LETTER HEAD

<Organisation Address>

<Organisation Details>

<Today's date>

(Name and address of addressee)

Sent by post/password protected email on ………………………………..

Dear ……………………………………………………

**Name: <Patient Name>**

DOB: <Date of Birth>

Address: <Patient Address>

NHS number: <NHS number>

 MEDICAL REPORT[[1]](#endnote-1)

I write in response to your letter of instruction, dated ……….., and received on …………

In preparing this report I confirm that I am aware of my duty to the court, whether acting as an expert witness or witness of fact, and that this overrides any obligation to the person instructing me. I confirm that I have complied with my duty to act independently and to be honest, trustworthy, objective and impartial.[[2]](#footnote-1) Whether I am writing a report as an individual’s GP, or on someone I do not have any prior clinical relationship with, the duty to the court remains the same.

Where I express an opinion, I will make clear that I am doing so, and will only do so on matters within my field of expertise. [[3]](#footnote-2) My CV is attached.

***I confirm that insofar as the facts stated in my report are within my own knowledge I have made clear which they are and I believe them to be true, and that the opinions I have expressed represent my true and complete professional opinion.***

You have asked me to address the following issues:

*Enter body of letter/report (usually the questions set by the solicitor) here and bold or do something to make it stand out so it gets read.*

**Important Background Information about the *.................name of your service.......................***

 *AMEND TO REFLECT YOUR SERVICE*

1. Any medical information we have provided must always be accompanied by the following notes which explain our strengths and limitations.
2. .................................. is a GP practice whose practice population is mostly asylum seekers and refugees. We have been open since 2002 and register about 700 new patients annually. This means that our staff are trained in and very familiar with the physical and psychological problems affecting asylum seekers and refugees. In addition, all clinical staff have undertaken training in identifying patients who may have been at risk of torture or other severe ill-treatment.
3. Clinicians at ............................. cannot prepare lengthy medico-legal/expert-witness reports on patients. Medico-legal reports for asylum claims are complex and time intensive undertakings (several hours per patient at least). In torture cases the injuries may need to be evaluated using the Istanbul Protocol[[4]](#footnote-3) in order to reach an opinion on the consistency of medical findings with the torture story. This practice lacks the resources for such detailed evaluation without otherwise impacting on NHS clinical duties which have to be our primary concern. We have large number of patients who may have suffered severe ill-treatment and we aim to screen for this as early as possible. Our clinicians will try to ascertain some brief details about the allegations and conduct an examination to identify the presence of scars. Obvious psychiatric symptoms will be noted.
4. We are happy to provide letters and brief reports based on our dealings with an individual, in general practice. These are professional reports based on our records. There may be issues within our expertise, where we are prepared to give an opinion.
5. When using GP records in asylum claims, as evidence of past heath and healthcare, it is important to consider their nature and limitations. The same applies to short medical reports based on GP records. The purpose of a GP record is to record health and health interventions and for clinicians and others to communicate with one another. In recent years, the GP record has become complex with entries from multiple GP services, primary care team members (not just clinicians) and other services. They are not written with a view to the record being used as evidence in medico-legal situations. It is important to be aware of the following points, which may vary across different GP practices:
	1. **Attendance.** Not all patients make use of their GP service. This can be for many reasons including lack of awareness about health and what can be offered, lack of assertiveness trying to get appointments, fearfulness and lack of trust. Some clinicians are confident in managing trauma and ask about it and facilitate regular follow-up. Other clinicians are not. Workload pressures in General Practice are severe and have a bearing on availability of support. The fact a patient is not regularly attending their GP practice does not necessarily mean that they are not having problems with their health.
	2. **Disclosure.** A significant proportion of patients do not disclose details of any past abuse (such as torture, trafficking or domestic violence), unless asked directly about it. Even when clinicians do ask, some patients may still take months to disclose full details. Some will never disclose everything that has happened to them. Sometimes patients even deny that anything adverse has happened because they are not comfortable, at that point in time, with a disclosure.
	3. **Quality of interpreting.** The quality of interpreters used by the NHS cannot be guaranteed. Most interpreting work is now provided via contracts with telephone interpreting services. Regrettably some consultations have to be conducted without interpreters. As a consequence, information available may be limited, and/or errors may be introduced.
	4. **Accuracy.** Whilst every effort is taken to ensure accuracy, GP records can nevertheless be inaccurate. Records may contain unclear abbreviations. There may be typing errors. Misunderstandings and interpreting mistakes are not uncommon. Patients do not get any opportunity to correct factual errors.
	5. **Mental health care.** GP practices and individual clinicians vary in their interest and skills around mental health, the amount of mental health prescribing they are happy with, and referrals made. Not many GPs have training in trauma and asylum related issues. In many areas it is also very difficult to get access to counselling and therapy for people seeking asylum because of a lack of resources in mental health services. Patients are often treated by default with medications for sleep and depression/anxiety. If they are prescribed medications without engagement and follow up, the individual may often just stop taking them and stop seeking help. The absence of appointments about, medications and referrals for mental health need is not always because there is no mental health need. Non-adherence to medication prescribed, in the absence of other support, does not indicate that a person is free of mental health difficulties.
	6. **GP records and suicide risk.** GP suicide risk assessments are usually made in the moment. They relate to acute suicidal ideation, rather than the level of chronic background risk which relates to life experience, social circumstances, and personality style. There can be sudden changes in risk level in response to changes in a person’s circumstances. Presence or absence of acute suicidal ideation at a particular point in time is only one component of overall suicide risk assessment and cannot be taken as a measure of risk at a different point in time.
	7. **Examinations of injuries and scars relating to ill-treatment.** If there have been any examinations made in general practice these are not likely to be comprehensive. Many GPs will be unaware of the significance of physical injuries in asylum claims.
	8. **Gaps in GP records.** There are many reasons why there may be gaps in a GP record or an apparent delay in registration. There are many possibilities including a patient choosing not to register, difficulty registering, lack of awareness of services or fears about registering. It is not rare for some patients to have more than one NHS number and set of records due to mistakes with the spelling of names and other personal details. If this comes to light the records can be merged as one, but there will be circumstances when it does not come to light and results in a gap in the record.

Dr ................add name ................... Quals

Signature

 Consider scanning in a signature

**Curriculum Vitae: Dr ...................................**

..........It is a good idea to have a brief CV..........suggestion below. Amend.

I am a General Practitioner (GP) who qualified from ................................ in ................. I completed GP training in .............................. This included time spent working in ..........list them...............................specialities.

Describe any particular experience, training you have had in working with asylum seekers and refugees.

**Qualifications**

**List**

**Membership of Professional Organisations**

General Medical Council (GMC): .............................

Defence Union: ..............................

1. This template has been created by TortureID as part of a bank of resources for NHS clinicians who are working with people who are seeking asylum. [www.tortureid.org](http://www.tortureid.org). It has been created by Dr Jo Miller who is a GP working with people seeking asylum. They are suggestions, drawn from practical GP experience, about how to respond to common requests.  They are not 'official' templates with the endorsement of any organisations. The asylum environment is fast changing, and materials are likely to need updating regularly. Each template needs to be read through, agreed and adapted to the needs of the service planning to use them. [↑](#endnote-ref-1)
2. GMC guidance “76. Whether you are acting as an expert witness or witness of fact, you have a duty to the court and this overrides any obligation to the person who is instructing or paying you. This means you have a duty to act independently and to be honest, trustworthy, objective and impartial. You must not allow your views about a person to affect the evidence or advice you give.” https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/acting-as-a-witness/acting-as-a-witness-in-legal-proceedings [↑](#footnote-ref-1)
3. From GMC guidance ’81 Witnesses of fact (also known as professional witnesses) provide professional evidence of their clinical findings, observations and the reasons for them. 82 As a witness of fact, your written …. evidence should be clear and concise and must be based on clinical records and notes made at the relevant period of time. You may include some opinion about the findings – for example, about how an injury … has been caused – but you should make clear what is factual evidence and what is your opinion based on your professional judgement and expertise.’ https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/acting-as-a-witness/acting-as-a-witness-in-legal-proceedings [↑](#footnote-ref-2)
4. Istanbul Protocol **UNHCR**: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (2022 edition) [↑](#footnote-ref-3)