Paediatricians and child protection: the need for effective education and training

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"Child protection training is essential for all health professionals engaged in services for children. It is not an optional extra" (Barry Capon, Chair of Independent Inquiry into Death of Lauren Wright)

Child maltreatment has become increasingly topical, and recent high profile cases of fatal abuse have attracted considerable attention from the media. Furthermore, independent inquiries have not only highlighted system failures in the child protection process, but have also been critical of the actions undertaken by health professionals and social workers. The most significant case in this respect is that of Victoria Climbié, whose death at the hands of her carers has prompted a major review of child protection procedures led by Lord Laming. His report is now available and should be carefully read by health professionals and social workers. Part 8 reviews has already identified similar themes and conclusions.

THE ROLE OF TRAINING

Perhaps the most significant factor in this context is impaired awareness of child protection issues resulting from inadequate training. Several authors have sought the views of trainees in a variety of front line specialties that have regular contact with children and their families regarding their satisfaction with their training in child abuse and neglect. These surveys have included those training in paediatrics, accident and emergency medicine, psychiatry, and primary care. Overall conclusions from these studies would indicate that many doctors perceive their training to be unsatisfactory in either quantity or in focus. In particular, many are confused regarding their specific role in the child protection process, are uncertain as to what they should do and say when they encounter abused children, and are uncertain regarding the consequences (private or otherwise) of divulging information to outside agencies. A study of general practitioners (GP) registrars in vocational
training schemes that included paediatrics in London revealed significant deficiencies in their child protection training, and a minority expressed confidence at the prospect of dealing with child protection cases in the future as GP principals.21

WHY TRAINING IS NEEDED AND HOW IT SHOULD BE DELIVERED
Effective participation in child protection work requires a range of clinical competencies in terms of history taking, clinical examination, documentation, communication skills, and decision making ability. Confidence and courage are needed to effectively confront abusing carers. Clinicians also need to cope with their own emotional responses provoked by disturbing cases of child maltreatment. Effective education and training should not only provide the knowledge and skills required to address these challenges, but also promote the development of appropriate attitudes and perceptions regarding the doctor’s role in the protection of children from abuse or neglect. There is a limited amount of research that has shown the effectiveness of child protection training in this regard, at least in the short term.22–24 The stakes in child protection are high, and the consequences of inappropriate management can have disastrous consequences for children, their families, and involved professionals.

In order that child protection training is effective in ensuring that paediatricians and other clinicians respond effectively when confronted by child maltreatment, the following principles are suggested:

1. Child protection should be viewed as representing a critical component of training of equivalent importance to Advanced Life Support.
2. Training must be offered to all doctors who have contact with children and their families. It should be remembered that doctors in disciplines other than child health may also encounter children in need of protection, including general practitioners, accident and emergency staff, genitourinary physicians, obstetricians, gynaecologists, and both general and orthopaedic surgeons.
3. The precise content and scope of training will vary according to the seniority of recipients and their role in delivery of health care to children and their families. The following levels of training might be considered:

- Basic, consisting of a short introduction (one hour), including an overview of local protocols and sources of help and advice, would be offered to all doctors and might be included in hospital and departmental inductions.
- Standard would require a day’s training and would focus on minimum competencies in knowledge, skills, and attitudes required of senior house officers.
- Advanced would include the preceding, but in more detail, and would be suitable for senior paediatric registrars and consultants; legal aspects, including court proceedings would also be covered.
- Named/designated doctor training would address the needs of those who have a special interest in child protection; this might consist of modular training, leading to postgraduate qualification (diploma or MSc); such an approach is being considered in the USA.25

4. Training could be developed by adopting approaches already successfully utilised by other core training programmes, for example, the Advanced Paediatric Life Support. There is much to be said for a universally recognised programme that has common and agreed aims, content, and method of delivery. The Royal College of Paediatrics and Child Health (RCPCH) has convened a working party to consider the development of such a course.

5. The scope of training may need to be broadened in several respects. For example, some authorities feel that paediatricians should possess an awareness of domestic violence and its adverse effects on child development and welfare.26 Furthermore, clinicians need to have an awareness of variations in childcare practices that exist between different cultural groups.2


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From Cosette to Climbié: “Progress is the aim, the ideal is the model”

In Hugo’s Les Misérables (1862), Cosette, a neglected and abused orphan is rescued from her exploitative carers by Jean Valjean who devotes his life to raising and caring for her. This picture taken from the late nineteenth century is a timeless illustration of the exploitation and abuse of children, everywhere and at any time in history.

“The whole person of this child, her gait, her attitude, the sound of her voice, the intervals between one word and another, her looks, her silence, her least motion, expressed and uttered a single idea: fear.”

As we read the Victoria Climbié report 140 years later, we pause and wonder whether things have really changed.

Of course we’re all more aware now, but that doesn’t make it any easier to consider, especially as the most likely scenario is another report sometime in the future on yet another child who was failed by the state.

Then we slowly realise this picture has a relevance beyond the single named child, embracing instead far too many children in the world. And whether we like it or not, all of us share some blame. One child’s unnecessary death is a tragedy; the death of millions becomes devalued to a mere statistic. The injustice of poverty in the developing world, our complaisance in the exploitation through unfair trade barriers, and the sanctioning by large multinationals of child labour (whose goods we willingly buy) are just a few examples. In the mid nineteenth century Hugo saw “the three problems of the age—the degradation of man by poverty, the ruin of woman by starvation and the dwarfing of childhood by physical and spiritual night.”

As child health professionals our role is not restricted to “our patch” but in endeavouring to improve the health of children everywhere.

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Reference