

Role of the tertiary child protection paediatrician: Expert and advocate

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Aim: The role of the child protection paediatrician is varied. This study examines perceptions of how tertiary child protection (tCP) paediatricians view their multifaceted roles, perceived adequacy of length of pre-FRACP training and how this relates to confidence and satisfaction in their roles.

Methods: An anonymous self-report survey was distributed to child protection paediatricians working in tertiary hospitals across New Zealand and Australia. The survey addressed the adequacy of training and confidence within the diverse roles encountered within child protection work. It also identified perceptions of stress and satisfaction.

Results: Responses were received from 32 out of 45 of eligible tCP paediatricians (72%). The majority (71.8%) had entered directly into a tCP unit in their first consultant position. Two-thirds (65.7%) of tCP paediatricians received less than 4 months of pre-FRACP child protection training while a third received no training at all. Generally tCP paediatricians perceived their training in all domains of child protection to be inadequate although their current confidence levels in all roles are high. They expressed most concerns within their role as forensic expert.

Conclusion: Despite receiving little or no training pre-FRACP in child protection, this group of tCP paediatricians function in their specialised roles in tCP and feel confident in fulfilling the dimensions of forensic expert and child advocate. As the field of medical child protection continues to evolve, it is important for training to keep pace with expectations of the varied roles of the paediatric specialist in child protection.

Key words: child advocate; child protection paediatrician; child protection training; forensic expert.

Interest and medical research surrounding child abuse and neglect has grown exponentially from its first descriptions over 40 years ago, when Kempe first described the battered child syndrome.¹ As a result, the role of the child protection paediatrician has evolved into an emerging subspecialty where clinical proficiency is required in all areas of child protection. The stakes in child protection are high and the consequences of inappropriate management can have disastrous consequences for all parties involved.^{2,3} The child protection paediatrician is inevitably faced with making difficult decisions based on the evidence at hand and the supportive research available to them. They may find themselves in a position of potential conflict in trying to balance an objective forensic opinion while maintaining their

role as the child's advocate. As expert witnesses, they are required to give impartial and objective evidence for the court, with an overriding duty to the court and not to any of the parties such as the prosecution, the defense, the local authority, the parents or the child.⁴ In multidisciplinary meetings, the child protection paediatrician may participate with other child protection agency stake-holders in decisions aimed to achieve the best child protection outcome. In these forums, the child protection paediatrician is not simply acting in an impartial forensic role but participates in shared decision-making. In their clinical work, child protection paediatricians may be called upon to advocate for the child for services and assess the development and behaviour of children who come from vulnerable populations who may have experienced abuse or neglect. Within these various roles it may seem to some paediatricians working in this field that the responsibilities at times conflict and role differentiation becomes blurred.

Over the last decade, physicians have attracted significant criticism within their role of expert witness. Several high profile cases within the UK have highlighted the shortcomings displayed by world-renowned experts within the field.⁵⁻⁸ Unfortunately, negative media attention these cases attract has major repercussions for the child protection system. Within the UK, the scape-goating of professionals has been particularly damaging and many doctors have reacted to the climate of blame and recrimination by retreating.^{7,9}

The judicial system has a right to trust that the testimony they receive from the expert witness is accurate, objective and well

Key Points

- 1 Many tCP have entered their current tertiary roles with little formal training pre-FRACP in child protection.
- 2 Many tCP feel confident with their work in both child advocacy and forensic expert roles.
- 3 In Australia and New Zealand tCP feel less concerned than paediatricians internationally about fears of litigation or risk of being discredited.

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researched¹⁰ and that there is a consistent level of uniformity and reliability in medical opinion across the medical child protection system. Clearly, competence in clinical forensic medicine is needed when evaluating injuries secondary to criminal trauma.¹¹ Doctors who take on these tasks need additional opportunities for training and professional development, and a means of accreditation that confirms their expertise to clinical and forensic colleagues and to the judiciary.⁶ This raises the issue as to whether, within the multidisciplinary child protection team, there should be an independent forensic paediatrician whose responsibilities lie ultimately with the judiciary, leaving the child advocacy role to others.^{12,13}

In response to these expectations, fellowship programmes in child abuse and forensic paediatrics have begun to appear overseas as well as in Australia and New Zealand.¹⁴ In the USA, efforts are being directed towards standardising the curriculum of available fellowship programmes. Within Australia and New Zealand, advanced training in child protection falls within the scope of Community Child Health. More recently advanced trainees who train under the Specialist Advisory Committee for Community Child Health, are required to complete 3 months of training in child protection. Historically however, many paediatricians currently working in child protection would have trained in general paediatrics.

The aim of this study is to understand how Australasian child protection paediatricians working in tertiary centres view their role across both the forensic and advocacy dimensions of child protection. We also aim to explore how adequate they perceive their training pre-FRACP in child protection and how this relates to current confidence within these roles. Finally, it seems appropriate to ask Australian and New Zealand child protection paediatricians how they view their role in light of recent events overseas to see whether they continue to derive satisfaction from the systems in which they work.

Methods

Study setting

A self-reporting survey was distributed by postal mail to all identified child protection paediatricians working in tertiary hospital child protection units across Australia and New Zealand during the period of September to December 2004. A list of tertiary child protection (tCP) paediatricians was compiled by direct telephone contact to each tCP unit, on two separate occasions, in order to identify each paediatrician and confirm their mailing address. The survey package included a self-addressed stamped return envelope and a covering letter outlining the purpose of the study, allowing 6 weeks for completion and return of the survey. A list of corresponding names identifying the respondents was initially retained in order to identify non-responders for purposes of a second mail out. Efforts were then made to confirm the non-respondents' contact addresses by telephone and maximise response rates. Identical survey packages were once again distributed to these paediatricians, allowing a further 6-week response period. The list was then destroyed and the data analysed anonymously. The study received approval from the Royal Children's Hospital Ethics Committee in Brisbane.

Survey instrument

The survey instrument was compiled from a similar tool used in previous research and then modified to suit the purpose of the proposed hypothesis. It was piloted within a Brisbane tCP unit by three child protection paediatricians and modified according to the recommendations made by them. The survey consisted of two parts. This paper outlines results from part II of the survey.

The questionnaire included quantitative variables, 5-point Likert scales, and some open-ended questions. Demographic items included gender; number of years in paediatric practice, number of years worked in child protection and postgraduate qualifications.

We surveyed the number of hours worked per week in child protection and the breakdown of their weekly tasks, expressed as a percentage, within the various domains of their work.

The remainder of the survey addressed the attitudes towards the different roles of the child protection paediatrician. This included perceptions of adequacy of training and confidence within these different roles. We also explored stress and satisfaction derived from these roles and identified potential conflicts that these concurrent roles might create.

Statistical analysis

The survey responses were coded and entered into a statistical database (Microsoft access) and subsequently imported into the statistical analysis software program, SPSS version 13, for data analysis. Data input was checked on two separate occasions to ensure accuracy.

Descriptive statistics were used to examine the distribution characteristics of different variables. The relationship between adequacy of training, confidence, stresses and satisfaction within different roles, was examined using Pearson's correlation coefficient.

Data derived from each Likert scale was grouped on either side of the neutral response ($n = 3$) such that the reported figures reflected a definite negative or positive response.

The level of significance was defined as $P < 0.05$.

Results

Originally, 46 tertiary hospital child protection (tCP) paediatricians within Australia ($n = 34$) and New Zealand ($n = 12$) were identified across 15 child protection centres. One paediatrician no longer worked in a tertiary hospital and these data were subsequently excluded. Two respondents had worked in tCP units for greater than 10 years but were not paediatricians. Data from these respondents was included in the analysis as justified in view of the considerable experience and contribution that these doctors make in the field of child protection. Thus 45 paediatricians were considered eligible for the study and of those, 32 respondents returned the survey completed and within the allotted time frame (overall response rate of 71%).

Within the final cohort, 56.3% (18/32) were female respondents. There was no difference between respondents and non-respondents with regards to gender. The response rate from Australian tCP paediatricians was 85%, while from New Zealand, 50% of those eligible responded.

Clinical experience

The majority (71.8%) tCP paediatricians entered directly into a tCP unit in their first consultant position. A total of 40.6% ($n = 18$) have worked in child protection for less than 5 years while 43.8% ($n = 14$) have worked in this field for more than 10 years.

Working week

Sixty-two and a half per cent ($n = 20$) of respondents are working 30 h or more per week overall, with only 12.5% ($n = 4$) working less than 20 h per week overall. There is no significant difference in gender distribution.

As a group, the respondents reported spending an average of 12.8 h per week doing child protection work. Only 12.5% ($n = 4$) of tCP paediatricians are doing child protection full or almost full-time (30 or more hours per week).

What are they doing?

Of the varied tasks that child protection encompasses, the group reported spending just under half of their normal child protection working week doing new assessments of children entering the child protection system referred from health (18.3% of the working week, $SD = 17.51$) or police and social services (30.8% of the working week, $SD = 24.7$). On average respondents reported spending 12.7% ($SD = 18.57$) of the child protection working week providing medical follow-up for children entering the child protection system. Half ($n = 16$) of the respondents monitor the developmental and behavioural progress in these children beyond 6 months.

Forty-one per cent ($n = 13$) of tCP paediatricians are involved in preventative child protection programmes. Of those who described the preventative strategies, 7/12 (58.3%) respondents described programmes which focus on high-risk families with young infants. Forty-seven per cent ($n = 15$) of tCP paediatricians were actively involved in child protection research at the time of the survey.

Training (see Fig. 1)

One-third (34.4%) of tCP paediatricians received no child protection training prior to working in this field. Overall, the average number of months spent training in child protection was 5 months (range 2–24 months).

There was no association between the number of years since receiving their FRACP and the length of child protection training undertaken.

Perceived adequacy of training

Participants were asked to rate their perceived adequacy of pre-FRACP training, in preparing them for the demands of four different roles encountered in tCP work, using a 5-point Likert scale. Reported responses have been grouped on either side of the neutral response ($n = 3$) (see Table 1).

There was a significant association between length of child protection training and perceived adequacy of this training in

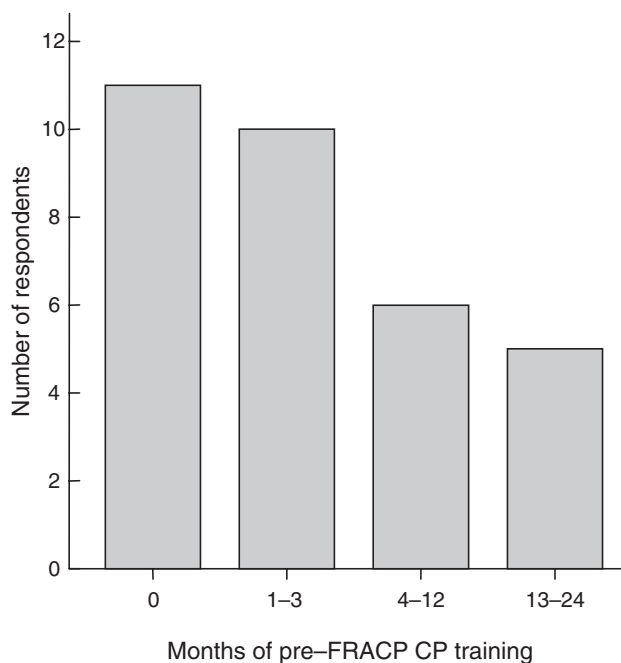


Fig. 1 Length of child protection training prior to FRACP. CP, child protection.

Table 1 Perceived adequacy of training

	Less than adequate to very inadequate n (%)	Adequate to very adequate n (%)
Child advocate role	15 (46.9)	5 (15.6)
Multi-agency decision-making	16 (50)	12 (37.5)
Behavioural/developmental role	12 (37.5)	11 (34.4)
Forensic role	20 (62.5)	7 (21.9)

the roles of child advocate ($r = 0.42/P = 0.02$), in multi-agency decision-making ($r = 0.68/P = 0.00$) and in the forensic role ($r = 0.65/P = 0.00$).

Fifty-nine per cent ($n = 19$) reported having attended post-FRACP training in child protection. A total of 31.3% ($n = 10$) of all respondents had previously participated in forensic courses covering physical or sexual abuse. A total of 18.8% ($n = 6$) of respondents had completed a DSAC (Doctors for Sexual Abuse Care Inc., Auckland, New Zealand) course in New Zealand.

Current confidence in child protection roles

Participants were then asked to rate their current confidence in these same four areas of child protection work (see Table 2).

There was a positive association between the current confidence and perceived adequacy of training in the role of behavioural and developmental assessments ($r = 0.51/P = 0.00$).

Table 2 Current confidence levels

	Less than confident to not confident at all <i>n</i> (%)	Confident to very confident <i>n</i> (%)
Child advocate role	1 (3.1)	26 (81.3)
Multi-agency decision-making	0	27 (84.4)
Behavioural/developmental role	2 (6.3)	24 (75)
Forensic role	5 (15.6)	22 (68.8)

There was no similar correlation with any of the other roles described.

Within the forensic role there was a significant positive correlation between the perceived confidence felt within this role and the length of time worked in child protection ($r = 0.49/P = 0.00$).

More than two-thirds of tCP paediatricians (68.8%) had not originally planned to work in child protection. Reasons for choosing to work in child protection were elicited using an open-ended answer format. These responses were grouped into common themes.

Approximately half (15/29, 51.7%) of those that did give reasons felt they were doing child protection because of an obligation to their wider role. These responses included comments such as; ‘... someone has to do it’; ‘... asked to do it’; ‘... part of my role’ or ‘... position became available’. The other half (14/29, 48.3%) gave more emotive reasons for their involvement in child protection. The responses included statements such as ‘... a chance to make a difference’; ‘... lifesaving for children’; ‘... interesting, worthwhile and rewarding’; ‘... positive or passionate work’; ‘... requiring skill and guts’ or ‘... to ease the trauma’.

Defining their role

Participants were asked identify all roles that they felt were relevant to their child protection practice, such as child advocate, forensic expert, or as a paediatrician assessing children from an at-risk population. Three quarters of these paediatricians believed that their position incorporated a responsibility to all these roles. A minority (15.6%) regarded themselves exclusively as forensic experts. Seventy-two per cent of tCP paediatricians did not believe that the child advocacy role should be independent of that of forensic expert. Less than a third (28%) found these roles conflicted in the management of child protection cases.

Stress and satisfaction

Participants were asked to rate the degree of stress and satisfaction derived from two pivotal roles in child protection – as a child advocate and as a forensic expert (see Table 3). Within both the role of child advocate and of forensic expert, no association was found between the perceived adequacy of training and the stress or satisfaction levels expressed. However, there

Table 3 Perceived stress and satisfaction within roles

	Stressful to extremely stressful, <i>n</i> (%)	Satisfying to extremely satisfying, <i>n</i> (%)
Child advocate role	13 (40.6)	20 (62.5)
Forensic expert role	23 (71.9)	16 (50)

was a significant association between current confidence levels and satisfaction derived from both the child advocate ($r = 0.55/P = 0.00$) and forensic expert roles ($r = 0.41/P = 0.02$).

The role of forensic expert

On average, tCP paediatricians reported making 6.7 court appearances per year (SD = 7.19, range = 1–35). More than half (56.3%) appear in court less than five times per year while a minority (9.4%) performed this function 20 or more times per year.

Those participants who appear in court more regularly have greater confidence in their role as forensic expert ($r = 0.40/P = 0.02$). There was also a significant positive correlation between the confidence felt within this role and the length of time worked in child protection ($r = 0.49/P = 0.00$).

Based on their expert testimony, less than a third (28%) of respondents expressed any concern about the threat of litigation or the risks of being discredited. However, the stress derived from the forensic role positively correlates with both their concerns for being discredited ($r = 0.48/P = 0.01$) and their concerns for potential litigation ($r = 0.42/P = 0.02$). There was no significant correlation between the degree of concern for becoming discredited or concerns for potential litigation, and the number of court appearances per year, perceived adequacy of training and confidence in the forensic role, or length of experience working in child protection.

Almost 60% (59.4%) feel concerned that children are over-investigated in order to satisfy potential legal arguments, 9.4% have felt personally threatened or harassed while working in child protection.

Discussion

The aim of this study has been to define the roles of the tCP paediatrician, and to explore how these professionals view their roles and how well they were trained to fulfil this position. The limitations of this study include the small sample size which may have influenced the statistical validity of some of the comparative results. The authors feel responses from this cohort adequately represents the opinion of the overall group of tCP paediatricians working in Australasia.

Three quarters of these tCP paediatricians clearly view themselves as fulfilling many roles both as child advocates and forensic experts. Most believe that these roles cannot be separated from one another. There were a small number of tCP paediatricians who viewed themselves as forensic experts only (15.6%), leaving the advocacy role for other members of the child protection team. Interestingly, under one-third of the child

protection paediatricians felt that these roles caused conflict in the management of child protection cases, which suggests an ability to maintain a balance within these roles.

These data suggest an ongoing interest and addition of younger paediatricians into the field of child protection, with 43.8% having qualified within the past 5 years. Overall, there is an equal gender representation within tCP; however, there have been an increasing number of women entering tCP over the past 5 years (ratio 2.5:1).

Generally, child protection work forms a small part of their overall work commitment with 44% of tCP paediatricians spending less than a quarter of their working week allocated to child protection tasks.

Of the time spent on the various tasks within tCP work there was a wide range of responses, as reflected by the large standard deviations for each task. Evidently some people have commitments which target specific areas of child protection while others have a broader range of commitments. Of interest, tCP paediatricians are spending almost half of their allocated child protection time doing new assessments of children referred into the child protection system from health, police and social services. Only 13% of their working week is spent on the ongoing medical follow-up of these children. In addition, only 50% of tCP paediatricians continue to manage behavioural or developmental problems identified in these children beyond 6 months. This suggests that half of these high-risk children receive long-term management elsewhere.

Given that almost three quarters (69%) of tCP paediatricians did not plan to work in child protection it would seem unlikely that trainee paediatricians would have the foresight to include child protection in their pre-fellowship training. Half of those paediatricians who gave reasons for working in child protection, found themselves obliged to do child protection work as part of their current position. Post-FRACP training in child protection seems one mechanism to ensure that these professionals can confidently enter into the field of child protection, equipped with the necessary skills. This survey identified a strong positive correlation between the perceived adequacy of training and the number of months of pre-FRACP child protection training, in the child advocate role ($P = 0.02$), in multi-agency decision-making ($P < 0.01$) and in the forensic role ($P < 0.01$). This reinforces the need for longer exposure to child protection in advanced training.

The issue of formalising child protection training has been addressed in other countries and is being broached within Australasia. This survey clearly highlights inadequacies in pre-FRACP training of child protection paediatricians in the past, with two-thirds of current tCP paediatricians having received less than 4 months of training in child protection prior to completing their FRACP. Even more alarming is the one-third of tCP paediatricians who reported receiving no training at all. It is unclear as to whether this is due to lack of opportunity for training or lack of interest or perceived relevance for post-fellowship work. Furthermore, within this group, there is no indication that those tCP paediatricians who have trained more recently are getting any more pre-FRACP exposure to this field during training. In the past, training in this area of paediatrics was not mandatory for advanced trainees. As training in child protection has now become mandatory hopefully we shall see

a change filtering through to the next generation of tCP paediatricians. This survey also highlights that many tCP paediatricians find post-FRACP child protection training essential for their confidence and skills in their work, particularly focused forensic training. This raises for consideration a training model which incorporates different tiers of knowledge and skills for paediatricians working in child protection. While some of this can be incorporated into pre-FRACP training curriculum, clearly post-FRACP training will continue to be important to ensure those working at the tertiary end of child protection have the knowledge and skills to manage the complex cases managed in tertiary centres.

Nonetheless this group as a whole has expressed confidence in all domains of child protection work. Their current level of confidence expressed in all of these roles was not linked to the length of pre-FRACP training and this suggests that they have developed these skills over time through self-motivated training, experience and peer support since then. Certainly those paediatricians who are confident within these roles derive greater satisfaction from them. Interestingly only in the role of behavioural and developmental paediatrics was their current confidence linked to adequacy of training ($P < 0.01$). The lack of correlation within the other roles may well reflect the small sample size, although it once again may reflect confidence built on self-motivated professional development in these areas, despite poor background training.

The area of forensics has been shown to be area where training is perceived to be the least adequate and the tCP paediatrician remains less confident in this role than in their other roles. This suggests an area of focus for future professional development.

For forensic issues there is a significant correlation between the confidence they expressed in this role and the length of time they have worked in child protection ($P = 0.004$) and the number of court appearances per year ($P = 0.02$). This may reflect a growing confidence with time and experience in the field.

This theme then continues when looking at the stresses and satisfaction derived from these roles. Despite 40% of these tCP paediatricians finding the child advocate role stressful, almost 2/3 found it satisfying. In contrast, the forensic role is perceived as stressful by more paediatricians (72%) with only half of them deriving any satisfaction from their role. The degree of stress derived from the role of expert witness is positively associated with the concerns expressed for being discredited based on expert testimony ($P < 0.01$) and their concerns for potential litigation ($P = 0.02$). A degree of disquiet may be inevitable by the very nature of this work however, this may well reflect the criticism that overseas child protection paediatricians have recently attracted under the international media spotlight.

For those paediatricians who contribute to decisions with other child protection stake-holders in multi-agency meetings, this survey has highlighted the limited training for this role prior to FRACP, with 50% of respondents stating it as less than adequate. This contrasts with their high level of confidence (84% now confident) once again highlighting the importance of post-FRACP training gained through networks, experience and ongoing professional development.

It seems timely to consider the Australian and New Zealand perspective on the role of the child protection paediatrician. It

is currently a time when a curriculum is being developed with a focus on child protection training. No doubt the time is coming when child protection will be elevated to a subspecialty in its own right. The creation of readily available child protection fellowships positions, longer mandatory training periods in child protection and postgraduate professional development support networks would go a long way to ensuring adequate and ongoing training for the future cohort of community paediatricians who will follow in the footsteps of those who have carved out this niche of paediatrics in previous decades.

References

- 1 Kempe CH, Silverman FN, Steele BF, Droegemueller W, Silver HK. The battered child syndrome. *J. Am. Med. Assoc.* 1962; **181**: 17–24.
- 2 Bannon M, Carter Y. Paediatricians and child protection: the need for effective education and training. *Arch. Dis. Child.* 2003; **88**: 560–2.
- 3 Johnson CF. Child abuse as a stressor of pediatricians. *Pediatr. Emerg. Care* 1999; **15**: 84–9.
- 4 David TJ. Avoidable pitfalls when writing medical reports for court proceedings in cases of child abuse. *Arch. Dis. Child.* 2004; **89**: 799–804.
- 5 Dyer C. Sally Clark freed after appeal court quashes her convictions. *BMJ* 2003; **326**: 304.
- 6 Hall D. Child protection – lessons from Victoria Climbe. *BMJ* 2003; **326**: 293–4.
- 7 Hobbs C. *Stop Abusing Child Experts*. Society Guardian, Website. Available from <http://society.guardian.co.uk/societyguardian/story/0,1195838,00.html> [accessed 22 August 2004].
- 8 Milroy C. Medical experts and the criminal courts. *BMJ* 2003; **326**: 294–5.
- 9 Royal College of Paediatrics and Child Health. *The RCPCH Child Protection Survey Executive Summary*. Available from http://www.rcpch.ac.uk/publications/recent_publications/Latest%20news/CP%20report.pdf [accessed 22 August 2004].
- 10 Williams C. The role of the expert witness. *Arch. Dis. Child.* 2002; **87**: 267–8.
- 11 Davies N. Clinical forensic medicine needs to become part of the syllabus. *BMJ* 2003; **326**: 1037.
- 12 Pardess E, Finzi R, Sever J. Evaluating the best interest of the child – a model of multidisciplinary teamwork. *Med. Law* 1993; **12**: 205–11.
- 13 Smith A. Doctor in the witness box: the loneliest spot on earth. *RACP NEWS* 2005; 20–1.
- 14 Starling S, Sirotnak A, Jenny C. Child abuse and forensic pediatric medicine fellowship curriculum statement. *Child Maltreat.* 2000; **5**: 58–62.