Expert Medical Evidence and the case of The GMC v Dr Waney Squier

Summary

By its findings and its prescription of erasure from the Medical Register, the regulatory tribunal in the recent case of Dr Waney Squier has set a dangerous precedent. It has usurped the function of the court by determining itself what expertise is required to give evidence. Without defining the boundaries of that expertise[1] it has in this case created a strict liability offence. To step outside that non-defined area of expertise is to be dishonest: the penalty is to be struck off

Importance of Expert Evidence

In cases of injury or death, civil or criminal, justice cannot be achieved without the court having the assistance of expert medical evidence.

> '*If matters arise in our law which concern other sciences or faculties we commonly apply for the aid of that science or faculty which it concerns. This is a commendable thing in our law. For thereby it appears that we do not dismiss all other sciences, but our own, but we approve of them and encourage them as things worthy of commendation'* (1553)[2]

All evidence presented to a court may be conveniently divided into evidence of fact and expert opinion evidence. No one, save for an expert, may voice an opinion. Within the judicial system there are controls on the provision and quality which have emerged through the common law of England (for example in the *Ikarian Reefer case*[3]*)* and are now embodied in procedural rules of the courts.

The relevant Civil Procedure Rules (1998) and Practice Directions (as amended) require that:

(1) the expert has an overriding duty to help the court on matters which lie within his or her expertise[4]. This duty overrides any obligation to the person instructing the expert or by whom he/she is paid;

(2) ….

[1] In this instance, the requisite expertise is in the shaken baby syndrome.
[2] Saunders J in *Buckley v Rice-Thomas* (1554) 1 Plowd 118 at 124.
[3] *National Justice Compania Naveira SA v Prudential Assurance Co Ltd, The Ikarian Reefer* [1993] 2 Lloyd's Rep 68.
[4] CPR 35.3; 35 PD para 2.2, Protocol 4.1.

(3) experts should provide opinions which are independent regardless of the pressures of litigation. ……

(4) experts should confine their opinions to matters which are material to the disputes between the parties and provide opinions only in relation to matters which lie within their expertise. Experts should indicate without delay where particular questions or issues fall outside their expertise (Protocol 4.4)…

Since expert opinion has to be formed in relation to facts, the opinion is likely to change with them. There is nothing improper about an independent expert advising the party instructing him how his or her opinion might change in different factual scenarios, even though this may be seen as trying to assist that party. In *Stanley v Rawlinson [2011]* EWCA Civ 405 Tomlinson LJ said:

> *"Experts are often involved in the investigation and preparation of a case from an early stage. There is nothing inherently objectionable, improper or inappropriate about an expert advising his client on the evidence needed to meet the opposing case, indeed it is often likely to be the professional duty of an expert to proffer just such advice. The opinion of an expert is often if not usually dependent upon the precise nature of a factual situation which he must to some extent assume to have existed. There is nothing improper in pointing out to a client that his case would be improved if certain assumed features of an incident can be shown not in fact to have occurred, or if conversely features assumed to have been absent can in fact be shown to have been present."*

This is a clear illustration of the duty of the expert to consider various factual scenarios which may support or detract from an expert opinion, including opinions advanced by experts for other parties. The evidence does not have to be before the court for an expert to give an opinion based on various hypotheses.

What makes an expert?

An expert is a person who has experience sufficient for it to be termed "expertise". Academic qualifications may confer a presumption of expertise, but the essential

qualities of an expert are knowledge and experience[5]. A person does not require academic and professional qualifications to be an expert but without them it is more difficult to establish the credentials. In the forensic environment this knowledge has both to be relevant and useful. This accords with the guidance given to medical practitioners by the GMC[6]:

> *You must only give expert testimony and opinions about issues that are within your professional competence* ***or about which you have relevant knowledge*** *including, for example, knowledge of the standards and nature of practice at the time of the incident or events that are the subject of the proceedings. If a particular question or issue falls outside your area of expertise, you should either refuse to answer or answer to the best of your ability but make it clear that you consider the matter to be outside your competence* (emphasis added).

Peer group assessment of an expert's expertise should be an important factor. I deal with this in greater detail below when considering the Tribunal's findings about Dr Squier's expertise.

Who decides on what an expert's "area of expertise" is?

First, Stage 1: In the first instance this must be the expert him or herself. Whilst such a determination is necessarily subjective, most experts would be guided to the correct answer by consideration of their own medical training, post-graduate qualifications, work experience, published literature and specialist knowledge. In its simplest form, a medical practitioner asked for a medico-legal opinion might ask the question whether by virtue of training and experience s/he had sufficient *specialist knowledge* to be able to give a useful opinion to the court in the relevant area.

Secondly, Stage 2: Those instructing the tentative expert may take a view as to whether s/he has the relevant expertise by reference to his/her cv or acceptance in other cases as an expert. The latter is an important controller.

[5] See the entries for "expert" and "expertise" on their etymology in the complete version Second Edition of the Oxford English Dictionary.
[6] Giving Evidence as an Expert Witness – para 12.

Thirdly, Stage 3: The court decides. This is the long stop. Any party or the court itself may wish to raise the matter of whether any particular person should be permitted to give expert opinion evidence on the basis of that person both having "expertise" and providing an opinion within it. The court not only controls medical experts but all experts, whether or not they are subject to a regulatory body which controls their behaviour.

If there is any concern about a person's expertise the court may have first to hear the evidence *de bene esse* before making a decision as to whether the opinion proffered is sufficiently "expert" to confer a benefit on the judicial process. The evidence has to have probative value. The court decides.

If there is any concern about an expert's independence from the exigencies of the litigation, or if there are challenges on the grounds of a conflict of interest (financial or otherwise) again the court decides if the expert can give evidence and if so, what weight is to be given to it.

Whilst paying due deference to medical regulatory tribunal decisions in the field of clinical medicine, the Court of Appeal has made clear that when it comes to expert medical evidence[7], it is a matter for the Court to decide who qualifies as an expert in a given field:

> *Whilst the Privy Council was, and now the Queen's Bench Judge is, free to upset the decision of the panel if clearly wrong, it has always been recognised that the appellate court must accord due deference to the evaluation of a panel substantially composed of doctors for the obvious reason that they are better placed to make a peer judgment. There can be no doubting that proposition where the charge before the panel relates to clinical work. But where the only charge relates to the doctor's evidence given during legal proceedings there is no similar foundation for deference. It is the judges, in judgments such as the Ikarian Reefer who set the standards that they require of the expert witnesses*

[7] Since this decision the MPTS has been introduced to create some distance from the GMC and to provide for a majority of medical laity in decisions affecting fitness to practice. However, the point remains good; it is for the court and not a regulatory tribunal to determine whether or not an expert falls below the standards set by the court.

> *appearing before them. In my opinion the judges are best placed to evaluate whether and to what extent an expert witness fell below those standards.*

The General Medical Council v Professor Sir Roy Meadow (Court of Appeal) [2006] EWCA Civ 1390, Thorpe LJ at para 280.

In the criminal courts[8] it is spelt out that when considering the reliability of expert scientific opinion the court should be astute to identify potential flaws in such opinion which detract from its reliability[9], such as:
(a) being based on a hypothesis[10] which has not been subjected to sufficient scrutiny (including, where appropriate, experimental or other testing), or which has failed to stand up to scrutiny;
(b) being based on an unjustifiable assumption;
(c) being based on flawed data;
(d) relying on an examination, technique, method or process which was not properly carried out or applied, or was not appropriate for use in the particular case; or
(e) relying on an inference or conclusion which has not been properly reached.

Therefore, in a trial, a court has to have regard for the fact that SBS is a causal hypothesis[11]. Its critics maintain it has no foundation in science and is not a verified scientific theory. This does not bar the SBS hypothesis being given in evidence to prove that the defendant (usually the person holding the baby at the point of its collapse) was responsible for the injury, but it is the duty of the court to see if that hypothesis stands up to scrutiny in the case before the court. A main way in which scrutiny is conducted is by the evidence of other experts (with sufficient expertise to do so) challenging the hypothesis. It does not matter how many people *believe* the hypothesis. One hundred times nought is nought. One hypothesis without scientific foundation is as good as any other and each remains an unproven hypothesis.

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[8] *Criminal Practice Directions - October 2015.*

[9] 19A.6.
[10] The Shaken Baby Syndrome is just such a hypothesis. It has been subject to much scrutiny but continues to have life notwithstanding that there appears to be no scientific evidence to support it.
[11] A proposition for phenomenon without any assumption as to its truth.

Although the SBS hypothesis could be challenged on any scientific basis (or none) challenges have more substance and credibility if based on science. English law allows an opinion doubting a hypothesis to be given by anyone who has sufficient knowledge of the subject. A court having decided that a medical practitioner has sufficient knowledge to be an expert, it is that doctor's duty to challenge hypotheses advanced by others as proof of causation.

In the administration of justice, judicial procedural control of medical expert evidence has long been considered sufficient and there is no move to change it. However, a tribunal of the Medical Practitioners Tribunal Service ("MPTS") which independently regulates medical practitioners on behalf of the General Medical Council ("GMC") has decided to intervene. In a dangerous precedent it has decided to define any medical practitioner's expertise itself and to control whether a medical practitioner can appear before a court to give opinion evidence. If the decision of the tribunal to erase Dr Waney Squier from the Medical Register is allowed to stand, the decision will adversely affect the courts' access to medical expert evidence and the administration of justice will suffer.

Interference of Medical Regulator

In Dr Squier's case, in respect of multiple charges of going beyond her expertise, the tribunal decided not only did this internationally renowned and acclaimed[12] paediatric neuropathologist give evidence "outside her expertise" but that she must have known that she was doing so – and therefore was dishonest. Throughout her evidence Dr Squier claimed she thought she was entitled to give evidence in the way that she did as an expert in neuropathology. Notwithstanding this, the finding of dishonesty was the basis of her erasure from the medical register.

There are three evils in the tribunal's decision. First, the tribunal went outside its own authority in deciding whether or not any particular issue is within or outwith a practitioner's expertise *so as to enable him or her to give expert opinion evidence in court*. Secondly, without particularising the precise minimum expertise required to give

[12] Champion of Justice Award presented by the Innocence Network at its annual conference April 8-9, 2016, in San Antonio, Texas.

an opinion[13], it concluded that providing opinion evidence outwith that minimum expertise is dishonest. Thirdly, it usurped the authority of the court.

Of course dishonest medical practitioners should be sanctioned. Quite properly the public should be protected by such practitioners being removed from the Medical Register. The GMC should discipline expert medical witnesses[14] who may bring the profession into disrepute but it is the finding of a disciplinary tribunal that a doctor has acted as an expert outside her field of expertise and *therefore* was dishonest[15] which is most disturbing. On the facts Dr Squier qualified her evidence where appropriate by saying that she was not an expert in biomechanics (for example), in accord with the GMC guidance, which permits an expert to answer a question outside his or her expertise provided that expert makes clear that he/she may be acting outside his/her competence. Nevertheless the tribunal still found her dishonest by doing so.

The tribunal has created a strict liability offence: act as an expert outside your area of expertise[16] and <u>you will still be struck off</u>. There is no defence. Even if you make clear that you are outside your area of competence, even if you acted honestly and even if you had the highest level of integrity, your career would be over. The propriety of such an important precedent is a major matter of public concern and is subject to Appeal.

An expert should not seek to go beyond her expertise. Yes, an expert should leave matters outside her expertise to those who have it. Deference to other areas of expertise should not be taken as acceptance *of the opinion* of those with that other expertise. Deference is simply to the expertise of another. One needs as much expertise in a subject to be able to agree with an opinion as to be able to dissent from it. Defer yes; *accept* the opinion from another expertise no. Non-acceptance of the expert opinion from another area of expertise is not only the right thing for an expert to do, it is the only thing to do – other than say "I am unable to comment".

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[13] In the case of Dr Squier whether or not SBS/AHT is the likely cause of the observed pathology.
[14] GMC V Meadow [2006] EWCA CIV 1390 (26 October 2006).
[15] Surely no honest and reasonable doctor would say that to give <u>any</u> evidence beyond one's field of expertise was necessarily dishonest. He or she would surely want to know "how much evidence?" – "what exactly did the doctor say and what was being asked?"
[16] "Area of expertise" is not defined but nevertheless is determined by the MPTS and an honest and even reasonable belief that the evidence was within the area of expertise is no defence – a finding of dishonesty and a penalty of erasure will follow. See Michael Birnbaum QC's article.

What expertise does an expert in SBS need to have?

In determining whether or not an expert had the expertise to opine in cases involving allegations of SBS –- it is first necessary to determine what expertise is required. Nevertheless, the tribunal found that Dr Squier did not have the expertise to provide an opinion on the cause of the findings that led to allegations of SBS without determining what expertise ***was*** in their lay opinion required. This is an astonishing conclusion since two of the three findings associated with allegations of SBS fall within the purview of neuropathology,[17] and all of the leading textbooks on neuropathology cover the very subject areas for which Dr Squier was criticised for venturing an opinion.

One might expect a respiratory physician to be able to opine on respiratory infections, chronic obstructive airways disease, asthma and so on. Similarly, without issue a cardiologist would be expected to be able to give an opinion on cardiac dysrhythmias without going beyond his or her expertise. But where a condition, *a fortiori* a syndrome, involves several medical specialties[18] each might give evidence *within their expertise* about the likely *cause* of the triad[19] of SBS/AHT. There is no specialist in SBS and any or all of the specialists into whose territory this spectrum of pathology encroaches may have the expertise to express a valuable opinion. If one specialty might be considered to have particular expertise in this area, that specialty would likely be neuropathology, which is defined as the study of disease of the central nervous system, including the brain.

Should the GMC or a tribunal of the MPTS decide who is an expert?

Now enters the MPTS. A lay tribunal[20], not having itself the expertise or the remit to determine the central scientific issue – the ***cause*** of findings often attributed to SBS/AHT – makes a determination as to whether certain opinion evidence is within or without a medical practitioner's expertise. Its determination (subject only to appeal) is

[17] The three findings most often associated with SBS are subdural hemorrhage, retinal hemorrhage and abnormalities of the brain. Subdural hemorrhage and brain abnormalities are conceded to fall directly under the discipline of neuropathology; retinal hemorrhage is closely related as the retina is encased by the same membrane (the dura) that surrounds the brain.

[18] *Inter alia*, paediatric ophthalmology, paediatric neurology, paediatric neuroradiology and paediatric neuropathology.

[19] Retinal haemorrhages, encephalopathy and bilateral thin layer sub-dural haematomata.

[20] Comprised of a retired RAF wing commander (chair), a retired senior policeman and a retired geriatric psychiatrist.

final. In finding that Dr Squier does not have the expertise to give an opinion on the cause of findings often attributed to SBS/AHT, the three stage safeguard in the expertise that is to be heard by the Court is usurped and Dr Squier's opinion evidence, by the tribunal's decision, is denied to the courts in any matter[21], in any case[22] and for all time[23].

The tribunal produced no clarity as to the expertise required. No criteria for the necessary expertise were set out. No one reading its decision could possibly determine the borderline, stepping beyond which is punished by the ultimate sanction. Although the tribunal did not know where the borderline was itself, it expected the expert to know it and to know that by going beyond it was necessarily dishonest. Strict liability requires strict criteria and there were none.

Professor Norman Guthkelch, who first described the SBS in 1971, wrote in a testimonial for Dr Squier in these terms:

> *"I am surprised and puzzled by the allegation that Dr. Squier transgressed the boundaries of her area of expertise, if transgression of these boundaries is a punishable offence then these should be clearly defined. The boundaries are a matter of individual opinion and they will change with the continuing advance of relevant knowledge. Yesterday's abstruse deduction is tomorrow's obvious consequence. These boundaries are artificial and subjective. The field of knowledge of an expert, whether in art or science, is not bounded by a rigid fence. Personal experience has taught me that an active doctor who takes a scholarly approach to his or her specialty finds that sphere of knowledge changes literally from day to day. This applies to Dr Squier too."*

Implications of the Precedent

The impact of the decision of the tribunal in the case of Dr Squier is stark. Although an expert may genuinely believe that the area in which his/her opinion is sought falls

[21] Including any case where her expertise is not in contention.
[22] Regardless of the factual circumstances.
[23] Until such time as Dr Squier's name is restored to the Medical Register. Erasure deprives her of her employment, her research base and for all practical purposes her ability to give expert evidence anywhere in the world.

within his/her expertise, is instructed and is allowed to give evidence by a court (the 3 stages being passed) – the practitioner still may be struck off for going outside what a lay disciplinary tribunal regards as the boundaries of the practitioner's expertise. The medical expert is censured, proclaimed dishonest[24], disgraced and struck off.

It is astonishing that any tribunal is a position to determine what is within and without any particular doctor's expertise. *A fortiori* where the subject matter is outwith every expert's expertise. SBS/AHT is necessarily a diagnosis which is dependent upon a number of different areas of expertise. Without overlapping expertise, knowledge would be sterile, untested and untestable by the learning in related areas of expertise. Such a silo approach is not reflected in the rules of the court or in the guidance of the GMC which allows an expert to answer a question outside his or her expertise provided the answer is to *the best of your ability but make it clear that you consider the matter to be outside your competence.*

Where a medical practitioner has a genuinely held and honest belief that the subject matter on which he/she is requested to give an opinion *is* within his/her expertise, how can such a person found to be dishonest and deserving of being erased from the medical register?

If the GMC/MPTS is to have this power to determine "expertise", let alone in the restrictive way it has sought to do so in the case of Dr Squier, what impact will this have upon other medical practitioners from giving expert evidence to assist in the judicial process? Surely they would see that, even were the court to permit them to give expert opinion evidence they might still be found to be acting outside their expertise by the MPTS, proclaimed as dishonest and struck off the medical register.

Would a medical practitioner in his/her right mind put him/herself at such risk? Is there a way of giving expert evidence where such a risk could be minimised or eliminated? Yes – by the provision of an expert opinion which is not likely to be contentious. Whilst clinical, radiological or neuropathological *findings/observations* may differ and these differences may be important, there is some safety here as there is often

[24] Even though both the expert and the court may have considered the evidence given to be within his or her expertise.

demonstrable objectivity and a ready means of corroboration. The experts identified in those respective fields above have the expertise to make those finding/observations. Those findings/observation themselves are not likely to be subject to any challenge or reference to the medical regulatory body[25]. However, a description of findings alone is of little use to a court. What the court requires is an opinion on the *significance* of the findings and their likely *cause*.

This is where the danger lies. An expert often has to look beyond his/her nominal expertise when opining on causation. A neuroradiologist is not able to provide an opinion on cause without correlating imagery with the clinical-pathological findings, and a clinician cannot provide an informed opinion on cause without considering the radiological and pathological findings. A neuropathologist can distinguish normal from abnormal tissue and categorise the nature of the abnormality, but providing an opinion on attribution requires the pathologist to be able to understand the clinical circumstances, the investigative sequence and so on before an opinion on the *cause* of tissue changes can be given.

Were medical experts only to be able provide descriptive findings, which are often highly technical, the court could rarely reach a conclusion on *cause* which is central to the judicial purpose and almost the sole real purpose of medical opinion evidence.

What is the answer?

How then is the danger of providing an expert opinion on cause to be avoided? To be facetious for a moment, perhaps a medical practitioner invited to provide an expert opinion might first approach the GMC/MPTS to obtain a declaration that he/she would be acting within his/her expertise by providing the required opinion. But how more practically could this "protection" be afforded? Perhaps the GMC could produce another guidance booklet with greater particularity whereby, for example, a paediatric neuropathologist could look up whether he/she would be acting outside his/her expertise if he/she gave an opinion of the likely cause of an abnormal brain pathology in a 16 year old patient, taking into account the clinical history and ante-mortem investigations? It would probably have to be even more prescriptive than that – for example (as the

[25] Unless plainly and recurrently demonstrative of incompetence.

tribunal in Dr Squier's case found) a neuropathologist would be outside his/her expertise were he or she to give an opinion on the cause of brain swelling.

The practical solution is obvious. The primary function of the medical regulator is the protection of the public. It is the *raison d'être* of the MPTS. Matters relating to the expertise of a medical practitioner (or any non-medical expert) *in relation to giving expert evidence to a court* should be left to the court. It is the court which should determine whether or not anyone has the requisite expertise to give opinion evidence. Only in cases where it can be clearly established that an expert has lied about his/her qualifications and/or experience or the behaviour of a medical witness been so heinous as to lead to a judicial referral to the GMC should the regulator become involved to avoid the medical profession being brought into disrepute.

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