Paediatric radiology experts
Foreword

This statement looks at issues faced by paediatric radiologists both as general radiologists working in district general hospitals and also those who provide specialist second opinions at tertiary centres, and demonstrates how The Royal College of Radiologists (RCR) proposes to support them. I would like to thank the following members of the working party who contributed to this statement: Dr Tony Nicholson, Dr Rosalyn Proops, Dr Rosemary Arthur, Dr Stephen Chapman, Dr Laurence Abernethy and Miss Anna Pickering. The statement examines the problems faced by radiologists in child protection work and commits the RCR to continued, improved support particularly in developing court skills training, education and the future development of paediatric radiology networks.

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The Royal College of Radiologists (RCR) is aware that there are a decreasing number of paediatric radiologists who are both willing and able to provide expert opinion in child protection cases. In 2008, the RCR and the Royal College of Paediatrics and Child Health (RCPCH) jointly published the document *Standards for Radiological Investigations of Suspected Non-accidental Injury*. A number of the recommendations made in these standards, which would have mitigated the current problems, have not been enacted and the RCR is keen to work with all relevant organisations including the legal profession (family and criminal court systems and the National Family Justice Council), the Department of Health and the RCPCH to ensure these standards are implemented.

The three main levels of concern regarding the involvement of paediatric radiologists in child protection have been identified as follows:

1. General radiologists working in district general hospitals who may not have trained in non-accidental injury (NAI) and child protection may not feel confident regarding primary involvement in diagnosing and reporting non-accidental injury
2. General paediatric radiologists are increasingly referring cases of suspected non-accidental injury to paediatric radiologists in specialist centres for second opinion
3. The numbers of experts in non-accidental injury are decreasing due to retirements and reluctance on the part of new consultants to become expert witnesses.

The RCR recognises that there are a number of factors causing these problems.

- There are concerns about training. The 2008 intercollegiate document, *Standards for Radiological Investigations of Suspected Non-Accidental Injury*, defines the standard required and states that, ‘Reporting on the radiology of NAI is within the core competence of all paediatric radiologists, both those working in specialist centres and those undertaking paediatric radiology as a special interest within a general department’. However, the FRCR is a core knowledge examination and is not an exit qualification. The general radiologist with a paediatric interest may not have been exposed to sufficient numbers of NAI cases to feel confident in an area which has such profound medico-legal and social consequences.

- The work is time consuming and may go unrecognised. Radiologists involved in this work may be criticised by colleagues and managers for their apparent low reporting output – even more so when acting as an expert.

- Unless trusts incorporate child protection work into job plans, this work may be undertaken outside programmed working hours.

- The court system is unpredictable and it can be very difficult to plan workloads or job plans when the individual paediatric radiologist does not know when or if they will be called as an expert witness.

- At the time of writing, electronic data sharing is not fully available across the country and, therefore, data in many cases is being sent by post.

- There are concerns about the anonymity of those involved. Although it is recognised that currently professional witnesses (the primary reporting radiologists) are protected, there is no legal protection for those acting as commissioned experts.

- Although *Standards for Radiological Investigations of Suspected Non-Accidental Injury* and subsequent publications in 2010 encourage the development of specialist advice and reporting networks, this has not been acted upon and many radiologists working in the NAI field feel unsupported and exposed to the vagaries of the court system.

- There is currently an expectation that both the local consultant radiologist providing the initial report and the consultant radiologist who double reports (thus providing second opinion and peer review) may both be required in legal proceedings as professional and expert witnesses respectively. This has significant time and resource implications.

All radiologists are bound by the regulations of Good Practice and must work within their area of expertise. The RCR recognises that in order for paediatric radiologists to develop their expertise in NAI to the level where they feel competent to act as an expert witness, local support, experience and training opportunities are essential.

The RCR therefore reiterates its earlier recommendations and recommends the following to support and encourage more paediatric radiologists to become involved with child protection and to act as expert witnesses.
1. The RCR will remind training programs of their curricular responsibilities in the training of general and paediatric radiologists to be confident in the recognition and diagnosis of NAI. Heads of training to ensure that sufficient exposure to NAI is provided by exploring inter-deanery transfers and providing an electronic logbook of cases.

2. Paediatric radiologists should work in managed network ‘care teams’ so that the responsibility, workload and funding of this essential work is shared among the individuals and the costs shared evenly across the trusts involved in the network. The operational detail of how these managed networks might function has been discussed in Child Protection Clinical Networks; Protecting Children, Supporting Clinicians published by the Department of Health and the RCPCH into which the RCR had significant input.
   - The current process of double reporting is the term used to describe how radiology professionals collaborate, share ideas and how clinical work is corroborated and discussed. This is the accepted definition of peer review. Double reporting must be accepted as the preferred and ideal clinical standard, comparable to well-established peer review processes.
   - With the establishment of reporting networks, the local radiologist will retain responsibility as the lead imaging clinician. When a skeletal survey is peer reviewed this should be documented in the clinical notes.
   - It is expected that the two radiologists will achieve agreement with the final report. If this does not occur, it is the responsibility of the second radiologist (the peer reviewer) to provide a second report.
   - This process would demonstrate that standards have been met while ensuring that all involved consultant radiologists are not called to appear in court in each individual case. The local radiologist, who will be well versed with the context and history of an individual case, may be the most appropriate person to appear in legal proceedings.

3. Service level agreements for the provision of second opinions should be set up within a network and trusts should be appropriately remunerated for this work.

4. Data sharing should by now be mandatory across the UK. That it is not, is largely down to the intransigence of hospital trusts. Data sharing to obtain quick and secure second opinions is vital.

5. The RCR will explore ways to make available court skills training (professional/expert witness training). Preliminary discussions have taken place with the RCPCH who currently run a court skills course, which could be adapted.

6. The funding system for paediatric imaging expert witness work to be reviewed and considered as a part of the NHS trust job plan. Court fees should ideally allow the trusts to arrange appropriate back-fill.

7. The income generated from providing second opinions would be recuperated if all activities were recorded through Payment by Results.

8. Support for less experienced consultants and trainees should be arranged through schemes such as the mini-pupillage scheme (already up and running for paediatricians and psychiatrists) and arrangements should be in place to allow radiologists (trainees and consultants) to ‘shadow’ colleagues attending pre-court and court proceedings.

9. Overseas experts must work to the same standards as UK experts.

10. Robust indemnity agreements need to be in place for both primary and second opinion reporters before the referral of any case.

Approved by the Board of the Faculty of Clinical Radiology: 25 February 2011

References
