Virtual Mentor
American Medical Association Journal of Ethics
February 2009, Volume 11, Number 2: 111-116.

CLINICAL CASE
What To Do when It Might Be Child Abuse
Commentary by Karen St. Claire, MD

Dr. Peterson took a deep breath and exhaled thoughtfully as she weighed the possible approaches toward a case that was scheduled for the afternoon. For several years, she had been the primary pediatrician for Adrian, now a rambunctious 7-year-old. During the course of that time, she had developed a constructive, friendly relationship with the boy's parents, who had been fastidious regarding his care and upbringing and seemed like involved, caring parents. Dr. Peterson had enjoyed appointments with this family, trusting that visits would be routine and the boy would be healthy, allowing some time to chat with the parents, who were both executives in a large company headquartered nearby. The boy had always been in good health, and seldom needed to come in for non-routine well-child visits.

Dr. Peterson now questioned her original assumptions. For the past year, Adrian had been in to see her four or five times with a succession of injuries. Dr. Peterson noted numerous bruises and lacerations in different states of healing dispersed on the boy's knees, thighs, and buttocks. Adrian needed a couple of stitches on one occasion. The last time he came in he needed treatment for a broken leg. During all of these visits, his parents had appeared concerned and anxious, attributing the injuries to Adrian's simply being a very active youngster. They told Dr. Peterson that he'd been involved with soccer and martial arts for the past year, and usually had a sports-related explanation for every injury, though they could seldom give specific details. Dr. Peterson was aware that these parents spanked on occasion when the boy misbehaved, but they said that they only swatted lightly, never leaving a mark. Both had been working overtime to handle financial problems, and said that Adrian was often left in the care of a babysitter or aunt.

During recent visits, Dr. Peterson had often noted that Adrian seemed either visibly upset or quiet and withdrawn, behaviors that were completely natural, given his sports-related injuries. Now she had to act on her growing suspicions, but what would that do to her relationship with the family?

Commentary
The diagnostic method is the intersection of medical science with the art of medical practice. Its goal is to establish a broad framework of possible diagnoses and determine through information gathering which, if any, of these diagnoses is correct. Information gathering is chiefly dependent on history-taking but also relies on physical examination and testing. The diagnostic process ultimately leads to a medical conclusion upon which treatments and therapies are based. Child abuse and

neglect (CAN) is one of many threats to child health that strongly relies on the diagnostic method to determine whether abuse or neglect have occurred so that treatment, intervention, and protection can be provided.

The situation in which Dr. Peterson finds herself with Adrian is universally uncomfortable and rarely produces an ideal outcome. If Adrian is an abused child, and if Dr. Peterson fails to recognize or address this issue, it is likely that Adrian will continue to be abused, with possibly devastating consequences. Moreover, if abuse is occurring, other children in the home are also at risk. Alternatively, if Dr. Peterson correctly identifies and addresses the problem, Adrian and his family will have to undergo a lengthy and difficult process of evaluation, intervention, and protection, but the outcome for Adrian will almost certainly be better. If Dr. Peterson suspects abuse, initiates the evaluation, and ultimately finds that no abuse has occurred, Adrian and his family will have had to undergo the evaluation process, but its positive outcome should provide closure for the family. Families that are experiencing dysfunction or stress at the onset of the evaluation may be at particular risk for further deterioration of the family system. Although Dr. Peterson worries about her therapeutic relationship with Adrian and his family, many families who find themselves in this situation and work through the process with their primary care physician choose to remain in the care of that physician.

Physicians see children and families every day with various levels of physical, emotional, and psychosocial functioning. When one of these children or families begins to stand out because of patterns in history or physical findings, the physician must rely on both her training and instincts in determining whether to take a closer look at the situation. In Adrian's case, Dr. Peterson has had growing concerns about the possibility of abuse, and she recently added this concern to Adrian's list of diagnoses. At this point, the question facing Dr. Peterson is, "How should I proceed?"

Understanding the Problem

CAN occurs more commonly in childhood than many other serious childhood disorders. National child maltreatment statistics from the U.S. Department of Health & Human Services indicate that in 2006 there were 3.6 million reports of child maltreatment (47.8/1,000) accepted for investigation by state and local Child Protective Services (CPS) agencies [1]. From these reports, 905,000 cases of child maltreatment (12.1/1,000) were substantiated. Of them, 64.1 percent were for neglect, 16 percent for physical abuse, 8.8 percent for sexual abuse, and 6.6 percent for emotional abuse. In 74.9 percent of investigated maltreatment cases, the initial report was made by a professional. About 80 percent of identified incidents of CAN were perpetrated by a parent or close caretaker of the child. In 2006, there were 1,530 CAN fatalities, 78 percent of them in children less than 4 years of age. Child maltreatment spans all economic, social, racial, cultural, and educational strata, with risk factors that include domestic violence, substance abuse, mental illness, poverty, social isolation, and prior history of abuse. Many physically and sexually abusive

acts perpetrated on children leave no specific long-term physical findings on the child's body, making the identification difficult.

Children who experience abuse or neglect are at high risk for developing long-term emotional, physical, and medical problems related to their early traumatic experiences [2, 3]. Studies on CAN recidivism indicate that maltreated children are six times more likely to experience recurrent maltreatment than children who have never been abused [4]. The risk for recurrence is highest in the first 30 days after the index episode. Clinicians should understand that they see only a small piece of the CAN puzzle in the clinical setting, and it is often other professionals and agencies that help determine whether or not abuse or neglect has occurred. Regardless of the outcome, the evaluation process is difficult for the children and families who undergo the necessary medical, social, and legal scrutiny. Whenever possible, the physician should remain involved with the patient and family to assist in providing support and medical care during the evaluation.

Physician Responsibility in Addressing Child Abuse and Neglect
The following steps offer guidelines for physicians who may confront situations in which they have to decide how to respond to suspicions of CAN.

Step 1
Maintain training in the recognition of and response to CAN and know how to perform a basic medical evaluation. Be familiar with your state's reporting statutes as well as the agencies empowered to investigate CAN [5]. Statutes generally require that reports of suspected CAN be made to CPS, law-enforcement agencies, or both. In most states, reports made in "good faith" are exempt from civil or criminal liability, even in cases where CAN is ultimately ruled out. On the other hand, failure to report suspected CAN may have adverse legal consequences.

Step 2
Review all available medical history and physical-exam information to determine if there is a reasonable concern for CAN versus an alternative explanation. This includes prior medical records and x-rays pertaining to previous clinic or emergency room visits for injuries. Consider conferencing with an experienced colleague or a local CAN consultant.

Step 3
Obtain additional information. Meet with the family and talk separately with the caretaker(s) and child.

If the additional information substantiates your concern, talk about it honestly and thoroughly with the caretaker(s). Emphasize that you will assist them in determining whether their child has been harmed so that they can best protect him or her. Avoid accusing or assigning blame at this point, inasmuch as there may be no clear indication of who might be harming the child. Ask about the child's symptoms and prior known injuries. Request specifics to determine whether there is consistency

between reported mechanisms of injury and clinical findings. Ascertain whether anyone witnessed the injuries or heard the child talk about how they occurred. Ask about family functioning, stressors, and risk factors, as well as the child's environment at home, school, and with other care providers. In the case we are discussing, Dr. Peterson should ask about Adrian's coaches and supervision during sports-related activities.

If there has been a change in the child's affect, ask the caretaker(s) about potential causes. Explain clearly to the caretaker(s) that at some point state statutes may require the involvement of other professionals and agencies, but that you will let them know if you have reached that level of concern. Reiterate that your concern is for the health and well-being of their child, and that you want to work with them to assure their child's safety.

With permission of the caretaker(s), talk separately with the child about whether something is bothering or hurting him or her. Developmentally normal children older than 3 years of age are usually able to participate in an interview to provide reasonable responses to open-ended questions about their experiences and environment. They are also capable of offering supporting details. Dr. Peterson, for example, should ask Adrian about his sports activities and hear from him how his injuries occurred.

Step 4
Following the interview with the child, complete a comprehensive physical examination of him or her, including inspection of all skin surfaces. Ask the child who he or she would like to have present during their exam. Ask the accompanying caretaker(s) to allow the child to answer questions during the exam. Directly ask the child about any scars, marks, or bruises seen on his or her body and how these occurred. If the child is reluctant to talk in front of the caretaker(s), meet separately with him or her following the exam.

Step 5
Perform or schedule any indicated tests and studies.

Step 6
Determine if additional expertise is needed, and make referrals to a clinical social worker, child-abuse pediatrician, or psychologist as indicated. One advantage to Dr. Peterson's referring Adrian and his family to a CAN specialist is that the family can then identify the abuse issues primarily with the specialist rather than with Dr. Peterson and her primary care practice.

Step 7
Based on information from the evaluation, determine whether the concern for abuse has risen to a suspicion. If so, report to CPS, a law-enforcement agency, or both, as dictated by the state's CAN statutes. Review your conclusions and your reporting decision with the caretaker(s). If Dr. Peterson decides a report to CPS is not

necessary, she may still want to refer Adrian for mental health counseling to explore the reasons for his change in affect ("often visibly upset or quiet and withdrawn"), which may be unrelated to his sports injuries but can be directly related to the family's financial stresses.

Step 8
Address any issues related to the child's safety or mental health and emotional needs as indicated.

Conclusion
Ultimately, Dr. Peterson's responsibility is to the well-being and safety of her young patient. She should be prepared to approach the possible diagnosis of child abuse or neglect in the same manner and with the same diligence that she approaches any other disorder or disease of childhood. By providing the best medical assessment, Dr. Peterson will help to identify whether or not Adrian has been abused or neglected. If her assessment concludes that CAN is suspected and she appropriately files a report, she will help assure that Adrian's case receives the most comprehensive assessment possible; that his medical, mental health and safety needs are addressed; and his family receives support and services.

References

1. US Department of Health & Human Services, Administration for Children and Families. *Child Maltreatment 2006.* Washington, DC: US Government Printing Office; 2006.
2. Corso PS, Edwards VJ, Fang X, Mercy JA. Health-related quality of life among adults who experienced maltreatment during childhood. *Am J Public Health.* 2008;98(6):1094-1100.
3. Chapman DP, Dube SR, Anda RF. Adverse childhood events as risk factors for negative mental health outcomes. *Psychiatr Ann*. 2007;37(5):359-364.
4. Hindley N, Ramchandani PG, Jones DPH. Risk factors for recurrence of maltreatment: systemic review. *Arch Dis Child*. 2006;91(9):744-752.
5. Flaherty EG, Sege RD, Griffith J, et. al. From suspicion of physical child abuse to reporting: primary care clinician decision-making. *Pediatrics*. 2008;122(3):611-619.

Karen St. Claire, MD, is the medical director of the Duke Medical Center Child Abuse and Neglect Consult Service in Durham, North Carolina, and works as a clinician and educator in child maltreatment.

Related in VM
To Report or Not Report: A Physician's Dilemma, February 2009

Suspected Child Abuse, November 2007

Liability for Failure to Report Suspected Child Abuse, December 2007

The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental.

The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of the AMA.