What role for the general practitioner in child protection?

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SUMMARY

Background. *New government guidance on cooperation in child protection confirms the importance of the general practitioner (GP) contribution. While research highlights the concerns of others about their role in the multi-agency process, relatively little is known about the views and experiences of GPs themselves.*

Aim. *To examine the understanding that each of the key professional groups had of its own and each other's roles in child protection to identify those factors seen to enhance or inhibit the effective performance of these roles.*

Method. *The research formed part of a larger investigation of the role of health professionals in child protection, which combined case study investigations of child protection networks in three health authority sites with a regional survey of Area Child Protection Committee members.*

Results. *A lack of correspondence was identified between GPs' perception and performance of their role in child protection and the expectations placed upon them by other child protection professionals and government guidance.*

Conclusion. *The study identifies the need for more explicit discussion of the nature and extent of the GP role in local interagency child protection networks.*

Keywords: child protection; general practitioners; interagency networks.

Introduction

NEW guidance for agencies and professionals cooperating in child protection restates the central role of general practitioners (GPs) at all stages of the interagency process.[1] Not only is it assumed that their regular contact with children enables the early identification of risk or abuse but their knowledge of families is also seen to give them a key role at meetings held to assess the extent of risk and in the development of subsequent plans for the child's care and protection. Research evidence, however, suggests that GPs may not be performing their role in either the extent or manner assumed. Studies indicate limited participation in interagency networks,[2-4] infrequent attendance at conferences,[4,5] and reluctance to disclose relevant information to other professionals.[6] GPs appear unclear about their role in child protection and are widely seen by fellow professionals to be difficult to work with in this context.[7,8] Lacking detailed knowledge of the child and his/her family, moreover, they are not typically operating as frontline identifiers of abuse.[9]

Reflecting this research, the 1998 consultation on the *Working Together*[1] guidance posed two central questions: 'How can we encourage more active participation in child protection work by GPs?' and, 'What barriers need to be removed to enable them to make a full contribution?'.[10] The subsequent guidance responds by proposing a range of measures to enhance the GP role, including additional training, improved information sharing and record keeping, and better knowledge of local procedures. However, the document effectively side-steps the more fundamental question of the nature of the GP role in child protection.

To address this question, more detailed information is needed on how GPs themselves currently perceive and undertake their role in child protection. Previous research on this issue is based on relatively small numbers.[11-13] A recent study reported in the *British Medical Journal*, for example, concluding that 'GPs are loath to report child abuse',[14] refers to discussions with only five responders. More extensive studies[5,15-17] need updating in the new legislative context.

Method

In November 1997, an extensive investigation of the role of health professionals in child protection was funded by the NHS Executive (South and West). This two-and-a-half-year project combined an in-depth case study approach[18] in three selected local authority sites with a postal survey of all area child protection committees within the South West region (Box 1). It set out to identify those factors enhancing and those appearing to inhibit the effective performance of health professionals within the interagency process.[19-21]

Within the case studies, in-depth interviews of around one hour were held with 100 GPs. These incorporated a schedule of questions also contained in a postal survey of fellow professionals, enabling direct comparison of attitudes and experience. While adequately reflecting the range of practice types (urban/rural, group/single, and (then) fundholding/non-fundholding), the responder group may overrepresent those with higher levels of knowledge of and/or interest in child protection issues. What follows draws largely on the results of the postal survey of frontline professionals and the responses of GPs to the same questions, although reference is also made to the qualitative data and to the findings of the regional survey.

Results

GPs' involvement in child protection cases

Of the 120 child protection conferences observed by researchers, only 11 had a GP present. In interview, GPs reported that on average they saw fewer than two child protection cases a year (range = 0–7, mean = 1.56), although proportionately more cases were seen in urban (mean = 1.92) than in rural areas (mean = 1.2). Only 16 out of the 93 who had been invited to a case conference over the past 12 months had attended the meeting. While the great majority (86%) had consulted another professional over their last case, the most frequently cited reason for doing so was to seek advice/information (41% of cases); in only 16% of cases

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Case studies = three health authorities (HAs):
- Members of three ACPCs[a] (whole population: *n* = 67, 100% response).
- Designated/named professionals (3HAs) (whole population: *n* = 19, 90% response).
- Postal questionnaire to non-GP professionals[b] (whole population: *n* = 175, 45% response).
- GP interviews incorporating professional questionnaire (two HAs):
  - HA 1: group/practice (multistage: *n* = 41, 60% response)
  - HA 2: individual (whole population: *n* = 59, 22% response).

Regional postal survey = South West NHS Executive Region:
- members of 15 ACPCs (whole population: *n* = 140, 67% response).

[a]Area child protection committee; [b]attending child protection conferences over case study period (six months).

Box 1. Sampling procedures and response rates.

was it to act jointly and in 14% of cases it was to pass the case on. A large majority (84%) indicated they 'never' or 'did not usually' consult the local child protection register.

There was, nevertheless, evidence of considerable use being made of GPs within the child protection process, by both health and non-health professionals. Around four out of every ten health (39%) and non-health (42%) professionals responding had consulted a GP over their last case. While this was fewer than had contacted a health visitor (69%), it was more than had consulted a designated child protection doctor/nurse (17 [13%]).

In respect of this last case, just under half (49%) of the 127 non-health professionals felt that the GP input had been 'significant' to some extent, although nearly three out of every ten (29%) did not feel able to assess the significance of any input.

External perceptions of the GP role

Table 1 demonstrates that health responders were significantly clearer about the GP role than non-health responders ($P<0.05$, $V = 0.189$). Overall, both health and non-health professionals were clearest about the role of the health visitor and least clear about that of accident and emergency doctors/nurses. While most responders considered that the GP played an important role in child protection, health professionals were more likely than their non-health colleagues to consider this role 'essential' ($P<0.05$, $V = 0.161$). The majority of all responders perceived the role of the health visitor to be more important than that of the GP and second only to the social worker in terms of overall importance (Table 2).

Other health professionals were significantly more likely than their non-health colleagues to indicate that they found GPs to collaborate with easy ($P<0.001$, $V = 0.490$). There was less difference, however, between the health and non-health view on the question of the adequacy with which GPs were seen to perform their role (Table 3). Excluding those with insufficient experience to comment, GPs achieved the lowest overall performance rankings, with no significant differences emerging between health and non-health professionals, or GPs themselves, in this respect.

Analysis of qualitative data reveals two dominant explanations for this assessment. The majority of health responders (28 out of the 48) were health visitors who were uneasy about what they saw to be GPs passing their child protection responsibilities onto them. In respect of non-health responders, the perceived low level of GP involvement in the child protection process, especially in terms of attendance at conferences, was predominantly viewed as reflecting a lack of commitment to interagency working.

GPs' evaluation of their role in child protection

Table 3 indicates evaluation of performance. The majority of the GPs were clear about the role they performed within the child protection process, although only just over one-third (35%) professed to be 'very clear' on this question and they were generally clearer about the health visitor's role than their own (Table 1). A central finding, however, is that GPs' view of the nature of their role differs significantly from that of other professional groups (and official guidance). The regional survey reveals that members of the Area Child Protection Committees are markedly more likely than GPs themselves to perceive the family doctor role as 'significant' across all stages of the child protection process ($P<0.001$, $V = 0.532$ [identification]; 0.432 [assessment]; 0.497 [management]). Exactly one-third of GPs felt they have no significant role play in the ongoing management of cases (Table 4). Qualitative data indicate that child protection work is largely seen to be the preserve of the health visitor on whom the GP typically relies for information about the social situation of the child/family and for decisions about referral to social services departments.

The qualitative data also reveal a range of factors seen by GPs adversely to inhibit their role in child protection. Reasons given by responders for not attending case conferences confirm those documented elsewhere[5,16] about inappropriate timing (44 responses), increased workload pressures (30 responses), and lack of notice (27 responses). Three findings, however, suggest the operation of additional constraints. Thus, we find that two out of every 10 of the 100 responders indicated that they had not attended the case conference because they did not feel that their input was relevant; that over one-quarter (26%) perceived they lacked any relevant knowledge; and that only a small minority (13 of the 100 interviewed) would try to attend, even if they felt they had a significant contribution to make.

Reflecting long-standing debate in the medical press,[22-25] there was evidence of continuing (minority) concern about the confidentiality of information passed to other professionals. Confirming Monro,[26] a larger minority highlighted the potential tension between participation in child abuse enquiries and the role of the family doctor. That raising concerns would trigger an inexorable and possibly overzealous process was also offered as a reason for caution. This view was matched in frequency with the opposing perception that the thresholds for intervention on the part of other professionals, particularly social workers, were too low and services too slow to respond when alerted. Other minority concerns were expressed about interventions based on subjective evidence, the lack of clear guidance to underpin clinical judgements, and the possibility of legal action from those wrongly accused.

Discussion

The new government guidance, *Working Together*, focuses on the need to improve procedures such as communication, training, record-keeping and information exchange, with some clarification provided on the issue of confidentiality.[1] All these factors were highlighted in this study but potentially more deep-seated issues surrounding the GP role also emerged. While it is clear that the majority of child protection professionals value the GP contribution to child protection, it is also clear that a distinction is drawn between this 'in principle' perception and the reality experienced via the management of individual cases. Most consultation with GPs involved information exchange, rather than joint working or decision making, and their involvement was predominantly at the early identification stage. In respect of non-attendance at case conferences, limited participation within area

Table 1. Clarity of general practitioners (n = 100), other health professionals (n = 48), and non-health professionals (n = 127) on health professionals' roles in child protection.

	Degree of clarity (%)				
	Very clear	Fairly clear	Unclear	Very unclear	No experience
General practitioner role					
NHS professional	73	20	7	0	0
non-NHS professional	50	37	5	4	4
GPs	35	50	15	0	0
Health visitor role					
NHS professional	91	7	0	0	2
non-NHS professional	68	23	7	2	0
GPs	53	37	7	2	0
A&E staff role					
NHS professional	65	22	1	2	0
non-NHS professional	48	26	8	1	0
GPs	32	43	15	2	8
Paediatrician role					
NHS professional	73	22	2	0	3
non-NHS professional	52	29	8	1	10
GPs	36	46	10	2	6

Table 2. Importance of different professional roles in child protection as graded by health professionals (n = 48) and non-health professionals (n = 127).

	Importance of role (%)			
	Essential	Important	Not important	Not known
GP role				
NHS professional	57	38	2	2
non-NHS professional	40	50	4	6
Health visitor role				
NHS professional	81	19	0	0
non-NHS professional	70	28	2	0
Paediatrician role				
NHS professional	57	34	6	2
non-NHS professional	36	42	3	17
A&E staff role				
NHS professional	53	34	2	2
non-NHS professional	28	40	7	25
School nurse role				
NHS professional	47	45	4	9
non-NHS professional	24	58	9	9
Social worker role				
NHS professional	94	6	0	0
non-NHS professional	98	2	0	0
Police role				
NHS professional	59	39	2	0
non-NHS professional	61	34	3	1
Teacher role				
NHS professional	60	36	0	4
non-NHS professional	54	40	3	3

child protection committees, and a widely perceived inaccessibility, the evidence appears to confirm earlier research about the relative isolation of the GP from the interagency child protection network.

From the GP perspective, obstacles to more active involvement include the inconvenient timing and lack of notice of meetings, the time-consuming nature of meetings, and the difficulties of arranging locum cover. More fundamentally, however, GP responders also appear to be questioning the relevance of their input to case conferences and subsequent stages of the multiagency process. In particular, even if they had the time, the majority consider it inappropriate for GPs to play a role in ongoing case management. As they see it, their responsibility is to raise initial concerns, discuss these with the health visitor, and refer on, if necessary, to social workers or other professionals.

This evidence thus suggests that the central issue surrounding the role of GPs in child protection may be their only limited ability to meet the expectations of other professionals in respect of interagency collaboration. Before implementing a range of mechanisms designed to fine tune the role of the GP, therefore, it seems sensible to address the more fundamental question of the nature of that role. In this respect, we suggest there are two broad options.

The line of least resistance would be to respond to what GPs

Table 3. How well different professionals perform their roles in child protection as graded by general practitioners (n = 100), other health professionals (n = 48), and non-health professionals (n = 127).

	Performance of role (%)				
	Very clear	Fairly clear	Unclear	Very unclear	No experience
General practitioner role					
NHS professional	15	34	36	3	22
non-NHS professional	13	48	20	6	13
GPs	13	52	24	1	9
Health visitor role					
NHS professional	57	36	2	0	5
non-NHS professional	43	50	3	0	4
GPs	51	39	1	0	10
A&E staff role					
NHS professional	17	14	11	4	54
non-NHS professional	13	36	2	4	45
GPs	18	33	6	1	43
Paediatrician role					
NHS professional	26	54	7	2	11
non-NHS professional	17	40	9	2	32
GPs	30	41	2	1	25

Table 4. Comparison of general practitioners' (n = 100) and area child protection committee members' (n = 67) views on the significance of the general practitioner role in different stages of the child protection process.

	Significance of role (%)				
Responder	Very	To some extent	Not very	Not at all	Not known
Identification stage					
ACPC	71	22	5	2	0
GPs	22	24	23	24	6
Assessment stage					
ACPCs[a]	34	53	11	2	0
GPs	15	31	25	23	6
Ongoing management					
ACPCs[b]	26	54	17	3	0
GPs	6	26	29	33	6

[a]Missing cases = 5; [b]missing cases = 6.

appear to be saying about the limited nature of their current contribution to the child protection process. Such a response would acknowledge the restricted boundaries of what is seen to remain a predominantly medical role. It would also formalise the current situation revealed in this and other research, whereby GPs are involved in identification but the responsibility for assessment and ongoing management is assumed by the health visitor or other designated members of the primary health care team.

A more radical approach, however, would attempt to align more closely the role of the GP with the expectations of fellow child protection professionals, enabling more active involvement across all stages of the multi-agency process. In addition to the measures contained in the new guidance, this would need to attend to other key constraints identified by the GPs in the study. In particular, ways would need to be sought to strengthen GPs' connections with local inter-agency networks, at both frontline and strategic levels. These may include establishing more informal lines of communication with other professionals, particularly social workers, possibly via a 'named' social worker and/or by the identification of a 'designated' professional within the practice. Greater opportunities would also need to be provided locally for interagency and/or practice-based training to develop agreed thresholds for referral and intervention. Recognition of the reality of the time constraints highlighted by GPs may require consideration of other mechanisms, such as holding conferences in surgeries and/or more formal representation of individual doctors by a nominated member of the primary health care team.

Although itself questioning the role of the GP in child protection, the new government guidance, in our view, ultimately fails to provide any adequate answer. Consideration of the family doctor contribution is brief and undifferentiated from that of the wider primary health care team. If the present unsatisfactory situation is not to continue, however, our data suggest that this is a nettle that the new primary care groups/trusts will need explicitly to grasp. Consideration should be given to the two broad options set out above and, whichever is adopted, explicit steps should be taken accordingly to clarify the expectations of the GP role held by fellow child protection professionals.

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