Child Abuse Training for Physicians in Texas

INTRODUCTION

The data of child maltreatment show that children under three are at the highest risk of abuse or neglect. Because children under three are not yet in school, it can be very difficult to identify abuse that may be occurring in the home. Other than parents and relatives, medical professionals often have the most contact with children in their earliest and most important years of development.

TexProtects recommends increasing training on recognizing, reporting and preventing child abuse and neglect for medical professionals (nurses and physicians) that largely interact with children and parents in a medical setting [family practice/PCP, pediatricians, emergency medicine, OB/GYN etc.], using at least one of the following strategies:

1. Expand current Continuing Medical Education (CME) credit requirements on an ongoing basis or every certain number of years
2. Have the training as a condition to sit for boards/licensure/license renewal
3. Incorporate training into medical school curricula
4. Incorporate training into an increased number of residency programs (as elective or mandatory rotations)

IMPORTANCE OF MEDICAL PERSONNEL IN REPORTING

Children under three are in a uniquely vulnerable position as they have a much more narrow scope of interaction with others than children over three. In fact, in 2013, 25,802 out of the 66,398 child abuse victims (38.9%) in Texas were under the age of three. Medical professionals have a key role in protecting the well-being of all children, but especially those of infancy and toddler age. In 2013, the largest source of reports for completed child abuse and neglect investigations came from medical personnel (17.6%; 33,464 investigated reports) followed next by school personnel (17.5%), law enforcement (16.3%), and relatives (11.3%). Despite the fact that they accounted for the largest percentage of reports and that they are mandated professional reporters in the state of Texas as defined in section 261.101 of the Texas Family Code, physicians are not required to complete training on how to recognize, report, or prevent child abuse and neglect. Meanwhile, professional training on recognizing, reporting and preventing suspected maltreatment is now required for all new school, charter school and university professional employees.¹

¹ Texas Education Code § 38.0041
INCONSISTENT CURRENT REPORTING AMONG PHYSICIANS

Literature on child abuse and neglect has clearly demonstrated that for a variety of professionals, the inability to recognize maltreatment and a lack of awareness of reporting procedures are impediments to reporting suspected maltreatment to the appropriate authorities. A 2008 study of 434 pediatric primary care clinicians, known as the Child Abuse Reporting Experience Study (CARES), found that the decision to report suspected child maltreatment was chiefly influenced by four main variables: injury circumstances and history, knowledge of and experience with the family, consultation with others and available resources, and previous experience with child protective services and expectations of the CPS response. Of the 15,000+ children with injuries evaluated by the CARES clinicians, 10% were suspected of having an injury due to maltreatment, but less than three-quarters of those injuries were reported to CPS.

The decision to report suspected maltreatment to CPS is typically influenced by several factors, as mentioned above. For instance, in the aforementioned study, familiarity and a good relationship with the family made providers more reluctant to both report and modify their reports. In one study of primary care providers, the two most cited reasons for failing to report were previous experience with the CPS system and the belief that the report and therefore intervention from CPS would not benefit the child(ren). Additionally, there are a number of clinical factors that contribute to physicians not recognizing and reporting child abuse in cases where abuse was subsequently identified. These factors include inattention to skin, acceptance of inadequate explanations of signs and symptoms, and incorrect diagnoses from radiologic examinations.

Furthermore, another study demonstrated that providers with formal education in child abuse after residency were 10 times more likely to report suspected abuse compared to providers with no education.

ROOM FOR INCREASED TRAINING IN MEDICAL SCHOOLS

Medical schools in the U.S. are accredited through the Liaison Committee on Medical Education (LCME). The majority of state licensing boards require medical school to be accredited. The LCME standards state that “the curriculum of a medical education program must prepare medical students for their role in addressing the medical consequences of common societal problems (e.g., provide instruction in the diagnosis, prevention, appropriate reporting, and treatment of violence and abuse). Although the accrediting standards for medical education explicitly include a requirement for education in social

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4 Ibid


7 Significance level; p = 0.01


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issues such as child abuse, the responsibility for curriculum development rests with medical school faculty.

Over the last decade, there have been recommendations that curriculum related to child abuse and violence be more standardized across medical schools. For instance, the Council on Medical Student Education in Pediatrics, an organization of U.S. and Canadian educators with administrative responsibility for undergraduate medical education in pediatrics, have developed curricula for child abuse education for medical students (www.comsep.org). However, there is little data on the quantity and quality of medical student education on child maltreatment.

**EFFICACY OF INCREASED TRAINING IN RESIDENCY PROGRAMS**

According to the Accreditation Council for Graduate Medical Education, there are no specific accreditation requirements for residency programs regarding child abuse and neglect training. Although studies have shown that some residency programs across the country – primarily pediatrics – provide residents with training and resources on child abuse, most residents enter the field with little to no knowledge of how to manage a case of suspected maltreatment. Given the current prevalence of this public health issue, training during medical school and even residency seems both appropriate and imperative.\(^9\)

A 2006 survey of pediatric residency programs indicated that one-quarter of accredited pediatric residency programs offered no rotation in child abuse and neglect and only 41% required mandatory clinical experience. Mandatory rotations tended to be shorter than elective rotations, and, therefore, clinical exposure to maltreated children was significantly greater in elective rotations. The level of preparedness of the residents was positively associated with the number of patients seen and usefulness of didactic sessions. A majority of residency programs felt that more training was needed.\(^10\) Due to the increased attention child maltreatment has received, it is possible that the amount of training has increased since 2006; however, updated information is unavailable.

While training during some residency programs occurs, it can greatly vary. A 2012 study showed that pediatric residents received more training as compared to family and emergency medicine residents. As a result, the pediatric residents were significantly more knowledgeable about child abuse and reported more comfort with managing child maltreatment cases. Residents with higher knowledge scores were significantly more likely to come from programs with an interdisciplinary team that specialized in child abuse pediatrics, had a physician responsible for training, used a written curriculum for training, and had a required rotation in child abuse pediatrics.\(^11\)

More specifically, increased training for the medical community on recognizing sexual abuse is needed, given that it can be the most difficult to correctly identify and substantiate. This is especially important for emergency medicine physicians and those that most commonly evaluate children for suspected sexual abuse. In an evaluation of emergency care physicians, it was shown that they were correct about

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the diagnosis and management of these cases only 54% of the time. However, training increased the accuracy of their diagnosis and management to 70%.12

RECOMMENDATIONS

TexProtects recommends to increase training on recognizing, reporting and preventing child abuse and neglect for medical professionals (nurses and physicians) that largely interact with children and parents in a medical setting [family practice/PCP, pediatricians, emergency medicine, OB/GYN etc.] in at least one of the following ways:

1. Expand current Continuing Medical Education (CME) credit requirements on an ongoing basis or every certain number of years
2. Have the training as a condition to sit for boards/licensure/license renewal
3. Incorporate training into medical school curricula
4. Incorporate training into an increased number of residency programs (as elective or mandatory rotations)

Children under three years of age are uniquely vulnerable to maltreatment because of their large lack of interaction with schools and other entities besides family. Doctors and nurses are in a special position with this population to be able to both intervene in cases of abuse and neglect and prevent them. Texas’ absence of legislation for standardized child maltreatment training for medical personnel leaves the protection of a child at the mercy of the education a doctor or nurse has happened to receive. Measures need to be taken to ensure that all medical personnel undergo the training they need to best serve this population.

For More Information
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TexProtects’ mission is to reduce and prevent child abuse and neglect through research, education, and advocacy. TexProtects effects change by organizing its members to advocate for increased investments in evidence-based child abuse prevention programs, CPS reforms, and treatment programs to heal abuse victims.

## Appendix 1a. Current CME Requirements in Texas – Texas Medical Board

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<tr>
<th>Texas Medical Board</th>
<th>Physician licenses and permit</th>
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<tr>
<td>Requires the Texas Medical Board by rule to adopt, monitor, and enforce a reporting program for the continuing medical education of physician license holders and to adopt and administer rules relating to the continuing medical education of license holders. Section 156.051, Occupations Code</td>
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<td>Requires a physician to complete 48 credits of continuing medical education every 24 months; requires at least 24 credits every 24 months to be from formal courses that are designated for credit or approved by specified entities; requires at least two of the credits from formal courses to involve the study of medical ethics or professional responsibility; authorizes the remaining 24 credits to be composed of informal self-study, attendance at hospital lectures, grand rounds, or case conferences not approved for formal continuing medical education. <strong>22 T.A.C. Sections 166.2(a)(1), (2), and (3)</strong></td>
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<td>Presumes a license holder is in compliance with continuing medical education requirements if, during the 36 months preceding the date of the required registration, the license holder becomes board certified or recertified by a specialty board approved by the American Board of Medical Specialties or the American Osteopathic Association Bureau of Osteopathic Specialists. Section 156.052, Occupations Code</td>
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APPENDIX 1B. CURRENT CME REQUIREMENTS IN TEXAS – TEXAS ADMINISTRATIVE CODE

22 Texas Administrative Code (T.A.C.) Section 166.2(a)(1), (2), (3), and (4)

(a) As a prerequisite to the registration of a physician's permit a physician must complete 48 credits of continuing medical education (CME) every 24 months. CME credits must be completed in the following categories:

1. At least 24 credits every 24 months are to be from formal courses that are:
   - designated for AMA/PRA Category 1 credit by a CME sponsor accredited by the Accreditation Council for Continuing Medical Education or a state medical society recognized by the Committee for Review and Recognition of the Accreditation Council for Continuing Medical Education;
   - approved for prescribed credit by the American Academy of Family Physicians;
   - designated for AOA Category 1-A credit required for osteopathic physicians by an accredited CME sponsor approved by the American Osteopathic Association;
   - approved by the Texas Medical Association based on standards established by the AMA for its Physician's Recognition Award; or
   - approved by the board for medical ethics and/or professional responsibility courses only.

2. At least two of the 24 formal credits of CME which are required by paragraph (1) of this subsection must involve the study of medical ethics and/or professional responsibility. Whether a particular credit of CME involves the study of medical ethics and/or professional responsibility shall be determined by the organizations which are enumerated in paragraph (1) of this subsection as part of their course planning.

3. The remaining 24 credits for the 24-month period may be composed of informal self-study, attendance at hospital lectures, grand rounds, or case conferences not approved for formal CME, and shall be recorded in a manner that can be easily transmitted to the board upon request.

4. A physician who performs forensic examinations on sexual assault survivors must have basic forensic evidence collection training or the equivalent education. A physician who completes a CME course in forensic evidence collection that:
   - meet the requirements described in paragraph (1)(A) - (C) of this subsection; or
   - is approved or recognized by the Texas Board of Nursing,
   - is considered to have the basic forensic evidence training required by the Health and Safety Code, §323.0045.
APPENDIX 2. OTHER STATES WITH MANDATORY CME TRAINING ON CHILD MALTREATMENT

1. **Pennsylvania** – “Under the amended Child Protective Services Act (CPSA), all physicians seeking to renew their license on or after Jan. 1, 2015, will need to complete two hours of approved training on child abuse recognition and reporting as a condition of licensure.”

2. **New York** – “Effective January 1, 1989, Education Law requires certain individuals, when applying initially for licensure or a limited permit, to provide documentation of having completed two hours of coursework or training regarding the identification and reporting of child abuse and maltreatment. This is a one-time requirement and once taken does not need to be completed again. This requirement applies to: chiropractors, dental hygienists, dentists, optometrists, physicians, podiatrists, psychologists, and registered nurses.”

3. **Iowa** – “A licensee who regularly provides primary health care to children shall indicate on the renewal application the completion of two hours of training in child abuse identification and reporting in the previous five years. "A licensee who regularly provides health care to children" means all emergency physicians, family practitioners, general practice physicians, pediatricians, and psychiatrists, and any other physician who regularly provides primary care to children.”

4. **Kentucky** – “House Bill 157 . . . requires training on the recognition and prevention of pediatric abusive head trauma (also known as shaken baby syndrome) for physicians likely to see children, including pediatricians, radiologists, family practitioners and emergency medicine and urgent care specialists. Starting July 15, 2014, these physicians are required to complete a one-time, one hour course that includes new science not widely taught in medical schools: Bruises in children can be the most overlooked signs of abuse.”

5. **California** – The Mandated Reporting of Child Abuse and Neglect, a self-paced training for physicians and other medical providers, was developed by the Child Abuse Prevention Center in collaboration with a panel of physicians and child abuse experts. The training is comprised of five self-paced modules: Physical Abuse, Sexual Abuse, Emotional Abuse, Neglect, and How to Make a Report.

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