

How to protect general practice from child protection

The tragic deaths of Victoria Climbié and Peter Connelly (Baby P) and the ensuing moral panics have driven the world of child protection into a spiral of defensiveness, posturing, and bureaucratic box-ticking that is now threatening to engulf general practice — to the detriment of both doctors and any children who might need safeguarding.¹

Over the past month I have received requests from local child protection authorities for reports on 18 children. These follow a standard form, opening with a request for 'specific medical history' and proceeding to solicit further information under a number of headings: the 'developmental needs of the child' (with five subheadings); the 'capacities of parent/carer to respond appropriately to those needs' (six categories); the 'impact of family and environmental factors on parenting capacity and the child' (six categories); and, finally, 'any other relevant information'. The letter emphasises the need to complete 'promptly' this comprehensive assessment of the medical, social, psychological, and cultural disposition of the child and its family, 'within 48 hours' (bold type in original). There is no mention of issues of consent or confidentiality and no indication of why any of this information is required.

The most striking feature of the reports peremptorily demanded by social services is that they reflect a profound misunderstanding of the nature of general practice. We tend to see children episodically, infrequently and in brief consultations when they are ill, and usually accompanied by parents devoted to their welfare. Our job is to attempt to diagnose and treat them. We lack the time and the expertise (and in my case, the inclination) to adopt the roles of social worker, psychologist, policeman, or priest in relation to the intimate personal lives of the children and families who come to our surgeries seeking respite from illness.

We are currently sinking under the weight of guidelines (arriving at the rate of one every 12 months for the past 5 years) and unreadable minutes of case

conferences (in which any useful information is buried in pages of politically correct declarations).²

Every inquiry into the death of a child leads to a renewed chorus of demands that GPs should be compelled to attend case conferences (organised at short notice during surgery hours), endure compulsory 'training' in child protection (of the sort that has failed to make any difference in the past) and attend weekly meetings with health visitors (who have generally been redeployed in locations remote from GP surgeries). The sheer impracticality of these proposals — reflected in the increasing strident rhetoric with which they are promoted — suggests that a radical rethink is overdue.

It is time to acknowledge the simple fact that, because issues of child abuse come up only rarely in general practice, GPs have little role to play in child protection. My modest proposal is that all contacts between GP surgeries and child protection authorities should be suspended and any concerns should be mediated through local community paediatricians. A brief phone call is all that is necessary to share essential background information, avoiding reports, meetings and case conferences in all but the most exceptional circumstances.

Of course, under such a system — as under past arrangements (and indeed under the system currently being imposed on general practice) — some cases of abuse will be missed. But it would provide better protection for cases that are recognised without bringing the whole of primary health care to a halt under the burden of paper and irrational expectations.

REFERENCES

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2. Learner, S. After Baby P: can GPs follow child protection guidance? *BMJ* 2011; **342**: d707.

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