An Ethical Debate

Child protection: medical responsibilities

If a doctor has reason for believing that a child is being physically or sexually abused, not only is it permissible for the doctor to disclose information to a third party but it is a duty of the doctor to do so.

Working Together, 1988¹

The title *Working Together* is attractive: it was the first of three documents produced by the Department of Health as guides to arrangements for interagency cooperation for the protection of children from abuse.¹ Next came *Working Together under the Children Act 1989*,² and recently an addendum to this has been published by a joint working party set up by the Department of Health, the BMA, and the Conference of Medical Royal Colleges chaired by Dr Sandy Macara, primarily for doctors: *Child Protection: Medical Responsibilities*.³ This document, in my opinion, does not resolve the doctor's dilemma over disclosure, though perhaps the advice is more balanced than in *Working Together*, paying due regard to ethical issues of confidentiality. On page 2 the General Medical Council's current advice (May 1993) is quoted: "Where a doctor believes that a patient may be the victim of abuse or neglect the patient's interests are paramount and will usually require a doctor to disclose information to an appropriate, responsible person or officer of a statutory agency."

But on page 5 we read: "There comes a point after careful evaluation ... when a doctor must refer these concerns to the statutory agencies" and on page 6: "Doctors must be aware ... that the decisions rest ultimately with the statutory agencies." Later (page 17) there is less compulsion in the advice given: "Knowledge or belief of abuse and neglect is one of the exceptional circumstances which will usually justify a doctor making disclosure to an appropriate ... agency."

This vacillation between "must" and "should" usually results in a doctor being able to justify himself or herself whatever he or she does: if you disclose to an appropriate person, the GMC will support you against a charge of breach of confidentiality; if you do not disclose, you may righteously claim your ethical duty of confidentiality.

Case study

A 15 year old patient came to see me with her mother. She was pregnant. She was only just 15 so intercourse would have occurred when she was only 14. With her daughter out of the room, the mother revealed at once who the father was: her husband, stepfather of her daughter.

I told them both I was going to get them help and that an experienced social worker would come to talk to them. Following my revelation the social workers behaved mainly as investigators of an abuse case. From the beginning it was made clear that all the children would be removed if the abuser remained in the home. The police were involved side by side with social workers.

The family became increasingly paranoid, and not without good reason. The father faced the charge

(which he did not deny in private) of making his stepdaughter pregnant. She offered no explanation, claiming she must have slept through anything that happened. He denied that penetration had occurred. (It emerged later on that the social workers were unaware of the possibility of conception taking place without full penetration.) The legal advice given to the father was: admit nothing. The social workers felt that "no comment" was evasive and explored the possibility of his own children, aged 5 and 9, being at risk too.

A termination was arranged. A police constable sat in on the consultation with the agency doctor. Against the girl's wishes the products of conception were removed for forensic analysis, including tissue typing, which took more than two months and confirmed the suspected paternity.

A guardian ad litem was appointed, someone I felt able to give some details to, but only with the girl's knowledge. At the formal assessment stage of the process, at a case conference, the mother was told that her husband could speak to a forensic psychologist with the assurance that what he said would be inadmissible in court, but this conflicted with the idea that the psychologist would be making a recommendation as to the safety of father remaining in the home. Two opposing camps were forming: those of us, including the health visitor, prepared to try to work with the family intact; and the team of social workers (involving several changes of key persons) determined to remove the father permanently from the home.

In my written report for the lawyers I pointed out that the family was in a double bind: if the family fell apart under the strain of it all it could be portrayed as dysfunctional; if family members displayed no outward reaction (and the girl displayed little or none) they were regarded as either covering things up or showing an inappropriate emotional response. The court decided to allow the father to remain in his home.

The doctor's dilemma

As these events unfolded I began to feel I had made a mistake by involving the social services. No member of this family, it seemed to me, had a safe place where they could talk. As a result of my initial disclosure criminal proceedings were underway, and everyone knew the consequences could be serious. Who could anyone talk to? How could I, the doctor, be trusted since I had invited the social workers and police into this home?

I have no simplistic solutions to these problems, but I am now clearer about my job as a doctor. We need to re-establish the fact that a doctor's confidentiality can be relied on. The principle has been eroded not only in cases of child abuse but also where medical reports are concerned and no doubt in other cases.

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BMJ 1996;313:671-3

I explained my misgivings about what I had done to members of this family and to some extent, as far as I can tell, regained their trust. In their distress at being interviewed and cross examined they did come individually, and I listened and sympathised without judgment.

The problem with the case conference method of dealing with child abuse is that everyone present has a different agenda, different training, and different experience. The police have to deal with a criminal investigation. Social workers are aware of their responsibilities for the welfare of children but also of how they are criticised when things go wrong. In this case the first visit after my disclosure to the child protection team leader was carried out jointly by a policewoman and social worker.

Because it is such a difficult problem I worry that we as doctors are content to offload the responsibility on to someone else and having done so feel we have done our duty. But who are we loading the responsibility on to?

The GMC guidelines are aimed at defending a doctor from the charge of breaking the code of confidentiality. There is no advice in these documents as to how doctors may be able to help individuals or families involved in child abuse, sexual or otherwise, apart from pointing out that it is not their statutory responsibility. I think the idea is that the doctor should be able to con-

tain anxieties coming at him or her from many different angles. We as doctors should not evade responsibility for deciding what should or should not be revealed. On balance, the guidelines have eroded the principle of confidentiality.

It is my experience that people involved in charges related to child abuse need somewhere to talk without fear that everything said is being taken down and may be used in evidence. The so called abuser was more often than not abused himself as a child and could be helped by careful advice coming from a trusted doctor in the intimacy of the consulting room, but this needs general practitioners to take an interest and to have training in these matters. It was apparent to me that the victim was at risk of being abused again—by the investigation. It is apparent that abuse takes place in both local authority and in foster homes, so we must be on guard against sending someone from the frying pan into the fire. Doctors should not pass the buck; perhaps we are better qualified than we think to attempt involvement in cases of child sexual abuse.

1 Department of Health. *Working together*. London: HMSO, 1988.

2 Department of Health. *Working together under the Children Act 1989*. London: HMSO, 1991.

3 Department of Health. *Child protection: medical responsibilities*. London: DoH, 1995.

Commentary: A flexible approach—but not too flexible

F N Bamford

The purpose of child protection procedures is to protect children. Usually doctors engaged in such activities will also be the servants of their families, and it is commendable that Dr X sees this as his role. However, the interests of abused children and their families may not necessarily coincide, and it is important to recognise that it is the child who is the patient to whom the doctor has a primary obligation.

The “go it alone” approach is superficially attractive but can be extremely dangerous. It is naive to assume that episodes of abuse are single incidents and will not happen again. Experience teaches that they are often recurrent and commonly escalate in frequency and severity.

Doctors have no power to intervene except by persuasion and advice; those with statutory powers are the police and social workers. Once a case is referred, control passes to somebody else. It is true, as Dr X states, that people in different occupations do not have the same priorities, but they do have the same fundamental intent: the protection of children. In this sense they are and should be treated as colleagues.

Our first duty must be to safeguard the medical welfare of children, and it is a reasonable argument that this must take precedence over all other activities. In a case like the one described the priority should be the safe management of pregnancy and labour or of termination of pregnancy, and this should include screening for sexually transmitted infection.

Not unreasonably, the priority of the police will be the investigation of crime. There is an almost inevitable tension between the police and the medical profession arising from the duty of one to protect the public and the expectation that the other will strictly maintain individual confidence. Most police officers understand our difficulties and many respect our position, but understanding is also needed on our part. If I may raise a problem arising from personal experience, what should we do if a 15 year old pregnant patient has told

her parents, and through them the police, that she conceived as a consequence of rape? Do we allow 50 police officers assigned specifically to catching the rapist to continue their fruitless search if the girl has confided in us that the father of her baby was her equally young boyfriend? Is this a case for unprincipled common sense?

We all value the Hippocratic tradition, and if life and our problems were simple we could afford to be inflexible about maintaining strict confidence; but child protection is not simple. It may involve not only differing claims within families but also conflicting interests between families and the public. Generally the former should prevail unless there is a major threat to public safety. Turning again to personal experience: what should we do in the case of a child who has been sexually abused by a baby sitter if we are confident that she will be protected in the future but know that the family will face real danger from the extended family of the abuser if the matter is disclosed to the authorities? Should the good doctor accede to pleas of the parents not to disclose?

In this example the public interest clearly conflicted with that of the family. Child protection guidelines do not allow for such conflicts of interest, and I know of none that do not state unequivocally that cases should be referred for investigation whenever there is a reasonable suspicion of abuse. Dr X and I would almost certainly agree that guidelines should be guidelines and not inflexible rules. The General Medical Council is careful in its advice: “The patient’s [that is, the child’s] interests are paramount and will usually require a doctor to disclose information to an appropriate, responsible person or officer of a statutory agency.”

Unfortunately, child protection guidelines have acquired the status of rules, and adherence to the rules has become, if not a condition of employment, certainly a threat to employment if they are not followed. This is regrettable and potentially damaging to patients. Though