General practitioners' conflicts of interest, the paramountcy principle and safeguarding children: a psychodynamic contribution

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ABSTRACT

Wainwright and Gallagher propose that when child protection concerns emerge significant difficulties arise for General Practitioners because of conflicts between the individual interests of children and parents who are their patients and the Paramountcy Principle. From a psychodynamic perspective their analysis does not give sufficient weight to the nature of personal as opposed to interpersonal conflict of a conscious or unconscious nature. When issues of major import arise, ordinary parenting inevitably involves parents in putting their children's needs first if competing possibilities occur. It is an over-simplification to present this as a conflict between the interests of children and parents. Parents' own best interests are served by securing their children's safety and welfare. An appreciation of this is crucial in order to implement child protection procedures appropriately. Errors may occur because the complex emotions and relationships involved lead professionals to experience themselves as potential agents of harm rather than benefit.

Wainwright and Gallagher[1] propose that when child protection concerns emerge significant difficulties arise for General Practitioners because of conflicts between the individual interests of children and parents who are their patients. They argue that "uncritical adoption of the Paramountcy Principle is too simplistic and can lead, paradoxically, to greater harm" and that practice should be based in "a more subtle and nuanced view of interests and of conflicts of interest in safeguarding children." Whilst their exposition usefully highlights some key ethical considerations relevant to the nature of interests, this paper challenges their position with respect to the nature of personal and interpersonal conflict, particularly when considering parent- child relationships. The impact upon professionals as third parties to the relationship may lead to misunderstandings and misattributions which, in turn, may place children at greater risk if this inhibits them from ensuring thorough assessment through appropriate use of child protection guidelines.

THE NATURE OF CONFLICT

Conflict arises not only in the interpersonal sphere. It can be an internal process whether interpersonal conflict is present or absent and, according to psychoanalytic theory, it can be conscious or unconscious. In consequence, an absence of interpersonal conflict cannot be equated with an absence of conflict. Various parties may be in agreement about a course of action but there may remain significant internal conflict for one or more of them. Determined action can still occur but it requires active management of conscious issues and monitoring for the potential effects of *un*conscious influences.

Psychoanalytic theory proposes the concepts of projective identification, transference and countertransference to describe how individuals 'come under the influence of forces [in relationships] of which they may not be aware'.[2] *Transference* describes the way in which a person (the subject) unwittingly experiences and acts towards the other (the object) as if they are a key historical figure from their lives, for example, a parent or sibling. The impact of this upon the object is *countertransference*. For the purposes of this paper, it is reasonable to consider projective identification as a less well-defined evocation of a state within the object.

These concepts hold a central position in terms of understanding relationships generally, the specific conduct of psychoanalytic/psychodynamic psychotherapies and of patient/client—professional—relationships in general. Their power 'is such that at times thinking, and therefore decision-making, may be adversely affected, with consequent effects on behaviour'.[2] The likelihood of a major impact from such forces relates to the particular contingencies involved, for example, emotional investment, the nature of a relationship, threat to physical or psychological integrity. It is fundamentally important that professionals strive to avoid being driven to actions which are 'simply' governed by these forces: action which is driven by them is termed 'acting out in the countertransference'. Professionals need to take account of the existence of these forces and simultaneously manage themselves through appreciating their significance for themselves and their patients.

In child protection practice these processes may lead to distortions even when the sole designated 'patient/client' is a child, for example, 'false engagement'.[3] The position of GPs in simultaneously having parents and children as their patients adds further complexity.

CARING *ABOUT* AND CARING *FOR*: DO PARENTS HAVE TO LOOK AFTER THEIR CHILDREN?

Along with other approaches, Psychoanalytic theory and psychodynamic practice in general, highlight the potential for profound adverse effects if healthy affectional bonds are disrupted. But it is possible for children and parents to thrive if they do not live together despite feelings of sadness and suffering at what has not been.

While parents are usually expected to make the overarching decisions about how their child is cared for, this is not the same as providing each and every aspect of care. For example, it is accepted as being within the range of ordinary devoted parental care for parents to ensure that their child is looked after for the majority of time by people other than themselves, for example, in a boarding school placement. Concern may actually arise if parents will not allow others to be involved with the education, care or upbringing of their child. In England, in accordance with the Education Act (1996), section 7,[4] parents are required to ensure appropriate education for their child and can be asked to demonstrate that what is available to their child is within an acceptable range, for example, if the child is not attending school.

The usual expectation is that parents will ensure they are not the sole providers of their child's developmental needs by making available other relationships for social, emotional, educational and health purposes. The integrating principle is they are expected to be responsible for making reasonable decisions about the form of care and range of experiences of their children and to demonstrate this through their actions. If concerns arise that they are not doing so through their own resources and proper use of other resources to supplement and complement these, then further investigation will be warranted.

Although parents may strive to ensure that their children are looked after reasonably, a variety of impediments can occur, for example, personal psychological or physical abilities, financial resources, social upheaval. Hence parents cannot be absolutely *required* to care for their children themselves. However, if there is an 'objective view' that an inability is serious and definable as a fundamental property of the parent(s), an alternative authority, and if necessary, alternative provision, may be sought under the Children Act (1989).[5] For example, a parent who will not allow their child to attend school and cannot demonstrate that the alternative they are providing is acceptable may have their wishes overruled: this may even mean that the child ceases to live with them.

Seeking to ensure the care and protection of children is suitable should not be conflated with action which may produce sanctions against a parent. A decision that parental behaviour requires action under criminal legislation is separate from any action under child welfare legislation. C*apability* and *culpability* must be differentiated although the two may be interrelated.

Bad care is bad

Wainwright and Gallagher[1] generate a hypothetical example in which, subsequent to child protection procedures, a child suffers abuse after removal from parents. They use this to illustrate why doctors may fear that adverse effects will flow from taking action under child protection guidelines. However, they do not counterbalance this with what may happen if the alternative of *in*action is taken.

The adverse effects upon children of abuse and neglect are well documented. Minty and Ashcroft[6] suggest that there is a group of children from neglectful homes whose social development through to adulthood would be significantly enhanced by long term substitute care. Minty[7] further compared boys who had short periods of public care and those with very extensive public care and found a lower incidence of crimes against the person in the 'extended public care' group. A recent review[8] raises further concerns about the causes and effects of children remaining in the care of parents who are not able to care adequately for them: '[The] negative view of care in England and Wales is closely related to how it is evaluated and the way that data on young people's outcomes is misinterpreted. … In reality, there is a dissonance between the evidence on the impact of care, and the public perception of the system. Currently, this stigmatisation of the care system, combined with concern about the upfront costs to the state, means that some children who might benefit from the care system do not do so.'

Developmental processes or therapeutic change may make it possible for parents and children to come together in satisfactory ways at later stages *because* they have not been together at earlier stages. The key issue is that bad care is bad for children whether at the hands of their parents or other people.

Intimacy and interest

The particular nature of an intimate affectional bond alters the impact of another person's needs or desires on an individual. What may in other relationships be experienced as an imposition or of minimal or no significance is more likely to be experienced as identical with, or indistinguishable from, the needs of oneself. In relation to the earliest relationships, Winnicott[9 10] described the particular form of this for 'the ordinary devoted mother' with her baby as 'primary maternal preoccupation'. For a child's developmental trajectory to proceed within a reasonable range, he requires ordinary devoted care which is sufficiently driven by his needs as they vary over time.

Good-enough parenting involves a necessary and sufficient degree of differentiation of action, or a drive towards action, which is truly derived from the child's needs as opposed to those derived from parents' needs. Confusions in this respect do not necessarily bring destructive adversity for the child: failures of differentiation may simply form part of the richness of experience of children and parents. However, some failures cause profound harm: a beating which is 'for your own good … it didn't do me any harm' may derive from a parent's need to believe that it was not, and is not, harmful in order to avoid a sense of pain and vulnerability which lives on in them because of their experiences at the hands of their own parents.

If emotional health and development is to be maintained, a child in such a situation has to find it in himself somehow to contend with, solve and re-solve potential contradictions and develop good judgement. The association between child abuse and mental health problems indicates that many do not manage this. It is clearly against their interests to allow such a situation to continue: whether it is in a parent's interest to allow such a situation to continue is considered below.

Parenting and professional practice

Parenting involves being able to function in the service of a child when the very nature of processes involved may affect the ability to reason and manage one's own behaviour. Being 'in the service of their child' does not equate to parents being enslaved by their child's wishes, but it does require taking proper account of such wishes. This can be juxtaposed with Palmer *et al*'s statement[11] (cited by Wainwright and Gallagher[1]), that professional roles are 'not simply the proper exercise of judgement, but the proper exercise of judgement in decisions made on behalf of others'. What can be added to this is '*whether or not* the judgement is in agreement with the judgement of the other'. This is not to imply that a professional's decision should be decisive, merely that a professional must proceed on the basis of their own informed consent or dissent within the bounds of their professional authority and authorisation.[2 12]

Children's views and wishes should be taken into account, but adults cannot abdicate responsibility for deciding on actions. Doctors must take account of the views of parent and child

patients but they must participate on the basis of being properly informed, whether or not it is on agreement with their patients' wishes.

The child in mind and body: preference and preservation

Wainwright and Gallagher[1] highlight Luke's[13] analysis of the place of personal, 'subjective' preference in contradistinction to 'objective' requirements for human welfare. Survival and development require that, at times, parents place restrictions on their child's actions whatever the child's personal preferences. But does this apply only to children?

Placing 'conflict of interest' only in the interpersonal sphere risks missing a key point. The presence or absence of *internal* conflict, and the management of it, may be the decisive factor in being able to determine if a parent can act in their child's best interests. In the Biblical story of *The Judgement of Solomon*, the ability to act to secure the child's survival despite the mother's own wish to be in possession of the child was the decisive indicator of her fitness to fulfil parental functions as well as her being the actual parent.

The football manager Bill Shankly quipped 'some people think football is a matter of life and death … I can assure them it is much more important than that'.[14] He captures the paradox that a simple choice of being alive or dead may not be decisive; a quality of experience may be held to be of sufficient import to risk life and limb despite apparent objective triviality. Even though people may appear to thrive in a particular social and cultural environment, others may experience it as a state of living which is a fate worse than death. Emotional investment can lead to conflicting views about the bare necessities of life.

Parents can live without caring for their children, even if they would prefer not to have to do so, while continuing to care profoundly about them. The ability to identify one's own interests as *preference* as opposed to one of the *necessary conditions of human welfare* is an essential component of making judgements for oneself as well as on behalf of others. It could appear to trivialise the matter to place caring for one's own children and being cared for by one's own parents under the heading of 'preference', but this is not my intent. Knowing what one can or cannot do properly for one's child is essential for parenting.

Paternalism and parenting

In addition to the distinction between preference and necessity, Wainwright and Gallagher[1] cite Luke[13] as describing a third aspect of 'interest'. This is involved with long-term goals and referred to as 'a constitutive of wellbeing': the benefits of living in hope or expectation of good or better times.

Parents' wellbeing may be enhanced by their child's satisfactory present and future progress and adversely affected by its absence. Although unpleasant effects may follow from identifying failures of parenting, in the long term is it in any parent's interest to be allowed to continue caring for a child against that child's interests, that is, *badly*?

The immediate or future sense of 'unsatisfactoriness' for parents not allowed to care for their own children is not to be ignored. What must also be considered are the possible effects if there is no challenge, or an insufficiently robust challenge, to seriously failing care. My clinical experience as a child psychiatrist is of many cases in which intergenerational deprivation and abuse feature strongly. Parents may bring to the relationship with the professional overt or covert (unconscious) expectations or beliefs that dependent relationships are crucibles for neglect and cruelty: 'in the transference' they experience the professional as just such a parenting figure. A failure by the professional to act robustly when significant concerns arise, that is, 'acting out in the countertransference', may serve to compound the parent's views and experiences of relationships. The maxim 'Qui tacit consentire videtur' needs to be understood for its psychological not only its legal possibilities.

Parents may rightly come to feel betrayed if allowed to continue unchallenged in forms of care which they later view as adverse or abusive. This in turn may have an impact on their ability to make good use of professional services if they themselves come to be in need. For some parents, robust challenge may facilitate the development of *healthily discriminative* trust,[15] through which they become better able have confidence in their ability to judge whom to trust or distrust. Parents can feel, or later come to feel, that there was common cause with professionals in the actions around their child even if there is major disagreement.

CONFLICTING INTERESTS OR CONFLICTING PILLARS OF PRINCIPLISM?

Wainwright and Gallagher discuss the complications which may arise when a 'paramount' and a 'primary' consideration are confounded. The former allows of no equal or overriding considerations while the latter may be first among equals without necessarily being decisive.

Principlism, with its 'four pillars' of respect for autonomy, beneficence, non-maleficence and justice still holds considerable influence in healthcare and medical education in the UK. The preceding argument has been implicitly focused around issues of justice while illustrating the complexity of 'respect for autonomy' when children are involved. This section focuses on the balance of beneficence and non-maleficence from a psychodynamic point of view.

Beneficence or maleficence

The establishment and maintenance of a professional role requires being prepared and able to engage in consideration of different forms of conflict of interest. Opinions reached and actions recommended must be formulated with appropriate professional authority, that is, one's knowledge of health and illness, legislation related to the field and the expertise and responsibilities of other people. The key questions for professionals, including GPs are:

- Do I have necessary and sufficient information?
- Do I have the ability to formulate this accurately and comprehensively?
- Do I have the ability to ensure I contribute appropriately to further investigation and action?
- Do I have the ability to properly appreciate the possible outcomes in order to manage my current responsibilities?

In so far as these are questions about the contributions that doctors can make, they are *clinical* in terms of the skills of a doctor and the evidence for their practice, but *professional* in terms of their place alongside other parties, including professionals from health, welfare and law. They relate to the basis on which medical decisions are made about assessment, investigation, diagnosis and intervention and the place of doctors in people's lives alongside other people whose roles, responsibilities and abilities they may complement.

Wainwright and Gallagher[1] state 'even when there is no alternative to taking action … there may be a form of iatrogenic harm as a result of the child protection process'. The postulated harm in their example is not counter-balanced by a list of other possible harms caused by *inaction*. I have argued above that failing to act can have adverse effects upon abusive/failing parents themselves not only their children.

Fault lines

Postulating *iatrogenic* harm as a result of the child protection process calls for closer examination. If adverse effects occur, to what extent can they be attributed to the doctor's actions and by whom are the attributions made?

In considering the dictum of 'primum non nocere', Harris[16] emphasises that guilt may be felt irrationally, 'when we are forced by circumstances to choose between evils [it should not] prevent us from choosing the lesser evil'. Medical practice is often carried out in the context of a *sense* of danger and an imperative to action despite uncertainty. Despite a doctor's best efforts, in the immediacy of this sense, formulating and holding reasonably to the fact that one course of action is a 'lesser evil' may be not be easy. The experience of such personal conflict, particularly in working with parent and child patients, may lead to misattribution of agency or an imbalance in the view of the contributory weight to the outcome of their own or other people's actions.

Any view of 'iatrogenic harm' needs to be considered in this context. A *sense* of responsibility which arises because of caring about what happens is not the same as *actual* responsibility. Good medical practice requires that doctors seek to be well informed and appraise the basis for their practice. Child protection expertise is generally deemed to be in the domain of social welfare practitioners rather than medical practitioners unless they specialise in the field. Hence choosing inaction without seeking to inform and be well informed by such practitioners should require a greater justification than a fear derived from non-specialist practice.

The aim of child protection investigatory procedures is neither to ensure children remain in the care of their parents nor to ensure they do not. The aim is to ensure well-informed decisions are taken, and who can and should provide properly for a child. There is no less an obligation upon doctors to ensure that they take appropriate steps to investigate child protection concerns than if they find a lump which they think could be cancer. The conclusions of Lord Laming[17] point to failures to act to ensure appropriate clinical assessment and investigation. Whether concerns are about child protection or about cancer, the risks and benefits of the investigatory process do need to be taken into account. This in turn means making a judgement about whether a doctor in isolation has the necessary information and clinical skills upon which to have a well informed, professional opinion. *Iatrogenic* harm can flow from failure to act because of pre-judgements about the outcome of proper assessment or through ignorance and prejudice about the effects of children being cared for by people other than their parents.

'Primum non nocere' may, as Gillon[18] stated, be 'best consigned to the medical history books' but 25 years on it remains as an influence. Conflict in child protection work may well be a problem of a conflict of two pillars in Principlism rather than a conflict between the interests of the different patients. The possibility of being a potential agent of harm rightly gives rise to careful thought. From a psychodynamic point of view, those thoughts should include 'Are the processes of projective identification or countertransference significant in this situation? Is my *sense* of being an agent of harm a realistic appraisal, a consequence of the emotional dynamics of the relationships and events with which I am involved or a mixture of both?' Fear of causing harm may be given undue weight in relation to possibly doing good; it may unconsciously act as a greater restraint on initiating child protection procedures than an act of omission which maintains the status quo. 'Acting out in the countertransference' may leave a child in danger. It may not only leave a (possibly) abusive parent as an actual agent of harm, it may also, in the conscious or unconscious experience of doctor and parent, leave a (possibly) non-abusive parent as an apparent agent of harm.

SUMMARY AND CONCLUSIONS

While agreeing with Wainwright and Gallagher[1] that there are dangers in the unthinking acceptance of simplistic formulations of the paramountcy principle, I feel the ethical argument needs to be extended to include an appreciation of the complexity of the psychodynamics of parent-child relationships.

GPs are in a particularly complex situation if they feel their responsibilities to children and parents are in conflict. Intimate relationships, with the conscious and unconscious identifications which occur, inevitably and necessarily give rise to confusions as to whose interests are or are not being served: being a third party within this is complicated. However, what may appear to be a conflict between a child's and a parent's interests, may not in fact be so. Seeking the safety and welfare of a child *is* in a parent's interest: failure to explore reasonable concerns about a parent's behaviour towards their child is against a parent's interests.

The complexity of emotional and procedural issues involved in child protection tests the ability of professionals to function at their optimal level. The potential to enact prejudice or act in ignorance, rather than in awareness of one's limitations, is increased: for this reason, it is even more important to avoid making decisions in isolation. This is the purpose of child protection procedures and why they represent an essential mechanism to be used in the service of children, parents and professionals.

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