
General dental practitioners' perception of their role within child protection: a qualitative study

R.R. WELBURY¹, S.G. MACASKILL², J.M. MURPHY³, D.J. EVANS⁴,
K.E. WEIGHTMAN⁵, M.C. JACKSON⁶, M.A. CRAWFORD⁷

ABSTRACT. *Aim* This was to assess general dental practitioners' knowledge, attitudes and practice regarding their role within child protection in relation to child abuse. **Methods** Structured interviews with seven key informants from general dental practice (2), local dental committees (1), social services (2), paediatric dentistry (1) and community child health (1), together with five focus groups comprising 23 general dental practitioners (GDPs) on Health Authority Lists in Tyne and Wear and Northumberland (UK). **Results** GDPs reported feelings of isolation with little communication with other health professionals or local authority services. The majority had scarcely considered child protection issues in their clinical practice although those qualified for less than 15 years were more aware. GDPs acknowledged a lack of awareness of signs and symptoms of physical abuse and even less confidence in dealing with emotional or sexual abuse. Dentists expressed concern, even fear, about the outcomes of reporting suspicions, and had little knowledge of the local Child Protection mechanisms. **Conclusion** GDPs in Tyne and Wear and Northumberland feel unprepared to undertake a role in the child protection process with confidence. National and local initiatives may be required to address existing barriers.

KEYWORDS: Child abuse, Dentists, Orofacial signs.

Introduction

Child abuse and neglect are significant problems in the UK and elsewhere today: in the year ending 31 March 2002 there were 25,700 children on child protection registers in England. This figure represents 28 children per 10,000 of the population under 18 years of age [Department of Health, 2002]. Children of all ages are subjected to abuse. In England and Wales there are four nationally defined categories: physical, sexual, emotional, and neglect [Department of Health, 1989; Department of Health, 1999]. In Scotland there is a fifth category of 'failure to thrive' [Protecting Children, 2000]. The majority of cases occur in younger children, in those under two years of age most at risk from severe child abuse [Meadow, 1989].

Studies analysing the attendance of children in accident and emergency departments of hospitals have shown that in the USA perhaps as many as 10% of children under 5 years of age [Holter and Friedman, 1968]. In Denmark 1.3 children per 1,000 per year [Breiting et al., 1989], will have injuries wilfully inflicted by carers. Fatalities as a result of abuse on children are much less common, and where these occur the younger the child, the greater the vulnerability. Approximately 95% of head injuries in children under the age of 1 year are non-accidental [Billmire and Myers, 1985] and more than 65% of all cases of physical abuse involve injuries to the head, neck or mouth [Becker et al., 1978; da Fonseca et al., 1992; Jessee, 1995].

General dental practitioners (GDPs) are perceived to have regular contacts with a significant proportion of the child population: in the quarter ending 30 June 1999 there were 7.4 million active child registrations with dentists throughout England and Wales. Within the North East of England, this translates to 64 child patients (aged under 18 years) per 100 local population registered with over 15,900 children receiving a routine dental examination

The work was conducted within Tyne and Wear and Northumberland UK

¹Glasgow Dental Hospital and School, University of Glasgow

²Centre for Social Marketing, University of Strathclyde

³Independent Child protection Consultant

⁴Tyneside Primary Care Trust, Benfield Road, Newcastle upon Tyne

⁵Northumberland, Tyne and Wear Strategic Health Authority,

Newcastle General Hospital

⁶University of Wales, Bangor

⁷Darlington Primary Care Trust

during that quarter [Dental Data Services, 2000]. Previous research has also suggested that whilst abusing caregivers may be reluctant to return to the same medical practitioner or hospital Accident and Emergency Departments, they have little hesitation in returning to the family dentist [Needleman, 1986]. This combination of factors places GDPs in a good position to undertake a role within the child protection process, particularly in relation to cases of non accidental injury (NAI).

The primary aim of all professionals involved in the child protection process is to ensure the safety of the child. The secondary aim is to provide help and counselling for the parents or caregivers so that the abuse stops [Department of Health, 1999]. It has been estimated that in the USA 35%-50% of previously abused children, returning home without some form of intervention, are likely to receive serious re-injury [Schmitt, 1986].

Within the UK, in contrast to the USA [Sfikas, 1996], there is no legal obligation for any health professional to report suspected cases. Research [Department of Health, 1995] suggests that the vast majority of children involved in the Child Protection Process remain with or return home to their natural parents. Unfortunately press coverage tends to highlight the more dramatic cases where professionals have been shown to have poor judgement and children have been removed from home. In one year (1992) out of 160,000 referrals in England and Wales, 120,000 (75%) led to a family visit, 40,000 (25%) resulted in Child Protection Conferences and 24,000 (15%) children's names were added to the Child Protection Register. Less than 6,500 (4%) children were removed from their natural families and the majority were eventually returned to the care of their natural parents. Over 35% of the children who were newly placed on the register in 1992 were registered because of concerns about physical abuse.

Health professionals (health visitors, general medical practitioners, hospital staff etc.) are already significantly involved in identifying suspected abuse, with 17% of all referrals being made by them. This was second only to education staff (teachers, school nurses, education welfare), who made 23% of referrals, and equal to those made by household/family members and the lay community (also 17%) [Gibbons et al., 1995].

In every Local Authority in the UK, Area Child Protection Committees (ACPCs) have been established as formal structures to coordinate services for children at risk of significant harm. Each ACPC has had to develop its own interagency procedural guidelines for use in suspected child abuse cases for all staff who work with children. These are based on National Child Protection Guidelines [Department of Health, 1999] and issued in

loose-leaf format to allow for updating. In one local authority, an example of ACPC accepted guidelines for dental professionals in primary care covers issues such as:

- What must I do if I have concerns giving rise to suspicions of abuse?
- Who do I consult/inform in my own agency?
- Who else do I inform?
- When and how do I tell them?
- What are my record keeping requirements?
- Who makes the decision of future action?
- What action should I take and what responsibility do I have to follow up?

However, despite the existence of such guidelines and their circulation to some dentists, it is not known whether GDPs in the UK themselves believe they have a role in child protection or whether they have perceived needs in developing their role further. This paper reports qualitative research carried out with GDPs in Tyne and Wear and Northumberland; its aim was to assess current knowledge, attitudes and practice regarding their role within child protection.

Materials and methods

A qualitative method was used which cannot make statistical estimates but which does allow qualitative exploration of respondents perceptions [Krueger, 1988; Kitzinger, 1995]. Initial one-to-one depth interviews were undertaken in order to identify issues and inform the development of a discussion guide for the main research. Seven key informants were identified from relevant areas of: GDPs (2), social services (2), local dental committees (1), paediatric dentistry (1), and community child health (1).

The main research used a focus group method [Krueger, 1988; Kitzinger, 1995]. This technique allows for a free and informal discussion to take place, moderated by a highly experienced researcher. Use of a topic guide ensures issues of interest are explored in depth, but participants are encouraged to discuss additional aspects of interest to them in their own language, free from, for example, researcher preconceptions or observer bias. Qualitative methods are being increasingly used in medical and dental research. [MacAskill et al., 1989; Hastings et al., 1994; Kitzinger, 1995; MacAskill et al., 2002]].

Five focus group discussions were carried out with GDPs in the National Health Service (NHS) in the North East of England (n=23) (Table 1). All practices in the study area received information about the study and were advised they might be invited by telephone to participate. To ensure a range of perspectives and experiences relevant to the study aims, respondents were recruited on

Group	Health Authority	Registration Year	Gender	Postgraduate Course Attendance
1	Mixed	Mixed	3 female 1 male	All attenders
2	Northumberland	15 years or more	3 female 2 male	One attender (earlier course)
3	Newcastle and North Tyneside	Less than 15 years	2 female 3 male	No attenders
4	Gateshead and South Tyneside	Less than 15 years	3 female 3 male	One attender
5	Sunderland	15 years or more	1 female 2 male	One attender

TABLE 1 - Composition of focus groups for study on general practitioners perceptions of child protection.

the basis of practice location, length of time qualified, as it was expected that undergraduate input in child protection would be negligible for those less recently trained, and attendance at postgraduate courses in child protection issues. Lists of potential respondents were drawn up from each of the four health authorities in the Northumberland, Tyne and Wear area, with additional stratification by year since qualification (<15 years:15+ years) and an additional list comprised past attendance at the relevant postgraduate courses. Respondents were recruited by telephone from the lists, whilst also ensuring that there was a mix of males and females in each group and that only one dentist was recruited from an individual practice. Groups were held in convenient locations for respondents: three in hotels and two in Health Action Zone premises. The focus group discussions lasted approximately 90 minutes and all respondents were offered a fixed monetary incentive for attending. All discussions were tape recorded with the participants' permission, transcribed and subjected to thematic analysis.

Results

Research revealed background issues relating to general dental practice as well as specifically to child protection, and factors that would inhibit or motivate action were identified.

General dental practice: relevant background issues

Isolationism. Most dentists felt that they were very isolated as a profession, with little communication with other GDPs, even within their own practice. There was

even less experience of contact with other members of primary care and wider NHS networks and virtually no links with social services. Thus, there was lack of experience and confidence in acting in the multi-professional context which is needed for effective child protection. There was also a lack of potential support networks in deciding whether to take action and following through a case.

Lack of holistic approach to patient care. In addition, while discussing their work, it was apparent that much of dental practice focuses on a clinical approach, identifying signs and symptoms within the orofacial area and responding within established protocols. While some practices were adopting an extended role, for example being more active in health promotion, few dentists were experienced or confident in the more holistic approach to child health that would be needed in child protection, encompassing both clinical and non-clinical issues.

Respondents reported considerable variety of continuity of care and development of relationships with their child patients. While most felt they knew some of their patients and families well, perceived limitations in many consultations reflected short and busy appointments, parents' attitudes to follow-up appointments, continued ease of changing from dentist to dentist and lack of transfer of clinical notes. In addition, dentists felt that those who practiced where low levels of parenting skills were perceived as 'the norm' might become desensitised to negligence and potential signs of abuse. There was also the potential problem of cultural relativism whereby expectations of 'normal' children's presentation in deprived areas are lowered by professionals.

Attitudes to further training and professional development. While the need to keep up-to-date was recognised, time and financial pressures together with low levels of external requirements limited participation in postgraduate training. Courses on child protection, when available, had to compete with more clinical topics.

Perceptions and behaviour in Child Protection issues

Many respondents had scarcely considered child protection in relation to their every day work, although those more recently trained were more aware of the issues.

Perceptions. These were largely formed by sensationalist media reporting of 'worst scenario' cases, in which professionals were later deemed to have acted inappropriately with considerable consequences for children and families. These underlying perceptions contribute to hesitancy in taking action by GDPs. Many reported that they would depend on their general training in observing abnormalities, although those more recently trained had received undergraduate lectures on signs of abuse/NAI and one group had attended a postgraduate day course on the subject.

Overall though, few GDPs had facts at their fingertips in relation to the range of indicators of child abuse, local referral routes and potential outcomes from an initial referral. When asked to consider child protection, therefore, most anticipated relying on 'common sense' and 'muddling through'.

The most obvious form of abuse dentists would come into contact with was felt to be physical abuse. However, when treating trauma cases, dentists felt they were unlikely to question children about the circumstances, apart from a conversational enquiry. In addition, it was felt to be far harder to identify other forms of abuse as any unusual behaviour that might indicate emotional or sexual trauma could be attributed to the stress of the consultation.

Behaviour. In practice, only three respondents had acted on concerns they had about children and in each case no further involvement had been needed after contacting other professionals (social and education). A further few indicated that they had had worries about individual children but had not taken any action.

Note keeping was confined to recording specific oro-facial details and would not include any wider concerns they might have about a child. Thus, any observation of injuries or behaviours that might cause concern would be kept 'in their head' and the individual dentist would depend on remembering their initial worries as a mechanism for their concerns to be passed on.

In the absence of experience, dentists anticipated a variety of potential actions if they became concerned about a child:

- avoiding or postponing the issue;
- discussing with practice colleagues;
- asking practice colleagues to examine the child for a second opinion;
- contacting a specialist paediatric dentist known to have an interest in child protection;
- consulting the child's general medical practitioner, their school or local police.

The least likely route anticipated was contacting social services, although those more recently trained were more open to doing so. Interestingly, it was apparent that while some would consult others in order to have a second opinion and for the good of the child, an underlying hope was that they could 'pass the buck' and not have further involvement or responsibility.

Inhibiting and motivating factors in Child Protection

All respondents acknowledged an ethical responsibility as professionals and members of society to act to protect children who they felt were at risk. However, the range and strength of potentially inhibiting factors was considerable, reflecting interaction between aspects of general dental practice and practitioners' perceptions of child protection.

Difficulty in identifying abuse. Physical abuse could be hard to determine, because "children were always getting cuts and bruises". Less obvious forms of abuse would be more difficult to identify and unusual behaviour could be attributed to stress of the session. Varied levels of child care skills and locally accepted norms of parenting could reduce sensitivity to care that was negligent and potentially abusive. The rushed nature of individual consultations and lack of continuity of care potentially limited the likelihood of identifying problems, especially as child protection issues would not be front of mind.

Comments made up GDPs included: "I think you can identify and do something about it. It's important, but you're limited in your capacity because you're unsure about what is child abuse... you don't want to upset anyone by accusing them wrongly as was done in the past by Social Services... If they're going to get it wrong then how can we get it right?"

Concern about the outcome. On the one hand, dentists were concerned about the impact on the child and family if they "got it wrong" and the risk of "making things worse". This reflected the largely erroneous perception that action would immediately be taken if they referred a child, including removal from home. On the other hand,

and to a varied extent, there were concerns for themselves and their practice. At the very least they anticipated antagonism from parents, with verbal and physical abuse likely. In addition, the impact on the practice and their livelihood ranged from expected loss of patients from local 'word of mouth' to physical damage to the premises. However, most stated that if they were "certain" there was a problem, their concerns would be set aside for the child. "If I thought that somebody was being abused then I would report it but... there is definitely a grey area and I'm not trained to pick it up".

Need for certainty before action. Difficulty in identifying abuse and concerns about the outcome enhanced a perceived need for certainty. Coping with uncertainty contrasted with routine practice, where dentists were accustomed to feeling confident in identifying signs and symptoms of disease and trauma and the appropriate actions to deal with them. Poor knowledge of signs and symptoms, referral routes and potential outcomes contributed to lack of certainty and made action less likely.

Discussion

The range and strength of potentially inhibiting factors were considerable and tend to build a strong argument (from the respondents' viewpoint) against involvement and action. However, in viewing these there is considerable scope for approaches which would potentially facilitate a role in child protection. Table 2 highlights inhibitors that emerged from the research and links these with potential 'facilitators'.

Previous research and publications have actively promoted the potential child protection role of dentists in primary care [Laskin, 1978; Blumberg and Kunken, 1981; Croll et al., 1981; Kittle et al., 1981; Carlin and Polk, 1985; Needleman, 1986; Kassenbaum et al., 1991; Blain, 1991; Welbury, 1994; Murphy and Welbury, 1998; Tsang and Sweet, 1999; Senn et al., 2001]. However, GDPs in this study suggested that there are generic factors associated with their practice and specific issues in relation to child protection which militate against primary care dentists' undertaking a role in the child protection process.

Generic factors associated with general dental practice. The focus group dentists suggested that the reality of NHS dentistry for children in the 1990s meant that a potential role in child protection may have been overemphasised. Whilst over 60% of the child population is registered, there is such mobility of patients and associates across practices in some areas that continuity of care is not developed. Poor clinical note taking with limited sharing of records further limit

the potential for involvement.

Whilst encouraging a holistic approach to health and social care with good integration of all those involved in children's well-being is a recognised tenet of government policy, pragmatically, a seamless approach is not promoted by the current health and social care systems. GDPs have little involvement with either professional colleagues or other primary care health workers (e.g. general medical practitioners', health visitors, school nurses) whether in single or multiple handed practice. They have even less involvement with teachers, social services or other local authority staff.

Now that the minimum amount of postgraduate education has been defined in the UK it is hoped that additional postgraduate funding will be available to allow practitioners to attend inter-agency training. It is anticipated that some of these issues will be addressed in developing clinical governance in dental practice.

Specific issues related to child protection. Few studies have investigated GDPs' views on their role within child protection or on possible barriers specifically related to child protection which militate against their undertaking such a role [Needleman et al., 1995; Adair et al., 1997a; Adair et al., 1997b]. This research suggests that GDPs do recognise a moral and ethical obligation to report incidents of child physical abuse which present to them through their clinical role. Despite this, considerable ambivalence was expressed as to whether GDPs would be aware of or recognise such incidents in the first instance as well as about the potential consequences of being involved in child protection at all. These findings are similar to other studies where dentists felt some reluctance in being involved with anything to do with child protection because of their lack of knowledge both of the signs of child abuse and the workings and functions of other agencies [Needleman et al., 1995; Adair et al., 1997a; Adair et al., 1997b].

Awareness of child protection issues around neglect, emotional or sexual abuse that might present through surgery situations was even less clear than for physical abuse. GDPs were inclined to consider neglect a cultural norm and aberrant behaviour in the surgery a result of stresses associated with treatment. As the most important factor in recognising child abuse is to be aware, the low levels of awareness demonstrated by GDPs must give cause for concern.

Furthermore the majority of dentists were not confident about how to act or whom to contact if or when they had suspicions of abuse. They also reported significant concerns about how notifying possible incidents might affect the child, family unit and practice (particularly if suspected of making 'false allegations'). This suggests a lack of knowledge about

the aim of the child protection agencies that are not only to protect children from further abuse but also to strengthen the family unit.

In considering education, there are very few funded postgraduate courses for GDPs in the UK and they tend to focus on the orofacial signs of child physical abuse and neglect interagency training. It is unclear if comparable undergraduate training is undertaken throughout the 16 UK dental schools, or indeed elsewhere in Europe. This is hardly surprising when the General Dental Council Guidelines for undergraduate training in the UK make no mention of Child Protection issues [General Dental Council, 2002].

In order to overcome these concerns it will be necessary for GDPs to:

- establish a communication structure;
- develop child protection support networks;
- develop child protection approaches.

These 'facilitating factors' are outlined in Table 2.

Conclusion

GDPs recognised a limited role for themselves within child protection and felt unprepared, lacking in skills, knowledge and confidence to undertake their expected role in child protection. There appeared to be both generic and specific factors about the current practice of NHS dentistry associated with the child protection process which needed to be changed before GDPs could discharge their role effectively. It appears highly likely that presently in the UK children presenting to GDPs with indicators of potential abuse, neglect etc., will receive an inadequate and/or inconsistent response to their need for protection. This is particularly disturbing when the consequences of such inadequate responses from health and social care professionals have been outlined recently in the Laming Report into the widely publicized death of a child, Victoria Climbié [Department of Health, 2003]. Urgent national and local measures are needed to

INHIBITORS	FACILITATORS
<p><i>Nature of dentistry</i></p> <ul style="list-style-type: none"> - Underdeveloped communication structure both within and outside the dental community. - Lack of time, financial incentive and awareness of available course for professional development. - Clinical focus. - Varied continuity of care and difficulty in building relationships. - Desensitisation to negligence and potential signs of abuse in certain geographical areas. <p><i>Child protection: perceptions and behaviour</i></p> <ul style="list-style-type: none"> - Media sensationalism places worst-case scenarios top-of-mind. - Difficulties in identifying physical signs of abuse: common occurrence of cuts and bruises in children. - Complexities of identifying emotional signs of abuse: naturally stressful environment. - Mixed perceptions of appropriateness of child protection role in dentistry: relative infrequency of contact, lack of relationship, colleagues' unwillingness to get involved. - Reluctance to adopt an extended role: delegation of oral health education tasks to ancillary staff. - Poor knowledge of referral routes and procedures. - Avoidance behaviour is common: postpone action, lack of certainty, desire for suspicious to be unfounded. - Perceived exaggerated and negative outcomes for dentist, dental practice, child and other family members. 	<p><i>Establish communication structure in general practice</i></p> <ul style="list-style-type: none"> - Frequent communication with practice staff through formal meetings and informal discussions: dentists, dental nurses, receptionists etc. - Establish links and contact with other dentists, general medical practitioners, other professionals etc. - Development of interaction skills and long-term relationships with children and families. <p><i>Develop child protection support networks</i></p> <ul style="list-style-type: none"> - Informal professional advice (non-authority). - Local support from colleagues. - Feedback system involving dentists. <p><i>Develop child protection approaches</i></p> <ul style="list-style-type: none"> - Raise awareness of relevance of the issue. - Undergraduate and postgraduate training. - Wider promotion of courses. - Circulation of guidelines. - Address the following issues: <ul style="list-style-type: none"> *significance/salience of child abuse; *skills in identifying physical and emotional signs of abuse; *value of dentists role in child protection; *importance of recording suspicious injuries; *need for user-friendly written material; *realistic outcomes of a case: case studies; *skills in developing better communication structures with patients, colleagues and other professionals.

TABLE 2 - Summary of inhibitors and facilitators related to adopting a child protection role for dentistry.

rectify current deficiencies in the pre and post qualifying training and support for general dental practitioners.

References

- Adair SM, Wray IA, Hanes CM, Sams DR, Yasrebi S, Russell CM. Perceptions associated with dentists' decisions to report hypothetical cases of child maltreatment. *Pediatr Dent* 1997a Nov-Dec;19(8):461-5.
- Adair SM, Yasrebi S, Wray IA, Hanes CM, Sams DR, Russell CM. Demographic, educational, and experiential factors associated with dentists' decisions to report hypothetical cases of child maltreatment. *Pediatr Dent* 1997b Nov-Dec;19(8):466-9.
- Becker DB, Needleman HL, Kotelchuck M. Child abuse and dentistry: orofacial trauma and its recognition by dentists. *J Am Dent Assoc* 1978 Jul;97(1):24-8.
- Billmire ME, Myers PA. Serious head injury in infants: accident or abuse? *Pediatrics* 1985 Feb;75(2):340-2.
- Blain SM. Abuse and neglect as a component of pediatric treatment planning. *J Calif Dent Assoc* 1991 Sep;19(9):16-24.
- Blumberg ML, Kunken FR. The dentist's involvement with child abuse. *N Y State Dent J* 1981 Feb;47(2):65-9.
- Breiting VB, Helweg-Larsen K, Staugaard H, Aalund O, Albrektsen SB et al. Injuries due to deliberate violence in areas of Denmark. V. Violence against women and children. Copenhagen Study Group. *Forensic Sci Int* 1989 Jun;41(3):285-94.
- Carlin SA, Polk KK. Teaching the detection of child abuse in dental schools. *J Dent Educ* 1985 Sep;49(9):651-2.
- Croll TP, Menna VJ, Evans CA. Primary identification of an abused child in a dental office: a case report. *Pediatr Dent* 1981 Dec;3(4):339-41.
- Da Fonseca MA, Feigal RJ, ten Benschel RW. Dental aspects of 1248 cases of child maltreatment on file at a major county hospital. *Pediatr Dent* 1992 May-Jun;14(3):152-7.
- Dental Data Services 2000, Dental Practice Board, Eastbourne, England.
- Department of Health. Child Protection Messages from Research. London: Her Majesty's Stationary Office; 1995.
- Department of Health. Referrals, Assessments, and Children and Young people on Child Protection Registers, England: 2001/2002. London: Her Majesty's Stationary Office; 2002.
- Department of Health. The Children Act 1989. London: Her Majesty's Stationary Office; 1989.
- Department of Health. The Victoria Climbié Inquiry. Report of an inquiry by Lord Laming. London: Her Majesty's Stationary Office; 2003.
- Department of Health. Working Together to Safeguard Children (A Guide to Arrangements for Inter-Agency Co-operation for the Protection of Children from Abuse). Her Majesty's Stationary Office; 1999.
- General Dental Council. The first five years (the undergraduate dental curriculum). London: GDC; 2002.
- Gibbons J, Conroy S, Bell C. Operating the Child Protection System. London: Her Majesty's Stationary Office; 1995.
- Hastings GB, Lawther S, Eadie DR, Haywood A, Lowry R, Evans D. General anaesthesia: who decides, and why? *Br Dent J* 1994 Nov 5;177(9):332-4.
- Holter JC, Friedman SB. Child abuse: early case finding in the emergency department. *Pediatrics* 1968 Jul;42(1):128-38.
- Jessee SA. Physical manifestations of child abuse to the head, face and mouth: a hospital survey. *ASDC J Dent Child* 1995 Jul-Aug;62(4):245-9.
- Kassebaum DK, Dove SB, Cottone JA. Recognition and reporting of child abuse: a survey of dentists. *Gen Dent* 1991 May-Jun;39(3):159-62.
- Kittle PE, Richardson DS, Parker JW. Two child abuse/child neglect examinations for the dentist. *ASDC J Dent Child* 1981 May-Jun;48(3):175-80.
- Kitzinger J. Qualitative research. Introducing focus groups. *BMJ* 1995 Jul 29;311(7000):299-302.
- Krueger RA. Focus Groups: a Practical Guide for Applied Research. USA: Sage; 1988.
- Laskin DM. The recognition of child abuse. *J Oral Surg* 1978 May;36(5):349.
- MacAskill SG, Hastings GB, McNeill RE, Gillon J. Scottish attitudes to blood donation and AIDS. *BMJ* 1989 Apr 15;298(6679):1012-4.
- MacAskill SG, Stead M, MacKintosh AM, Hastings GB. "You cannae just take cigarettes away from somebody and no'gie them something back": can social marketing help solve the problem of low income smoking? *Social Marketing Quarterly* 2002;8(1):19-34.
- Meadow R. Epidemiology. In: Meadow R. (ed). *The ABC of Child Abuse*. London: British Medical Journal Publications; 1989.
- Welbury RR, Murphy JM. The dental practitioner's role in protecting children from abuse. 3. Reporting and subsequent management of abuse. *Br Dent J* 1998 Feb 14;184(3):115-9.
- Needleman HL. Orofacial trauma in child abuse: types, prevalence, management, and the dental profession's involvement. *Pediatr Dent* 1986 May;8(1 Spec No):71-80.
- Needleman HL, MacGregor SS, Lynch LM. Effectiveness of a statewide child abuse and neglect educational program for dental professionals. *Pediatr Dent* 1995 Jan-Feb;17(1):41-5.
- Protecting Children. A shared Responsibility. Guidance for Health Professionals in Scotland. Scottish Executive. January 2000.
- Senn DR, McDowell JD, Alder ME. Dentistry's role in the recognition and reporting of domestic violence, abuse, and neglect. *Dent Clin North Am* 2001 Apr;45(2):343-63, ix.
- Schmitt BD. Physical abuse: specifics of clinical diagnosis. *Paediatric Dentistry* 1986;8:83-7.
- Sfikas PM. Does the dentist have an ethical duty to report child abuse? *J Am Dent Assoc* 1996 Apr;127(4):521-3.
- Tsang A, Sweet D. Detecting child abuse and neglect--are dentists doing enough? *J Can Dent Assoc* 1999 Jul-Aug;65(7):387-91.
- Welbury RR. Child physical abuse. In: Andreasen JO, Andreasen FM (ed). *Textbook and Color Atlas of Traumatic Injuries to the Teeth*. 3rd ed. Copenhagen: Munksgaard; 1994.

Design: Qualitative study with detailed interviews. Results: Participants described their experiences of patients' complaints in three stages: initial impact, conflict, and resolution. The first stage described being out of control, feelings of shock and panic, and a sense of indignation towards patients generally. Conclusion: The initial impact stage and conflict stage may be necessary aspects of the experience that general practitioners endure when they have a complaint made against them. Support structures should, however, be in place to help general practitioners through these stages. Key messages. Patients' complaints against general practitioners are increasing. In the medical profession, a general practitioner (GP) is a medical doctor who treats acute and chronic illnesses and provides preventive care and health education to patients. A general practitioner manages types of illness that present in an undifferentiated way at an early stage of development, which may require urgent intervention. The holistic approach of general practice aims to take into consideration the biological, psychological, and social factors relevant to the care of each patient's ADOHTA Journal is proudly sponsored by Mother's perceptions of mainstream dental health messages for their children: a qualitative study M.G Gussy MEd, PhD1,2,5 E. Waters PhD5 E. Riggs5 N.M. Kilpatrick, BDS, PhD, FDS RCPS, FRACDS (Paed Dent)2,3,4 1 School of Dentistry and Oral Health, La Trobe University, Bendigo Australia 2 Murdoch Childrens. At the time of the study free/low cost similar concerns and show that mothers reported engaging dental services were offered to primary school aged children +, %'1*(+*#- 0#-%+ -+,3 =,"># ()1 (+(**/&0 through the School Dental Service, but not to preschool have negative. effects on dental healthMY9MO.

@article{Harris2009SafeguardingCI, title={Safeguarding children in dentistry: 1. Child protection training, experience and practice of dental professionals with an interest in paediatric dentistry}, author={J. C. Harris and C. Elcock and P. Sidebotham and R. Welbury}, journal={BDJ}, year={2009}, volume={206}, pages={409-414} }. General dental practitioners' perception of their role within child protection: a qualitative study. R. Welbury, S. Macaskill, +4 authors M. Crawford. Medicine.