Editorials

Role of the medical community in detecting and managing child abuse

Child abuse is a common problem that all practitioners who see children should be able to recognise

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Child abuse is common. In the 2011–12 financial year, Australia had over 250 000 notifications of suspected child abuse.[1] Of the cases investigated, 45% were substantiated.[1] Among non-substantiated cases, some were likely to have been abuse, but with not enough evidence to be confident that abuse had occurred because of the young age of the child in physical abuse or the lack of a witness in sexual abuse. This is a common problem in child abuse.

The most severe forms of physical abuse occur in pre-verbal children and present as an "accident". Sexual abuse is done in secret; there are no corroborating witnesses and the child is usually threatened with dire consequences if the abuse is ever revealed. Consequently, certainty can be difficult.

In this issue of the Journal, Gwee and colleagues report that a fortnightly retrospective audit of case files for children aged 0–3 years presenting to an emergency department (ED) with an injury improved the detection of cases of non-accidental injury.[2] The audit included a paediatric forensic expert reviewing files of children with suspicious injuries not initially identified by ED staff, and advising on appropriate follow-up.

Most child abuse is never reported, only coming to light during population or community retrospective surveys. Australian studies show that 5%–9% of the population was physically abused during childhood.[3,4] For child sexual abuse, including non-penetrative forms, the prevalence is 12% for males and 23% for females.[5] Neglect and emotional abuse, possibly the kinds seen most widely in general practice, are estimated to occur, respectively, in 12% and 11% of Australian children.[6] These are massive public health problems.

All Australian states and territories have legislation requiring medical practitioners to report suspected cases of child abuse to the appropriate child protection service. Medical practitioners should make themselves familiar with the reporting requirements in their own state. Despite such legislation, only 5.6% of reports investigated in 2011–12 were from medical practitioners.[1]

Several factors may explain this. First, although over 10% of children seen by family practitioners or ED staff may have suffered abuse at some stage, most of their presentations to health professionals are for the range of medical problems common to all children.

Second, when children do present with features of abuse, they may not be recognised as such if the practitioner is not aware that this is a common childhood problem and lacks training in recognising and managing potential abuse.

Third, this is an uncomfortable diagnosis to contemplate. There is no simple treatment, the doctor may have to relinquish some degree of control once a statutory authority is notified, and there may be concerns about damaging a good relationship with the child's family. It may be difficult for the doctor to believe that the parent could have harmed the child. There may be concern about divided loyalties towards the adult and the child patient.

Despite these problems in recognising and accepting abuse, it is essential to do so. These children need protection. Their parents may need help. Child abuse is a serious problem, not only because of what has been done to the child, but also because of the longer-term problems that occur in many of these children: depression; low self-esteem; anxiety; antisocial behaviour; substance misuse; and difficulties in sustaining close, caring relationships and in functioning as effective parents.[7,8]

How can the medical community better detect child abuse? The first step is to be aware of the extent of this problem, to know that it occurs in all social classes, and to recognise that it has serious, long-term consequences.[9]

The second step is to be aware that some injuries and presentations should arouse suspicion. In physical abuse, these include petechiae from trauma, unusual bruise patterns (particularly in soft tissue areas not normally bumped in play), bruises and fractures of any type in premobile children, and more serious injuries, particularly when the physical findings are inconsistent with the explanation given by the parent or caretaker.[10] In early infancy, sentinel injuries such as bruising may be a precursor to subsequent, more serious abuse and should not be ignored.[11] In sexual abuse, anogenital injuries, signs of sexually transmitted infection and sexualised behaviours should sound an alarm, although it is important to know that most child sexual abuse is not violent, that there are usually no physical signs, and that the story given by the child is usually the strongest indicator.[12]

The third step is to make a commitment to become more aware of this problem. This could involve undertaking some basic training, such as that offered by the Royal Australian College of General Practitioners.[13] Doctors should know their statutory obligation to notify. They need to be aware of appropriate ways to manage abused

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children, even if it is only to refer them to a more experienced colleague or hospital Child Protection Unit. This is the responsibility of all doctors who see children, specialists as well as general practitioners. Child abuse is as common as asthma, although far more complex. Like asthma, medical professionals should be able to recognise it, know how to manage less complex cases, know when they need help and how and when to refer concerning cases for more expert opinion.

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