postScript

LETTERS

Expert witnesses: opinion and dogma are pitfalls in medical journalism as well as in reports

Professor David's leading article provides a welcome summary of the Code of Guidance for Expert Witnesses in Family Proceedings. All paediatricians who undertake this type of work should be familiar with the Code of Guidance and have due regard to it. However, Professor David also goes on to express some highly personal opinions which, while forcefully argued, are un referenced and not evidence based. The most obvious example in the article is Professor David's views on interviewing the parents or carers. He comments that "a paediatrician who does not attempt to interview the parents risks being criticised for by-passing the usual routines and failing to consider all aspects of the case". He goes on to say that paediatricians willing to make a confident diagnosis of abuse with out ever meeting the parents risk making parents exceptionally aggrieved, alluding to recent press publicity.

The undersigned are all experienced in the field of child protection and between us have considerable experience of expert witness work. In our experience, a substantial proportion of Expert Witness Reports are prepared on the basis of a paper review. This has hitherto been regarded as perfectly sound medical practice, which is not explicitly discouraged in any of the published Expert Witness guidance. We would suggest that Professor David's views should not be accepted unquestioningly, and that this issue should be debated openly.

It is undeniable that treating paediatricians need to take a good history from parents, carers or others, especially where child abuse is being considered in the differential diagnosis. The situation is different, however, for an Expert Witness who assesses the case many months after the parents have been confronted with the initial concerns about child abuse. The parents are likely to have had many opportunities to discuss their case and rehearse their history; for example in case conferences, meetings of professionals, and with their lawyers. Usually they will have produced detailed witness statements in conjunction with civil and/or criminal proceedings. Interviewing carers in this context is not something which paediatric training fully prepares you for, and even experienced paediatricians may have little experience of this. There are significant risks:

1. Parents, whether innocent or not, will naturally attempt to idealise their histories and portray themselves or other carers in a favourable light. Guilty carers are likely to be distressed and may become prejudiced against an Expert Witness who assesses the case. They may insist on the interview being recorded, which adds delay and expense. If the interview is not recorded the carer may later deny something that they said to the paediatrician if it is unhelpful to their case.

2. Given that the courts are experiencing extreme difficulty in recruiting Expert Witnesses, adding a further obligatory interview, regardless of its relevance, may deter paediatricians even further from taking on cases.

3. The new Protocol for Family Law cases was introduced to avoid delays in proceedings and a requirement to interview carers in all cases would inevitably add delay.

4. The Expert Witness Guidance specifically forbids paediatricians to seek to resolve disputed issues of fact in their reports. There is a risk that in interviewing the family and generating new information the paediatrician may be drawn into this particular trap.

5. In some cases there may be a risk of physical harm or intimidation of the Expert Witness. Often we are invited to meet with the family in their own home and without chaperones. This also leaves doctors vulnerable to false accusations concerning their behaviour in interviews. The carers may try to challenge or "cross-examine" the doctor at interview. Doctors need to consider carefully their own health and safety in these circumstances.

6. The parents may misinterpret, misrepresent or take "false hope" from things that the paediatrician has said to them, or may press for a provisional opinion on the case, which of course should not be given.

7. Not infrequently, parents or their advocates are suspicious about the paediatrician's motive in wanting to interview the family, even when the doctor is jointly instructed and acting in a completely neutral capacity. The interview being recorded and transcribed, which adds delay and expense. If the interview is not recorded the carer may later deny something that they said to the paediatrician if it is unhelpful to their case.

8. Given that the courts are experiencing extreme difficulty in recruiting Expert Witnesses, adding a further obligatory interview, regardless of its relevance, may deter paediatricians even further from taking on cases.

9. The new Protocol for Family Law cases was introduced to avoid delays in proceedings and a requirement to interview carers in all cases would inevitably add delay.

10. Parents often find interviews such as this very stressful. This is only justified if there is clear benefit. Where complaints are received, for example by an NHS Trust or the GMC, it is important that the doctor's performance is judged on the basis of currently accepted and "reasonable" medical practice, and that the opinions of those making these judgements are not influenced by skilfully argued, but personal and controversial views such as those expressed by Professor David.

In some cases, of course the Expert Witness will wish to meet with the carers before coming to a diagnosis. We would not argue that it is wrong to do so subject to the cautions mentioned above, but it should not be regarded as obligatory. The undersigned are all experienced in the field of child protection. Certain well known campaigners, accused parents, and journalists often refer to the fact that a Paediatric Expert Witness had not met the family before coming to a diagnosis, in an attempt to discredit them. In this context, the idea that interviews with parents or carers should be conducted purely to appease them and reduce the likelihood of them complaining is highly controversial and there is no reason to believe that goal would be achieved. Where complaints are received, for example by an NHS Trust or the GMC, it is important that the doctor's performance is judged on the basis of currently accepted and "reasonable" medical practice, and that the opinions of those making these judgements are not influenced by skilfully argued, but personal and controversial views such as those expressed by Professor David.

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Should expert witnesses interview parents?

Professor David’s article \cite{David} was in the main a helpful guide to those involved in this specialised work. I wonder how many of the readers are involved in this sort of work?

As a recently qualified general paediatrician I was surprised to read his recommendation that expert witnesses should interview the family. In the few child protection cases that I have been involved in as a witness to the fact, colleagues acting as expert witnesses have not interviewed the family. They have restricted themselves to their expert opinions on specific questions of medical knowledge that the legal teams have felt would be helpful to clarify. I read that other expert witnesses agree.

I was also surprised to read Professor David’s views without a response from those who have differing opinions, especially as he is intimately involved in Professor Southall’s controversial General Medical Council hearing. I do trust that you will uphold the essential principle of good journalism and allow an open debate on this issue with equal prominence to differing views.

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 Babies born to HIV positive women

The book does have a good review of the history and methods of preventing mother to child transmission of HIV. This provides excellent background to this topic. However more practical information for managing these babies is provided in the British HIV Association (BHIVA) pregnancy guidelines, available at www.BHIVA.org.

I found the chapters on HIV in the central nervous system and gastrointestinal system very useful. I have already shared these with colleagues in child development centres and dieticians. Other organ specific members of the multidisciplinary team looking after children with HIV, would find other specific chapters helpful. The chapter on palliative care was particularly moving, encouraging those in this field to have humility and perseverance.

My main criticisms of the book were that it was too focussed on practice in the United States (not surprising when all the authors work there) and missed some recent developments. If a second edition is planned I hope it will include reference to the landmark HIV Paediatric Prognostic Markers Collaborative Study, detect that the organism that causes PCP is now named Pneumocystis jiroveci (not P carinii), and have some authors from outside the USA.

I would recommend that this book is available in every paediatric department who might see children with HIV. However it would be even more important for these units to have access to the guidelines on the CHIVA website and to have access to an expert in paediatric HIV. The establishment of clinical networks for paediatric HIV across the UK, as has already occurred, should improve this.

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CORRECTION

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1 C K Wong, M L Murray, D Camilleri-Novak, et al. Increased prescribing trends of paediatric psychotropic medications (Arch Dis Child 2004;89:1131–2). The footnote for figure 1 in this short report was published incorrectly and should read “USA data is by ten thousand prescriptions”. The authors apologise for the error.

www.archdischild.com