

Children Abuse: Factors Affecting Case Reporting by Physicians

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Objective: To identify the factors inhibiting first contact physicians (primary care physicians, pediatricians and emergency physicians) from reporting child abuse to Child Protection Committee in 2008.

Design: Cross sectional descriptive study.

Setting: Salmaniya Medical Complex and health centers.

Method: The study was conducted during the months of June and July 2008. A proportionate stratified sample of 190 physicians was drawn from first contact physicians (primary care physicians, pediatricians and emergency doctors) working in the public sector. Data of physicians' personal and professional characteristics, awareness of parental behaviors, risk factors and clinical features of child abuse, inhibiting factors for reporting and preferred course of action were collected by a pre-structured self administered questionnaire.

Result: Only 140 physicians completed the questionnaires. All physicians revealed an acceptable level of awareness of clinical presentation and risk factors of child abuse. Primary care physicians scored 1.20 ± 0.48 compared to emergency doctors who scored 0.93 ± 0.49 . Females scored 1.25 ± 0.38 , while males scored 1.01 ± 0.56 . Board certified physicians scored 1.19 ± 0.47 , which is higher than others.

Physicians' apprehension, avoidance of a conflict with the family and lack of knowledge about reporting were found to be the most important factors for inhibiting reporting.

Conclusion: Physicians' apprehension of reporting children abuse, mainly to avoid conflict with the family and lack of knowledge of reporting mechanisms were found to be the most important factors.

It is recommended to support the physicians in decision-making in the practice setting and to attend communication skill workshop, dealing with family conflicts, educational initiatives and child abuse reporting.

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Child abuse includes in its definition physical, emotional, sexual, as well as neglect¹. The United Nations Convention on Rights of the Child defines a child as “every human being below the age of 18 years”².

Child abuse is recognized internationally as a public health issue. Its significance has been reinforced with the developments of human rights, law and forensic medicine. However, it is well documented that child abuse is preventable³. Initiatives in prevention and mitigation depend on the recognition and reporting of cases. Child abuse is a sensitive topic and is characterized by both failure and unwillingness on the part of physicians to report cases⁴. Studies reported that 43% of physicians surveyed had failed to report suspected cases of child abuse⁴.

Although there is little literature available about the extent and the scope of this problem in the Arab communities, it could be assumed that under-reporting might be a feature and the causes are many^{5,6}.

In Saudi Arabia, an “increasing” number of child abuse cases have been reported⁵. Nevertheless, the numbers are small in comparison with other countries. Al Mahroos has found that health professionals in 11 case reports studies in Saudi Arabia identified only 40 cases of child abuse⁷. In addition, three studies from Kuwait identified 27 children, 22 with physical abuse, 3 with sexual abuse and 2 with Munchausen's syndrome by proxy (MSP) and 3 deaths. In Oman, 5 cases of MSP were reported and in Yemen, population based survey revealed a wide spread use of corporal punishments and cruelty to children⁷.

Some studies reported failure to recognize cases and risk factors; other studies revealed lack of confidence in the decision-making process^{4,8-13}. Health professionals should maintain high index of suspicion of child abuse, especially if they are dealing with non-specific symptoms and without plausible explanation¹⁴.

Studies have revealed that approval of physical punishment as a disciplinary act by health care providers influences child abuse reporting negatively^{15,16}. A study has shown that children were commonly subjected to physical abuse in a disciplinary circumstances⁶. In a study of 184 schoolgirls aged 9-12, in Bahrain 1997, corporal punishment was experienced by 23% and verbal insults were reported by 78%⁷. Furthermore, corporal punishment at home was reported by 25% of the girls⁷. In addition, research has shown that physicians' negative experience with child protection services inhibited reporting^{4,8,17,18}.

Child abuse legislation has been ratified in many countries. In spite of this, there is still reluctance on the part of professionals to report^{17,19}. It has been documented that medical personnel are the source of fewer than 10% of total abuse reports to child protection agencies²⁰. Furthermore, primary care physicians do not report 1 in 4 cases of suspected physical child abuse²¹.

In Bahrain, significant attempts have been made to address the problem of child abuse. In 1991, a Child Protection Committee (CPC) was established and in 2007, Bahrain Centre for Child Protection was launched^{22,23}. Al Mahroos et al in recent studies performed in Bahrain showed that 23 children were identified with abusive head trauma between 2000-2009; a second study showed 36 children were identified with skeletal injuries from 1991-2009; a third

study showed 411 child sexual offenders characteristics were identified from 2000 to 2009^{14,24,25}.

The aim of this study is to identify the factors that inhibit first contact physicians (primary care physicians, pediatricians and emergency physicians) from reporting child abuse to CPC.

METHOD

The required sample size was calculated using statistical formula resulted in sample size of 190. Complete lists of physicians were obtained from each department. A total of 345 physicians constituted the study population (230 primary care physicians, 67 pediatricians and 48 emergency physicians). The required sample of 190 was selected using random numbers. A proportionate stratified sample was prepared, yielding 127 primary care physicians, 37 pediatricians and 26 emergency physicians.

An anonymous self-administered questionnaire was used. The questionnaire was developed and used previously among pediatricians in Kuwait⁹. Permission was taken from the author to use this questionnaire.

A 5-point Likert scale ranging from +2 to -2 was used in three parts of the questionnaire i.e. recognition of parental behavior, risk factors and clinical features associated with child abuse. A score between 0-2 was considered to be an acceptable one.

Data were distributed and collected by two methods, personal and proxy. The significance of mean differences in awareness was evaluated using the one-way analysis of variance for categorical variables with more than two categories and two independent samples t-test for dichotomous variables. Chi-square test was employed to test the relation between reporting behavior and the other factors and was used to test the difference in percentage of agreement regarding recognition of parental behavior associated with child abuse. Results with p-values less than 0.05 were considered statistically significant.

Data were analyzed using the SPSS version 15.

RESULT

One hundred forty questionnaires were returned, 89 primary care physicians, 32 pediatricians and 19 emergency physicians, a response rate of 74%. Participants demonstrated an acceptable level of awareness. The level of awareness was computed by calculating the mean score for each participant on the relevant three parts of the questionnaire i.e. recognition of parental behavior, risk factors and clinical features associated with child abuse. Females had higher scores of awareness than males (1.25 ± 0.38) and board certified participants had higher scores of awareness than non-certified (1.19 ± 0.47), see table 1.

Table 1: Relationship between Selected Variables and Level of Physicians' Awareness

| Variables | | Mean Score & SD | P value |
|---------------|--------------|-----------------|---------|
| Gender | Male | 1.01 (0.56) | 0.006 |
| | Female | 1.25 (0.38) | |
| Nationality | Bahraini | 1.18 (0.46) | 0.23 |
| | Non-Bahraini | 1.04 (0.51) | |
| Qualification | Board | 1.19 (0.47) | 0.04 |
| | Non-Board | 1.00 (0.48) | |
| Specialty | Primary Care | 1.20 (0.48) | 0.07 |
| | Pediatrics | 1.12 (0.45) | |
| | Emergency | 0.93 (0.49) | |

The reporting behavior of participants was found not to be associated with gender or qualification but associated with the participant's specialty, see tables 2 and 3. Several inhibiting factors for reporting were studied. It was found that physicians' apprehension and avoidance of conflict with the family were significant factors in primary care, see table 4.

Table 2: Relationship between Selected Variables and Reporting Behavior of Physicians

| Reporting Behavior of Physicians | |
|----------------------------------|-----------------------|
| Variables | Child Abuse (p-value) |
| Gender | 0.39 |
| Nationality | 0.16 |
| Qualification | 0.81 |
| Department | 0.01 |
| Status | 0.74 |

Table 3: The Percentage of Participants in Each Specialty Reporting Child Abuse Cases

| Specialty | Percentage of Participants Reporting Cases of Child Abuse | P-value |
|-------------------------------------|---|---------|
| Primary care (89) | 48 (54%) | |
| Pediatrics (32) | 24 (75%) | |
| Emergency (19) | 16 (84%) | |
| Total Physicians who reported abuse | 88 (63%) | 0.01 |

Table 4: Inhibiting Factors for Reporting and Specialty

| Reasons Inhibiting Reporting | Primary Care (89) | Emergency (19) | Pediatrics (32) | Total (140) | P value |
|--|-------------------|----------------|-----------------|-------------|---------|
| Unable to obtain adequate history | 42 | 6 | 10 | 58 | 0.15 |
| Lack of knowledge of child abuse | 21 | 4 | 6 | 31 | 0.18 |
| Apprehensive about reporting | 34 | 1 | 3 | 38 | 0.001 |
| Lack of knowledge of reporting | 35 | 7 | 11 | 53 | 0.83 |
| Lack of privacy in the setting | 21 | 5 | 10 | 36 | 0.73 |
| To avoid conflict with the family | 33 | 1 | 5 | 39 | 0.003 |
| Child will not benefit from the process of reporting | 15 | 1 | 5 | 21 | 0.41 |

To alleviate the physicians' apprehension in suspected child abuse case, participants were asked to choose their preferred course of action. Formal approach was chosen by pediatricians and emergency physicians, primary care physicians preferred "in house" approaches, e.g. talking to parents, informing the head of department. Table 5 shows the response of the three specialties.

Table 5: Selecting Preferred Course of Action

| Preferred Course of Action | Primary Care (89) | Emergency (19) | Pediatric (32) | P value | Total (140) |
|---|----------------------|-------------------|-------------------|---------|----------------|
| Treat the problem and keep quiet | 6 (6.7%) | 1 (5.3%) | 2 (6.3%) | 0.97 | 9 (6.4%) |
| Try to solve the problem yourself by talking to the parents | 35 (39.3%) | 2 (10.5%) | 5 (16%) | 0.006 | 42 (30%) |
| Call social worker | 63 (70.8%) | 8 (42%) | 19 (59%) | 0.049 | 90 (64.3%) |
| Inform the head of the department | 33 (37%) | 1 (5.3%) | 4 (12.5%) | 0.002 | 38 (27%) |
| Inform child protection committee | 71 (79.8%) | 14 (73.7%) | 28 (87.5%) | 0.44 | 113 (80.7%) |
| Inform the police | 11 (12.4%) | 5 (26.3%) | 1 (3.1%) | 0.049 | 17 (12%) |

DISCUSSION

Only minor differences in the levels of awareness were observed between the three specialties, which failed to reach statistical significance ($p=0.07$), see table 1. The overall score for each specialty was acceptable, ranging from 0.93 to 1.12 (a score below Zero is considered low). This suggests that some participating physicians had a level of awareness that would enable them to identify child abuse, which is different from other studies^{4,8-11,13,16-18,26-28}.

This study revealed that female physicians had higher level of awareness of child abuse than males, similar to the findings of other studies⁹. Some studies have not revealed any significant relationship of awareness and physicians' gender^{11,27}. This study failed to find an association between the level of awareness and reporting behavior; this finding was similar to other studies^{19,27}.

In this study, no gender difference was found in reporting child abuse; other studies had found that females were more likely to report child abuse cases than males.

This study showed that emergency physicians were more likely to report a case of child abuse ($P=0.01$, table 3); unlike other studies, which showed that pediatrician were more likely to report child abuse^{4,8,21}. Other studies have not found such difference^{13,26,27}.

Primary care physicians' apprehension about reporting and wishing to avoid conflict with the family were the main barriers to reporting. In addition, physicians may lack the communication skills necessary to handle the conflict effectively and in turn search for ways to delay or share the responsibility of reporting e.g. informing the head of department or social workers, some studies cited similar barriers^{6,13,15,18,29}.

About 80% of the physicians indicated that they would like to report cases to a child protection committee. About 40% of primary care physicians and about 35% of pediatricians and emergency physicians cited lack of knowledge of reporting. Other studies have shown similar findings¹⁹.

Physicians' negative experience with child protection services has been identified as a barrier to reporting in several papers. Some physicians assumed that the child would have no beneficial outcome from the process of reporting^{4,8,17,18}. This barrier was identified by a few physicians in the present study.

CONCLUSION

In this study of first contact physicians in Bahrain, the issue of awareness of child abuse was not a factor in under-reporting cases. Several other key issues were identified. Difficulties with reporting played a crucial role. Potential conflicts with families rendered primary care physicians reluctant to report. Furthermore, lack of knowledge of reporting was identified as an inhibiting factor.

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