Non-accidental injury to children: a survey of professional attitudes

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SUMMARY. A small sample of general practitioners was questioned about non-accidental injury to children. Differences emerged between those qualifying before and after 1960. Differences were also found in management between the general practitioners and other workers in this field, health visitors, social workers and the police. The need to include this subject in the continuing education of general practitioners is stressed.

Introduction

NON-ACCIDENTAL injury to children (NAI) first came to the widespread attention of the medical profession in 1962 when it was described as 'the battered child syndrome'.[1] The incidence with its resultant mortality and morbidity is difficult to quantify. It has been estimated that for every 10,000 children under four years of age in England and Wales, 10 will be severely injured and one will die from inflicted injuries each year. Minor cases may be four to six times as common.[2] As many as six out of 10 of these children may be reinjured and some of the injured will be permanently disabled.

To combat this serious social problem NAI Review Committees have been created at local level with the responsibility of setting up adequate machinery for cooperation between agencies in the identification and subsequent handling of cases and in maintaining the effectiveness of these procedures in the light of practice. The Review Committee in Lothian Region, in line with others throughout the country, established a register of children abused or at risk of abuse and in 1980 published *Guidelines* of procedure.[3] The Social Work Services Group of the NHS has issued a circular aiming to standardize registers and professional procedure in Scotland.[4] The process suggested certainly has the effect of alerting all those involved to the possibility of domestic violence but, at the same time, parents are becoming increasingly aware of the possibility of surveillance. While this is desirable in true cases of NAI it has been suggested[5] that genuine accidental injuries are not being reported by the parents for fear of being misdiagnosed. The risk that the programme is becoming self-defeating has to be considered.

One of us (E.M.B.) used her student elective period studying NAI in the Department of Forensic Medicine. The opportunity was taken to conduct a small survey of general practitioners' attitudes as well as those of other professionals who might be involved with such children.

Method

A questionnaire was designed to identify the diagnostic criteria of NAI and possible action by general practitioners. It was also concerned with their attitudes to the register and to the use of the *Guidelines*. The questionnaire was used at a structured interview.

A sample of 10 per cent of the 260 general practitioners in contract to the Lothian Health Board and working in Edinburgh was selected at random. The sample size was dictated by the length of the student elective and such a small sample may not be truly representative. These doctors were asked by letter if they would consent to the interview.

The scope of the study was broadened by contacting a sample of health visitors, not selected at random but attached to the practices of general practitioner respondents. A modified form of the questionnaire was used for this purpose. In addition three nursing officers, supervising health visitors, were seen. Several senior social workers with special responsibility for NAI (one hospital-based) were interviewed as was a senior police officer.

Results

Twenty-one of the 26 general practitioners in the sample were interviewed, two having refused to participate, two failing to keep their appointments and one having left the area. It became apparent that there were differences between the older and younger principals. The practitioners were accordingly divided into two groups—the eight who qualified before 1960 and the 13 who qualified after that date.

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Table 1. Summary of some of the results obtained from returned questionnaires.

	General practitioners' responses	
	Doctors qualified before 1960 (n = 8)	Doctors qualified after 1960 (n = 13)
NAI cases (average) since 1977	<1	2-3
Births per annum among patients on list (per general practitioner)	18	20
NAI enters the differential diagnosis		
Never	1	2
Rarely	5	4
Always	2	7
Factors arousing suspicion of NAI		
Nature of injury	7	9
Delayed reporting	-	3
Inconsistency	2	6
Furtive motive	1	1
Over reporting	5	6
Lay reporting	-	-
Other (family circumstances, alcoholism, etc.)	6	13
Refer child to hospital		
Always	4	3
Sometimes	4	7
Rarely	-	3
Never	-	-
Action if child presented with typical history of NAI		
Send to hospital	3	2
Consult register	-	2
Consult health visitor	1	9
Consult social worker	1	6
Consult medical colleagues	2	1
Confront parents	1	2
Call case conference	-	1
Involve police	1	-

Some results are summarized in Table 1. As compared with their younger colleagues, those qualifying before 1960 had less experience of NAI and were less likely to consider the condition in their differential diagnosis.

Neither group used the NAI register to any great extent for reference purposes. Names were usually placed on the register after a case conference, as is recommended. Most doctors wanted the parents to be told of registration and some older doctors thought this procedure might act as a deterrent to further episodes. The younger practitioners, however, were more worried lest such information might sour the doctor-parent relationship.

None of the older group had ever referred to the *Guidelines*. Four had read them (in two cases as preparation for the study interview); four had them to hand and five had at least heard of them. Nine doctors in the younger group had heard of them and eight of these had them to hand. Only four said they had read them and two had had occasion to use them.

The doctors qualifying before 1960 had little experience of NAI case conferences, only two having attended any. They thought that these might be useful to social workers but not to general practitioners. All but one of the younger group had attended at least one case conference. It was considered that case conferences were time consuming and revealed no information to the general practitioner but several doctors felt they should attend because they might help in reaching a decision.

The older doctors were inclined to manage NAI cases on their own with minimal aid from health visitors and social workers. They felt that cooperation was good but, in view of their personal reluctance to involve others, this might be taken to mean cooperation between other interested parties. General practitioners in the younger group thought it was essential to work in a team but they tended to think that their role should be to stay in the background while the health visitor and social worker provided most of the support. They considered cooperation to be good in most cases but that communication between doctor and social worker could be better—in both directions.

Neither group wished the police to be involved unless the case was a serious assault but some of the younger group were willing to consider inviting the police to a case conference.

Eight health visitors were interviewed and all had experience of at least one case of NAI in the last five years. In management the health visitor would, in every case, follow the procedures advised in the *Guidelines*. All had referred (through their nursing officers) to the at-risk register at some time. They considered case conferences were vital in the overall management. They believed there was enough cooperation with general practitioners (all were attached to practices) but some felt that the social workers could do more to keep them informed of developments in specific cases.

Five senior social workers were interviewed. They regarded the management of NAI as a team effort centred on the case conference. Once again there were mixed feelings as to whether the police should be involved. In contrast to general practitioners, social workers invariably use the at-risk register as a reference system. Their policy is to tell the parents whenever a child's name is placed on the register and they have a routine for a regular review of cases.

The police have a clear policy regarding NAI. They insist that they must work within the law at all times, and this means that they must pursue inquiries whenever a possible crime comes to their notice, including by way of a case conference. This worries the other personnel concerned but the police stress that they make their inquiries with discretion and respect the confidentiality of information obtained except on the few occasions when a case goes to court.

Discussion

It is clear that there are differences in the experience and attitudes of the general practitioners surveyed. The younger doctors were more conscious of NAI as an entity and had on average identified more cases. Possible explanations were considered: that older doctors had older patients—but in fact there was no real difference in the average practice births per annum between the two groups; that none of the younger doctors was in single-handed practice, unlike many of the older group, and it could be postulated that working in a group practice involves closer contact with health visitors; that junior hospital experience and vocational training will have been different. Older doctors seemed reluctant even to admit that NAI could occur in their practices, and this possibility has been described as an emotional block to making the diagnosis.[6]

Because of their hierarchical structures, health visitors, social workers and police are bound to follow their internal routines derived from the *Guidelines*. General practitioners, on the other hand, showed no such routine observance. They are, in their daily work, constantly accustomed to individual decision-making. It was disturbing to find the lack of interest in and availability of the *Guidelines,* which had been distributed to all general practitioners in 1980. Although only offering guidance to the independent practitioner, the *Guidelines* could provide him or her with an accepted code of practice when confronted with a battered child.

Many of the general practitioners surveyed had no experience of a case conference. The timing may be wrong, clashing with surgery hours, it is time consuming, and doctors are worried about the breach of confidence involved. Most of all it is 'foreign' to them. Nevertheless their contribution arising from their knowledge of the total family situation may be valuable.[7]

The role of the general practitioner in NAI was detailed by the Royal College of General Practitioners in their evidence to the Select Committee of the House of Commons.[8] The Committee's report[2] included a recommendation that the presentation and management (including the use of case conferences) of NAI should be included in medical student training and in refresher courses for general practitioners. This survey suggests the need for this recommendation to be implemented more fully, or perhaps suggests that the central government departments should pause from circulating further recommendations on NAI until the acceptability of their advice has been studied on a larger scale.

References

1. Kempe CH, Silverman FN, Steele B *et al.* The battered child syndrome. *JAMA* 1962; **181:** 17-24.
2. Select Committee of the House of Commons. *First report from the Select Committee on Violence in the Family.* London: HMSO, 1977.
3. Lothian Regional Review Committee for Non-Accidental Injury to Children. *Guidelines.* 2nd ed. Edinburgh: Lothian Region Social Work Department, 1980.
4. Social Work Services Group. Circular SW 4/82 (NHS circular 1982 (GEN) 18). 1982.
5. Anonymous. Child abuse: the swing of the pendulum. (Editorial) *Br Med J* 1981; **283:** 170.
6. Speight ANP. Recognizing child abuse. (Letter) *Br Med J* 1980; **280:** 1144.
7. Department of Health and Social Security. *Child abuse, a study of inquiry reports 1973-1981.* London: HMSO, 1982.
8. Royal College of General Practitioners. Ill-treated children. *J R Coll Gen Pract* 1976; **26:** 804-815.

Acknowledgements

The authors wish to thank all those who agreed to be interviewed. Part of Miss Boyter's expenses were funded by the Royal Medical Society of Edinburgh.

Note

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