

Abuse

Is protecting children bad for your health?

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Commentary on the paper by Bennett *et al* (see page 1112)

In the last few years a series of child abuse tragedies and fiercely contested murder trials has put paediatricians under the spotlight as never before. There is a growing reluctance among consultants and trainees to get involved in child protection. The attempt by Bennett and colleagues¹ to measure and analyse the stress and burnout among child protection professionals in Canada is, therefore, very timely—but inevitably it also poses a number of further questions. Can slippery concepts like stress and burnout be reliably defined in operational terms? Is child protection different from other healthcare tasks and if so, does it affect different disciplines in different ways? Are there differences between countries and if so, do these relate to their cultural attitudes or child protection systems? Do stress and burnout affect people in other walks of life? And, most important, what are the risk factors for burnout and what might be done to reduce the risks of these (presumably) negative consequences of such work?

DEFINING THE TERMS?

The literature uses various terms with related but sometimes poorly defined meanings: stress, burnout, compassion fatigue, secondary traumatic stress reactions (STS) or vicarious traumatisation (VT), and traumatic countertransference (a psycho-analytic term).

Stress can be defined as “demands (internal or external) that are judged by an individual to tax or exceed their resources” and *coping* is defined as “behaviours, thoughts, and feelings adopted to protect against stress”. *Burnout* is a prolonged response to chronic emotional and interpersonal stressors on the job, and is defined by the three dimensions of mental and physical exhaustion, indifference and cynicism, and a sense of failure as a professional and as a person. The warning signs of impending burnout include anger, hostility, and reduced productivity or effectiveness at work. Depression may be a prominent feature and may overlap with burnout. Other responses include the avoidance of problems and

decisions, ambiguity about managers' expectations, and reduced success in meeting them.

The term *compassion fatigue* was coined by Joinson in 1992, to describe nurses who were worn down by daily hospital emergencies. The dictionary meaning of compassion is a “feeling of deep sympathy and sorrow for another who is stricken by suffering or misfortune, accompanied by a strong desire to alleviate the pain or remove its cause”. Compassion fatigue describes a reduced capacity or interest in being empathic or “bearing the suffering of others” and may be the price of caring without reward or result.

Posttraumatic stress is a natural consequence to a markedly distressing and unusual human event; *secondary traumatic stress* (vicarious traumatisation) is a natural consequence resulting from *knowing about or witnessing a traumatising event experienced by a significant other*.

Within the healthcare professions, the causes of stress and burnout vary according to the discipline involved. For example, in one study paediatric oncology nurses were found to have a preoccupation with death and dying, they saw themselves as fighters in the “war” against cancer, and they resented their perceived inferior professional status compared with that of physicians. Nurses who care for children with chronic disabling disorders may suffer more compassion fatigue than those who work in critical care where there is sometimes the reward of dramatic recovery against the odds. Intensivists and accident and emergency consultants have high levels of stress related to their perceived workload, lack of resources, and disrupted family life.

WHAT IS DIFFERENT ABOUT CHILD PROTECTION?

Healthcare professionals may suffer secondary traumatic stress in some cases of child abuse, but many factors probably make this work more stressful than dealing with illness or accidental trauma. There is often much doubt about whether or not abuse has occurred and these doubts, unlike many

other clinical conundrums, often remain unresolved either by investigations or by the passage of time. Management of suspected child abuse is usually shared with or handed to other professionals such as social workers or the police and, for many health staff, this loss of control and a lack of mutual trust and respect between disciplines add to their anxiety. For community based staff, working in deprived areas away from the (relative) safety of the hospital, there is a growing concern about intimidation, violence, and personal safety whenever child care or protection issues are raised. But these issues are not new and do not account for the recent reluctance of many paediatric staff to deal with these problems.

It is widely believed—though hard to confirm—that the change in attitude to child protection is primarily the result of high profile complaints against professionals by aggrieved parents.³ Doctors are the usual subjects of such complaints, though nurses have also been involved. A minority of cases involve straightforward clinical errors in diagnosis, such as mistaking osteogenesis imperfecta for non-accidental injury, but most have been related to the contentious issues of multiple unexplained infant deaths in a family or to suspected fabricated or factitious illness. There have also been a number of fiercely contested cases of chronic fatigue syndrome, where professional perceptions clash with those of the parents to the extent that child protection proceedings are considered.

Complaints of this kind can be launched through several different routes and it may be years before the matter is resolved. Parents who wish to pursue a grievance can obtain information and network with others in similar circumstances around the world, using the internet. Websites are used to name and abuse those who are perceived to be responsible for initiating child protection proceedings.⁴ Verbal and even physical assaults on other members of doctors' families have been reported. Systematic and unrelenting attacks on some staff are undoubtedly designed to destroy their careers.

IS THERE ANYTHING UNIQUE ABOUT STRESS AND BURNOUT IN THE HEALTHCARE PROFESSIONS?

Doctors are not alone in facing unprecedented and often orchestrated hate campaigns.

An internet search using the terms stress, burnout, or compassion fatigue combined with police officer, teacher, or priest produces a wealth of material on this theme, including some black humour.⁵

Mother to son: Time to get up and go to school.

Son: I don't want to go. It's too hard and the kids don't like me.

Mother: But you have to go—you're their teacher!

For teachers, complaints about verbal, physical, or sexual abuse are a constant threat and one that can be exploited by pupils. A public campaign against certain police officers continues 15 years after the Hillsborough football stadium disaster, in which they were blamed for inadequate crowd control. Fear of a child protection disaster hangs over social workers.

HOW TO REDUCE STRESS AND BURNOUT IN CHILD PROTECTION WORK

No health professional who sees children, or who has adult patients with children, can ignore possible child abuse. If the complaints culture is indeed the biggest cause of stress and burnout, it is important to minimise these by straightforward measures—good initial training and continuing education, familiarity with national and local guidelines, willingness to consult and obtain second opinions when in doubt, access to designated experts, a debrief with colleagues after dealing with particularly stressful cases, good legal advice, and the support of senior management. Follow up of abused children will remind staff that a well conducted child protection case can be just as rewarding as solving a more typically “medical” problem.

Unfortunately, adherence to good practice is no longer enough. Some countries have adopted *mandatory reporting*—any professional who has any suspicion about child abuse has an obligation to report it to the relevant authorities.⁶ There is however no clear evidence that this effectively protects professionals against complaints. An alternative approach would be to introduce *mandatory protection* for professionals when reporting possible abuse, so that anyone acting in what they reasonably believe to be the child's best interests would be immune from complaints even if the concern turned out to be unfounded. Current legal opinion suggests that the Children Act 1989 already offers such protection if interpreted as Parliament intended, by the courts and the regulatory authorities. The principle that the child's interests are paramount was reaffirmed recently when the Law Lords ruled in three cases that the professional's duty of care was solely to the child and not to the parents.⁷

The regulatory authorities should now take account of this judgment and consider a change in the initial evaluation of complaints against staff in respect of child protection work.⁸ Concerns about a professional's behaviour or competence raised by a magistrate, judge, or director of social services must be investigated, but the regulatory authorities should not accept complaints about child protection work initiated by members of the public unless they have first been investigated and upheld by an appropriate local multi-agency procedure.

Child protection work must be done to the highest standards and there can be no excuse for careless diagnosis or incorrect procedures, but changes in child protection systems are now urgently needed to address the problems highlighted by the Canadian team.

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IMAGES IN PAEDIATRICS

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Kayser Fischer ring

A 12 year old girl was admitted for poor school performance, and slurring of speech for the past three months. Of late she was noticed to have involuntary movements and tremors. She also had mood changes. She had no significant past illness. Family history was insignificant except that her brother had recurrent episodes of jaundice from the age of 5 years. Examination revealed mild hypertonicity of all four limbs, ataxia, and intention tremor with mild pallor. Examination of the eyes suggested the diagnostic approach. Kayser Fischer ring is a golden brown deposit at the level of the Descemet's membrane of the cornea, and is seen in various conditions such as Wilson's disease and primary biliary cirrhosis.

Kayser Fischer ring is seen in most Wilson disease cases presenting with neurological symptoms. It may be visualised sometimes with the naked eye examination, but a slit lamp examination is always required to rule it out.

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