14th October 2011

GMC consultation on Protecting children and young people: the responsibilities of all doctors

1. I write with regard to the GMC consultation on Protecting children and young people: the responsibilities of all doctors.

2. The Royal College of General Practitioners is the largest membership organisation in the United Kingdom solely for GPs. Founded in 1952, it has over 44,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. We are an independent professional body with enormous expertise in patient–centred generalist clinical care. Through our General Practice Foundation, established by the RCGP in 2009, we maintain close links with other professionals working in General Practice, such as practice managers, nurses and physician assistants.

3. The College welcomes the opportunity to respond to this consultation. We have considered the guidance document and agree that it is useful, very well constructed and fully worthy of the GMC. That said, we do have a number of comments.

4. We note that discussion of capacity, otherwise known as ‘Gillick competence’, is reserved to Annex B. We would have thought this might usefully have been discussed at an earlier stage in the body of the text, as it underpins many of the judgements that the medical practitioner will be expected to make and has important implications for example with regard to teenage pregnancy and contraception.
5. We have addressed some of the specific consultation questions below:-

2. Do you think the eight core principles cover the most important duties that apply to all doctors where they have concerns about abuse or neglect?

Paragraph 5e and/or Annex D could usefully have more discussion of what constitute the ‘best interests’ of the child, including discussion of the extent of the child’s right to withhold information from parents or others.

3. Do you agree that all doctors have a duty to identify patients in need of support, and to provide such support or refer them to other agencies?

Yes, we do agree – moreover these are statutory duties under the Children’s Acts 1989 and 2004. Such duties should apply to all doctors who deal directly with patients of any age, as well as doctors who carry out only administrative and commissioning responsibilities as child protection concerns must underpin all children’s services commissioning and health care organisation. All doctors must be aware of and be able to understand:

- the impact of parental risk factors on parenting ability,
- on foetal and infant mental health and development,
- attachment theory
- the causal effects of childhood stress on development of chronic long-term conditions in adult life including CVD, diabetes mellitus, mental health issues, and the public health, general societal implications and financial cost of child abuse

9. Do you have any other comments about the advice in paragraphs 6 – 14?

The advice is reasonable and in accordance with the UN Convention on the Rights of the Child.¹

10. Do you think this advice will help doctors to communicate well with children and young people of different ages and maturity?

This advice is helpful. Doctors and other health professionals can fall into a habit of communicating only with carers or parents, this refers not only to children presented for

care but also to other vulnerable groups such as adults with disability or communication disorders.

Doctors would benefit from training delivered at undergraduate level on effective communication with vulnerable patients, disabled patients, and patients with communication disorders, and on how to develop effective strategies to elicit a history from such patients.

12 Do you think the draft guidance provides the right balance between trusting and questioning parents?

Yes, provided following the advice does not increase risk to the child or cause risk to the doctor. The benefits of openness and transparency have to balanced against risks in dealing with parents/carers with a history of causing harm, mental health issues or addictions leading to clouding of judgment, or the risk that the child will be punished if disclosure of abuse is revealed. All doctors should receive training in communication skills and basic mental health risk assessments as part of undergraduate training, and would benefit from greater support available in the community.

15 Do you think this advice is helpful?

Yes, basic Child Protection training also offers this stepwise approach.

- If a child is injured or suffering or in imminent danger referral for appropriate care should be immediate and urgent.
- If there is some evidence but it is considered safe for the child to be left in the care of a non-abusing parent/ carer then an urgent Social Services referral should be considered.
- If a health professional has reason to be concerned but no objective evidence, then colleagues should be consulted and the RCGP Safeguarding Toolkit² advises internal consultation within the GP Practice followed by seeking external information from other agencies and advice from child protection specialists such as Named GPs or specialist nurses if still concerned.
- If concerns are more in the form of suspicion and relatively low level then consultation with other agencies might lead to more information on which to make a decision about referral.

17 Do you have any other comments about the advice in paragraphs 24 – 41?

There may be exceptions if the young person is thought to be incapable of rational judgement by reason of learning difficulties, mental health issues or addictions, or is at risk of self harm, parasuicide or suicide. These are always challenging situations where it may be very difficult to find the right action, and doctors should seek advice from child protection specialists.

There will need to be systems in place to deal with health professionals seeking advice, Social Services in some areas have a ‘what –if’ telephone advice line for anyone wishing advice on concerns without necessarily disclosing the child’s identity, but specialist safeguarding/ child protection services usually do not have the resources to provide such a help line.

19 Do you have any other comments about the advice in paragraphs 42 – 49?

Paragraph 43: Distinguishing in records between factual information and hearsay or supposition is very important in, for example domestic abuse reports where it is essential that the history be recorded on the records of the child and abused parent, usually mother, but that that nothing is placed on the record of the alleged perpetrator unless a conviction has been obtained.

Paragraph 46: We agree with the insistence that case conference notes are filed with the medical records – but this section could usefully give more advice about what to do in the case of electronic notes, which most GPs now use, and into which other reports are often scanned. Please see the Good Practice Guidelines for GP Electronic Patient Records (version 4)3 for applicable advice.

Paragraph 47: We would note that linking between the records of a child and their family or carers has become exceptionally difficult with vulnerable and complex families often having children, half-siblings, step-siblings, step parents, step grandparents, grandparents and parents with several different surnames and addresses, registered with more than one GP.

22 Do you think this advice is helpful for doctors in managing situations when child protection meetings are organised at short notice or start at inconvenient times?

Yes, the advice is helpful, and is right to acknowledge that doctors sometimes find it difficult to attend case conferences in person as they are often called at short notice and to attend would require cancelling a clinic or surgery with patients already booked. The venue may be some distance away requiring hours of travel. It is sometimes felt that colleagues in social work or health visiting do not always understand GPs’ obligations with regard to access for all patients, and may have a perception that GPs are not interested in attending child protection meetings, when often this is far from the case.

However it is essential for doctors to provide as detailed a report as possible and many areas now have pro-formas and templates for this purpose. The time required to fill out a report should not be underestimated, as such children often have lengthy medical histories. Failure to attend for screening and preventative care and to attend booked appointments in primary, community and secondary care should be recorded in addition to unscheduled attendances at GP out of hours services and Accident and Emergency Departments. Parental history is also very important - especially parental risk factors for child abuse.

23 Do you have any other comments about the advice in paragraphs 62 – 66?

Paragraph 62: Where GPs work in traditional primary care settings there may be no barriers to effective communication with health visitors and others. However, many GPs are not now working in those settings – and it should be noted that the realignment of health visitors with local authority teams may have a detrimental effect on cross-disciplinary communication.

Paragraph 63-64: Many Social Service departments are understaffed and have high thresholds for accepting referrals. When making referrals doctors need to be able to articulate their concerns clearly and in detail and also to indicate what action they feel might be required.

27 Do you have any other comments about the advice in paragraphs 70 – 91?

There have been occasions where professional medical colleagues who have given evidence have been publicly vilified on websites, have had their persons and families
threatened and property vandalised. Measures need to be taken to protect expert witnesses from such abuse and for perpetrators to be treated as criminals.

6. We gratefully acknowledge the contributions of the College’s Safeguarding leads in formulating this response.

Yours sincerely

Professor Amanda Howe MA Med MD FRCGP
Honorary Secretary of Council