NARRATIVE WORKS
Issues, Investigations, & Interventions

Narrative Rhetoric in Expert Reports: A Case Study

Clive Baldwin[1]
St. Thomas University

Rhetoric within narratives has been the focus of attention for several well-known scholars in the field of literary criticism. While other forms of writing, such as professional reports, have been analysed through the lens of narrative, the rhetoric therein has received little attention. Although the official position is that UK child protection proceedings are inquisitorial and evidence-based, it is possible to identify rhetorical practices in both narratives of professional reports and the court proceedings. Drawing on Aristotle's *Rhetoric*, I will analyse rhetorically the expert pediatric reports presented in a case of alleged Munchausen syndrome by proxy, focusing in particular on ethos and pathos. In so doing, I will seek to illustrate how rhetoric permeates child protection proceedings and indicate how rhetorical analysis might aid the evaluation of evidence and testimony.

Introduction

While it is claimed that narrative cuts across disciplines and opens up the social sciences to literary theory (Gergen, cited in Segal, 2005, p.61), the study of narrative rhetoric as found in the works of Booth (1961), Chatman (1978), and Phelan (1996) does not seem to have yet made that transition. An exception to this is Hall's (1997) study of social work as a storytelling and persuasive activity and it is on this I hope to build in this article. Narrative rhetoric, according to Bartlett and Wilson (1982), is concerned with syntactic structures and vocabulary, temporal organization, causal structure, narrative voice, and level of explicit detail. In this paper I am concerned primarily with narrative voice as it pertains to the ethos of the author and is addressed to a particular audience: that is, with a specific configuration of rhetorical techniques as they are found in one pediatrician's reports prepared for UK child protection proceedings concerning a case of alleged Munchausen syndrome by proxy (MSbP). While this paper focuses on the reports of one pediatrician in a single case of alleged MSbP, the analysis that frames the paper emerges out of a

[1] I would like to thank my research assistants, Carolyn Hill and Brandi Estey-Burtt, for their assistance with this article.

©Clive Baldwin, 2011

study of a number of such cases in both the UK and the US. The case I draw upon here is useful heuristically and can serve as an exemplar of the processes identified in other cases. It is worth noting at the outset that while this paper deals with rhetoric in cases of alleged MSbP, the analysis here may well be applicable across other areas of alleged child abuse.

Section one will provide some brief background information regarding MSbP in general and the case to which the reports I examine relate. In section two, I raise some general points about rhetoric before embarking on an analysis of ethotic rhetoric and pathos in sections three and four respectively. In conclusion, I will offer some commentary on the role of rhetoric in the analysis of expert reports.

1. MSbP and the Case of P,C,&S vs United Kingdom

Munchausen syndrome by proxy (MSbP) is generally thought of as a form of child abuse in which the mother fabricates or induces illness in her child(ren) in order to seek medical attention. The harm done to the child might be as a direct result of the fabrication or inducement, say in the case of poisoning, and/or indirectly at the hands of medical practitioners treating the child unnecessarily. Since its genesis by Meadow (1977) to describe two cases of alleged salt poisoning, clear indicators and perpetrator characteristics have been identified.

MSbP, however, is a much contested concept. Its proponents claim that it is a valid diagnostic category with a respectable history that has saved the lives of many children over the years (see Wilson, 2001). There is a significant literature that describes different manifestations of the phenomenon and there have been some attempts at explanatory hypotheses (see, for example, Schreier & Libow, 1993). In the UK, MSbP has been accepted as a valid diagnosis in family and criminal legal proceedings and has found its way into governmental guidance on child protection (Department of Health, 1999). On the other side of the debate there are respectable authors—pediatricians, psychiatrists, lawyers, psychologists, social workers, and academics—who question the validity of MSbP, pointing out that it is conceptually confused, empirically flawed, and operationally questionable (for example, Baldwin, 1996; Mart, 1999; and Morley, 1995). Such authors point to the numerous different definitions of MSbP; the lack of agreement amongst the medical community as to whether it is really a syndrome or whether it is a psychiatric diagnosis of the perpetrator or a pediatric diagnosis of the child; the unproven and potentially un-provable nature of the theory; vague and contradictory indicators; wide, all-embracing, and gender biased perpetrator indicators and practices; the lack of scientific rigour; the rejection of MSbP in courts in the US, Australia, and the UK as lacking evidentiary probity; questionable practices by some of the proponents of MSbP; the increasing number of miscarriages of justice; bias within the

system of child protection in the UK; and the fact that after over 30 years, the term has still not been included into either the World Health Organisation's International Classification of Diseases or the American Psychiatric Association's Diagnostic and Statistical Manual (for a summary of and reference to these, see Baldwin, 2005).

What can be gleaned from these debates and the records in individual cases is that MSbP is regarded as a complex phenomenon that stirs strong emotions and in which both sides view the stakes as high. For those diagnosing MSbP, the issue is the very serious one of protecting children from harm if not death; for those opposing the diagnosis, either by claiming that MSbP is not applicable in any particular case or is not in general a valid diagnostic category, the stakes are the unnecessary breakup of families through miscarriages of justice either in the family or the criminal courts.

The case of P,C,&S[2] arose against such a contentious background. This case involved allegations by Rochdale Social Services in the UK that the mother, P, had been found guilty previously of MSbP abuse on her second son (in the US) and that she was repeating her abusive behaviour with her unborn child, S, now that she was living in the UK. The child was removed from the parents shortly after birth and there followed protracted legal proceedings. During the final hearings, which lasted approximately four weeks, P was left legally unrepresented following the departure of her solicitor when the judge, Justice Wall, refused a short adjournment for her to find further legal counsel. During the proceedings, P made frequent reference to what she saw as a violation of her human rights (to be legally represented), but these appeals went unheeded. Consequently, P had to conduct her own case in the face of experienced and senior legal representation on the part of the Local Authority and the Guardian ad litem, both of whom were arguing for the permanent adoption of S.

Key to these proceedings were the expert reports of the pediatrician (the reports with which this paper is concerned) and the psychiatrist who, basing his view on the report of the pediatrician, recommended immediate and permanent adoption. The pediatrician's reports were thus central to the argument being made by the Local Authority and the Guardian ad litem that S be removed and adopted outside of the biological family.

Finally, S was freed for adoption and the judge refused leave to appeal. The parents, again legally unrepresented, made an appeal to the Appeal Court but this was rejected. The parents then took the case, this time represented pro bono, to the European Court of Human Rights (ECHR), which ruled that the domestic proceedings had violated the parents' rights under the right to family life and the right to a fair hearing and the child's rights under the right to family

[2] I use the term "P,C,&S" throughout for the sake of consistency—during the domestic proceedings, the case was known under a different appellation.

life. In making this ruling, the ECHR stated that the child had been removed "without relevant and sufficient reason," that the action taken by the Local Authority was "draconian" and "unnecessary to protect the child," and that the ECHR could not rule out a different outcome had the domestic hearings been conducted properly. The UK government was directed to pay costs and reparation to the parents. The child was not returned to the parents, however, because the Local Authority, refusing to await the outcome of the ECHR proceedings, had proceeded with the adoption and under UK law there is no means by which to undo this.

2. Rhetoric

Before embarking on my analysis of the reports under consideration, a few introductory remarks about rhetoric are in order.

First, rhetoric is the art of suasion. The term is often used, albeit misleadingly, in opposition to the term *reality*, implying that what is claimed by the rhetoric is either untrue or does not live up to what is "true" or "real." Hence, numerous texts claim to explore and analyse "rhetoric and reality" or the "reality behind the rhetoric." What the authors of such texts often miss is that rhetoric is an integral part of the truth- or reality-making process. Rhetoric, as the art of suasion—either per-suasion or dis-suasion—is found as much in ostensibly objective, scientific texts as it is in political speeches, where one might expect to find it. Indeed, Booth (1961) states that an "author cannot choose to avoid rhetoric; he can only choose the kind of rhetoric he will employ" (p.149). The techniques used in different spheres might be different; the art, however, is the same. Each seeks to persuade the reader that what is being presented is plausible, efficacious, or, preferably, true.

According to Aristotle (n.d.), there are three purposes of rhetoric: *epideictic*, *deliberative*, and *forensic*. Epideictic rhetoric is concerned with praise and blame and is often found in funeral orations, obituaries, graduation speeches, and the like. Deliberative rhetoric attempts to persuade others towards (or away from) a particular course of action. Forensic rhetoric concerns itself with guilt and innocence pertaining to past actions. In child protection proceedings, often all three forms of rhetoric are mobilised: some guilt or innocence regarding past actions (e.g. harm to a child) is established, a perpetrator is often characterised in a negative fashion (that is, established as blameworthy), and a course of action is determined upon (a care plan is established).

According to Aristotle (n.d.), there are three means of persuasion: *ethos*, *pathos*, and *logos*. Ethos pertains to the credibility, authority, worthiness, and intent of the speaker. Pathos refers to persuasion by means of appeal to the emotions of one's readers (though this might be extended to include appeal also

to the pre-dispositions, self-interest, and/or identity of one's readers). Logos is persuasion by inductive or deductive reasoning, evidence, and the marshalling of support for one's argument. In terms of *taxis* or structure, the classical view of argumentation involved the *exordium*, in which the speaker would attempt to establish her/himself before the audience; the *narration*, or case outline, presenting supporting examples or evidence; the *confutation* or *refutation*, where the speaker would attempt to pre-empt or deal with arguments that might be raised by way of challenge; and the *conclusio* or *peroration*, in which the speaker would gracefully withdraw (see Nash, 1989). In this paper I will confine my analysis to that of ethos and pathos as these are generally overlooked aspects in discussions concerning the trustworthiness of evidence in child protection proceedings, which are based, supposedly, primarily on evidence and argument, that is, in Aristotle's terms, logos. Given my focus herein, most of the discussion will centre on the exordium and peroratio within the pediatrician's reports, although some examples of ethos and pathos are found elsewhere in the reports and these will be drawn upon where relevant.

Second, when considering ethos and pathos as rhetorical techniques it is important to note that each can be realised both positively and negatively: for example, one can present oneself as credible while also positioning one's opponent as lacking credibility; and one can appeal to one's readers' positive emotions toward oneself while fostering negative emotions toward one's opponents. The important thing to remember is that while negative techniques can be used to undermine the persuasiveness of the argument of one's opponent and thus make one's own argument seem, in contrast, more persuasive, negative techniques do not in and of themselves add to the correctness of one's own argument. We shall see, for example, occurrences of negative ethos being applied to the mother, thus avoiding the necessity to deal with the challenges to the pediatrician's use and interpretation of the medical evidence raised by the mother's analysis.

Third, the application of rhetoric does not necessarily imply or involve the deliberate manipulation of others into believing something that the author does not believe to be true, whether by fabrication, misrepresentation, or falsification of evidence, though, of course it may. In what follows I will assume for the sake of argument that the pediatrician believed genuinely in the evidence and findings presented in her/his reports. The reports thus served the dual purposes of serving the court in its deliberations and contributing to the protection of a child that the pediatrician believed to be at risk. Whatever rhetorical features and techniques we might identify through the analysis here that might question the pediatrician's presentation and interpretation of the material should be understood in that context. Similarly, while I might argue that certain aspects of the pediatrician's authorship served to enhance unduly the persuasiveness of the report, I am not suggesting in any way that the pediatrician was deliberately engaging in rhetorical trickery so to do.

Furthermore, the analysis presented here is independent of whether one accepts or rejects the opinion of the pediatrician as to whether the case in question was one of MSbP.

3. Ethotic Rhetoric

In this section I will explore the ethotic rhetoric of the reports. Section a) will discuss the positive ethotic rhetoric pertaining to the pediatrician her/himself, Section b) the negative ethotic rhetoric applied to the mother.

a) Ethotic Rhetoric in the Presentation of Self

It is primarily in the preamble that the pediatrician seeks to establish credibility and thus acceptability before her/his audience, that is, the court. This is done, as is the case with all expert reports, through noting relevant occupational positions, qualifications, clinical and academic activities, and professional memberships. By demonstrating the respect in which s/he is held by her/his community of peers (for example, through membership in the Royal College of Pediatricians and Child Health, positions of authority in child protection structures, and the refereeing of articles for a prestigious journal), the pediatrician seeks to establish her/his credentials and authority to speak of the matter before the court. None of this is contentious or unsurprising—indeed it is what is expected. All of these claims to authority are external and verifiable. In this case, however, the pediatrician goes slightly further to include information that might serve as bolstering this claim to authority by inference and association but which is also less verifiable and more open to challenge, namely the claim of having:

- read over 300 articles and the three scientific books on the subject;
- engaged in research and publication of major articles on the subject (in collaboration with notable figures as identifiable via the references supplied at the end of the report);
- submitted an MD thesis; and
- acted as an expert witness in around 20 cases, usually on behalf of the Guardian ad Litem (GaL).

The inferences intended for the audience to draw from these statements, I contend, were that the pediatrician was well-read, at the forefront of the area, had undertaken work of sufficient quality to be awarded a higher degree, and had acted previously in the same capacity in which s/he was being asked to act currently by the GaL. While not necessarily unreasonable inferences, the point

here is that there is nothing inherent in these statements warranting the positive connotations of those inferences. Let us take each in turn.

With regard to the pediatrician's reading of the subject, there is nothing in the statement that inherently implies that the pediatrician had understood all, many, or indeed any of these articles, or whether s/he had critically evaluated these as to their worth. Similarly, there is nothing in the claim to collaborative research that indicates the quality of that research, though the adjective "major" applied to the pediatrician's articles implies that these were high-quality and important articles. Further, the reference to the submission of an MD thesis carries no inherent indication of quality—as the thesis had not at that point been examined and might have been rejected (indeed a significant number of such theses are rejected). Finally, the statement as to previous experience in the capacity of expert carries no indication of quality and no information as to whether the reports had been accepted or rejected. Now, it may be that all of these statements do reflect aspects of the pediatrician's activities that support her/his claim to being a credible expert witness. The point here is that all the positive connotations that these statements carry with them serve a rhetorical function in enhancing the ethos of the pediatrician. In other words, the persuasiveness of the statements relies upon the inferences made by the audience.

The problem with relying on the audience to make inferences is that of indeterminacy; inferences are not determined by the original statement and as such the audience may make inferences other than the preferred ones. For example, the positive connotations associated with authorship of two "major" articles might be undermined by knowledge of the heavy criticism that at least one of those articles received, criticism that identified methodological problems, problems of interpretation, and lack of clarity in presentation of findings.[3] Similarly, the statement that the pediatrician had previously acted as expert in around 20 cases without further detail might be inferred as masking a high error rate, especially since the pediatrician was specifically instructed to state her/his error rate in such cases but avoided so doing. If these alternative claims and inferences are themselves persuasive this would impact negatively on the pediatrician's credibility in two ways: first, that the claims themselves do not support the claim to credibility; second, and perhaps potentially more damaging, by making unsupported or debatable claims, the pediatrician, in her/his authoring of the report, might be seen as exaggerating her/his expertise or, perhaps worse, misrepresenting her/himself to the court.

The rhetorical strategy of relying on the audience to make the preferred inferences thus may appear to be a risky one, not because the pediatrician is

[3] In this context it is interesting to note that the data on which one of these articles was based was accidentally shredded and thus there is no means by which to assess the data, the quality of the research process, or the validity of the interpretation of findings.

deliberately deceiving her/his audience and may be "found out," but because inferences are simply that, inferences, and as such can be challenged by claims that cast doubt on the preferred inferences (as indicated above). At this point, it is important to remember the context in which such rhetorical techniques operate.

First of all, there is the ideological perception of professionals as generally benevolent and benign (see Ingleby, 1985). It is possible to see this ideology at work in the case of P,C,&S through examining the approach of the judge, Justice Nicholas Wall, towards both the pediatrician and the Local Authority Social Services.[4]

With regard to the pediatrician, the judge stated that s/he "… began [her/his] assessment of the medical records *by hoping that the case against factitious illness would not be made out*" (my emphasis) and referred to her/him as having gone to some effort to find in favour of the mother rather than come reluctantly to the conclusion that this was a case of MSbP and that the child should, in all probability, be removed from the birth parents. This view expressed by the judge was subsequent to his dismissing each and every allegation made by the pediatrician regarding the mother's behaviour towards the index child (that is, the child subject to this case, S), thus partially undermining the pediatrician's argument about a continuing pattern of behaviour; dismissing each and every allegation made against the mother regarding her own health behaviour while in the UK; and not mentioning anything regarding the mother's behaviour in relation to her first child. So despite ruling against the pediatrician's interpretation and representation of the evidence, the judge still claimed that the pediatrician had acted with a bias of goodwill toward the mother, rather than come to the (in some ways more consistent and logical, though harsher) conclusion that the pediatrician had become, in Phelan's (2007) terminology, an unreliable narrator in reporting, interpreting, and evaluating the evidence. This apparent inconsistency can, I think, be explained by the fact that to have taken that step would have undermined the judge's own rhetorical project as the pediatrician's reports formed much of the argument for the removal of the child from her biological parents.

A similar attitude can be detected in the judge's comments about the behaviour of the Social Services. Near to the beginning of the case, the Social Services required the parents to attend a psychiatric consultation with their chosen MSbP expert. The subsequent report, though critical of the parents, did not rule out the possibility of working with the family, and indicated the expert's willingness to be involved with the case. The Social Services did not

[4] Again, I am not implying that Justice Nicholas Wall was deliberately manipulating the situation in any way—merely that his actions can be seen as embodying the ideological (and common) perception of professions as benevolent and benign.

disclose this report, despite being asked to do so on a number of occasions, for several months, by which time they had insisted that the parents attend a second evaluation with another MSbP expert, whose report was more negative and more in line with the Social Services' already established view that this was a case of MSbP.[5] In addressing this issue in his judgment, Justice Wall stated that the Social Services could only be criticised for giving to the parents a stick with which they could beat the Social Services. In other words, the deliberate non-disclosure of this key document was presented as a mistake (because of the parents' hostile reactions) rather than any maleficence or unprofessional behaviour on the part of the Social Services.

These two examples are substantive enough to suggest, I think, that the prevailing attitude of the court was that the professionals involved were generally benevolent and benign in their actions—the pediatrician attempting to find in favour of the mother and the Social Services not attempting to interfere with due process and the examination of all the evidence.

A second feature of the context into which the pediatrician submitted her/his report was Justice Wall's own position on expert witnesses, one which granted such witnesses a great deal of deference. In 1997, Justice Wall wrote that expert witnesses should be accorded "courtesy and respect by judges" and protected from "cross examination which is hostile, discourteous, or personal." Indeed, the mother was prevented from asking certain questions in cross-examination that challenged the credibility and/or reliability of the pediatrician's testimony.[6]

Within this context it is reasonable to suppose that the inferences invited by the gaps in the pediatrician's preamble would be filled positively rather than negatively, and in so doing, any awkward questioning of those gaps might be averted.

Finally, it is worth noting that positive rhetoric is not limited to the preamble. In two other places, the pediatrician counters challenges to her/his expertise and on a number of occasions s/he presents herself as being careful, reasonable, fair-minded, and cautious in making her/his diagnosis of MSbP, a diagnosis that might have very significant consequences for the family.

With respect to the first of these, the mother made two challenges to the expertise of the pediatrician. The first of these was on the basis that s/he was not a specialist in gastroenterology and given the focus on the gastroenterological symptoms of the second US child, the UK pediatrician was

[5] That the Social Services had already determined that this was a case of MSbP is indicated by their numerous attempts to argue *estoppel*, i.e., that the case had already been determined in the US and that it was unnecessary to re-argue the evidence, the only issue being that of disposal.

[6] The reports were also submitted to a very favourably inclined audience in the Social Services (see later under the discussion of pathos). I have reserved discussion of this contextual element as it seems to fit better alongside the discussion of alignment and asymmetry, though of course it has relevance at this point also.

not best placed to interpret the medical records. The pediatrician responded by claiming that the case did not require a gastroenterological specialist but a more generalist evaluation and hence s/he had the necessary expertise to evaluate the medical records. By redefining the problem—from a gastroenterological condition to one of suspected MSbP—the pediatrician was able to reclaim her/his expertise. The second challenge concerned the test for phenolphthalein, which was interpreted as evidence of laxative abuse. The mother presented evidence and testimony of experts to the effect that the single positive test was unreliable—the test was not undertaken properly, was not repeated as per protocol, that there were many hundreds of substances that produce a false positive on this test. The pediatrician, acknowledging that toxicology was not her/his field of expertise, nevertheless recuperated this challenge by arguing that the toxicologist was "… not best placed to weigh up a complex child protection case such as this. To do so requires a working knowledge of pediatrics spanning the different specialities" and that the case involved, "a difficult process of weighing up various possible risks to come to a conclusion about the welfare of a child, and this would not have been within his expertise." In other words, the pediatrician attempted, by side-stepping the issue of test reliability, to question the expertise of the toxicologist regarding the clinical significance of the test result (negative ethotic rhetoric) and re-establish the pediatrician's expertise over the toxicological evidence (positive ethotic rhetoric).

Elsewhere in the report there are other examples of positive self-representation (that is, positive ethotic rhetoric). For example, in acknowledging that there are differences between the UK and the US in respect of infectious diseases the pediatrician writes: "and I have attempted to bear this in mind also. I am confident that these issues would not prevent me from forming a reasoned opinion in this case." Here the pediatrician is presenting her/himself as thoughtful through the consideration of what might be thought to be confounding factors but able to come to a "reasoned" opinion. Similarly, in the fourth report, the pediatrician presents her/himself as not making a diagnosis on the basis of a perpetrator profile (one of the significant criticisms of the operationalization of the diagnosis of MSbP) thus distancing her/himself from the poor practice of doing so. Later on in that report, in responding to a challenge made by the mother, the pediatrician states: "I have presented examples which illustrate the evolution of this case. This is not rhetorical or prejudicial, merely an attempt to clarify how and why I came to my opinion. If the medical evidence had not supported a diagnosis of child abuse I would have said so." Again, the pediatrician is at pains to emphasise that her/his diagnosis is not the result of anything other than what the evidence reveals and that no personal bias should be attributed to her/him. And on the same page, s/he implies goodwill, helpfulness, and commitment by stating that by providing

"referenced rough notes," "I think I have gone beyond my basic remit which was to provide an opinion."

Finally, the pediatrician withdraws (the conclusion) by indicating her humility before the court: "My personal opinion, humbly but strongly felt …." Thus we have seen the range of rhetorical techniques utilised in the self-presentation of the pediatrician in establishing her/his credibility, authority, worthiness, and intent. The other side to ethotic rhetoric is the presentation of one's opponent, in this case the mother, and it is this to which we now turn.

b) Ethotic Rhetoric and the Presentation of One's Opponent

It is important to note at the beginning of this discussion that negative ethotic rhetoric is fundamental to the diagnosis of MSbP; that is, the diagnosis of MSbP is based on establishing that the mother has acted deceitfully and dangerously, in a way that has harmed her child. Other characteristics, though not necessarily fundamental to the diagnosis, that are linked with MSbP are manipulation of others, antagonism towards professionals, litigiousness, relationship and employment difficulties, and denial (see, for example, Baldwin, 1996). As such, the whole diagnostic process could be seen as an exercise in ethotic rhetoric: that is, arguing that the mother lacks credibility (in her account of events); authority (in that her account carries less weight than that of documentary evidence); worthiness (in that discrepancies are interpreted as being the result of the mother's deceitfulness); and intent (in that the mother intends harm to the child). As such, it has many features in common with other rhetorical disorders (see Chesebro, 1982, on illness as a rhetorical act; Segal, 2005, for a discussion of hypochondria as a rhetorical disorder; and Segal, 2007, on illness as argumentation in contestable disorders).

Here, however, I will attempt to separate the rhetorical act of the diagnosis of MSbP from the specific rhetorical techniques found in the pediatrician's reports that adversely reflect upon the mother's credibility as a speaker about (rather than within) the events under discussion. There are a number of occasions where the pediatrician states or implies that the mother's character is such that the audience should be cautious in accepting her statements as valid or at face value. These have little, if anything to do with the diagnosis per se, but can be seen as having the result (and perhaps the intention) of undermining the ethos of the mother.

On two occasions in the main report, the pediatrician makes reference to what s/he believes to be "customary" in cases such as these (i.e., cases of MSbP). In the first, s/he says, "It is customary in these cases for the alleged perpetrator of their legal representative to break down the alleged abuse into its component parts and attempt to 'shout down' the evidence piece by piece. This is illustrated here." In the second, s/he states, "It is customary for the parent or their legal representative to attempt to limit the analysis of the medical history

to the index child only …. This is illustrated here." There are two rhetorical techniques at play here. The first is the presentation of the mother's actions within a customary context that links her actions with those of other alleged perpetrators. No evidence is presented as to the veracity or reliability of the pediatrician's claim that this behaviour is, in fact, customary, and the pediatrician makes no statement as to how many of these alleged perpetrators were able to establish their innocence in this way. By the pediatrician's linking the mother with a negatively evaluated customary context, the reader is left to infer that the mother is somehow doing something that is untoward—an undermining of credibility by association.

The second rhetorical technique is in the very framing of these actions in the context of MSbP rather than in legal discourse. The full rhetorical effect can be illustrated by comparing what stands as due process under the law with the pediatrician's claims. Twining (1990), in discussing the rationalist model of adjudication, states that:

> The direct end of adjective law is rectitude of decision through correct application of valid substantive laws … and through accurate determination of the true past facts material to precisely specified allegations expressed in categories defined in advance by law (i.e., facts in issue) proved to specified standards of probability or likelihood on the basis of the careful and rational weighing of evidence which is both relevant and reliable, presented in a form designed to bring out the truth and discover untruth, to supposedly competent and impartial decisionmakers, with adequate safeguards against corruption and mistake and adequate provision for review and appeal. (pp. 72-73)

In this context, the mother's arguments can be seen as perfectly legitimate—by questioning individual events (the evidence), she could be seen as attempting to "accurately determine true past facts," for if indeed the child in the US was ill on the occasions under discussion, the "pattern" so frequently referred to by the pediatrician would break down. She could also be seen as addressing "precisely specified allegations"—i.e., the allegations of administration of laxatives on identifiable occasions and contributing to the "careful and rational weighing" of "relevant and reliable" evidence (for example, by ensuring proper examination of the documentary evidence and by focusing on the index child).

Within this legal framework, the arguments presented by the mother appear in a far more positive light than when framed within that of MSbP. My argument here is thus not about the merits of the mother's arguments but about the framing of these within one discourse rather than another. The choice of context is thus a rhetorical technique focusing on the ethos of the mother rather

than the arguments being presented by the mother (for a discussion of rhetoric in context, see Linstead, 2001).

4. Pathos

Ethotic rhetoric concerns itself with the speaker her/himself. Pathos turns towards the audience and addresses in particular how the speaker seeks to persuade the audience through appeal to emotion, pre-disposition, self-interest, and/or identity. In this, such rhetoric can be seen as both within and contributing to what Bachrach and Baratz (1970) call the "mobilization of bias," that is, "a set of predominant values, beliefs, rituals and institutional procedures … that operate systematically and consistently to the benefit of certain persons and groups at the expense of others. Those who benefit are placed in a preferred position to defend and promote their vested interests" (p. 44).

Three forms of pathos can be identified within the pediatrician's report: first, the general rhetorical approach of *kairology,* or timeliness and fit; second, the alignment of the pediatrician's narrative with the predisposition and interests of the Social Services; third, asymmetrical approach to evidence and testimony on the part of the pediatrician.

Kairos

The term *kairology* refers to "the principle of contingency and fitness-to-situation. Arguments are persuasive, said the Sophists, early rhetoricians, when they aptly meet conditions of time, place, and audience; arguments have a quality of truth *in those situations*" (Segal, 2005, p. 22, emphasis in original).
The first kairotic act, repeated in the second report, is the signed cover sheet by the pediatrician claiming that her/his statement "is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated in it anything which I know to be false or do not believe to be true." While this is a legal necessity, it is nonetheless a rhetorical act, for without it the statement would not fit the conditions of legal proceedings, or the audiences of the Social Services and the court who were seeking a reliable basis for their decision-making. This kairotic act is then supported by the pediatrician's signature on each page of each report. In this statement, also, space is prepared to allow the pediatrician the possibility of stating as fact things that s/he "believes to be true" whether or not s/he actually verified these. For example, the social worker had indicated in her report that the mother had fabricated the events of a house fire and that she, the mother, had suffered severe loss of blood. The pediatrician repeated these unsubstantiated incidents in her/his report without checking the veracity of

either. If challenged, her/his argument would merely have to be that s/he believed these to be true, not that she had actually checked the truth of the statements, thus allowing her/him to present as fact events that were in actuality fabricated.

Another aspect of kairos appears in the general assumptions of the report, such as what constitutes acceptable/unacceptable illness-seeking behaviour; that conditions are best understood as having a single explanation (the concept of mono-causality); and validity and reliability of MSbP as a diagnostic category. At various points in her/his reports, the pediatrician refers to the mother's behaviour in ways that explicitly or implicitly contrast with the requirements of the sick role, namely the lack of direct responsibility for being sick, the requirement to try to get well and not to prolong the period of sickness, and the requirement to comply with competent help (see Parsons, 1951, for a discussion of the sick role). In the reports the mother is presented as being directly responsible for her child's illness through, for example, the administration of laxatives or reporting long lists of allergies; for extending periods of sickness by extending the list of conditions in her reports of her child's symptoms; and for refusing to comply with medical advice, for example, over admission to hospital shortly prior to the birth of the index child. These assumptions are kairotic in that they help fit the reports to prevailing normative attitudes.

Similarly, the emphasis on mono-causality in the reports reflects the Western medical model practice of discrete etiology and differential diagnosis. While testimony in the US trial on behalf of the mother indicated the strong possibility of multiple causation—for example, chronological links between periods of stress and gastroenterological problems, allergies being more severe at different times of the year and so on—the UK pediatrician is clearly of the mind that all symptoms (respiratory, gastroenterological, and other) should be explained by a single cause, namely, the mother's MSbP behaviour. In the conclusion to her/his original report the pediatrician states that MSbP "is the unifying hypothesis in this case, i.e., it is the diagnosis that readily explains all the known facts." The joint assumptions of mono-causality and that mono-causality is preferable to multiple causation in complex cases are indicative of the kairotic rhetoric of fitness-to-situation.

The final assumption made by the pediatrician was of the validity and reliability of MSbP as a diagnostic category. While on the surface this might not seem unreasonable, it is important to note the rhetoric at play in this assumption. The role of the pediatrician was to help the court make its own impartial decision but by omitting any reference to the contested nature of the diagnosis (see above), the pediatric reports project only one part of the overall picture of MSbP—thus, perhaps, leading the court in one direction rather than another. This implicit signposting can be seen as kairotic rhetoric in that it

implicitly presents medical knowledge as scientific or objective rather than interpretive and uncertain.

Alignment

Linked to kairos but more specific is what I shall term *alignment*. Whereas kairos is about fitness-to-situation within a wider cultural framework (see Segal, 2005), I use the term alignment to refer to the specific alignment between the pediatrician's reports and the predispositions and interests of the Social Services. On a number of occasions, the Social Services had attempted to argue for estoppel on the grounds that the case had already been heard and decided upon in the US and all that was required in the UK was a decision on the disposal of the case, namely a decision about the future of the index child. This was the Social Services' position from the outset and the pediatric report neatly fitted into that predisposition and neither the Social Services nor their legal team identified or raised any concerns about the quality of the pediatric reports or the conclusions therein. In other words, the pediatric report can be seen as persuasive because it aligned with what the Social Services already believed.

Similarly, the interests of the Social Services were not threatened by the pediatrician's reports in that the reports of the social worker were taken at face value as being accurate and reliable, at least enough to repeat unquestioningly. Even when the misreporting of the fire was brought to the attention of the pediatrician, no comment was made about the social worker's reporting. Indeed, the whole issue was glossed over in a single sentence, "The clarification of the reported fire was helpful." In contrast, any perceived misreporting on the part of the mother was heavily criticised and this leads to the third feature of pathos, that of asymmetry in the stance taken to the evidence and testimony of different actors.

Asymmetry

Asymmetry is the process of treating differently the evidence and testimony of individuals based on who the individual is rather than on the application of consistent criteria for reliability and verification. Numerous examples of such asymmetry are to be found in the case of P,C,&S where the evidence and testimony of professionals was accepted at face value while that of the mother was questioned, viewed with suspicion, or simply dismissed. Two examples from the pediatric reports will suffice to illustrate. First, the pediatrician refers to the mother as having a "propensity to cast aspersions on the integrity of experts, without producing the evidence," leading the reader to infer that such behaviour is suspicious or at least unfair. On the other hand, when the social worker made claims that the mother fabricated a report of a

house fire and reported severe postnatal blood loss, these were accepted as reliable reports despite being unsubstantiated by evidence. This asymmetry in approach to the statements of the opposing parties is again rhetorical in that it implies the unreliability of one and the reliability of the other, an implication that serves the overall argument of the report that this is a case of MSbP.

A second asymmetry is apparent in the way that the pediatrician treated the US doctors' reports as compared to her/his treatment of that of the mother. Although the pediatrician argued that there were discrepancies and inconsistencies in the mother's reporting of symptoms (both her own and those of her children), the same attention to detail was not apparent when it came to the reporting of the US doctors. In preparing her case, the mother produced a list of approximately 80 occurrences of discrepancies, inconsistencies, and contradictions between reports and statements made at different times by the same doctor (not discrepancies between doctors). It is interesting to note that not one of these was commented upon by the pediatrician in her/his reports. Either s/he did not make note of these, or if s/he did, then was of the opinion that such discrepancies need not be included in her/his reports. In either case, there seems to have been an asymmetrical approach to the evidence in hand. This asymmetry fitted well with the approach of the Social Services in a number of ways. First, it supported their predisposition that this was a case of MSbP; second, it fitted well with their argument because it supported, rather than complicated, the case; and, third, it helped justify their decision to remove the index child at birth on the basis of the US evidence and to have this evidence questioned at this stage in the proceedings could have proved embarrassing.

Concluding Remarks

In the above analysis I have attempted to illustrate the operation and impact of the rhetorical strategies of ethos and pathos as they are found in the ostensibly logos-driven arena of child protection proceedings in the UK. I have attempted to show how such strategies may strengthen the persuasiveness of the argument by drawing attention to the credibility, authority, worthiness, and intent of the author and by appeal to the predispositions of other parties, notably the Social Services and the court. While I have not addressed, here, the rhetoric of the argument of the reports—a task yet to be completed—I have tried to indicate how flaws in that rhetoric can be glossed over by applying the rhetoric of ethos or pathos. In so doing, we can see traces of the mobilization of bias within the court proceedings—a subject again for another day.

By providing such an analysis I hope to have demonstrated how an understanding of rhetoric can inform our evaluation of evidence and the operations of the UK domestic courts. By making explicit the rhetorical strategies employed by, in this case, the pediatrician, we are in a better position

to evaluate the complex picture and decide whether the Social Services and judge were correct in the claims that this was a case of MSbP and that the child's interests were best served by removal from the birth family and placement with adoptive strangers. The above rhetorical analysis has also indicated how rhetoric operates by alignment with the predispositions and self-interest of the audience—in this case, those of the Social Services and the court. This, in turn, suggests the need to foreground such predispositions and interests in order to subject these to critical evaluation, rather than leaving them unacknowledged and thus unexamined. In other words, rhetorical analysis allows us to explore and evaluate the interactions between author and audience, their respective intents, motivations, predispositions, and, perhaps, prejudices. If Twining's view of the process of law is one that seems to invite our allegiance, then rhetorical analysis can help us properly to evaluate both argument and process.

References

Aristotle. *Rhetoric* (W. R. Roberts, Trans.). Retrieved from http://classics.mit.edu/Aristotle/rhetoric.html

Bachrach, P., & Baratz, M. (1970). *Power and poverty: Theory and practice.* New York: Oxford University Press.

Baldwin, C. (1996). Munchausen syndrome by proxy: Problems of definition, diagnosis and treatment. *Health and Social Care in the Community*, *4*(3), 159–165.

Baldwin, C. (2005). Who needs fact when you've got narrative?: The case of P,C&S vs United Kingdom. *International Journal for the Semiotics of Law*, *18*(3-4), 217–241.

Bartlett, E. J., & Wilson, J. C. (1982). *A study of narrative rhetoric: Final report*. Retrieved from http://www.eric.ed.gov/PDFS/ED234414.pdf

Booth, W. (1961). *The rhetoric of fiction.* Chicago: University of Chicago Press.

Chatman, S. (1978). *Story and discourse: Narrative structure in fiction and film.* London: Cornell University Press.

Chesebro, J. (1982). Illness as a rhetorical act: A cross-cultural perspective. *Communication Quarterly*, *30*(4), 321–331.

Department of Health. (1999). *Working together to safeguard children*. London: Department of Health.

Hall, C. (1997). *Social work as narrative: Storytelling and persuasion in professional texts*. Aldershot: Ashgate.

Ingleby, D. (1985). Professionals as socializers: The "psy complex." *Research in Law, Deviance and Social Control*, *7*, 79–109.

Linstead, S. (2001). Rhetoric and organizational control: A framework for analysis. In R. Westwood & S. Linstead (Eds.), *The language of organizations* (pp. 217–241). London: Sage.

Mart, E. (1999). Problems with the diagnosis of factitious disorder by proxy in forensic settings. *American Journal of Forensic Psychology*, *17*(1), 69–82.

Meadow, R. (1977, August 13). Munchausen syndrome by proxy: The hinterland of child abuse. *Lancet 2*(8033), 343–345.

Morley C. (1995). Practical concerns about the diagnosis of Munchausen syndrome by proxy. *Archives of Disease in Childhood 72*(6), 528-529.

Nash, W. (1989). *Rhetoric: The wit of persuasion*. Oxford: Blackwell.

Parsons, T. (1951). *The social system*. Glencoe, IL: The Free Press.

Phelan, J. (1996). *Narrative as rhetoric: Technique, audience, ethics, ideology*. Columbus: Ohio State University Press.

Phelan, J. (2007). Rhetoric/ethics. In D. Herman (Ed.), *The Cambridge companion to narrative* (pp. 203–216). Cambridge: Cambridge University Press.

Schreier, H., & Libow, J. (1993). *Hurting for love: Munchausen by proxy syndrome*. New York: Guilford Press.

Segal, J. (2005). *Health and the rhetoric of medicine*. Carbondale: Southern Illinois University Press.

Segal, J. (2007). Illness as argumentation: A prolegomenon to the rhetorical study of contestable complaints. *Health* (London), *11*(2), 227–244.

Twining, W. (1990). *Rethinking evidence*. Oxford: Blackwell.

Wall, N. (1997). Judicial attitudes to expert evidence in children's cases. *Archives of Diseases in Childhood*, *76*(2), 185–189.

Wilson, R. G. (2001). Fabricated or induced illness in children: Munchausen by proxy comes of age. *BMJ: British Medical Journal*, *323*(7308), 296-297.

Clive Baldwin is Canada Research Chair in Narrative Studies, St Thomas University, Fredericton, New Brunswick. His research interests centre around the narrative dynamics in social and health care interactions and organizations and the use of narrative in social and health care education. He has written previously on ethics, dementia, technology, and child abuse allegations.