
Symposium on covert video surveillance

Covert video surveillance – a response to Professor Southall and Dr Samuels

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Abstract

In their reply to my recent paper on Munchausen's syndrome by proxy (1), Professor Southall and Dr Samuels (2) concede that some things may be learned from my observations. They do not attend to the main argument of the paper, however, that the proportion of research interest in their use of covert video surveillance merits consideration of the research protocol by an independent research ethics committee. It will not do simply to assert that the use of this technology for the purposes outlined in their accounts is not research. I formulated arguments based on facts divulged in those published accounts for regarding their work as containing a considerable proportion of research activity. Unfortunately their reply did not address these arguments. Until such points are adequately answered the protection of patients calls for satisfactory judgments to be made on certain important issues which any research ethics committee would be obliged to consider in an evaluation of their activities. I suggest that some of these features will create more difficulties for approval of such a protocol than others.

In their reply to my paper David Southall and Martin Samuels concede that the surveillance aspect of their use of covert video surveillance (CVS) is really police activity. I argued for this and regard the concession as a valuable gain in understanding. This raises interesting questions about whether it is proper for nurses to be requested to perform the function. One of my contentions was that the use of CVS involved a confusion between clinical practice and criminal surveillance. The admission that the lack of police presence was not ideal vindicates part of my ethical objection to the procedure being carried out by health care professionals. I am also gratified that the respondents claim to have addressed a number of important criticisms of their work made in my paper, though they do not detail the criticisms in question. It is not clear, therefore, whether or not they acknowledged the import of any

Key words

Munchausen's syndrome by proxy; covert video surveillance; adverse events; consent; confidentiality.

of my central arguments in the paper, *viz* that their use of covert video surveillance contains a large element of research activity and that, as such, it ought to have been considered by an independent Local Research Ethics Committee (LREC).

Certainly no rebuttal of my arguments that the use of CVS should be regarded as a research activity appear anywhere in their response to my paper, though my evidence for this was all drawn from their own published accounts of the activity. I am, however, accused of not troubling to find out all the facts before writing my paper. They take care to avoid the many facts I did carefully uncover from the published accounts of their research activities regarding the diagnosis of imposed upper airway obstruction, on the basis of which I argued that there was a considerable research element in the use of CVS. Simply to assert that the use of CVS is not research will not do. I look forward to seeing an attempted rebuttal.

Any submission of the protocol to an ethics committee for consideration as a research study would have to cover carefully a number of aspects of the use of CVS.

1. The *background* of the study would need to provide details of the development of home-monitoring technology by the team and outline the importance of a proper assessment of its efficacy. I imagine that it would not be difficult to persuade such a committee of the value of such technology and of the need to evaluate its accuracy in order to avoid the drastic consequences for children and their families of false positives.

2. The *objectives* of the study would have to be spelled out unambiguously. These can be detected in the written accounts of the research provided by the team in learned journals. I alluded to them in passing in my original article. They could be stated as follows:

- i) to compare the readings on multi-channel physiological recordings in cases of naturally occurring apnoeic attacks with readings on the same equipment recorded during confirmed cases of imposed upper airway obstruction (attempted suffocation).
- ii) to analyse such results to see whether a distinctive

pattern of recordings can be identified in the imposed upper airway obstruction cases, thus confirming the equipment as a useful diagnostic tool for establishing life-threatening abuse.

Again, I cannot imagine that an ethics committee would have difficulty in seeing that such objectives were worthy goals of research and that they were realisable.

3. The possibility and nature of *adverse events* presented by the study would have to be canvassed. From the published accounts of the studies so far completed and, moreover, from the response to my paper by Drs Southall and Samuels, these will include the heightened risk of serious physical assault and injury including the fracture of limbs, poisoning, suffocation, physical attack with implements and, finally, emotional abuse.

Numbers of these events are life-threatening, or, even if intervention avoids the loss of life, at least more than mildly harmful. The guidelines of the British Paediatric Association (3) concerning research on children insist that the risk of serious harm would never be countenanced by an ethics committee. Though they do not say that they never should be so countenanced I think that that is probably the meaning of the assertion. I strongly suspect that members of an ethics committee would not readily imagine themselves agreeing that a child of their own be subjected to such risks in the name of research, nor would they, I imagine, consider it proper for any other parents to so agree if the opportunity was presented to them. In the present studies, of course, no such opportunity can be provided. This feature of the study would probably present the greatest difficulty to an ethics committee.

4. The *consent* of the participants in the study would have to be canvassed. It is clear that to seek informed consent in such a study would be self-defeating. The committee would need to be shown why this was so and would need to consider whether consent properly could be waived in a study where the consequences could be far-reaching for the parent in question and her family.

Psychological studies

There are studies, of course, where the waiving of consent and the practice of deception are both necessary for the trial to proceed and where such measures may be considered proper. These are usually psychological studies. The guidelines of the British Psychological Society make it clear that such measures have to be balanced with subsequent measures such as the debriefing of the subjects after the study. The likelihood of participants objecting or showing unease at debriefing renders a study unacceptable (4). Whether the consent issue would constitute a sticking point for some committees is uncertain but that the subjects

should be protected from the effects of discovery or doubts about their possible participation is, I suspect, unquestionable.

5. *Confidentiality* is also a crucial consideration. This is standardly promised to subjects in clinical research studies. It usually takes the form of guaranteeing that any information about them gathered in the study which shall be used in the publication of results and subsequent research will be anonymised, thus making identification of individuals impossible and avoiding any subsequent embarrassment or inconvenience.

Serious breach

I suspect that making collected data available to police authorities which had themselves declined to participate in their collection for the purposes of maintaining law and order would serve as a serious breach of confidentiality and would demand strenuous defence before an ethics committee would be sympathetic to it.

Such matters, amongst others involving statistical significance and so on, would inevitably play a proper part in the ethical review of a study of the sort reported by the North Staffordshire Hospital paediatric team. They would be regarded as integral considerations in ethical evaluation. Until the team satisfactorily rebut the claim that such research objectives are part of their strategy in their use of CVS the case for consideration of these issues seems to me to be overwhelming.

In their response to my paper the team accuse me of conducting a campaign against the practitioners in question. The analysis of material submitted for publication in learned journals and thus placed firmly in the public domain is an integral part of serious academic activity. My paper and the letter published in the columns of the *British Medical Journal* (5) were submitted at the same time. I was not responsible for the time-lag between their appearances. On publication of the paper I was approached to answer questions about my remarks by various individuals. In my interview with BBC Radio in Staffordshire I simply repeated my claim that the protocol was not presented to the Local Research Ethics Committee for approval. That assertion was made on the basis of careful research. The annual reports of the relevant Staffordshire LREC contain no mention of such a protocol being presented to the committee for opinion or approval, neither is there any mention of chairman's action concerning the protocol. I shall be happy to withdraw my claim if evidence of such consideration is forthcoming from the committee. I do not have in mind here any hospital ethics committee. No such committee is entitled to bypass the LREC and the independence required for a proper ethical evaluation would not be seen to apply if an in-house committee was responsible for its consideration.

Thus all the respondents' references to their use of hospital committees is by the way. In this connection I am not responsible for the inaccurate reporting of my remarks in the *Times Higher Educational Supplement* to which they refer.

I am also accused of stating that *overt* video surveillance would possibly be more appropriate and that such a suggestion is silly, or at least does not accord with common sense. That would indeed have been a silly suggestion had I made it. The most careful scrutiny of my paper will show that I suggested no such thing. Such a suggestion would have cast doubt on the soundness of my arguments.

I am sorry if my paper has provoked large amounts of uninformed criticism, as is alleged by the respondents. I am aware that there has also been informed criticism from responsible bodies such as the Royal College of Nursing, which has serious misgivings about nurses playing the kind of role asked of them in the use of CVS (6). There is a proper way to deal with unjustified criticism – that is to refute it reasonably by taking seriously the arguments or alleged facts on which that criticism is based and showing them to be flawed. If patients are to be properly protected then open and frank discussion of

clinical activities must be encouraged and not replaced by mere assertion.

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References

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- (3) British Paediatric Association. Guidelines to aid ethical committees considering research involving children. *British medical journal* 1980; 293: 229.
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News and notes

Summer Seminar in Health Care Ethics

Sponsored by the Department of Medical History and Ethics, School of Medicine, University of Washington, the seminar will be held in Seattle, WA, August 5–9, 1996. Directed to physicians, nurses, social workers, chaplains, teachers, and others involved in the care of patients or the education of providers, this annual Summer seminar provides an intensive introduction to the concepts, methods, and literature of health care ethics. Albert Jonsen, faculty and chairperson in the Department of Medical History and Ethics, will lead the seminar. The seminar is designed to familiarize health care professionals with the field of bioethics, and to provide participants with skills and information

sufficient to enable them to make competent ethical decisions in clinical situations. The University of Washington School of Medicine designates this continuing medical education course for approximately 30 hours of Category 1 of the Physician's Recognition Award of the American Medical Association. For information on specific objectives, and to receive a Seminar brochure (IN APRIL) with full details and registration form, contact: Marilyn J Barnard, Program Coordinator; Medical History & Ethics; Box 357120; School of Medicine; University of Washington; Seattle, WA 98195–7120; Phone: (206) 616–1864. Fax: (206) 685–7515; E-MAIL: mbarnard@u.washington.edu