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Three models of child abuse consultations: A qualitative study of inpatient child abuse consultation notes☆

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ABSTRACT

Child abuse pediatricians have multiple roles in caring for abused children, including prevention, diagnosis, treatment, and, when needed, expert legal opinion. The child physical abuse consultation differs from the traditional medical consultation in that it has medical, investigative and legal audiences, all of whom have different information needs. How child abuse pediatricians approach their cases and how they document their initial inpatient consultations that will be used by such a diverse audience is currently unexplored. We used content analysis to examine 37 child physical abuse consultation notes from a national sample of child abuse pediatricians in order to understand physicians' approaches to these consultations. Three commonly used models of child physical abuse consultation were identified in the data that we named the base model, the investigative model, and the family-dynamic model. While model types overlap, each is distinguished by key features including the approach used to gather information, the information recorded, and the language used in documentation. The base model most closely mirrors the traditional medical approach; the investigative model concentrates on triangulation of sources of information; and, the family-dynamic model concentrates on physician perceptions of family relationships. The three models of consultations for child physical abuse mirror the areas of child abuse pediatrics: diagnostic, forensic and therapeutic. These models are considered in relationship to best practice from other medical specialties with forensic components.

Introduction

Medical diagnoses require physicians to select, assemble and document relevant facts from the large amount of information available from patients and families. These facts, including the patient's chief complaint, history of present illness, past medical history, family and social history and current risk indicators for disease, are assembled in order to arrive at and order a list of likely diagnoses (Bickley, Szilagyi, & Bates, 2009). The differential diagnosis list then guides the medical work-up needed to confirm or rule out the diagnoses at the top of the differential list. The medical evaluation of suspected child physical abuse uses the same iterative process of differential diagnosis as other medical diagnoses. The medical diagnosis of child physical abuse, however, has unique elements that present potential challenges to the traditional process of diagnosis and to the process of documentation in the consultation note.

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In contrast to a traditional medical consultation, in which a physician prepares a consultation intended to inform other medical colleagues, child abuse consultations also must be informative to outside agencies including children's protective services, the police, attorneys and judges (David, 2004). Clinicians who work with abused children have an awareness of how their medical evaluation and documentation will be used by this diverse audience. Although the majority of child abuse consultations never result in court proceedings, the potential for court involvement is present throughout the course of the medical evaluation (Palusci, Hicks, & Vandervort, 2001). Physicians may consciously or unconsciously self-edit their consultations in response to the perceived needs of investigating agencies or in anticipation of court proceedings.

Child abuse pediatrics is a new subspecialty that concentrates on the increasingly complex diagnosis and care of abused and neglected children. In 2012, the Children's Hospital Association (CHA) reported that there were 264 board certified child abuse pediatricians (CAPs) who consulted on 91,973 inpatient and outpatient cases at CHA hospitals ("Children's Hospital Association, 2012 Survey Findings Children's Hospitals Child Abuse Services", 2012). In addition to working with medical colleagues on these cases, child abuse pediatricians (CAPs) interact with social welfare agencies, law enforcement and the judicial system. A child abuse inpatient consultation for an injured child reflects this multidisciplinary audience, recommending diagnostic testing to rule out overlooked medical etiologies of physical findings (such as bleeding disorders) as well as testing to identify additional injuries that would not require medical treatment but would support a diagnosis of abuse (such as healing rib fractures). This dual role of the CAP, as both clinical and forensic expert, created controversy in the naming of the new pediatric subspecialty and highlighted a philosophical difference within child abuse pediatrics practice (Block & Palusci, 2006). Some physicians philosophically favored the name child abuse pediatrics to emphasize their clinical pediatric-based expertise, while others favored the term forensic pediatrics, to emphasize the legal and forensic aspects of their work. Currently, how child abuse pediatricians approach and document their work is unstudied. This study explores the content of inpatient child physical abuse consultation notes in order to elucidate both how CAPs approach their initial consultations and how this approach may reflect the CAPs underlying practice philosophy.

Methods

Study Context

Data for the current study were collected in the first year of a three-year period of data collection for a larger mixed method study of risk perception in child physical abuse. The larger study collected CAP consultation notes of three types of injury in children 4 years of age and younger: neurotrauma, long bone fracture, and skull fracture. The consultation notes were written after the evaluation of the injured child was completed and reflect the key features of the case that the CAP determined were pertinent to supporting his or her diagnostic decision-making. The study was reviewed and approved by the Institutional Review Board of the University of Utah and by each participant's Institutional Review Board. A Certificate of Confidentiality was obtained from the Eunice Kennedy Shriver National Institute of Child Health and Human Development.

Study Design

Participants were asked to cut and paste their de-identified consultation notes from completed consultations of injured children into a secure, web-based interface. Participants selected consultation notes for the study based on random dates that were sent to participants every three months in order to reduce potential selection bias. The web-based interface asked participants to enter their notes in the order of a standard medical history including history of presenting illness, past medical history, review of systems, family history, social history and physical exam. In order to preserve participants' documentation style, participants were not constrained by this system and were allowed to place their de-identified note into the web-based system as an entire document if they did not use a standard pattern for their evaluations. Participants also entered laboratory values and radiographic images with results for each case. Information about the participant's decision for each case (probable abuse, probable not abuse, and indeterminate) with their level of certainty in the diagnosis was collected.

Participants

Study participants were 32 CAPs who were recruited from two national, professional physician child maltreatment groups: the Ray E. Helfer Society and the American Academy of Pediatrics, Section on Child Abuse and Neglect. Participants were recruited through notices posted to the listserv of each group. In order to be eligible to participate, CAPs were required to have five years in pediatric practice post-residency, have obtained board certification in pediatrics, spend at least 50% of their clinical time evaluating possible child abuse cases including physical abuse, and be at an institution with an Institutional Review Board. Board certification in CAP was not required because board certification was not offered until the year participant recruitment began (2009). In order to insure a diverse physician group, minority physicians were over-recruited through snowball sampling in addition to the listservs. This resulted in a participant group that was primarily female (84%), Caucasian, non-Hispanic (81%), and highly experienced, with most participants reporting greater than 10 years of child abuse practice (62.5%).

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