Improving Communication With Families for Evaluation of Child Abuse

Lauren Riney, DO1, Theresa Frey, MD1, Emily Fain, MD1,2, Elena Duma, MD1, and Patricia Chambers, MD1

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Child abuse is a leading cause of morbidity and mortality in pediatrics. Children presenting with injuries concerning for child abuse require a thorough evaluation. A standardized guideline can result in a more complete and evidence-based evaluation for child abuse, with decreased bias and variation among health care providers (Figure 1) (1). This evaluation often includes a social services consultation, laboratory studies, and imaging depending on the child’s age. This process can be stressful for both families and care providers. Effective communication between caregivers of an injured child and the health care team is essential in providing the best outcome for the child and family. The implication that a child’s injury may have been inflicted rather than accidental is difficult to discuss. Obtaining bloodwork and imaging for young children is an uncomfortable and time-consuming process. Caregivers should understand the rationale for this workup and will need an explanation of the components and sequence of the evaluation. Health care providers vary greatly in their word choice, degree of explanation, and delivery of information to caregivers of children being evaluated for child abuse. This variation can produce distrust and frustration with the health care team, which could lead some families to resist proceeding with the child abuse evaluation.

Our team has developed a framework of tools for optimizing communication and answering common questions to develop a therapeutic alliance with families throughout the child abuse evaluation.

The discussion topics were developed based on the review of feedback, both solicited and unsolicited in the form of patient complaints, from families who have undergone a child abuse evaluation. The recommendations were developed by local consensus through an interdepartmental and multidisciplinary improvement team.

If the evaluation reveals no concern for an abusive injury, we want families to know that the evaluation was important and appropriate. If concerning or definitively abusive injuries are diagnosed, we need to maintain a therapeutic relationship with families as medical care progresses to allow for the best outcome for the patient. Our global aim is to provide compassionate evidence-based care to the injured child, ensuring that inflicted injuries are identified, and all injuries are treated, while providing care that is free of racial, ethnic, and socioeconomic bias.

We propose the following recommendations to guide communication with families about the child abuse evaluation. These techniques can serve as a resource for health care providers and support staff of multiple subspecialties in managing the expectations of the child’s family.

Practice Self-Awareness Prior to Interacting With Families

Acknowledge personal emotions such as anger and stress before entering the patient room. Leave these feelings at the door to avoid emotional language and noticeable speculation. Debrief with the entire care team early in the evaluation to maintain consistent language and conversation. Strive to present a united front and use similar verbiage when discussing the plan. Acknowledge to the family that this evaluation is done for any young child with certain signs, symptoms, or injuries to determine whether other injuries exist. Do not speculate on proposed mechanism of injury. It is important

1 Division of Emergency Medicine, Department of Pediatrics, Cincinnati Children’s Hospital Medical Center, University of Cincinnati College of Medicine, Cincinnati, OH, USA
2 Division of Emergency Medicine, Department of Pediatrics, Monroe Carell Jr. Children’s Hospital at Vanderbilt University, Nashville, TN, USA

Corresponding Author:
Lauren Riney, Division of Emergency Medicine, Department of Pediatrics, Cincinnati Children’s Hospital Medical Center, 3333 Burnet Ave ML 2008, Cincinnati, OH 45229, USA.
Email: laurencriney@gmail.com

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to be transparent that the evaluation process is stressful and time-consuming but necessary.

The language used in our emergency department to introduce the child abuse evaluation can serve as an example.

Today you have brought your child to the ED for an injury. Because we care about your child and the health of all children, there are certain tests we need to complete. When a young child has an injury, we want to be sure that there are no other injuries that are less obvious. The evaluation will include blood tests, urine tests, and imaging studies. As part of the evaluation, we will also be asking a member of our social work team to talk with you so that we can understand the injury. We also may need to ask a specialist to consult, depending on the injuries. This is a stressful process and it is time consuming. We truly appreciate your cooperation with this process and will update you when we have results.

**Explain the Evaluation in a Step-by-Step Manner**

Explain that bloodwork is obtained to assess for other injuries, which requires a needle stick and possible IV placement. Sometimes more than 1 needle stick is necessary to successfully obtain samples due to the difficult nature of obtaining blood from a small child. Explain that a skeletal survey is a series of radiographs (X-rays) of all the bones in the body to evaluate for orthopedic injuries, which includes approximately 20 images that require appropriate positioning of the child. This process is not painful but can be uncomfortable. Fingers or extremities may need to be compressed under clear plastic to obtain proper images. A computed tomography (CT) scan of the head and/or abdomen and pelvis may also be needed, requiring the child to be stationary and positioned appropriately on a CT table.

**Address Caregiver Concerns as Honestly and Accurately as Possible**

We have attempted to address the most frequent caregiver concerns we encounter during the child abuse evaluation process.

**Questions About Radiation**

Everyone is exposed to natural background radiation from the environment. Communication regarding radiation exposure can be easier for caregivers to understand when using language related to natural background radiation. A skeletal survey is equivalent to approximately 24 days of background radiation (2). A CT scan of the head is equivalent to approximately 7-8 months of background radiation (2,3). A CT scan of the abdomen and pelvis is equivalent to approximately 3 years of background radiation (3). The risk associated with obtaining a CT scan or skeletal survey is less than the risk of an undetected severe injury.
Questions About Reporting to Children’s Services and Refusal Rights

The discussion about reporting to Children Protective Services should occur in conjunction with social work and a child abuse expert, when possible. All providers are legally required to report to Children Protective Services when child abuse is suspected.

Questions About Test Results

Below are recommended scripts for discussing test results depending on outcomes.

When an injury is diagnosed. “Unfortunately, the tests that were done revealed that your child has ***. Because of this injury, there are further steps to take.”

When the evaluation is negative, and no report is being made to children’s services. “We are happy to report that there are no signs of injuries to your child. Our evaluation is now complete, and we will be able to discharge you home. Thank you for allowing us to fully evaluate your child to make sure (s)he is safe.”

When the evaluation is negative but a report to children’s services is being made. “We are happy to report that no additional injuries have been discovered. However, we have concerns about an injury like this and therefore we are required to report this to Children’s Services.”

When the evaluation is inconclusive or has subtle findings. “Our workup today found some unclear abnormalities. You will be able to go home, but repeat x-rays are needed in the next few weeks. These x-rays can help us to decide if this is an important finding.”

In summary, unifying communication and developing a therapeutic alliance with families can ensure that the evaluation for child abuse is consistently executed for any child with an injury concerning for physical abuse to avoid confusion and inconsistency.

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ORCID iDs

Lauren Riney, DO @ https://orcid.org/0000-0002-8671-9432
Theresa Frey, MD @ https://orcid.org/0000-0002-3105-9748

References

1. Riney L, Frey T, Fain E, Elena MD, Berkeley LB, Eileen Murtagh K. Standardizing the evaluation of nonaccidental trauma in a large pediatric emergency department. Pediatrics. 2018;141:e20171994.
2. Rao R, Brown D, Lunt B, David P, Peter R, Patrick K. Radiation doses in diagnostic imaging for suspected physical abuse. Arch Dis Child. 2019;104:863-8.
3. Jones JG, Mills CN, Mogensen MA, Christoph IL. Radiation dose from medical imaging: a primer for emergency physicians. West J Emerg Med. 2012;13:202-10.

Author Biographies

Lauren Riney is a pediatric emergency medicine physician at Cincinnati Children’s Hospital Medical Center. Her area of interests is improvement of quality of care for children with suspected physical abuse in the emergency department.

Theresa Frey is a pediatric emergency medicine physician at Cincinnati Children’s Hospital Medical Center. Her area of interests is improvement of quality of care for children with suspected physical abuse in the emergency department.

Emily Fain is a pediatric emergency medicine physician at Monroe Carell Jr. Children’s Hospital, Vanderbilt, previously at Cincinnati Children’s Hospital Medical Center. Her area of interests is improvement of quality of care for children with suspected physical abuse in the emergency department.

Elena Duma is a pediatric emergency medicine physician at Cincinnati Children’s Hospital Medical Center. Her area of interests is improvement of quality of care for children with suspected physical abuse in the emergency department.

Patricia Chambers is a pediatric emergency medicine physician at Cincinnati Children’s Hospital Medical Center. Her area of interests is improvement of quality of care for children with suspected physical abuse in the emergency department.