Child protection

Protecting children, supporting professionals

D Hall

How can clinicians, managers, and national bodies maintain a high standard of child protection work as part of mainstream practice?

Child protection is for many clinicians an important part of child health practice. Multidisciplinary teamwork in early recognition of child abuse and support for the family may be very rewarding, although paediatric assessment and clinical evidence often play only a minor role. Very few cases involve criminal proceedings or high profile publicity. Yet in recent years the UK paediatricians' professional body, the Royal College of Paediatrics and Child Health (RCPCH), has been aware of more complaints and controversies arising from child protection than from any other area of paediatric practice. Paediatricians have been criticised for ignoring signs of abuse, being over-zealous, making wrong diagnoses of abuse, failing to involve other agencies, upsetting parents, breaching confidentiality, or giving biased evidence in court. Websites criticise doctors and nurses working in child protection, and the media disseminate libellous inaccurate stories, without fear of reprim. The unfortunate but predictable result is that professionals are increasingly reluctant to be involved with child protection.

This article considers how clinicians, managers, and national bodies can maintain a high standard of child protection work as part of mainstream practice, support staff and minimise the risk of complaints.

WHAT CLINICIANS CAN DO

Appraisal of clinical and research evidence

Child abuse can masquerade as, and be mistaken for, a wide range of disorders. Missing the diagnosis, or deliberately ignoring it to avoid “getting involved”, can spell tragedy for the child. The opposite error, attributing clinical findings to abuse when they are in fact a manifestation of serious disease, is distressing for all concerned but can be largely avoided by consulting colleagues or searching the literature whenever the significance of the findings is uncertain.

Child sexual abuse (CSA)

The physical examination can be difficult but is usually just part of a wider investigation. Experience takes a long time to acquire and anomalies and abnormalities are difficult to describe accurately, particularly when examining the prepubertal female genitalia. Sketches are easily challenged in court and even when colposcopic photographs are available, there may be disagreements between experts. The over-interpretation of “sexualised behaviours” is also a hazard.

Whether right or wrong, even a suspicion of CSA has a catastrophic effect on the family and the alleged perpetrator. Errors can be minimised by joint planning of the investigation with police and social services. Two observers are better than one. Regular peer review, by examining children in pairs or by review of colposcopic photographs, is probably the best way of reducing error, avoiding over-interpretation of subtle and often insecure physical signs and making it easier to acknowledge uncertainty. Parental anxiety and hostility may be reduced by planned follow up and investigation when appropriate. Meticulous documentation of consent and of the physical findings is crucial.

Fabricated and induced illness (FII)

This is a difficult and often contentious diagnosis. Given the protean manifestations of FII, it is inevitable that sometimes one’s initial suspicion will be wrong. Conversely, it is easily missed, particularly if the child is presented to specialists in a variety of disciplines or at different hospitals. Covert video surveillance (CVS) has shown unequivocally how parents can induce serious and sometimes fatal events in their children. FII is now accepted as a diagnosis, but has become a focal point of campaigns by aggrieved parent groups.

The clinician as expert witness

The right to give and to challenge expert evidence in court must be preserved, but arguments between experts present social services, the police, and the judiciary with serious dilemmas and greatly increase the difficulty of effective case work with an abusive family. Experts should be familiar with current literature on issues such as the interpretation of growth charts in children with slow weight gain, the pathogenesis of subdural haematoma and effusion, or the significance of hypernatraemia, and must be able to defend their own interpretation of the evidence.

What can be done to minimise bruising encounters in court, which are stressful and time consuming for clinicians and often damaging for the child and family? First, some problems might be avoided if clinicians were more ready to consult their local designated doctor and other colleagues when the clinical findings were unusual or puzzling. Second, doctors should not allow adversarial legal proceedings to force them into polarised positions which may be scientifically unjustified and may not represent their genuine uncertainties. Third, better training and perhaps accreditation of expert witnesses might benefit children and help the judiciary. This is discussed further below.

Clinical records

Several complaints against paediatricians have involved accusations of dishonesty, hostility, verbal abuse, and even physical violence against family members. Wherever possible, conversations with parents or carers should take place in the presence of another professional. Detailed, objective, contemporaneous notes of who was present and what was said in every conversation have repeatedly been crucial in the investigation of complaints. Lord Laming stated that there should only be one set of notes, although some paediatricians feel that, in exceptional circumstances, separate private notes are essential. The policy on this may be governed by local factors such as the security of the ward office or the quality of professional relationships and mutual trust.

Attitudes to multidisciplinary decision making

All paediatricians experience difficulties in making unbiased judgements about the probability that a particular parent may have abused their child. Professionals need to be aware of their own reactions to the range of emotions and responses exhibited by parents when child protection issues must be confronted.

Abbreviations: CFS, chronic fatigue syndrome; CSA, child sexual abuse; FII, fabricated and induced illness
Problems have arisen for clinicians who take on a greater degree of individual responsibility for assessment and management than is necessary. There is often uncertainty surrounding both the clinical findings and the identity of the perpetrator. Clinicians may come under pressure at child protection conferences to be more definite about the clinical features than is justified. The Social Services Department is the statutory body responsible for protecting children and it is the job of the conference to consider all the evidence available. The task of the judge is to determine whether a crime has been committed and, if so, by whom. This multiagency approach is particularly vital in complex cases, for instance when multiple victims or perpetrators are involved.10

A doctor’s duty of care is not necessarily totally discharged by referral to the statutory agencies or even by participation in a case conference, and some paediatricians have experienced difficulties when their own view of the evidence and the need for action has conflicted with that of colleagues in social services or the police. Before taking action in such circumstances, it is wise to consult with colleagues and senior management and to document each conversation and decision.

When there are difficult decisions to be made about returning a possibly abused child to the parents, society has placed the burden of responsibility on the judiciary, not the paediatrician: “... the Court needs all the [paediatric and psychiatric] help it can get. But that dependence in no way compromises the fact that the final decision is the judge’s and his alone”.11 Paediatricians who wish to participate in decision making about intervention and placements must keep up with the substantial body of social sciences research in this field.12 13

Confidentiality and consent

The paediatrician’s duty of care is first and foremost to the child, not to the parents. If the duty of confidentiality to the parents is in conflict with their duty to the child, the child’s interests must come first. A landmark judgment14 (which may however go to the Court of Appeal) required that “once the decision arises about someone who was the mother of a patient, there was a clear duty to investigate in the interests of [the child] ... in fact the doctors could be negligent in certain circumstances to the child if they did not do so ... public policy considerations militate strongly against the existence of any duty of care to [the mother]”.

This principle is not universally accepted, however; for example, in a recent General Medical Council (GMC) hearing regarding a child with chronic fatigue syndrome (CFS), the lawyer for the claimant said “Dr X appears to believe that as a consultant paediatrician he had a duty to Miss A, which transcended his duty to follow the wishes of her parents. We submit that in this he was mistaken” (author’s italics). In this case, the GMC decided that the doctor was not guilty of serious professional misconduct. Nevertheless, the diagnosis and, more often, the management of CFS have caused difficulties for many paediatricians and some cases have been handled as a form of FII. This interpretation is often met with outrage by the family, and the courts have in general been reluctant to support it.

It might be unwise to rely too heavily on the judgements mentioned here—they may be overturned. Most paediatricians would probably feel that they can put the child’s interests first and yet still take into account the interests and privacy of parents or other adults involved in child protection cases.

Would paediatricians be better protected against such complaints if the reporting of suspected child abuse were to be made mandatory, as in the USA and Australia? Experience from those countries suggests that this would confer some advantages, but also create a number of problems.15 Such legislation might make children more reluctant to seek help, both from statutory services and from independent agencies such as Child Line.16 They should provide office space for the Doctor and Nurse as required by Department of Health guidance, and allocate adequate time and resources for them to consult with colleagues and to inform parents and other adults involved in child protection cases.

The duties of the college

Confidentiality and consent

The paediatrician’s duty of care is first and foremost to the child, not to the parents. If the duty of confidentiality to the parents is in conflict with their duty to the child, the child’s interests must come first. A landmark judgment14 (which may however go to the Court of Appeal) required that “once the decision arises about someone who was the mother of a patient, there was a clear duty to investigate in the interests of [the child] ... in fact the doctors could be negligent in certain circumstances to the child if they did not do so ... public policy considerations militate strongly against the existence of any duty of care to [the mother]”.

This principle is not universally accepted, however; for example, in a recent General Medical Council (GMC) hearing regarding a child with chronic fatigue syndrome (CFS), the lawyer for the
primary care organisations in respect of child protection are stressed in guidance to be published by the College early in 2003. A review is being prepared on confidentiality in child protection work, in partnership with the General Medical Council. Within the College research division, a survey of complaints against doctors in respect of child protection is underway. A systematic review of the physical signs in sexually abused children has been commissioned and will underpin a revision of current guidance. The research division is also completing a review on the practical management of CFS which, though distinct from child abuse, has sometimes presented paediatricians with child protection dilemmas.

Teaching and training
A collaborative project is underway with the NSPCC to develop a coordinated approach based on a study guide using a range of articles, pictures, and videos, to ensure that all paediatricians receive theoretical and clinical training in child protection, and an introduction to Children’s Rights concepts and legal principles. These topics will feature in College examinations and assessments. The mini-pupillage scheme whereby doctors spend time sitting with a judge in children’s cases is beneficial to both professions. In the USA, fellowships are now available for paediatricians to undertake training and gain experience in child protection—such a scheme should perhaps be considered in the UK.

Every paediatrician must be prepared to respond to child protection issues as they arise, but we must also develop the next generation of experts and leaders in the subject. Expertise is needed in the mental health and psychiatric aspects of child abuse, domestic violence, forensic work—by which is meant understanding of the need for objectivity and respect for the rules of evidence—and legal procedures. Mr Justice Wall has stressed the need for a national register of experts and an accreditation process, noting that “parents [may] seek to challenge a fragile profession in the task of protecting children without feeling that they are putting their careers and their families at risk.

**ACKNOWLEDGEMENTS**
I thank Professors Southall, Lynch, and Craft, and Dr Pat Hamilton, for helpful comments and discussion on earlier drafts and on child protection issues in general.

**REFERENCES**
2. MAAMA (Mothers against Munchausen syndrome by proxy allegations). Available at www.mampa.com. Accessed 12.03.03.