

A Multidisciplinary, Experiential, Educational Curriculum in Child Abuse: The Pediatrician's Role in Early Recognition, Documentation, Management, and Legal Advocacy

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Setting and Problem

Pediatrics residents are educated in the care of abused children, yet exposure to patients with signs of abuse, particularly in the outpatient setting, may be highly variable. Frequently abused children are not recognized on their first encounter with the health care system. Many residents report that they do not feel comfortable assessing and reporting abuse. In addition, residents' exposure to legal aspects of child abuse pediatrics may be limited, or of variable educational benefit. Using a general pediatric practice as the setting, we developed a curriculum for pediatrics residents to enhance their knowledge of caring for the patient with suspected nonaccidental trauma.

Intervention

We developed a standardized, multidisciplinary, experiential curriculum incorporating clinical recognition of child abuse, instruction in and evaluation of physician documentation of child abuse, communication skills in cases of abuse, managing cases of child abuse, and navigating interface between the pediatrician and the legal system. The first portion of the curriculum was presented as a standardized patient encounter with a parent presenting to the clinic with an infant with "new onset irritability." Residents were unaware of the purpose of the encounter, which occurred in the context of their scheduled didactic conference time. The standardized patient scenario included many of the possible "red flags" residents should recognize as potential for abuse. Dolls were purchased from a retail store, and fingerprint bruising was simulated on the back and thigh. In addition, the thigh was stuffed with cotton so that it appeared to be swollen.

The standardized patients were given a short script describing their role as the parent. The patient's clinic chart, including the growth chart, was given to the residents and

each resident then had 20 minutes to complete the clinic encounter. The sound of a crying, inconsolable baby was streamed during the encounter. The resident was instructed to document the encounter, including an assessment and plan, and to communicate their plan to the standardized patient. The standardized patient then provided feedback on the residents' communication skills.

For the second portion of the curriculum, documentation was reviewed by faculty physicians as well as legal counsel from the local district attorney's office. The following week, the residents were taken to the county courthouse and 2 residents were chosen to "testify" regarding the simulated encounter based on their documentation. The residents were questioned by the prosecution and defense to simulate an actual courtroom experience. The assistant district attorney stressed to the residents the importance of how the accuracy of their documentation could impact a child's life and the outcome of a trial. In addition, residents were given instruction from the attorney regarding providing testimony in a trial.

Outcomes to Date

Feedback from the residents was generally positive regarding the utility of the curriculum and the mode of implementation. All residents found the experience beneficial. Prior to the experience, 48% (10 of 21) of residents felt confident that they would recognize abuse in the primary care setting, while after the experience 71% (10 of 14 residents completing all stages of the experience) reported they were confident in their ability to recognize abuse. Several residents indicated the standardized patient evoked significant anxiety for them. Residents reported that their skills in the appropriate management of suspected child abuse improved as a result of the experience. The importance of accurate and complete documentation was also reinforced. Pediatrics faculty, including a child abuse specialist, and attorneys reported positive informal feedback from the learners and meaningful questions.

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New Ideas

Implementation of a Monitored Educational Curriculum and Impact on Pediatrics Resident In-Training Examination Scores

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Setting and Problem

Due to changes in duty hour restrictions implemented in 2011, the number of formal didactic sessions for pediatrics residents at the University of Maryland Children's Hospital was reduced by half.

The potential negative impact on resident education resulting from restricted duty hours has been a frequent topic in the graduate medical education literature. This was echoed by our residency leadership who were concerned that the decrease in didactic time would adversely affect resident education, resulting in a decrease in the board pass rate and in preparedness for independent practice.

Intervention

To offset the potential negative impact of decreased didactic time, we implemented a monitored educational curriculum, partially modeled after the continuing medical education requirements of state licensing boards. Our objective was to determine the effect of this intervention on resident learning as measured by the change in residents' pediatric in-training examination (ITE) scores over time.

The ITE scores were chosen due to their strong association with scores on the American Board of Pediatrics (ABP) certifying examination.

We created a central online repository for all required learning materials, selected by consensus by the pediatric education leadership, using the Blackboard Learn online coursework management system. Residents are required to complete a prespecified number of learning activities in 2 categories: (1) Category-A activities are required of all residents, and include PREP questions, the Yale Primary Care Pediatrics Curriculum, and monthly *Pediatrics in Review (PIR)* articles; and (2) Category-B activities are individualized and chosen based on residents' interests. They include attendance at daily conferences and a variety of other learning activities. Residents' achievement of required points is monitored by the chief residents through Pedialink for PREP questions and Blackboard Grade Center for most other activities. E-mail confirmations of educational activities not on Blackboard are also accepted for points. Points are recorded on a spreadsheet that is publically shared with the residents on a monthly basis. We implemented this innovation in the 2011–2012 academic year, assessed the impact on ITE scores (for graduating classes of 2011–2015), and collected resident feedback.