-examination.
2. To render an expert opinion based on the available information.
3. To present his or her findings in a clear, objective and fair manner. This may be assisted by the use of visual aids such as photographs, diagrams and models. The expert witness should at all times remember that he or she is not a 'hired gun' but an unbiased expert.

Benefits of good medical records

If the records are clear and accurate the health care practitioner may not be called to court to give evidence. The parties can agree to accept the report.

5.5.4

Cross-examination

Evidence given by doctors and health care workers should be able to stand the test of cross-examination. Cross-examination by the other side's lawyers is designed to separate lies from the truth, what witnesses heard from what they know, opinions from facts, things that actually happened from things that the witness thought happened, and conclusions drawn by witnesses from things that the witnesses claim to remember. Cross-examination usually takes the form of the lawyer putting a statement to the witness and then trying to get the witness to agree with it.

Lawyers often try to discredit witnesses in cross-examination but this does not usually work with expert witnesses. The main purpose of cross-examination should be to obtain concessions in the evidence of the other side's witness so as to narrow the conflict in that witness' evidence and the evidence of the witnesses on the side of the cross-



LIES vs TRUTH

Cross-examination is designed to separate lies from truth.

examining lawyer. The object is to weight the balance of probabilities in favour of the evidence and case of the cross-examining lawyer. Expert witnesses must be prepared to defend the integrity of their findings and opinions against the questions of the cross-examiner.

The superficial medical examination

A. EVIDENCE IN CHIEF

1. Defence lawyer: "Dr Fluffit please tell the court what you found when you were called to the police cell on 21 March 2000 at 23h00."
2. Dr Fluffit: "I found the deceased lying on the floor with a nylon washing line cord around his neck. The cord was wrapped twice around his neck and had a complex knot at the back with a severed end. He had a ligature mark around his neck."
3. Defence lawyer: "What did you conclude?"
4. Dr Fluffit: "I agreed with Sgt Balala who said that they had found the accused hanging from the grill bars and he must have committed suicide."

B. CROSS-EXAMINATION

1. Prosecutor: "Dr Fluffit, you arrived at the cell at 23h00, didn't you?"
2. Dr Fluffit: "Yes."
3. Prosecutor: "It was at night wasn't it?"
4. Dr Fluffit: "Yes."
5. Prosecutor: "You relied on the light in the cell for your examination, didn't you?"
6. Dr Fluffit: "Yes."
7. Prosecutor: "You did not use a flashlight, did you?"
8. Dr Fluffit: "No."
9. Prosecutor: "You only examined the deceased's neck didn't you?"
10. Dr Fluffit: "Yes."
11. Prosecutor: "You agreed with Sgt Balala's conclusion that the deceased had committed suicide by hanging before you had conducted an autopsy didn't you?"
12. Dr Fluffit: "Yes."

C. RE-EXAMINATION

1. Defence lawyer: 'Why did you not use a flashlight to examine the deceased?'
2. Dr Fluffit: 'Because there was enough light from the cell light'.
3. Defence lawyer: 'Why did you conclude that the deceased had committed suicide by hanging?'
4. Dr Fluffit: 'It was my first impression. I knew that I would still be conducting an autopsy, but it seemed obvious to me that the accused had hanged himself'.



Based on *S v Balala* in DJ McQuoid-Mason and MA Dada *Guide to Forensic Medicine and Medical Law* (2000)

