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NEWS AND NOTES

SUPPLEMENT

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CORRESPONDENCE

- *All letters must be typed with double spacing and signed by all authors.*
- *No letter should be more than 400 words.*
- *For letters on scientific subjects we normally reserve our correspondence columns for those relating to issues discussed recently (within six weeks) in the BMJ.*
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- *Because we receive many more letters than we can publish we may shorten those we do print, particularly when we receive several on the same subject.*

Suffocation and videos

SIR,—Professor Roy Meadow's leading article (27 June, p 1629) highlights many constructive uses to which video technology can be put. However, many other aspects are ignored and in view of current intense media interest in child sex abuse this may lead to misunderstandings. We have recently examined some of the ethical dilemmas associated with the use of video recording[1] and write now as observers, not self appointed experts, which this subject seems to attract.

Many child psychiatrists use videos routinely as part of their clinical work and for teaching. Some now find themselves as reluctant witnesses in court proceedings. The BMA and medical defence societies have issued recommendations that video tapes should be regarded in the same way as written notes, with the same rules of confidentiality (that is, until they are subpoenaed) and similar regulations precluding erasure—the latter being totally impractical by reason of expense and lack of storage space. Professor Meadow sidesteps these issues, as he does the matter of consent, and ignores the question of who should carry out video recorded interviews: the police, the clinicians concerned, social workers, or independent psychiatrists? Is this likely to be in the interest of the child, the police, the family, or society? Finally, there seems to be a widespread need to deny that sexual abuse has its roots in family life, and there is a danger that it is seen as a purely criminal matter which the legal system, with the help of cooperative doctors, can eradicate. Talk of diagnosing (sic) sexual abuse feeds into this. Though physical signs may be detected in a minority of cases, child sex abuse is no more a diagnosis than, say, murder or neglect. It is usually one aspect, albeit a particularly distressing one, of general deprivation and it is that which we should seek to eradicate.

A S DAVID
M FARRELL

Maudsley Hospital,
London SE5 8AZ

1 David T, Farrell M. Child sex abuse under the spotlight. *Maudsley and Bethlem Gazette* 1987;**34**:22-3.

SIR,—The last paragraph of the important paper by Dr D P Southall and colleagues (27 June, p 1637) ends, "smothering is a comparatively rare but dangerous and preventable cause of hypoxaemic episodes in young children." The behaviour shown by their two mothers is uncommon, but I doubt that it is rare.

In our 1985 report on young children abused in north east Wiltshire we described 39 such child victims who suffered at least 58 suffocatory assaults.[1] Four of the children had been held under water and 13 suffered throttling or strangling (often to the point of unconsciousness); but the remaining 22 were assaulted in ways comparable to those described by Dr Southall and colleagues. In my *BMJ* paper of 1983 at least 34 of the main group of 513 abused children had been subjected to suffocatory techniques, and I described a characteristic vignette of a mother whose behaviour differed from the maternal behaviour described by the authors only because she reacted in stress and anger whereas their two mothers practised calculated bouts of suffocation of their babies. As with their two cases, all our child victims of suffocatory assaults had parents who themselves had been victims of child abuse.[2]

Professor Roy Meadow (p 1629) rightly identifies the child victim as the primary patient but favours medical confrontation with mothers where the diagnostic probability is strong *before* involving the police and secret video recordings, as do Dr Southall and his team. It is hard to follow this logic, which seems to put a tremendous burden on the paediatrician, excludes the police at a crucial stage, and sidetracks the courts. Long term efforts to protect the child would be undermined, leaving as the only option years of unremittingly sustained first class social and medical therapy without the authority to enforce such treatments. Professor Meadow nevertheless goes on to support the case for allowing secret video recordings where there is diagnostic uncertainty.

Following the Beckford inquiry the DHSS draft guidelines on child abuse contained totally inadequate definitions of child abuse. I and the Wiltshire child protection committee have written letters complaining about this, making particular mention of the failure of the DHSS even to be aware of suffocatory episodes being a form of physical abuse, let alone a (not rare) form of abuse that leaves no evidence.

J E OLIVER

Pewsey Hospital,
Pewsey,
Wiltshire SN9 5NQ

1 Oliver JE, Graham WJ. *Generations of maltreated children in north east Wiltshire*. Oxford: Oxford University Unit of Clinical Epidemiology, 1985.
2 Oliver JE. Dead children from problem families in north east Wiltshire. *Br Med J* 1983;**286**:115-7.