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Is the diagnosis of physical abuse changed when Child Protective Services consults a Child Abuse Pediatrics subspecialty group as a second opinion?

James Anderst[a,*], Nancy Kellogg[b], Inkyung Jung[c]

[a] Division of Emergency Medical Services, Section for Children at Risk, Children's Mercy Hospitals and Clinics, University of Missouri at Kansas City, 2401 Gillham Road, Kansas City, MO 64108, USA
[b] Division of Child Abuse Pediatrics, UT Health Science Center San Antonio, USA
[c] Department of Epidemiology and Biostatistics, UT Health Science Center San Antonio, USA

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ABSTRACT

Objectives: To characterize the changes regarding the diagnosis of physical abuse provided to Child Protective Services (CPS) when CPS asks a Child Abuse Pediatrics (CAP) specialty group for a second opinion and works in concert with that CAP group.
Methods: Subjects were reported to CPS for suspected physical abuse and were first evaluated by a physician without specialized training in Child Abuse Pediatrics (non-CAP physician). Subjects were then referred to the area's only Child Abuse Pediatrics (CAP physician) group, located in a large metropolitan pediatrics center in the United States, for further evaluation. The diagnoses regarding abuse provided by CAP physicians working in concert with CPS were compared to those provided to CPS by other physicians.
Results: Two hundred consecutive patients were included in the study. In 85 (42.5%) cases, non-CAP physicians did not provide a diagnosis regarding abuse, despite initiating the abuse report to CPS or being asked by CPS to evaluate the child for physical abuse. Of the remaining 115 cases, the diagnosis regarding abuse differed between non-CAP physicians and CAP physicians working in concert with CPS in 49 cases (42.6%; $\kappa = .14$; 95% CI, −.02, .29). In 40 of the 49 cases (81.6%), CAP assessments indicated less concern for abuse when compared to non-CAP assessments. Differences in diagnosis were three times more likely in children from a nonurban location (OR 3.24; 95% CI, 1.01, 11.36).
Conclusions: In many cases of possible child physical abuse, non-CAP providers do not provide CPS with a diagnosis regarding abuse despite initiating the abuse investigation or being consulted by CPS for an abuse evaluation. CPS consultation with a CAP specialty group as a second opinion, along with continued information exchange and team collaboration, frequently results in a different diagnosis regarding abuse. Non-CAP providers may not have time, resources, or expertise to provide CPS with appropriate abuse evaluations in all cases.
Practice implications: Though non-CAP providers may appropriately evaluate many cases of physical abuse, the diagnosis regarding abuse provided to CPS may be changed in some cases when CAP physicians are consulted and actively collaborate with CPS investigators. Availability of Child Abuse Pediatrics subspecialty services to investigators is warranted.
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* Corresponding author.

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Introduction

Child abuse is a common condition, occurring in approximately 11/1000 children in the United States annually (Department of Health and Human Services, Administration on Children, Youth and Families, 2008). Primary care providers and other physicians without special expertise in child abuse may appropriately evaluate many cases; however, other cases may be more challenging, time consuming, or complex. In these instances, special expertise in and dedication to child abuse may be beneficial. In these cases, a Child Abuse Pediatrician may provide the needed expertise and availability to ensure the best possible outcome for both the child and the family involved in the investigation.

Child Abuse Pediatrics (CAP) is an emerging subspecialty. The American Board of Medical Specialties approved the CAP application for subspecialty status in 2006, and the first subspecialty certification exam will occur in 2009 (American Board of Medical Subspecialties, 2008). Evaluating complicated cases of possible abuse frequently requires an understanding of important and emerging scientific knowledge base of Child Abuse Pediatrics. Studies have addressed the importance of the history provided by caregivers (Hettler & Greenes, 2003), biomechanical analysis of fracture morphology (Pierce, Bertucci, Vogeley, & Moreland, 2004), mechanical and physiological analysis of head injury (Duhaime et al., 1987; Prange, Coats, Duhaime, & Margulies, 2003; Raghupathi, Mehr, Helfaer, & Margulies, 2004) and scientific evidence regarding bruises and burns (Allasio & Fischer, 2005; Committee on Child Abuse and Neglect, American Academy of Pediatrics, 2002; Daria et al., 2004; Drago, 2005; Dunstan, Guildea, Kontos, Kemp, & Sibert, 2002; Feldman, 1992; Maguire, Mann, Sibert, & Kemp, 2005a, 2005b; Maguire, Mann, Sibert, & Kemp, 2005b; Mathew, Ramamohan, & Bennet (1998); Moritz & Henriques, 1947; Spiller et al., 2003; Sugar, Taylor, & Feldman, 1999). These data have increased the ability of physicians to accurately determine the likelihood of abuse in a scientific manner. It is not yet known what, if any, effect Child Abuse Pediatricians with knowledge in these areas may have on investigations conducted by Child Protective Services (CPS).

In the United States, CPS conducts investigations involving alleged child physical abuse. Many of these cases involve medical evaluations and resulting diagnoses regarding abuse. This information may be critical in determining the outcome of CPS abuse investigations. A major function of the CAP subspecialty is to provide Child Protective Services (CPS) with information regarding the diagnosis of physical abuse in children with suspicious injuries; however, this service may not be available in all locations. In these instances, CPS must rely on physicians without specialized training in child abuse to assess the likelihood of abuse in an injured child, even when cases are difficult, complex or time-intensive. Previous studies have documented physicians' mistrust of CPS and lack of willingness to report some cases of child abuse (Flaherty, Jones, & Sege, 2004; Jones et al., 2008). Some physicians may withhold a specific diagnosis regarding abuse in an effort to decrease involvement in an abuse investigation and/or decrease likelihood of receiving a subpoena to testify regarding the diagnosis of abuse. Additionally, some physicians may feel uncomfortable making a diagnosis regarding abuse based solely on information available at the time of the medical evaluation or due to a lack of expertise. As such, physicians may not provide CPS with a diagnosis regarding abuse in some cases. Additionally, the added expertise of CAP physicians, coupled with continual availability to CPS that allows CAP physicians and CPS to work in concert over time on cases of possible physical abuse, may result in changed diagnoses regarding abuse in some cases.

Previous studies have documented challenges in accurately diagnosing physical abuse in younger children. Jenny found that cases of missed abusive head trauma were more common in younger children (Jenny, Hymel, Ritzen, Reinert, & Hay, 1999). In addition, many clinicians fail to consider developmental status of the child, which changes most rapidly and significantly during the first year of life, when assessing for abuse (Anderst, 2008).

Children in rural locations present a unique challenge when the possibility of child abuse arises. Previous research has shown that the diagnosis of abuse differs between dedicated children's hospitals, which are typically located in more populated areas, and general hospitals (Trokel, Waddimba, Griffith, & Sege, 2006). Clinicians providing care to children in rural locations may have less training in pediatrics (Goodman & the Committee on Pediatric Workforce, 2005) and potentially different relationships with families and communities than urban physicians (Shapiro & Longenecker, 2005). Additionally, CPS offices located in rural areas may cover a larger geographic region, have access to fewer physicians trained in pediatrics, and may conduct fewer physical abuse investigations. Obtaining medical assessments regarding abuse may be more difficult for CPS workers in these locations. It is unknown how these factors unique to the physicians in rural locations may affect the diagnoses regarding abuse provided to CPS.

We hypothesized that the diagnoses regarding abuse provided to CPS by non-CAP physicians would differ significantly from those provided by CAP physicians working in concert with CPS, and that, in many instances, non-CAP physicians would offer no information to CPS regarding the diagnosis of abuse. Additionally, we hypothesized that different diagnosis would be more common in children less than 1 year of age than in older children. Lastly, we hypothesized that different diagnoses would be more common in children from rural locations than in children from urban locations.

Methods

The authors abstracted information from a local database involving all patients referred by CPS to a CAP subspecialty group from 11/06 to 6/07. This time period was selected as the CAP clinic opened in mid-2006, and by late 2006, data collection processes were standardized to allow for appropriate information collection. From its inception, the CAP clinic was made available to and advertised to local and regional CPS offices and investigators. In the months following the end of the study period, advertisement of the clinic to the local medical community commenced. Knowledge of the CAP clinic

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