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wardround

The MDU journal for foundation year doctors

Child protection

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EDITORIAL

what's inside

04

08

11

FEATURES & GUIDANCE

Cause for concern

Reflections on FY training

Safety first

When it's not what you think!

Child protection jargon buster

13

14

16

ADVICE LINE DILEMMAS

Keep out of reach of children

A history of violence

Attempted suicide

An investigation

An upsetting incident

18

NEWS

Waiting for a miracle

An excellent result

Consultant paediatricians

Countdown to revalidation

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Introduction from the medical editor

In 2011, over 50,000 children in the UK were known to be on child protection registers or subject to a child protection plan[1]. In many cases, the alarm would have been raised by a doctor.

Recently allegations have come to light regarding the late Jimmy Savile which have caused shock waves in society and various organisations he was associated with, including some involved in healthcare. However, recognising the warning signs and acting on them is often only easy with hindsight, as many doctors have found to their cost. In addition, there are likely to be understandable concerns about the consequences of raising concerns for the child and his or her parents and emotions will be running high. These uncertainties recently prompted the GMC to publish detailed guidance for all doctors on their responsibilities to protect children which it hopes will give them the 'confidence to act when they need to'.

As an FY doctor, you will not be closely involved with child protection cases in your day-to-day practice but it is essential to know how to respond if you suspect, for example, that a child has non-accidental injuries, or if you are worried that an adult patient poses a risk to children.

To help shed some light on this challenging area of practice, this issue of Ward Round focuses on child protection. MDU medico-legal adviser Dr Catherine Wills explains the ethical responsibilities of all doctors, while on page 8 we speak to a paediatric consultant and designated doctor for child protection about the difficulties and rewards of her job and what advice she has for junior doctors who have concerns about the welfare of a child. We also explore some child protection dilemmas, based on calls from members to the MDU advice line.

We hope you find this issue a useful and thought-provoking read. Perhaps the most important 'take-home' message is that FY doctors who suspect a child may be in danger of harm should not hesitate to seek support and advice from their supervisor or a child protection lead.

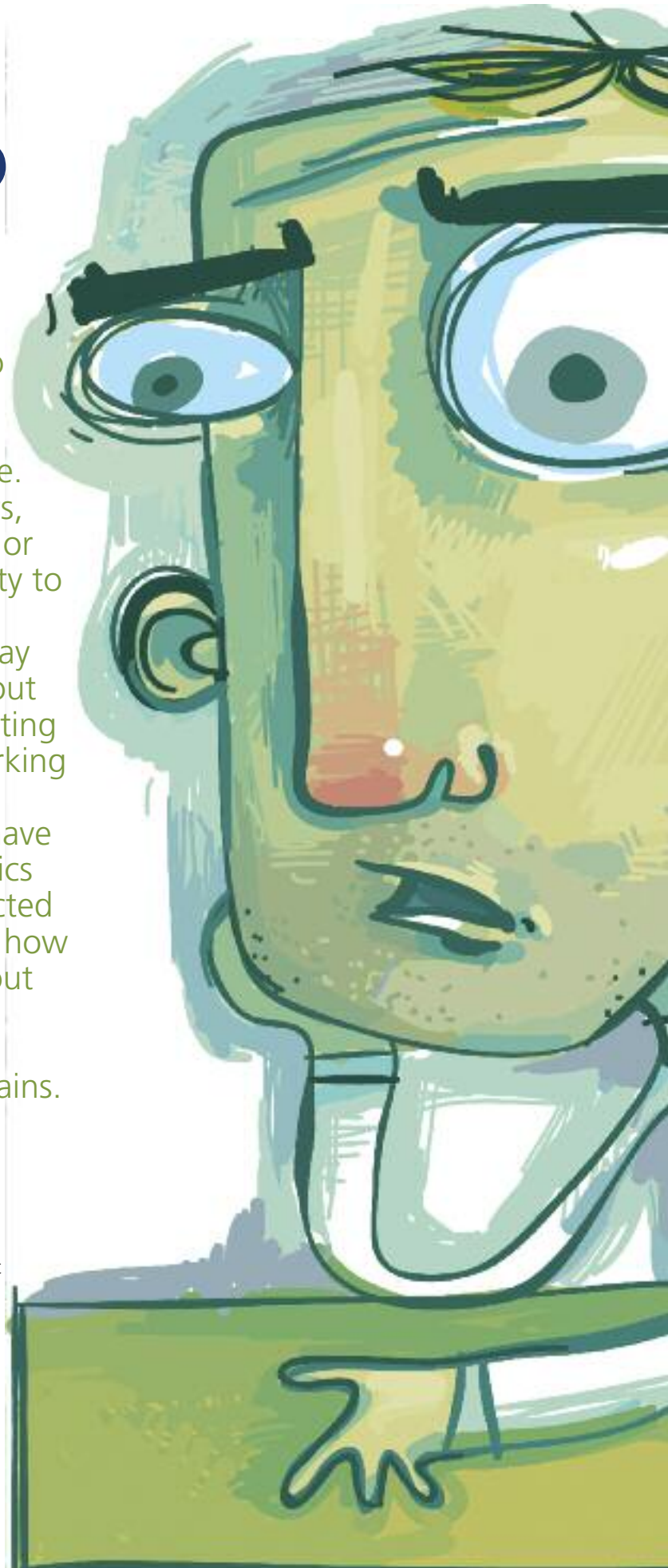
Remember, if you need any specific advice from the MDU's team of medico-legal experts, you can call our 24-hour freephone advisory helpline on **0800 716 646.**

Dr Sally Old
Ward Round medical editor

1 Child protection registers statistics at 31 March 2011 (31 July in Scotland) – UK, NSPCC, accessed 20 September 2012. http://bit.ly/wardround10

FEATURE

Cause for concern?



Every doctor has a duty to protect and promote the health and well-being of children and young people. This means that all doctors, whether treating children or adults, have a responsibility to act on concerns about a child's welfare. Doctors may come across concerns about children when least expecting to, for example when working solely with adult patients. Even those doctors who have no experience of paediatrics and child health are expected to be aware of and know how to deal with concerns about child protection. Dr Catherine Wills, medico-legal adviser, explains.

You may be aware of a number of high profile child abuse cases and public inquiries[1] that have highlighted the need for vigilance, and for professionals to take action when they have any concerns about the safety and welfare of children. Indeed, doctors who have concerns about child protection and fail to act could be liable to criticism.

The following fictionalised case studies show how child protection concerns can come to the attention of junior doctors, even those treating adult patients, and explain the relevant guidance and sources of support. Child protection cases can often be very challenging, practically and emotionally. But all MDU members can be sure that our medico-legal advisers are on hand to advise and support doctors facing such difficult decisions.

FEATURE

the scene

An F2 doctor based on an orthopaedic ward was reviewing the notes and prescription charts for a middle-aged male patient in traction for a lower limb fracture. The doctor needed to see the observation chart, and went to the patient's side room to fetch it. As the doctor was about to enter the room, he heard shouting. Hesitating at the door, the doctor heard the patient shouting that, were he not in hospital, he would 'do the usual'. Feeling apprehensive, the doctor entered the room and saw that the patient was apparently being visited by his wife and child, a boy of about nine years old. The boy looked frightened and was cowering by the bed, with his head lowered. The patient looked flustered and angry, and shouted at the doctor to leave the room. Instead, he stood at the end of the bed and asked the patient's wife and child if they were alright. Neither answered, and left hurriedly. The doctor followed a few seconds later, but the wife and child had left the ward. The doctor was aware that the family lived in poverty and that the patient was a drug user.

the advice

The F2 doctor believed there was no doubt that the patient in front of him posed a threat to his child. Unsure of how to deal with his concerns, he called the MDU advisory helpline and spoke with an adviser, who reminded him of his duty to protect all children, even where the adult concerned was his patient and the child was not. The adviser reassured him that acting on concerns about the safety of a child is justifiable even if it turns out that the child is not actually at risk, as long as the concerns are honestly held, reasonable and raised through the proper channels. The doctor was advised to seek guidance from the named lead for child protection in the hospital.

The MDU received around 200 calls in 2011 from doctors with concerns about child protection. Not surprisingly, many queries are from GPs or paediatricians but some are from doctors in other specialties. Even doctors who treat adult patients only must be alert to the possibility that their patient may pose a risk to a child or young person, and know how to act on such concerns.

It is important for all doctors to keep up-to-date with best practice in child protection through training appropriate to their role, and of course foundation year doctors working in adult specialties are likely to have much less expertise and experience than other more senior doctors, particularly those treating children. But every doctor should have a working knowledge of local procedures and should be aware of where to turn for advice: the named or designated professional or lead clinician at the Trust or, if none is available, a colleague who has experience in making decisions about the safety and welfare of children and young people.

New GMC guidance *Protecting children and young people* was introduced in September this year. It sets out the GMC's expectations and is essential reading for every doctor. You should also be familiar with other key guidance such as the Department for Education's *Working Together to Safeguard Children* (2010), and guidance from NICE and the Royal College of Paediatrics and Child Health.

the outcome

The doctor alerted his consultant to the situation and made contact with the consultant paediatrician who was the named doctor in the Trust. The paediatrician came to the ward to speak to the F2 doctor and to the patient about the concerns that had been raised. The patient was angry at first but admitted that there was a problem at home and agreed to a referral to the social services, which duly took place.

FEATURE

the scene

An F2 doctor in A&E was called to see a 15-year old girl with abdominal pain and distension. It became immediately clear on examination that the distension was due to a previously undiagnosed pregnancy. The girl was shocked to discover that she was pregnant and told the doctor that she did not want to keep the baby. She revealed she was worried about getting into trouble with her father because he did not approve of her relationship with a family friend aged 20. She also seemed anxious about how her boyfriend would react to news of the pregnancy and asked to see someone who could offer a termination without anyone else knowing. The doctor was worried because the girl seemed frightened. She also had a number of bruises on her arms and breasts, and did not have an explanation for them. The doctor was not sure whether he could disclose information about the patient to her parents or anyone else, and called the MDU for advice.

the advice

Confidentiality is key to the trust between doctors and patients; this is true for young people as well as adults.

The GMC advises that doctors should usually share information about sexual activity involving children under 13, who are considered in law to be unable to consent.[2] For older children engaged in sexual relationships, each case should be taken on its merits taking into account the young person's behaviour, living circumstances, maturity, serious learning disabilities and any other factors that might make them particularly vulnerable. If a child or young person is involved in abusive or seriously harmful sexual activity you must protect them by sharing information with appropriate people or agencies, quickly and professionally.[3]

This case raises serious concerns about the safety of the young person involved. She seems frightened of her father and also her boyfriend, who is much older, and she has unexplained bruising. These features could be indicators of an abusive relationship.

The primary concern must be the best interests of the young patient. The GMC advises doctors that information can be shared without consent if the benefits to the patient outweigh the possible harm, both to them and to the overall trust between doctors and patients of all ages. The possible consequences of each course of action need to be weighed carefully and 'if a child or young person is at risk of, or is suffering, abuse or neglect, it will usually be in their best interests to share information with the appropriate agency'.[4]

As well as the question of whether or not to disclose information without consent in order to protect the patient herself, this scenario raises the question of consent to treatment. In order for a 15-year old to be able to provide consent to medical treatment, she must be 'Gillick competent' but it is not yet clear whether this particular patient would have sufficient maturity and understanding to consent to a termination, even if it were feasible to offer one at her stage of pregnancy. If the pregnancy is to continue, the team involved will also need to consider the best interests of the baby.

the outcome

The F2 doctor discussed the situation with a senior doctor within the department and took advice from the Trust's named doctor for child protection. After further discussion with the patient, she agreed to inform her mother and a referral was made to see the obstetrics and gynaecology department. The doctors weighed up the possible risk of the patient being a victim of abuse against the possible damage to the patient's trust and decided to disclose information about her situation to the local social services. The doctors kept a careful record of their decisions and reasons.

Summary

- Child protection is the responsibility of every doctor.
- All doctors should have a broad understanding of local procedures and know who to turn to for advice, even those who do not treat children.
- Raising concerns is justifiable even if it turns out that the child or young person is not actually at risk of abuse or neglect, as long as the concerns are honestly held, reasonable and have been raised with the appropriate authority.
- Try to obtain consent before making a disclosure. If there is no consent, weigh up the possible risk of abuse or neglect against the possible harm to trust. It will usually be in the best interests of a child or young person for a disclosure to be made.
- Keep careful records of decisions and the reasons for them, in case you are later asked to justify what you have done.

References

1 Notably the public inquiry chaired by Lord Laming following the death of Victoria Climbié in 2000, and Lord Laming's further report following an Inquiry into the death of Baby P, 2009.

2 The law governing sexual offences is different in Northern Ireland where you should also have regard to the Criminal Law Act (Northern Ireland) 1967, which places a duty on everyone to report relevant offences to the police unless they have a reasonable excuse.

3 GMC '*0-18 years: guidance for all doctors*' (2007) para 64-67

4 GMC: *Protecting children and young people, the responsibilities of all doctors* (2012) para 37

GUIDANCE

Reflections on FY training

The summer before I started my F1 year, a well-meaning relative gave me *'Trust me I'm a (junior) doctor'*[1], an account of a junior house officer's life when 90-hour weeks were the norm.

It's a good read but it didn't fill me with confidence, only adding to the ever-expanding list of character traits and attributes that I wanted to develop. Not to mention giving me visions of scrabbling around for that vital piece of information the consultant wanted yesterday as bits of paper fly everywhere from my own disorganised mess. Looking back, I think I only focussed on those bits because of my own mounting anxiety.

So was my fear justified? Well, you will already know that there is a leap from student to doctor and qualities like organisation, unflappability and not taking your work home with you are great in theory, but don't always work in practice! Here are a few suggestions, based on my experience which may help you along the way.

The most important thing to know is that you are not alone, practically and emotionally. On the ward, a friendly attitude will help immensely and there are many people I have found invaluable over the past two years: pharmacists are the fount of all potion knowledge; physiotherapists, OTs and social services will help your patients get home; and a concern raised by a nurse regarding a patient is always worth an early look. Beyond the ward, your SpRs and consultants are paid to support you, so have the confidence to ask for their input early, even if it's just to clarify a management plan.

The emotional side of things can be more difficult to handle. Resilience is a great character trait to develop but we all make mistakes and have tough experiences that leave us struggling. Talking through what has happened with friends or a partner can really help you process things and become a better doctor.

If you find it all too much, have the courage to talk to someone senior. I have been lucky to have supportive educational supervisors. Try to take something positive from the bad experiences, as well as the good. For example, your reflections on what went wrong, why and how you will do things differently next time make a great addition to your eportfolio.

On the subject of the eportfolio, what they tell you about keeping on top of assessments is true. It is a pain, but it is really useful when it comes to showcasing your abilities for the next set of applications and interviews.

Most importantly, look after yourself. Don't go to work when you are sick – fainting over patients is never a good idea and remember, it is always possible to take a break during the day, however busy you are.

Don't expect these tips to transform you into that ultra-efficient, compassionate, calm doctor we all aspire to be but hopefully they will give you some confidence when looking ahead to life as a junior doctor.

Finally, if you find yourself looking around enviously at colleagues who seem to be taking things in their stride, it's perhaps helpful to remember the swan analogy: a calm exterior with powerful, slightly crazed, paddling underneath.

Rosie Arnott,
CT1 Medicine, East Midlands.

References

1 *Trust me, I'm a (Junior) Doctor*, Dr Max Pemberton, Hodder and Stoughton, 2008

FEATURE

Safety First

Paediatric consultant, Dr Alison Steele, is the designated doctor for safeguarding children at Newcastle Hospitals NHS Trust and is a member of the Newcastle Safeguarding Children Board (NSCB). In this interview, Dr Steele explains what her work involves and dispels a few myths.

How did you become involved in child protection work?

I had been considering a career in either paediatrics or general practice after qualifying in 1985. I spent my first senior house officer year in paediatrics and decided that was the specialty for me. Safeguarding children is at the heart of paediatric work. I became really interested in child protection while working as a registrar in Cleveland at the time of the abuse investigation[1]. I became a member of the RCPCH in 1990 and then qualified as a consultant paediatrician in 1997, before joining Newcastle Hospitals NHS Trust in 2006.

What are your responsibilities?

As the Designated Doctor for Safeguarding Children, I'm responsible for taking a strategic and professional lead in child protection across the area's health services. I sit on the Newcastle Safeguarding Children Board (NSCB) which provides a coordinated, multi-agency approach, involving organisations such as local authority children's services, the health service and the police. The NSCB oversees aspects of child protection such as training as well as holding serious case reviews if a child dies or is seriously harmed. I chair its Policy and Procedure committee which is responsible for developing and reviewing guidance on how different agencies should work together effectively.

Talk us through a typical day

Every day is different. Every day is always full and the work is fascinating. I might be at an NSCB meeting; talking to other health professionals who have concerns about a particular child; or carrying out a medical assessment of a child where he or she has a suspected non-accidental injury, in response to a request from the police or social services.

As I am on the rota for the regional Paediatric Forensic Service, I may also be asked to examine a child and obtain forensic samples in cases of suspected sexual abuse. I think it is reassuring for children for this to be done sensitively in a supportive environment by trained paediatric staff who can explain what to expect, obtain their consent and answer any questions they or their carers might have. We are one of a few services in the country to have been assessed as young people friendly as part of a National Quality Accreditation Scheme from the Department of Health called "You're Welcome"[2]

What are the most testing aspects of the job?

Dealing with suspected fabricated or induced illness can be very challenging. Most child protection cases are testing. In some cases it's clear what the correct course of action is but many cases have significant grey areas where it is difficult to determine what action is in the child's best interest.

I work with children up to the age of 18. Managing adolescents can also be challenging. It's often a matter of trying different approaches to gain their trust and

FEATURE

address their issues. We often work in tandem with other agencies such as schools, colleges, the local authority and occasionally the youth offending team.

Giving evidence in family or criminal court cases can be quite stressful too but that anxiety can be alleviated with thorough training and preparation. It is important for children and young people that paediatricians are prepared to do this work.

What do you think doctors find most difficult in child protection cases?

Many fear the prospect of an angry confrontation with parents; although in practice they may encounter a variety of responses. In some cases, parents may actually express relief as they were also worried that something was wrong.

Doctors also worry about getting it wrong and being responsible for a child being taken into care but this is something of a misconception. Most children who are the subject of a child protection plan are still at home and child protection professionals do everything we can to work with parents and keep families together. It can be a delicate balancing act but removing a child from their family is only considered as a last resort when there is a serious risk to their safety which meets the threshold for significant harm as defined by 1989 Children Act.

Finally, doctors may themselves be upset and emotional about what they have seen or heard which can make it difficult to manage the situation.

What advice do you have for junior doctors about child protection?

A child's safety is the responsibility of every doctor so they need to know how to respond appropriately if, for example, they examine a child with a fracture or an injury and they are not satisfied with the explanation given.

Junior doctors should be as open and honest as they can with parents about why they are concerned and what action they propose to take. For example, they could explain they are worried about an unexplained injury and would like to get the opinion of a senior doctor. It is imperative that doctors do not lie to the parents as maintaining their trust will be critical to ensuring their cooperation and helping the child stay safe.

In my experience, the more training that a doctor has had in child protection, the less worrying it will be for them to act on child protection concerns. Junior doctors should be familiar with the GMC's new guidance on child protection and know where to go for advice on child protection matters including their supervisor, senior paediatricians or the trust's named doctor for child protection. All hospital inductions include an introduction to child protection matters but junior doctors should be ready to discuss their training needs with their supervisors as there are many more in depth courses available. Most local safeguarding children boards provide additional training and the Advanced Life Support Group (ALSG) runs courses on child protection for doctors in training as does the Royal College of Paediatrics and Child Health.

How can junior doctors find out more about child protection work?

Many child protection specialists – including named child protection doctors – are trained community paediatricians so I'd suggest that any junior doctor who is particularly interested in this kind of work speak to their educational supervisor about applying for specialty paediatric training which will then give them the opportunity to sub-specialise. They could also speak to their local named doctor for safeguarding about additional training. Most safeguarding doctors are delighted to learn of junior doctors interested in this field.

It may also help to look at the intercollegiate guidelines[3] published by the RCPCH on behalf of a number of colleges and other health organisations. It defines the key knowledge and skills needed to work in child protection and the six levels of competencies required by staff within healthcare settings.

References

1 *Report of the Inquiry into Child Abuse in Cleveland* 1987, Her Majesty's Stationery Office ©1988

2 '*You're Welcome*': quality criteria for young people friendly health services, DH, 19 May 2011 http://bit.ly/wardround11

3 *Safeguarding Children and Young people: roles and competences for health care staff*, Intercollegiate document published by the RCPCH, September 2010 http://bit.ly/wardround12

GUIDANCE

When it's not what you think

uncommon conditions

If you examine a child with unexplained injuries, your suspicions may be aroused but you still need to consider the possible medical causes. Dr Kathryn Leask explains why it is important not to leap to the wrong conclusion.

It is a sad but accepted fact that some children are abused or neglected by those closest to them and as a doctor you are ideally placed – and ethically obliged – to raise the alarm. However, you need to bear in mind that abuse may be one possible explanation among several for a child's condition.

If a child is failing to thrive, for example, other explanations may include gastrointestinal problems affecting absorption and digestion of food, metabolic problems such as thyrotoxicosis, cardiac abnormality or reduced growth potential associated with a chromosome disorder.

Similarly, if the patient has injuries consistent with a fall, consider underlying predisposing conditions, such as a neuromuscular disorder or epilepsy. Fractures may be seen in a number of other medical conditions affecting bone such as osteogenesis imperfecta and rickets, other features of which may be elicited by careful history taking and examination.

Bruising, too, may have numerous causes including leukaemia or thrombocytopenia. Metabolic conditions should also be considered - for example, glutaric aciduria is a rare cause of subdural haematoma.

The risk of missing a treatable condition or making a wrongful accusation highlights the importance of taking a detailed family history to identify any genetic conditions that may also affect the parents or other siblings, as well as carrying out a careful examination and exploring concerns about a child in an open and non-judgmental way. This will best ensure that the child's needs are appropriately met, whether that means involving the child protection team, or uncovering information which suggests an alternative diagnosis.

The National Institute for Health and Clinical Excellence (NICE) has published guidance[1] for doctors about 'alerting features' - symptoms, signs and patterns of injury or behaviour which may indicate child abuse is taking place. It asks doctors to 'consider' whether abuse is one possible explanation for an alerting feature, bearing in mind that there may be other differential diagnoses. Doctors should 'suspect' child abuse if there is a serious level of concern, but this is not in itself proof that maltreatment is taking place.

The guidance makes clear that good communication is essential and that much information can be gained from simply observing and listening to the child and their carers, being careful to record their explanation of how the injuries came about in the child's clinical record, along with any concerns you may have. Doctors should take into account any additional needs or communication difficulties, such as arranging for an interpreter to be present and considering any cultural factors. Remember that parents or carers themselves may also require further social services or medical input.

As a foundation doctor, you should discuss any concerns that the child may have received their injuries as a result of abuse, with the named doctor in your organisation, or the local child protection lead or a senior colleague. The Royal College of Paediatrics and Child Health advises junior doctors not to confront or accuse parents of abusing their child, but to calmly explain what concerns you have and the reasons for them[2]. You should also explain why you feel you need to seek advice from other healthcare professionals.

References

1 *When to suspect child maltreatment.* National Collaborating Centre for Women's and Children's Health (commissioned by NICE), July 2009 (revised December 2009)

2 *Child Protection Companion*, Royal College of Paediatrics & Child Health, April 2006

GUIDANCE

Child protection terminology – what does it all mean?

Child protection is a complex area of medical practice and for junior doctors who are not actively involved in this work on a day-to-day basis, some of the terminology and abbreviations used can be confusing.

However, all doctors have an ethical duty to keep up-to-date with the relevant laws, codes of practice and guidance, so it's important to be familiar with the key terms used and understand the roles of other professionals and organisations involved in child protection. Clearly training plays a central part in this but we hope this guide will prove a useful starting point.

Designated doctor for child protection: Takes a strategic and professional lead on all aspects of the health service's contribution to safeguarding children across the area they serve and across all providers. Generally community paediatricians, designated doctors sit on local safeguarding children boards and their responsibilities include providing advice and support to named professionals within different organisations and ensuring staff training needs are addressed.

Named doctor: Within an NHS trust setting, named doctors are consultant paediatricians responsible for providing advice to fellow health professionals and promoting good practice within their organisations. Within Primary Care Organisations, a named GP has a similar role.

In Scotland, nurse consultants, child protection advisers and lead clinicians fulfil specialist roles in child protection.

Local Safeguarding Children Boards (LSCBs) (in Scotland, Child Protection Committees have a similar role): Established by local authorities under the Children Act 2004, LSCBs are there to provide a coordinated approach to safeguarding children across various interested organisations, such as the health service, social services and the police. Their role encompasses identifying and preventing maltreatment or neglect; working proactively with vulnerable groups such as families in need; and responding to children at risk of or suffering harm.

Section 47: If a child is suspected to be suffering, or likely to suffer, significant harm, the local authority is required under Section 47 of the Children Act 1989 to make enquiries. Their report will then be considered by a child protection conference (in Scotland: child protection case conferences fulfil a similar function) of all professionals involved in the child's care, the child's parents and (where appropriate) the child. The conference will then decide whether it is necessary to produce a child protection plan.

Child protection plan: Replacing the concept of an at risk register, children are now said to be the subject of a child protection plan if they are considered by a child protection conference to be at risk of significant harm. Regular meetings are required to review the plan and support provided to children and their families, which often include the doctors overseeing the child's care as well as the child's parents. Doctors working in urgent care settings should be aware of local procedures to find out whether a child is the subject of a child protection plan. The term child protection register is still used in Scotland.

Serious Case Review (SCR): Held by LSCBs to establish what lessons can be learned from particular safeguarding children cases, such as where a child sustains a potentially life-threatening injury or is seriously harmed. The purpose of the SCR is not to assign blame and it is not part of any disciplinary inquiry. As a doctor, you have an ethical duty to co-operate fully with any formal inquiry into the treatment of a patient if asked although in these circumstances it's a good idea to seek advice from your trust's named doctor or the MDU about your confidentiality obligations.

Child Death Review: Held by a sub-committee of the LSCB, a Child Death Overview Panel, when a child dies within the area. As with SCRs, the object is not to cast blame but to investigate what lessons can be learned to improve the health, safety and well-being of other children and prevent further similar deaths.

Looked-after child: A child in the care of the local authority, including those who are the subject of a care order.

Suggested further reading:

- Protecting children and young people: The responsibilities of all doctors, GMC, 2012
- Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children, HM Government, March 2010
- National Guidance for Child Protection in Scotland, the Scottish Government, 13 December 2010
- A guide to getting it right for every child, The Scottish Government, June 2012
- All Wales Child Protection Procedures, All Wales Child Procedures Review Group, 2008
- Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff, Intercollegiate document published by the RCPCH, September 2010
- When to suspect child maltreatment, National Collaborating Centre for Women's and Children's Health (commissioned by NICE), July 2009 (revised December 2009)

ADVICE LINE DILEMMA

Keep out of reach of children

An F2 doctor on a GP placement was due to carry out a medication review on a woman who had been taking strong painkillers for chronic sciatica. The doctor noticed in the medical records that the patient had taken her young son to A&E a few weeks before because she feared he had swallowed her medication. He was unharmed but the doctor was concerned about the continued risk and contacted the MDU for advice about the precautions he could take to ensure the child's safety.

In line with the GMC's prescribing guidance which states that doctors must always ensure their prescribing is 'appropriate and responsible and in the patient's best interests', the MDU adviser discussed with the member the need to assess the patient and consider alternative treatments such as an epidural steroid injection or surgery. These alternatives, their risks and benefits could be explored with the patient during the consultation.

If the doctor concluded that it remained in the patient's best interest for him to prescribe the painkillers, the GMC would still expect him to 'reach agreement with his patient on the use of any proposed medication, and the management of the condition by exchanging information and clarifying any concerns'. The MDU adviser suggested that this would include ensuring the patient now understood the risks that her medication presented to her son and the need to store them correctly.

The doctor had no reason to believe that his patient would intentionally harm her child but he appreciated that she was a single mother with no close family, she was in poor health and that drowsiness was a side-effect of the drugs she was taking. He was therefore keen to persuade the patient to accept additional help and support.

He discussed with the MDU adviser how this might be done and was advised that it was important to talk to the patient in an open and honest way about how she was coping and avoid being judgmental. By encouraging her to talk about how she saw her situation, it might be easier to gain her trust and suggest a solution, such as a visit from the local health visitor who could give her practical advice on how to store her medication safely. The MDU adviser also suggested the member obtained further advice from his supervisor before seeing the patient.

During his consultation, the doctor succeeded in gaining the patient's trust. She explained that the incident involving her son had come about because he had worked out how to open the blister pack in which her medication was packaged and confided her fears about his inquisitiveness. She had since moved her medication to a higher cupboard which the boy could not reach.

The doctor persuaded her to consent for him to request a home visit from the health visitor and to think about some of the alternative treatments for sciatica that he suggested. He agreed to write her a repeat prescription for the pain killers but brought forward the date of her next medication review. He also requested that the pharmacist dispense the drugs in a child resistant container.

ADVISORY LINE DILEMMA

A history of **violence**

An F2 doctor was on a GP placement when he saw a young woman who was clearly exhausted. She told him she had not been sleeping at night because she was feeling anxious and asked if he could prescribe sleeping tablets. When the doctor asked the patient whether there was any particular reason for her anxiety she revealed that her violent ex-husband had just been released from prison and had begun to hang about outside her flat. He had tried to talk to her and her young children and on one occasion had drunkenly threatened to break down her front door when she asked him to leave her alone. The doctor was uncomfortable with what he had been told and called the MDU for advice on what to do next.

The MDU adviser discussed with the member the GMC's latest child protection guidance[1] which says that doctors who are treating an adult patient must make him or her their first concern but also be aware of risk factors linked to abuse and neglect of children such as living in a home where domestic violence is suspected. They are also expected to look out for signs that a family requires extra support and refer them to other health or local authority services so they can get appropriate help.

The adviser agreed the ex-husband's recent behaviour and threats gave real cause for alarm. He reminded the member of his duty to act straight away in the interests of the mother and her children if he believed either was at risk of harm but suggested he also seek support and advice from his practice supervisor about the local procedures for protecting vulnerable adults and children.

In the first instance it was important to address this patient's health concerns. This would be an opportunity for the doctor to talk to her in an open and non-judgmental way about the threat posed by her husband, explaining that he proposed to contact social services who were likely to involve the police. He should make clear that this would involve disclosing her name, those of her children, and her ex-husband, as well as the reasons for his concerns and other relevant information such as her own health problems.

The member was advised that there was a chance the mother would be reluctant to consent to the social services being involved. However, even if she refused consent, he should still report his concerns without delay if he believed the risk outweighed the possible consequences to his relationship with the patient. He should then keep her informed about what was happening and explain where she could seek independent and confidential support and advice such as the Family Rights Group or the Citizens Advice Bureau.

With the support of his supervisor the doctor spoke to the mother who reluctantly gave consent to him informing social services. The case later become a matter for the local safeguarding children board involving the police and social services. The GP practice continued to provide care and treatment for the family.

References

1 GMC, *Protecting children and young people: the responsibilities of all doctors*, 2012

ADVICE LINE DILEMMA

Attempted **suicide**

An F1 doctor was treating a young single mother who had been admitted to A&E following an apparent attempted suicide. She referred the patient to the consultant psychiatrist. He reported that the patient showed insight into her actions and hadn't really intended to end her own life, but that it had been a spur of the moment reaction to the ending of a relationship by her boyfriend of six months. Although the patient's children did not appear to be at risk of harm, the F1 doctor was concerned that the family might need support from other agencies, but that would require disclosing confidential information about the patient.
She rang the MDU for advice.

The MDU adviser reassured the doctor that her concerns were justified and that she should discuss the need for further support with the patient in an open and honest way. If the patient refused permission for this the member would have to consider whether disclosure would be justified without the patient's consent in the interests of her children. Although there was no evidence of actual harm to the children, the mother's actions might indicate that their welfare could be compromised in future.

In line with the GMC's guidance *Protecting children and young people*, paragraph 43, the adviser suggested that the F1 discuss the case first with her consultant and then with the Trust child protection lead without revealing the identity of her patient. Risks to children sometimes become apparent only when a number of people share what seem to be minor concerns. The child protection lead acts as a focus for individuals to report their minor concerns and may be the only person able to see the bigger picture about the risks to a child or young person.

ADVICE LINE DILEMMA

An investigation

An F1 doctor called the MDU advisory helpline as she had been involved with the care of a child on the paediatric ward who had been brought in with a suspected non-accidental injury (NAI) and died. The doctor had been notified of a child death review and has been asked to write a report for the local safeguarding children board. She had not been asked to write such a report before and was concerned about the seriousness of the investigation and what was required of her.

The adviser explained that each local authority has a local safeguarding children board which will agree how organisations will co-operate to promote the welfare of children[1]. If a child dies unexpectedly, a child death review will take place.

The GMC expects doctors to 'participate fully in child protection procedures, and co-operate with requests for information about child abuse and neglect'[2]. This 'includes serious case reviews set up to identify why a child has been seriously harmed, to learn lessons from mistakes and to improve systems and services for children and their families'.

The doctor's report would need to be a factual account of her involvement with the child and should be typed on headed notepaper, clearly identifying the doctor's name, qualifications and her role at the time of the incident. The purpose of the report and the name of the person who requested it should be clearly stated. She should provide a chronological account of the events in question, such as when she first saw the child; what information was made available to her at that time; whether the child was examined; the outcome of that examination; who was with the child at the time; and if anyone else was present.

It was not her role to comment on what she might see as the rights or wrongs of another individual's actions but simply to provide a factual report documenting what others did and clearly identifying them by their name or title.

Disclosures about third parties, such as the child's parents, should be in line with GMC guidance on confidentiality. They may give consent for information to be disclosed and it would be normal practice to clarify if this has been provided. If consent has not been given and it is not thought practicable to obtain it, disclosures could be made in the public interest to help in the investigation of a possible serious crime[3]. All relevant information should be disclosed including 'family risk factors, such as drug and alcohol abuse, or previous instances of abuse or neglect'[4] and the parents would usually be informed of such a disclosure unless this would be impracticable, would put you or others at risk of serious harm, or prejudice the purpose of the disclosure.

The adviser suggested it would be appropriate for the member to seek advice from a senior colleague who may have experience of writing reports for such a review and that the MDU would be happy to review the report before it was submitted.

References

1 *'Working together to safeguard children; A guide to interagency working to safeguard and promote the welfare of children'*, HM Government, March 2010.
2 GMC, *0-18 years: Guidance for all doctors* (2007) paragraph 62
3 GMC, *Confidentiality* (2009) paragraph 54
4 GMC, *Protecting children and young people; the responsibilities of all doctors* (2012) paragraph 49

ADVICE LINE DILEMMA

An upsetting **incident**

An F2 in general practice was walking through to reception when she witnessed a three-year-old child being slapped hard on the arm by his mother. The child cowered but did not cry out. The member was about to call the mother and child into her consulting room but was now unsure how to proceed. There was nothing in the notes to suggest that this was a child at risk of harm or on the child protection register so she rang the MDU for advice about whether it was appropriate to raise her concerns.

From the reaction of the child, this may not have been an isolated incident and the MDU adviser reminded the member that all doctors need to act promptly to protect children if they identify any sign of abuse[1].

The medico-legal adviser suggested that the doctor's first step would generally be to raise the matter during the consultation and see if the mother was willing to discuss what had happened and why. In doing so, she might uncover underlying health problems which should be addressed, such as substance misuse or depression. However, in speaking to the mother, the GP would need to keep 'an open mind' about the possibility of abuse or neglect but to be aware of any inconsistencies in her story[2].

It would also be important for the doctor to speak to the child and check he was physically unharmed although if she felt he might be discouraged from being open by the presence of his mother, she could consider asking the mother to step outside. A suitably qualified person such as a practice nurse or child protection lead could be asked to provide support. The GMC expects doctors to 'listen to children and young people and talk directly to them, taking into account their age and maturity'.[3]

The MDU adviser suggested that, given her relative inexperience, the doctor might wish to ask for additional support from a senior member of the practice or the Lead for Safeguarding/Child Protection at the local hospital. In addition, other members of the healthcare team may have relevant information about the family that may be helpful both to the member and the child protection services.

If, having spoken to the mother and her son, the doctor continued to feel the child was at risk then she had an ethical duty to 'tell an appropriate agency, such as your local authority children's services, the NSPCC or the police, promptly.'[4] However, any disclosures would need to be in line with GMC's guidance as she continued to owe a duty of confidentiality to the child's mother[5]. Minimum relevant information only should be shared, eg the name of the child, his parents and the reasons for the doctor's concern.

The member was advised that in most circumstances she would explain to the mother that she had a duty to take her concerns further and seek her consent to share information with the child protection team. However, she could decide not to inform the mother if she thought it was in the child's best interests, for example if she had reason to believe this may put this child or any other children at increased risk.

If the mother refused, this should be documented but it was up to the GP to decide whether it was in the child's interest to disclose information to the child protection team without consent. The member was advised that if she decided to disclose she should consider telling the mother and explaining what information would be shared, with whom and how that information would then be used and where to go for independent advice[6]. The doctor should make a note of the exact information disclosed.

Finally, the adviser reminded the member that she may need to review the situation and take her concerns further if she felt the child remained at risk[7].

Outcome

The member sought advice from her trainer who came in to speak to the child and his mother about what had happened. As he checked over the child the GP trainer noted multiple bruises and other indications of possible abuse, so after discussion with the mother, the child was referred to social services.

References

1 GMC, *Protecting children and young people* September (2012) paragraph 3
2 GMC, *Protecting children and young people* September (2012) paragraph 19
3 GMC, *Protecting children and young people* September (2012) paragraph 15
4 GMC, *Protecting children and young people* September (2012) paragraph 32
5 GMC *Confidentiality* (2009) Para 53-56, 63
6 GMC, *Protecting children and young people* September (2012) paragraph 35
7 GMC, *Protecting children and young people* September (2012) paragraph 42

NEWS

Waiting for a miracle

Some terminally ill children are being subjected to aggressive yet futile medical treatment because of their parents' religious beliefs, according to an article in the Journal of Medical Ethics by doctors from Great Ormond Street Hospital.[1]

The authors reviewed cases involving end-of-life decisions over a three-year period. In 17 of 203 cases in which doctors recommended the withdrawal or limitation of invasive treatment, agreement could not be reached with parents despite extended discussions. Eleven of these cases had a religious dimension. Five were resolved after meetings with religious community leaders; one child had intensive care withdrawn following a High Court order,and in the remaining five, no resolution was possible.

The doctors said the legal process of seeking court permission to withdraw treatment should be speeded up and that the law needed to make clear that parents' beliefs should not be a 'determining factor' in such decisions.

[1] Current controversy: Should religious beliefs be allowed to stonewall a secular approach to withdrawing and withholding treatment in children? Joe Brierley et al, J Med Ethics medethics-2011-100104 Published Online First: 30 March 2012 doi:10.1136/medethics-2011-100104.

Preparing for life on the wards

From July 2012, all junior doctors had to shadow another doctor for at least four working days before starting work in order to reduce the stress associated with the first weeks of hospital medicine and help ensure their safe transition from students to doctors.

The initiative is part of Better Training, Better Care (BTBC), a Department of Health programme overseen by Health Education England (and until October 2012 by Medical Education England) which aims to ensure foundation doctors have the best possible training and support. The BTBC taskforce is running a number of other schemes including 16 local NHS trust pilots looking at ways to improve training which could be adopted across the NHS, as well as national schemes such as a project to recognise and accredit doctors who supervise trainees.

An excellent result

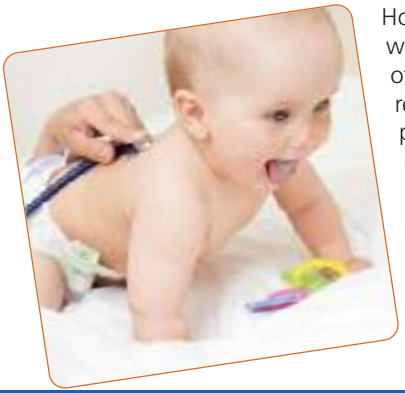
Members who need to contact the MDU's membership department will be reassured to hear that the team has recently received accreditation in the Customer Service Excellence Standard (CSE) . The award measures organisations against criteria such as the speed and quality of service. The CSE standard has been taken up by many organisations as a recognised benchmark of excellent service.

Ward rounds – a matter of teamwork

The Royal College of Physicians and Royal College of Nursing have called on doctors and nurses to work together to make effective ward rounds a top priority in patient care. The two colleges have issued joint best practice recommendations including the use of checklists to reduce omissions and improve patient safety. They are available on the RCP website: www.rcplondon.ac.uk

Consultant paediatricians

Nearly 90% of paediatricians who obtained their CCT or CESR in 2010 now have a consultant post, according to a study looking at career outcomes by the Royal College of Paediatrics and Child Health (RCPCH). However, the RCPCH said it was concerned that only 4.7% of new CCT holders were registered for community paediatrics, despite this area representing over one fifth of the wider consultant workforce and that this may not be sufficient to meet future needs. The full results can be found on the RCPCH website.

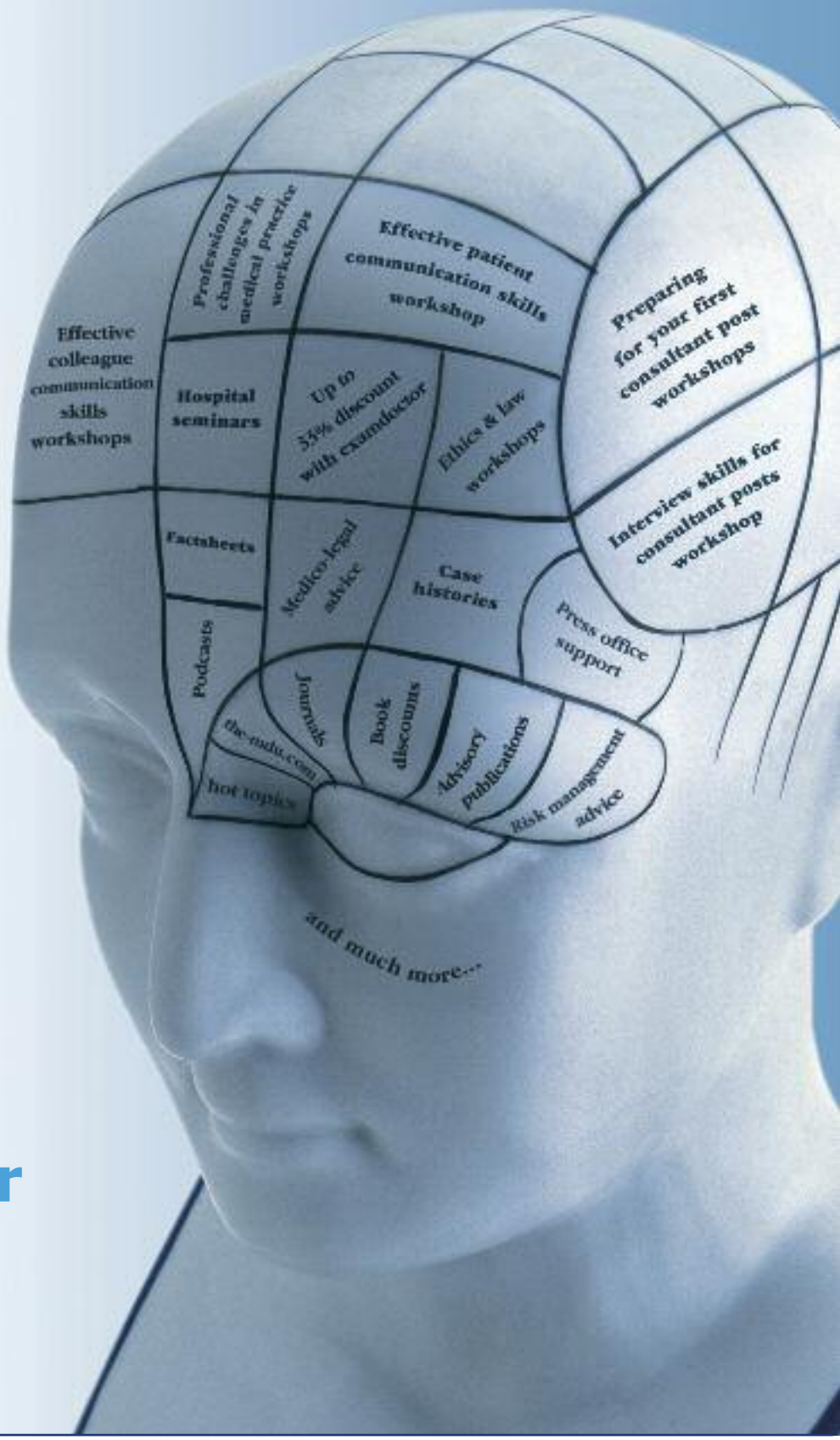


Countdown to revalidation

As the countdown begins to the start of revalidation, foundation doctors should now know their designated body and responsible officer (RO). In England and Wales, your designated body is your postgraduate deanery; in Scotland, it is NHS Education for Scotland; and in Northern Ireland it is the Northern Ireland Medical and Dental Training Agency. ROs at postgraduate deaneries were asked to complete a revalidation scheduling spreadsheet by 5 October 2012 so the GMC could begin to inform trainees of the date of their first revalidation from December 2012.

If you have any concerns about what you need to do to revalidate as a trainee doctor, contact the RO at your designated body. If you are still unsure whether you are connected to a designated body, contact the GMC straight away on 0161 923 6277 or email revalidation@gmc-uk.org

THE MDU



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