



Research article

Gray cases of child abuse: Investigating factors associated with uncertainty[☆]



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ABSTRACT

Research in child abuse pediatrics has advanced clinicians' abilities to discriminate abusive from accidental injuries. Less attention, however, has been paid to cases with uncertain diagnoses. These uncertain cases – the “gray” cases between decisions of abuse and not abuse – represent a meaningful challenge in the practice of child abuse pediatricians. In this study, we describe a series of gray cases, representing 17% of 134 consecutive children who were hospitalized at a single pediatric hospital and referred to a child abuse pediatrician for concerns of possible abuse. Gray cases were defined by scores of 3, 4, or 5 on a 7-point clinical judgment scale of the likelihood of abuse. We evaluated details of the case presentation, including incident history, patient medical and developmental histories, family social histories, medical studies, and injuries from the medical record and sought to identify unique and shared characteristics compared with abuse and accidental cases. Overall, the gray cases had incident histories that were ambiguous, medical and social histories that were more similar to abuse cases, and injuries that were similar to accidental injuries. Thus, the lack of clarity in these cases was not attributable to any single element of the incident, history, or injury. Gray cases represent a clinical challenge in child abuse pediatrics and deserve continued attention in research.

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Introduction

Uncertainty has a substantial presence in many medical diagnoses, and successfully managing uncertainty is an important aspect of clinical medicine (Hall, 2002). When making a diagnosis of child abuse, uncertainty is particularly disquieting given the high stakes of an inaccurate decision: returning a child to an unsafe environment or inappropriately disrupting a child's life (Deutsch, 2015; Moles & Asnes, 2014). Additionally, given the multi-disciplinary nature of child abuse investigations, the inherent uncertainty in medicine may not be well understood by colleagues in other professions (Lindberg, Lindsell, & Shapiro, 2008). Thus, uncertain cases of child abuse, the “gray” cases, represent a meaningful challenge in the practice of child abuse pediatricians (CAPs).

There are at least three factors that may contribute to a gray diagnosis. First is the availability of relevant research. Many gray cases have been averted by research that has advanced clinicians' abilities to discriminate abusive from accidental injuries. Specific injury patterns have gained recognition as highly suggestive of abuse including rib fractures (Kemp et al.,

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2008), bruising on the torso, ears, or neck (Pierce, Kaczor, Aldridge, O'Flynn, & Lorenz, 2010), and retinal hemorrhages (Bechtel et al., 2004; Levin, 2010). However, it is also recognized that abuse can manifest in unusual injury patterns, and some very concerning injury patterns can have plausible accidental explanations.

Second, identifying a case as gray is subject to variability in the clinical diagnosis patterns of CAPs. Studies of individual clinical decision-making in child abuse pediatrics have demonstrated high variability in clinicians' judgments and expert opinions (Laskey, Sheridan, & Hymel, 2007; Lindberg et al., 2008). Perceived divergence of expert opinions or variability in clinicians' certainty may encourage an individual CAP toward a gray diagnoses. Collaborative assessment and discussion by multiple CAPs as a team may provide clarity in some circumstances yet may be difficult to implement given the pressures of clinical care or structure of clinical practices.

Finally, gray cases have received little direct attention in research. In the absence of a diagnostic gold standard that would minimize uncertainty and control for CAP variability, research studies often use a panel of experts to establish a demarcation between abuse and accidental cases. The uncertain cases are then not studied, resulting in a lack of knowledge about them.

Therefore, since no previous study has focused on cases of suspected abuse that have been classified as uncertain, the purpose of this study was to describe a series of gray cases to clarify unique and shared characteristics compared with abuse and accidental cases.

Methods

We compared gray cases to abuse and accidental cases within a consecutive series of hospitalized children referred for consultation by a CAP. In order to identify salient patterns associated with gray diagnoses, we reviewed the medical record to evaluate the details of the case presentation, including history of present illness, patient medical and developmental histories, family social histories, relevant medical studies, and injuries. Representative cases were described more extensively to illustrate characteristics noted among the gray cases.

Study Sample

All cases referred for inpatient CAP evaluations at Yale-New Haven Children's Hospital from January 1, 2007 to December 31, 2010 ($n = 145$) were considered for this study. The decision to obtain consultation by the CAP was determined by the attending physician of record for the child, and no institutional guidelines for CAP consultation existed. Subjects were identified from an electronic referral database maintained by the CAP team. We included all cases for which a scale of the likelihood of physical abuse was available ($n = 134$). We excluded 11 cases: six cases with no suspected physical abuse and five with incomplete consultation data.

Study Data

CAP consult notes were generated per routine standard of care. The 2 CAPs (AGA and JML) who completed consultations during the study time period became board certified in Child Abuse Pediatrics at the first CAP American Board of Pediatrics examination in the fall of 2009.

At the time of patient discharge, the consulting CAP completed a 7-point clinical judgment scale concerning the likelihood of abuse; there were 3 levels of certainty for abuse (1 = definite, 2 = probable, and 3 = questionable), a middle score (4 = unknown cause), and 3 levels of certainty for accident/medical cause (5 = questionable, 6 = probable, and 7 = definite). Each point on the scale had predefined criteria (Thomas, Rosenfield, Leventhal, & Markowitz, 1991). Gray cases were defined as scores of 3, "questionable abuse," 4, "unknown cause," or 5, "questionable accident/medical cause." The CAP also completed eight questions to describe the consistency and plausibility of the history provided by caregivers with relation to the injury sustained. The questions assessed: (1) if caregivers attributed blame to someone, (2) if there was a delay in seeking medical attention, (3) if the history was consistent between caregivers and (4) if the history was consistent over time, and if the history was plausible for the injury on a scale of Yes, Maybe, or No in terms of (5) mechanism, (6) timing, (7) severity, and (8) overall.

Case information was retrospectively extracted from CAP notes and medical records. The majority of variables were extracted without interpretation. For some variables, discreet data points were combined or recoded to more clinically meaningful variables after discussion among the research team. "Adequacy of well-child care" included up-to-date immunizations and adherence to the well-child care schedule per documented conversation between the CAP and the child's primary care clinician. "Caregiver childhood adversity" included caregiver's history as foster child, history of child protective service involvement during childhood, or caregiver's personal history of child abuse.

Within the history of present illness, common features of the history describing the incident were also categorized. Incident histories were coded as "witnessed" if a responsible caregiver (e.g., a parent) witnessed the traumatic event. "Transition in responsible caregiver" included cases for which the injury purportedly occurred while the child was under the care of a person other than the caregiver presenting to healthcare; for example, if the incident history reported by parents was that the injury occurred while the child was with a babysitter. Injuries were coded as "found" if the injury was incidentally noticed without any known traumatic history; for example, a bump was noticed while giving a bath and an underlying skull fracture was detected after seeking medical attention.

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