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Brief Communication

Telling their stories: primary care practitioners' experience evaluating and reporting injuries caused by child abuse^{☆,☆☆}

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Abstract

Objective: To learn about primary care physicians' experiences in identifying and reporting injuries caused by physical abuse.

Method: Two qualitative analysts facilitated a focus group of six Chicago area, primary care physicians. Physicians representing diverse practice settings were selected to participate in the discussion. The analysts reviewed and analyzed the audiotape transcription of the focus group for common emergent themes.

Results: Two themes emerged: (1) the importance of the participants' own past experience identifying and reporting suspected child abuse and (2) the responsibility physicians experience as they strive to assess possible abuse within the time constraints of an office visit. Each physician described a sentinel event that continues to affect decision-making. The physicians described several obstacles to decision-making including a lack of knowledge about child abuse, their previous experience with child protective services (CPS), and the additional time required to evaluate and report suspected abuse. The discussion suggested that rapid availability of expert consultation improved participant comfort in decision-making when abuse or neglect is suspected.

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Conclusion: Primary care physicians reported being strongly influenced by their previous experiences with suspected abuse. A better understanding of office-based experiences with suspected abuse is needed to guide the development of tools and systems to enhance the ability of the primary care physician to provide the best care for children who may have been abused.

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Introduction

Child physical abuse presents unique diagnostic challenges for primary care physicians. Unlike other conditions, the child's parent or guardian may not provide a truthful history. There is often no single physical finding or diagnostic test that definitively demonstrates or rules out the possibility of abuse. Compounding these problems is the realization that child physical abuse may recur, sometimes with fatal consequences. On the other hand, the legal consequences of child abuse reporting may adversely affect the family and the doctor-patient relationship.

Primary care practitioners treat many childhood injuries (Flaherty, Sege, Mattson, & Binns, 2002; Hambidge, Davidson, Gonzales, & Steiner, 2002). Although there is no information available about how frequently practitioners suspect these injuries are caused by child abuse, previous surveys show that primary care physicians do see abuse-related injuries in their office practices. In a 1998 survey of pediatrician members of the American Academy of Pediatrics, 57% of 608 pediatricians reported that in the previous year they had treated at least one injury caused by child abuse (American Academy of Pediatrics Survey of Fellows No. 38, 1998). In a study of pediatric providers in a regional practice-based research network, 56% of 85 providers said they had treated abused children the previous year (Flaherty, Sege, Binns, Mattson, & Christoffel, 2000).

There are no studies that describe the frequency with which primary care pediatric providers report suspected abuse. However, based on the self-reports of physicians, they do not report all children they suspect were abused to child protective services (CPS) (Flaherty et al., 2000; Saulsbury & Campbell, 1985; Zellman, 1990). The most common reasons providers indicated for not reporting suspected abuse were (1) a reluctance to report before they were certain of the diagnosis and (2) a belief that they could work with the family without outside intervention. Physicians may not report because of previous experiences with CPS. About half of the physicians in one survey reported that their previous experiences with CPS made them less likely to report suspected abuse in the future (Flaherty et al., 2000).

These studies demonstrate that in order to improve the identification and management of child abuse in primary care settings, a more complete understanding is needed of how primary care practitioners currently determine that a particular injury may be suspicious for physical abuse, their experience reporting to CPS, and an analysis of factors that support practitioners' decision-making. As part of a larger project to study practitioner decision-making, we conducted a focus group of pediatric primary care practitioners and asked them to tell us about their experiences identifying and managing suspected child abuse injuries.

Method

A focus group was conducted to explore factors associated with the primary care practitioners' experiences evaluating and managing childhood injury cases and to develop working hypotheses to guide future research. A purposive sample was used to ensure that practitioners representing diverse practice settings and serving different patient populations participated in the discussion.

Focus group participants were asked to describe their practice setting, years in practice, and experiences treating childhood injuries in their offices. The physicians discussed their training about child abuse, what made them suspect an injury was caused by abuse, and the number of children they had seen with an injury they suspected was caused by abuse. They described their experiences with assessment, diagnosis, and management of injuries they suspected were caused by child abuse. They described how they use other professionals, specialists, and resources to help them make a decision about whether a child may have been abused, and they described the barriers they had encountered. The participants were asked to describe their experience reporting to CPS and the subsequent outcome of that report. They discussed the consequences of reporting, including the consequences for themselves, the child, and the family. They were asked to describe the resources they would like to help them intervene and prevent abuse and to help them better identify and report suspected abuse.

The group session was professionally facilitated, audio-taped and transcribed. The analysts (R.J. and C.K.), visually reviewed and analyzed the focus group transcript for common emergent themes.

The Children's Memorial Hospital Institutional Review Board approved the study. The participating physicians provided written consent prior to participation.

Results

Six Chicago-area, primary care physicians participated in the focus group in December 2001. The physicians were evenly divided along gender lines, and two were Hispanic (four were White, non-Hispanic). Three physicians worked in inner-city practices that serve mainly low-income children, and the rest were in suburban practices serving mainly children with private insurance. They had been in practice an average of 9 years with a range of 5–19 years.

Thematic analysis of transcripts revealed two important factors that influenced participant decision-making regarding potential child abuse: (1) past subjective experience, including the recall of single cases that profoundly influenced their personal practices; and (2) a sense of an enormous responsibility to make the correct assessment, usually within the time constraints of an office visit.

Past experiences influenced provider decision-making. Although the moderator never asked for descriptions of any individual case, every physician described an earlier, emotionally-charged, experience that continued to exert a strong influence on their responses to injuries seen in their practice.

Several physicians described children who had suffered terrible consequences because they had failed to recognize and report abuse. Other physicians had reported an injury to CPS, but then learned that CPS had unfounded the report or determined that the injury was not caused by abuse. This CPS response appeared to decrease the participating physician's confidence to detect abuse.

These critical experiences strongly affected their current approach to child abuse. Sometimes this experience caused the physician to change an office routine. One physician described an experience of missing apparent suspicious injury patterns in a patient who was later found to have been abused. The physician now always completely undresses every child. Sometimes, the experience impacted a specific

aspect of decision-making. For example, some physicians questioned the consequences of an investigation and the value of reporting suspicions of abuse to CPS. One physician, who reported a poor experience with CPS, described a particular case where a child was fatally abused following a CPS investigation.

Participants described feeling an enormous burden of responsibility to make the correct assessment often within the time limits of an office visit. Participants expressed concerns about the child abuse decision-making process. They said they were overwhelmed by the responsibility of making the *correct* decision. They were frustrated because sometimes the true cause was not resolved. They perceived themselves as having inadequate ability to manage cases of suspected abuse and said they lacked the tools to engage families in discussions about their child's injuries.

Barriers to reporting

Group participants reported several barriers to identifying possible abuse, including a lack of knowledge about child abuse and their relationship with families in their practice. All of the physicians said that they lacked knowledge regarding the identification and management of child abuse, because their training had been haphazard and infrequent. They reported that their relationships with families both facilitated and impeded their assessment of the cause of an injury. On the one hand, physicians said they feared offending families. They described how a close relationship with the family made it harder to consider abuse. If a physician knew the family well, they thought that they would be more likely to accept the family's explanation for an injury. On the other hand, physicians sometimes thought that their knowledge of certain problems within a family caused them to be more suspicious that an injury was caused by abuse.

These physicians commented that reporting suspected abuse to CPS forever changes their relationship with families. This relationship was changed even when they reported a suspicion that someone outside of the family had hurt the child. In those situations, the delivery of routine anticipatory guidance seemed of trivial importance when compared with the harm or potential harm that the child had suffered.

The physicians said that their experience with CPS was a potential barrier to reporting suspected abuse. Some physicians were discouraged and disappointed that they did not receive more support from CPS. When CPS did not follow-up on the physician's concerns, the physician felt "exposed." Physicians indicated that they did not always receive feedback from CPS after they made a report.

Bureaucratic issues also impeded the physicians' ability to assess and manage suspected child abuse. Office time was an important barrier. They described how certain insurance plans push the physician to hurry the office visit, thus limiting available time. The actual process of making a report can be time consuming. The CPS-reporting hotline may defer taking a report for hours, even though the patient and family are physically in the office waiting room. The lack of availability of an in-office diagnostic test was another barrier. Physicians found it awkward to explain to parents why they were sending a child to the hospital for a skeletal survey because of concern that the child might have been abused. Further, they reported that certain insurance carriers may not allow them to refer a child to an institution recognized to provide the quality diagnostic studies or the expert opinion needed to make the diagnosis.

Decision-making supports

The physicians described resources that helped them with their decision-making. They found it helpful to discuss their decisions with colleagues in their office. They appreciated having child abuse experts that

they could contact by phone. Additionally, Emergency Departments with pediatric expertise were a valued resource. They also said that the legal mandate to report facilitated their discussion of the possibility of abuse with the patient's family.

When asked to describe a resource that would help them in their office decision-making, they said they would like to have a clearinghouse that functioned like the poison control hotline. If they had a question, they could call and discuss their concerns or findings immediately with a child abuse expert.

Discussion

Child abuse recognition and management is an emotionally charged event for pediatricians. The physicians described a sentinel event earlier in their career that continued to influence their assessment of possible child abuse. In addition, awkward delays in decision-making or consultation, while the patient and family were in the office, strongly discouraged investigation, consultation, and reporting.

Most resident training programs focus on the cognitive aspects of child abuse recognition. These focus group discussions with physicians suggested that past personal experiences mediate current practice. Because these experiences may occur early in a career, they may have long-lasting and profound effects on subsequent practice. If these results are reproduced in future studies, they would have important training implications. Future training of physicians should possibly include exploration of past sentinel events. An understanding of the heuristics that practitioners employ when making decisions based on these sentinel events may help educators to develop models that will help physicians give the proper perspective to their individual experiences (Slovic, Fischhoff, & Lichtenstein, 1982).

These results also suggest that physician reporting would be facilitated by support at the time of initial assessment, including rapid access to child abuse consultants. CPS needs to recognize and respond to the special circumstances faced in the health care setting by allowing ready access to reporting hotlines and appropriate response and feedback to physicians who report suspected abuse. CPS response is important, because our previous results, confirmed here, suggest that physicians' adverse experiences in child abuse reporting may make them less likely to file subsequent reports to CPS.

These physicians expressed a need for more education about child abuse and wanted the skills to determine the cause of injuries. New York requires professionals to take a course about the identification of child abuse prior to licensure (Reininger, Robison, & McHugh, 1995). The focus group participants suggested an office-detailing format similar to that used by pharmaceutical representatives. The Pennsylvania Chapter of the American Academy of Pediatrics has developed an educational program, EPIC-SCAN (Educating Physicians in their Communities-Suspected Child Abuse and Neglect) that is presented by a team of professionals to physicians in their office, using an office-detailing model (Portnoy, 2001).

Although our study findings are limited to the results of a single focus group, these data provide insight to guide further investigation of the primary care physicians' experience with child abuse. The provocative results of this single focus group suggest that successful child abuse training should address affective as well as cognitive factors involved in this difficult field. In addition, resources to support office-based physicians should be developed based on an improved understanding of the practical difficulties of the child abuse evaluation process from the provider's perspective.

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Résumé

Objectif: Explorer l'expérience vécue de médecins qui ont administré des premiers soins en ce qui concerne l'identification et le signalement des blessures causées par des mauvais traitements physiques.

Méthode: Deux analystes qualitatifs ont animé des réunions de groupe avec six médecins de premier recours exerçant dans la région de Chicago. Des médecins exerçant selon des pratiques diverses ont été sélectionnés pour participer à la discussion. Les analystes ont contrôlé et analysé la transcription sur bande magnétique de la discussion du groupe en ce qui concernait les thèmes qui apparaissaient le plus fréquemment.

Résultats: Deux thèmes sont apparus: (1) l'importance de l'expérience personnelle antérieure du participant dans la détection et le signalement d'abus suspectés; et (2) l'expérience des médecins concernant leur responsabilité lorsqu'ils essaient d'évaluer la possibilité de présence de mauvais traitements dans les limites du temps d'une consultation. Chaque médecin a évoqué un événement faisant office de sentinelle qui affecte couramment leur prise de décision. Les médecins ont décrit plusieurs obstacles qui affectent leur décision, comme leur manque de connaissance en matière de mauvais traitements, leurs expériences antérieures lors de contacts avec les services de protection de l'enfance (CPS) ainsi que le supplément de temps nécessaire pour évaluer et signaler les abus faisant l'objet de suspicion. Dans la discussion il est apparu que la rapidité avec laquelle la consultation d'un expert est possible améliorerait le confort de la prise de décision en cas de suspicion de mauvais traitements ou de négligence.

Conclusion: Les médecins de premier recours ont fait état de l'importance très grande de l'influence de leurs premières expériences dans les cas de suspicion de mauvais traitements. Il serait nécessaire de mieux connaître

comment se passent les consultations au bureau du médecin lorsqu'il y a suspicion de mauvais traitements. Cela permettrait de mettre au point des outils et des systèmes qui amélioreraient la capacité du médecin de premier recours à donner les meilleurs soins possibles aux enfants qui peuvent avoir été maltraités.

Resumen

Objetivo: Aprender acerca de las experiencias de los médicos de atención primaria en la identificación y notificación de daños causados por maltrato físico.

Método: Dos analistas cualitativos actuaron como facilitadores de un grupo focal formado por médicos de atención primaria de seis áreas de Chicago. Se seleccionaron médicos que representan ámbitos de práctica profesional diversos. Los analistas revisaron y analizaron la transcripción de las grabaciones del grupo focal para localizar temas comunes emergentes.

Resultados: Se detectaron dos temas emergentes: (1) la importancia de la propia experiencia pasada de los participantes identificando y notificando sospechas de abuso sexual y (2) la responsabilidad de la experiencia de los médicos ***** para evaluar el posible abuso dentro de las limitaciones temporales de una visita. Cada médico describió un acontecimiento “centinela” que continúa afectando a la toma de decisión. Los médicos describieron varios obstáculos para la toma de decisión tales como una falta de conocimiento sobre el maltrato infantil, sus experiencias previas con los servicios de protección infantil y el tiempo adicional necesario para evaluar y notificar las sospechas de maltrato. La discusión sugirió que la rápida accesibilidad de una consulta con un experto aumentó el confort de los profesionales en la toma de decisión cuando se sospecha de maltrato o abandono.

Conclusión: Los médicos de atención primaria notificaron que estaban fuertemente influenciados por sus experiencias previas con sospechas de maltrato. Se necesita un mejor entendimiento de las experiencias de la consulta con casos de sospechas de maltrato para guiar el desarrollo de protocolos y sistemas que mejoren la habilidad de los médicos de atención primaria para proporcionar el mejor cuidado para los niños que pueden haber sido abusados.