Improving Physician Identification and Reporting of Child Abuse

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Abstract

- **Objective:** To discuss physician identification and reporting of child abuse and barriers that prevent physicians from properly addressing child maltreatment.
- **Methods:** Case presentation and review of the literature.
- **Results:** Physicians often fail to consider child abuse as a cause of a child’s injuries and even when they suspect child abuse, a quarter fail to report their suspicion to child protective services. Some of the reasons that physicians give for not reporting suspicious injuries include that they are uncertain about the legal mandate to report, they are uncertain whether the child’s injury was caused by abuse, they lack confidence in the investigation process, and they fear negative personal consequences including the loss of patients from their practice.
- **Conclusion:** All physicians who care for children need to understand how to identify child maltreatment and report suspected child maltreatment to child protective services. Physician failure to properly diagnose and report suspected child abuse may allow the child to suffer continuing abuse leading to short and long-term morbidity and potentially death.

Child maltreatment is not uncommon. About 3 million reports of suspected child maltreatment are made to child protective services each year in the United States and about 900,000 of these reports are indicated or found to be true [1]. More than 1700 children die because of maltreatment while many more suffer long-term and devastating physical and emotional consequences [2–4]. Child maltreatment and other childhood adversities may lead to adverse health outcomes for both children and adults [5–7]. A number of studies suggest that the incidence of maltreatment is much higher than current statistics suggest, as it is often not identified and reported to authorities [8–11].

Physicians play a critical role in identifying and reporting child maltreatment. Recent data, however, show that medical personnel including physicians made less than 10% of the reports of suspected abuse to state child protective services. When compared with investigations initiated by other reporters, a higher percentage of reports from medical personnel were found to be true or substantiated [1].

CASE STUDY

**Initial Presentation**

A 4-month-old girl presents to the clinic with a chief complaint of facial bruising. The child’s mother reported that she noticed the bruising when the child awakened from a nap. She denied any history of trauma or other bruises.

**History**

This patient has been followed in the practice since her birth. Aside from some mild gastroesophageal reflux, she has been healthy. She is the result of a pregnancy conceived through in-vitro fertilization. She was delivered via an uncomplicated vaginal birth, and has not had any medical problems. Her growth and development have been normal. Her family is well known in the community, and her parents have always appeared attentive to the child’s needs. There is no family history of any hematological disorders.

**Physical Examination**

On physical exam, the child appears alert. She is noted to feed vigorously from a bottle during the visit. Her cutaneous examination is significant for an approximately 2-cm by 1-cm purple bruise on her right forehead and a smaller bruise on her left cheek. The remainder of her physical exam is normal.

**Are these bruises concerning for child abuse?**

Bruises are the most common injury caused by child abuse and are frequently the only visible sign or clue that a child has been maltreated. Although bruises are common accidental injuries, about 50% to 90% of children who have been physi-
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cally abused have at least 1 bruise [12-14]. Bruises in children who have not begun to pull to stand and walk holding onto furniture are extremely rare and should raise concern for abuse [15]. Accidental bruises normally occur over bony prominences, for example, the foreheads of toddlers and shins of older children [16,17]. Bruises over soft, fat padded areas are more likely to have been caused by child abuse, for example, cheeks, neck, and abdomen. This child's bruises should make you concerned about child abuse, because she is only 4 months old and has 2 unexplained bruises and because the bruise on the cheek is over a soft, padded, nonbony surface.

Case Continued

You explain to the mother that you are concerned that the bruising may have been caused by inflicted trauma given the child's young age. The mother expresses offense that abuse would be suspected in her family. You explain to her that you are not accusing her of anything but are referring the child for additional medical studies.

- What is an appropriate workup for an infant with suspected abuse?

An appropriate workup and management of an infant with suspected abuse should involve a thorough medical evaluation in addition to ensuring the safety of the child while the evaluation and investigation are underway.

A skeletal survey is indicated for any child younger than 2 years of age with suspected physical abuse. While nearly all institutions perform skeletal surveys, the components of the imaging vary widely. A recent survey of children's hospitals found that many institutions were not performing adequate skeletal surveys [18]. Only 42% of the institutions reported acquiring more than 15 images, a number that approximates that recommended by the American College of Radiology (ACR) [19]. It is likely that institutions not specializing in pediatric care obtain even fewer images. Inadequate skeletal surveys pose a risk in both failing to identify fractures, and falsely reassuring clinicians that abuse has not occurred [20].

Skeletal surveys play a pivotal role in identifying fractures that would otherwise not come to a physician's attention. While any fracture can be caused by child abuse, certain fractures have a higher specificity for abuse, including classic metaphyseal fractures, rib fractures (especially posterior), scapular fractures, spinous process fractures, and sternal fractures [21]. While clinically occult fractures may not require medical treatment, their identification may be critical in ensuring a safe environment for the child.

Head imaging including computed tomography scans (CTs) and magnetic resonance imaging (MRI) also plays a significant role in the identification of child abuse and is clinically indicated when abuse is suspected in a child under 1 year old or in an older child with suspected inflicted head trauma [19]. Head CTs are a valuable tool for screening for head trauma [22]. They are typically easily and quickly obtained and can often be done without sedation. Brain MRIs also serve an important role in the evaluation of physical abuse. While they are typically less readily available than head CTs, MRIs offer several advantages. This modality allows for a more accurate characterization of extraaxial and brain structures, and can allow for more accurate determination of the age of the blood products. The lack of radiation offers another distinct advantage, particularly in infants and young children. An MRI is often indicated as a follow up study once trauma findings are noted on CT.

A dilated ophthalmology examination by an experienced ophthalmologist is indicated in the setting of intracranial injury that is concerning for abuse. While several ophthalmologic findings can accompany abusive head trauma, retinal hemorrhages are the most common, occurring in 30% to 100% of infants with abusive head trauma [23,24]. Since retinal hemorrhages can begin to resolve within a few days, this evaluation should be done as promptly as possible.

In cases of bruising or intracranial hemorrhage, a basic workup for coagulation disorders should be performed. This evaluation should include, at a minimum, a complete blood count with platelet count, prothrombin time, partial thromboplastin time, and platelet function tests. Further medical workup for a coagulopathy, genetic cause, or metabolic disorder may be indicated in some cases [25]. While certain situations may warrant a more exhaustive workup for a medical etiology of findings, it is important to remember that the incidence of child abuse is significantly higher than the incidence of the unusual medical conditions that can mimic child abuse.

Case Continued

The patient is referred to the local children's hospital for a physical abuse evaluation. Given the patient's young age and limited developmental abilities, reporting the bruising to child protective services is warranted. You decide it is reasonable to wait to report until the other studies are complete, since there are no other children in the home.

The emergency department (ED) physician, concerned that the bruises may represent recent head trauma, orders a head CT. The scan reveals bilateral extraaxial collections of varying densities, which are found to represent bilateral acute and chronic subdural hematomas on a subsequent MRI. An ophthalmology consultation does not reveal any abnormalities. A skeletal survey is done and is significant
for multiple healing rib fractures and a classic metaphyseal fracture of the left distal femur. Laboratory studies indicate normal coagulation. The ED physician contacts you to discuss filing a report of suspected child abuse with child protective services. You receive a page that the parents are angry and would like to speak to you. You are uncertain about how to best approach this family.

• What is a physician’s responsibility in reporting child abuse?

All 50 states have laws requiring that physicians report suspected child maltreatment to child protective services [26]. Legal protection is offered for physicians reporting in good faith [27]. Conversely, there can be adverse legal consequences for physicians who fail to report suspected child abuse.

While physicians may understand that they have a legal obligation to report suspected child maltreatment, there is a lack of consensus on the level of certainty required for reporting. The majority of states use the term “reasonable suspicion” in their mandated reporting statutes. A survey of Pennsylvania pediatricians found significant variability in the thresholds that physicians set for what constituted reasonable suspicion [28,29]. While 12% of the respondents reported that child abuse would have to rank first or second on the differential diagnosis list before reporting, 47% reported that the reasonable suspicion standard would be met if child abuse ranked as low as 10th on the differential diagnosis. Regardless of the precise definition used, all states require physicians to report suspicious cases to child protective services.

The physician’s role in child protection does not end when the child protective services report is made. Investigators depend on the knowledge and expertise of physicians in assessing whether a child has been maltreated. They frequently seek information about a physician’s experience with a child and family. Information pertaining to attention to medical care, child growth and development, and prior injuries or concerns can be critical to an investigation. While care should be taken to guard information that is not relevant to an investigation, HIPAA regulations specifically allow for information sharing in the context of mandated reporting of child maltreatment [30]. When reporting suspected child maltreatment, the child’s protected health information may be shared with child protection investigators with or without parental consent.

Physicians have said that they do not always report to child protective services all children they suspect have been abused or neglected [31–33]. Reporting rates vary depending on the type of suspected maltreatment. One study found that physicians were more likely to report physical abuse and sexual abuse (91% and 92% respectively) but were less likely to report physical neglect (58%), emotional abuse (45%), and medical neglect (43%) [31]. There is also variability among primary care providers, with general practice practitioners showing more caution in reporting than pediatricians in one Australian study [34].

• Why do physicians fail to report child maltreatment?

Studies have identified a number of reasons that physicians fail to report child abuse and neglect. Lack of certainty about whether the injury was caused by child abuse is the most common reason physicians give for not reporting suspicious injuries [11,32]. Physicians appear confused about the level of certainty needed to report abuse. In addition, there can be a lack of knowledge about reporting laws and the child protective services process [33]. Physicians’ lack of confidence in their skills to diagnose and manage child maltreatment also plays a role [35,36]. One study found that while pediatricians often felt competent in conducting medical exams for suspected maltreatment, they felt less competent in definitively stating a medical opinion, and generally did not feel competent testifying in court. The type of abuse also contributed to sense of competence, with pediatricians reporting less confidence surrounding sexual abuse versus other forms of maltreatment [37]. It has been shown that pediatricians are more confident in their ability to manage child abuse if they have received recent child abuse education [32].

Physicians’ familiarity with the child’s family can also impact their willingness to suspect and report abuse [38]. While knowledge of a family’s social risk factors or prior social services history may increase a physician’s willingness to report, prior positive experiences can lead to a physician not reporting suspected abuse. One study found that physicians were more likely to report families that had at least one risk factor [38]. Families unfamiliar to the physician were also more likely to be reported. Studies have also shown a greater tendency to suspect abuse in certain minority populations, including black and Latino families [39]. Physicians have also demonstrated a tendency to report cases involving Medicaid or self-pay health care more often than cases involving privately insured children [35]. A physician’s overall impression of a family may contribute to their failure to report. Physicians may not suspect abuse in a family that has demonstrated consistency in attending appointments and interacted appropriately with their child during office visits. In addition, physicians may be reassured by a lack of injuries or concerns in other children in the family [11,35,38].

The anticipated outcome of a child protection investigation can also influence a physician’s willingness to report
suspected abuse. Some physicians report that prior negative experiences with child protective services contribute to their reluctance to report suspected maltreatment [32]. They describe frustration if child protective services did not accept their report for investigation or if they perceive that nothing was done as the result of child protective services involvement. They are also cognizant of the stress that an investigation puts on a family and state that this weighs on their decision to report. Some physicians also believe that through frequent office visits and phone follow-ups they can manage the situation better than child protective services [40].

In addition to concern for negative consequences for the child and their family, physicians may also worry about negative personal consequences from reporting. Pediatricians voice concern that the involved family will leave their practice limiting their ability to follow up on the child and intervene in the future [38]. A loss of referrals is also a perceived negative consequence of reporting a case to child protective services. Though unlikely, physicians also express concern over potential lawsuits from reporting a family. Physicians who had prior experience being deposed or testifying in a child maltreatment case were less likely to report suspected abuse than those who had not had this experience [33].

**Case Continued**

You speak to the patient’s mother on the phone. She expresses confusion about the etiology of the injuries and insists there must be a medical cause. The mother reports anger and embarrassment over child protective services becoming involved with her family. She insists that she would not have brought her child for medical care if she had harmed her. The father is now present in the ED and expresses similar concerns to you. After allowing the parents a few moments to express their concerns, you explain your responsibility and role.

You explain to the family that anytime a child has injuries concerning for abuse, as in the case of their daughter, the law requires physicians to report these concerns to child protection officials. You explain that you are not implying that either parent has harmed their child. You also explain that subdural hematomas, fractures, and bruises in children of this age are often caused by child abuse and given that these injuries are very concerning for abuse, an investigation needs to occur. You attempt to partner with the parents by reminding them that everyone has the common goal of ensuring that their daughter is safe. While the parents are not pleased with the plan, they acknowledge that they understand the reason for the report. You then explain what they should expect will happen as a result of the report. You tell them that a child protective services investigator will contact them shortly and that law enforcement may also investigate given their daughter’s serious injuries and young age.

**Table.** Informing Caregivers of a Report to Child Protective Services

<table>
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<th>Instruction</th>
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<tr>
<td>Ensure the safety of the child and medical staff</td>
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<tr>
<td>Consider having another staff member present when informing caregivers</td>
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<tr>
<td>Remain calm and nonjudgmental</td>
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<tr>
<td>Directly state the cause of the concern</td>
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<tr>
<td>Allow caregivers to express their concerns about the report</td>
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<tr>
<td>Attempt to engage the caregiver by emphasizing the shared goal of child safety</td>
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<tr>
<td>Explain to the family what they can expect to happen next*</td>
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*Since the guidelines for child protective services and possible law enforcement response vary, physicians should familiarize themselves with the expected response in their area.

You are contacted by a child protection investigator several days after the report is filed. You provide information and medical records and explain the child’s injuries and their implications. You provide similar information to the police investigator who contacts you around the same time. Several weeks later you learn that the patient’s father confessed to causing the injuries. After being cared for by relatives during the investigation, the child is returned to the care of her mother.

**What are the consequences for the child if a physician fails to identify and report child abuse?**

While physicians may be uncomfortable reporting suspected abuse to child protection officials, it is critical that they fulfill their requirement to do so. In many cases involving children who are severely abused, physicians have missed opportunities to intervene and prevent further harm. A study of 173 children with abusive head trauma found that 31% of the children had been previously evaluated by physicians after the trauma and the abuse was not recognized [10]. This failure to diagnose had significant consequences for these children, resulting in re-injury (27%), medical complications (40%), or death (9%). In another study of children who had suffered fractures caused by child abuse, 21% had been seen by a physician prior to the diagnosis of child abuse [20].

Physicians may be uncertain as to the best approach to informing parents of their concerns about child abuse. While no one approach is best in all situations, a calm, nonjudgmental, direct approach is typically useful (Table). Parents can have a wide range of responses when they are informed about the need to report suspected child abuse. While some parents express an understanding of the need for investiga-
tions to ensure a child’s safety, others may express anger or offense when they are informed of the report. While the law does not require physicians to inform families that they are making a child protective services report, physicians may want to explain to the family why they are reporting and the investigation process. Families may lose trust in the physician if they are unexpectedly contacted by investigators after a report has been made without their knowledge.

Parents commonly fear that child protective services involvement will inevitably lead to the child’s removal from the home. Child protective services has several roles. First, they are able to conduct a thorough investigation of the family circumstances. While the investigation may confirm abuse, it may also reveal an accidental mechanism. When maltreatment is confirmed, child protective services typically provides support for the family to address the conditions that led to the maltreatment. For example, child protective services may be able to provide assistance with childcare, parenting support, and domestic violence intervention. In those cases where child protective services finds that the family cannot safely care for the child, there is close judicial oversight to protect parental rights. Only about 20% of the children whom child protective services determined have been maltreated are placed in foster care and about a quarter of these children are placed in relative foster care [2,41]. About half of these children will be reunified with their families after services are provided.

Conclusion

Physicians play a pivotal role in ensuring their pediatric patients’ health and well being. While many physicians have discomfort in their role as mandated reporters, it is imperative that they fulfill their legal obligation to report suspected child maltreatment. Physicians should be aware of reasons that providers fail to report and should work to maintain objectivity in evaluating and reporting abuse in their own practices.

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References


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