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Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

Policy Statement—Protecting Children From Sexual Abuse by Health Care Providers

COMMITTEE ON CHILD ABUSE AND NEGLECT

KEY WORDS
sexual abuse

ABBREVIATION
AAP—American Academy of Pediatrics

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abstract

Sexual abuse or exploitation of children is never acceptable. Such behavior by health care providers is particularly concerning because of the trust that children and their families place on adults in the health care profession. The American Academy of Pediatrics strongly endorses the social and moral prohibition against sexual abuse or exploitation of children by health care providers. The academy opposes any such sexual abuse or exploitation by providers, particularly by the academy's members. Health care providers should be trained to recognize and abide by appropriate provider-patient boundaries. Medical institutions should screen staff members for a history of child abuse issues, train them to respect and maintain appropriate boundaries, and establish policies and procedures to receive and investigate concerns about patient abuse. Each person has a responsibility to ensure the safety of children in health care settings and to scrupulously follow appropriate legal and ethical reporting and investigation procedures. *Pediatrics* 2011;128:000

INTRODUCTION

Pediatricians and other health care providers are entrusted with the responsibility to improve the health and well-being of children. However, recent allegations of the sexual abuse of hundreds of children by a pediatrician in the United States have reminded us that some among the pediatric profession may use their position of authority and trust to take advantage of their patients.[1] The prohibition against sexual misuse of one's patients goes back in history to Hippocrates, who said: "I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both male and female persons. . . ."[2] This ban is echoed by statements of the American Medical Association, the Canadian Medical Society, and the British General Medical Council.[2–4] The American Academy of Pediatrics (AAP) strongly endorses this social and moral prohibition, because it constitutes common justice; it is particularly important for pediatric patients, who have greater developmental vulnerability than adults. This policy statement provides guidance for health care professionals and parents faced with concerns of possible sexual abuse or exploitation and other abuse of children by pediatricians, other physicians, other health care professionals, and related health care personnel.

Preventing child sexual abuse is the primary concern of this statement (Table 1). Child sexual abuse is usually perpetrated by people who do not meet the criteria for a specific psychiatric sexual disorder and is defined by the act itself, which is criminal. Pedophilia and hebephilia

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TABLE 1 Definitions

Child sexual abuse is defined as engaging children in sexual activities they cannot understand or consent to, including genital or anal contact; exposing the child to exhibitionism, voyeurism, or sexually explicit material; using the child in pornography; and pandering the child for sex by others.[5]
Pedophilia is defined in the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV)* as "over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child or children" and that having "acted on these sexual urges or the sexual urges or fantasies cause marked distress or interpersonal difficulties."[6]
Hebephilia and ephebophilia are defined similarly to pedophilia, but the sexual focus is on postpubertal minor girls and boys, respectively. Hebephilia is commonly used to include both sexual attractions.
Paraphilias are persistent, deviant patterns of primary sexual attraction. Included are attractions such as exhibitionism, fetishism, frotteurism, pedophilia, masochism, sadism, transvestitism, and voyeurism.

are less common psychiatric disorders of sexual attraction, on which a person may or may not act. The sexual abuse of children is, by no means, limited to adults with these psychiatric disorders. Sexual misconduct with patients is a subset of abuse of patients by health care providers and involves issues of inappropriate provider-patient boundaries and sexual behaviors.[7] The AAP statement on professionalism also provides guidance on appropriate provider behavior.[8] Child sexual contact can vary from a single, situational event to planned, compulsive, repetitive behavior. In the extreme, the provider's sexual orientation is to children and the provider repetitively acts on this drive, exhibiting and acting on the paraphilias, pedophilia, or hebephilia.

EPIDEMIOLOGY

The medical literature on the frequency of sexual abuse of pediatric patients by providers is sparse[9–11] compared with what is known about abuse of adult patients. Likewise, there are few data on the incidence of pedophilia among pediatricians. What is known about sexual misconduct by physicians comes from surveys of physicians, surveys of adult patients, and studies of abusive physicians and of children reported for sexual abuse concerns. Data on sexual abuse of adult patients and the physicians who abuse them are reported to provide context to the epidemiology and offender behavior of patient sexual abuse.

Surveys of physicians and patients have revealed that sexual relations between physicians and adult patients are not rare and involve approximately 10% of all medical specialists who care for adults.[12] Fifty-six percent of these physicians indicated that they had never received training in provider-patient sexual boundaries. Most of them believed that sexual contact with current patients is wrong, but only one-third of them opposed sexual contact with former patients.[12]

Among the general literature about health or counseling care provider sexual misconduct with clients is a study of patients who sought psychiatric or counseling care secondary to previous provider sexual acts.[13] Fifty-one percent of the offending providers were clergy, and 49% were health care professionals. Of the health care providers, 85% were from various counseling professions, 7.3% were physicians in medical specialties, and 3.7% were nurses. Likewise, in Ontario, Canada, in the 1980s, one-quarter of the health care providers who had been legally charged with patient sexual contact were psychiatrists. Surveys of psychiatrists revealed that 7% to 10% reported that they had had previous sexual contact with patients.[14]

Studies that examined reports of sexual misconduct by physicians have provided further epidemiologic data. A Canadian task force on sexual abuse of patients found that patients younger than 14 years accounted for 8.7% of these reports, whereas 80% of patients subjected to sexual contact were adult women.[3] Male providers were responsible for 91% of the sexual contacts. Among 567 physicians disciplined by their state medical disciplinary boards between 1989 and 1996 for sexually related offenses involving patients, pediatricians accounted for 14 disciplinary events (2.9%), although they represented 7.8% of all physicians.[15]

Recent national data suggest that approximately 8% of American children experience sexual victimization in a given year,[16] although significant underreporting occurs. Official reports of sexual abuse provide some information on child sexual abuse by health care providers. In an Indiana study of children in out-of-home settings, including both general medical and psychiatric facilities, 1.56% of hospitalized children experienced any form of maltreatment.[17] Approximately half of these hospitalized children's maltreatment was sexual abuse, which constituted 0.85% of all hospitalized children. Rates of abuse were similar in foster homes (overall abuse rate: 1.69%); 0.52% of the children in foster homes sustained sexual abuse. In comparison, rates of abuse were higher in residential homes, such as group homes, in which the overall abuse rate reached 12.0%, and 5.8% of the group-home children were sexually abused. One-third of the maltreatment in hospitals was at the hands of staff, compared with 25% in residential homes. In foster homes, caregivers were responsible for 78% of the maltreatment.

In a study of 38 complaints of pediatric patient abuse by hospital staff, 52.9% involved sexual issues.[9] Males were accused in 87% of these sexual complaints. Physicians represented only

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14.3% of the accused, and other providers—nurses (42.9%), therapists (21.4%), and volunteers (21.4%)—were accused more often. Overall, 24% of the abuse complaints were felt to be substantiated by internal review by the hospital's child abuse program, and 18% remained indeterminate. Child protective services staff and police substantiated fewer cases than did hospital staff.

Some literature further characterized the sexual relations between physicians and adult patients and the attributes of practitioners who engage in sexual acts with patients. In an anonymous physician survey by Gartrell et al,[12] 42% of the physicians who had engaged in patient sexual contact had admitted doing so with more than 1 patient; 11 victims was the upper range. Male-physician-with-female-patient events constituted 89% of the reports, female-physician-with-male-patient events constituted 6%, male-physician-with-male-patient events constituted 4%, and female-physician-with-female-patient events constituted 1%. Many physicians reported ongoing sexual relationships with their adult patients that involved multiple encounters. Kardener et al[18] compared 59 physicians from adult specialties who acknowledged engaging in patient sexual contacts with 401 providers who denied such acts. Those who had engaged in sexual acts with patients were more likely to feel that provider-initiated, nonsexual affectionate physical contact with patients was appropriate. In addition, the physicians who admitted sexual contacts were more likely to perceive that such nonerotic physical contacts benefitted the patient and their relationship, contrary to the physicians who reported no sexual contact. It is unclear how these behaviors and attitudes with adult patients translate to pediatric patients, but rationalization and denial of effects on the patient seem to be a common thread.

Physicians who have sexual contact with patients come from all specialties of medicine. Most reported and recognized is inappropriate sexual contact between physicians and adult patients, which can vary from a single, opportunistic event to a pervasive, calculated pattern. When a single patient is involved, the physician may consider the events to represent consensual attraction while ignoring the inherent power differential in the relationship. Also ignored is the potential damage that may result. With multiple victims, the contacts are more likely predatory.

Child sexual offenders can have a "fixed" attraction to children or have a predominant sexual attraction to adults rather than to children but exhibit "regressed" sexual behavior by also sexually abusing children. Approximately half of the perpetrators of child sexual abuse have fixed (predominant) child attractions.[19] Those with fixed child sexual attractions are more likely to abuse strangers or casual acquaintances rather than family members. Fixed offenders select male victims more often (42%) than do regressed offenders (16%). Both types of offenders predominately use threats or intimidation (49%) or seduction or enticement (30%) to engage their victims. Twenty percent of offenses are violent or brutal. Both types of offenders tend to be consistent in the age and gender of victims they prefer and the type of abuse they perpetrate (eg, fondling versus penetration). Abuse by fixed offenders seems more often to be planned and to involve more victims, whereas that of regressed offenders is often impulsive.

Males are most often involved in sexual contact with patients. However, homosexual adults are no more likely to sexually abuse children than are heterosexual adults.[20] Jenny et al[21] also observed that among sexually abused children, the frequency of homosexual abusers was no different than their population prevalence.

Pedophilic molesters often choose vocations or activities that provide them access to children.[22] They carefully select victims, who are often vulnerable, and groom them for prolonged periods while assessing their response to gradually more intrusive sexual activities and their ability to remain silent. They also groom the child's parents and the community to trust them, or even depend on them, for isolated child supervision.

Childhood adversities, in particular, child sexual abuse, childhood family dysfunction, and childhood emotional abuse, likely play a significant role in the development of adult pedophilia.[23] However, most child sexual abuse victims do not become sex offenders. In a study of 224 sexually abused boys, 12% later committed sexual offenses.[24] Associated child neglect, lack of supervision, abuse by females, and intrafamilial violence were risk factors for their becoming offenders. Sexual abusers, in general, begin early in their lives. Forty percent of all sexual assaults against prepubertal children are perpetrated by older juveniles.[25] Some of these events provide the precedents for the development of adult pedophilia, which usually follows juvenile sexual offenses against younger children.

Several aspects of pediatric practice represent unique vulnerabilities for pediatric patients, including frequent, potentially private, contact with children. Pediatricians have a special responsibility to address these vulnerabilities and provide well-considered and well-implemented protections for the children in their care. However, any other field that provides frequent, potentially private, contact with children also has the same potential to at-

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tract adults with a sexual orientation to children.[25] The prevalence of pedophilia in the general population and among pediatricians is unknown.[25,26]

In summary, the available literature suggests that a minority of physicians, including pediatricians in particular, engage in sexual relationships with patients. Most of these encounters are heterosexual and occur between adult providers and their adult patients. However, some children are victimized by health care providers including pediatricians. There are no circumstances in which any sexual relationship between a physician and pediatric patient is appropriate. Concern about the sexual abuse of children by a physician requires careful investigation. The following guidance is offered to parents and pediatricians who have concerns of sexual abuse by a pediatric health care provider.

NORMAL PEDIATRIC EXAMINATION PRACTICE

Physicians are responsible for assessing the physical health and development of children, including genital health and pubertal development. Many diseases involve anogenital structures, and genital diseases and anomalies can have important consequences for children. During the course of pediatric physical examinations, it is often appropriate and necessary to examine a child's anogenital region. Other body regions also are sexually sensitive, such as the female chest; the perception of what is a sensitive area will vary among individual children. In addition to the physical examination, the provider's history-taking and verbal interaction can involve sensitive topics.[27]

Bright Futures, which describes preventive care that is to be covered under the Affordable Care Act of 2010 (HR 2590 §2713), is a common source for guidance on age-appropriate examinations during well-child care.[28] It provides recommendations for genital examinations from the newborn to preadolescent to adolescent periods. The newborn examination should assess for anogenital anomalies and testicular descent. The first year of life is an important time to observe for diaper-area skin problems, dislocated hips, femoral pulses, hernias, and normal testicular descent. It is also appropriate to ensure normal male and female anatomy during infant examinations. Subsequently, it is reasonable to assess for genital normalcy, including lack of inflammation, rash, or premature maturation, during each annual examination. Beginning at approximately the 7- to 8-year visits, *Bright Futures* recommends evaluation for signs of normal maturation and development to assist in health surveillance and anticipatory guidance. From then, into adolescence, the male examination will involve inspection for hernias, hydroceles, varicoceles, and inflammatory conditions. The female examination will include inspection for maturation, hymenal normalcy and patency, hernias, and dermatologic and inflammatory conditions. Routine intravaginal examinations and Papanicolaou tests are currently not recommended until the age of 21 years.[29]

In addition to regular well-child examinations, anogenital examinations are appropriate in relation to specific illness complaints. The rule in deciding whether to perform an anogenital examination during acute care should be the pertinence of the examination to the specific complaint. For example, a health care provider would be remiss not to perform a rectal examination in a child with encopresis, but such a procedure would be inappropriate for a simple sore-throat complaint. It is important for pediatricians to not avoid sensitive but indicated examinations for fear of abuse accusations. Certain conditions, such as vaginal and anal anomalies, may require repeated examinations, treatment, or dilations. Whether to wear gloves for genital examinations is dictated by local standards of care. Examinations of infants often will not involve the use of gloves, whereas gloving should become routine by the time the child is a preschooler. Gloving will also be determined by the specific complaint.

Patients should be provided privacy during disrobing and appropriate draping during examinations. Again, the age of the patient and the individual child's and family's temperament will dictate the level of draping and gowning required. The child's comfort should be paramount.

The AAP recently revised its policy on the use of chaperones for pediatric examinations.[30] In general, examinations of younger children should be chaperoned by the child's parent or caregiver. As children become older, their caregivers and the children themselves should participate in the decision of whether to use a chaperone. A full explanation of the examination and the reason(s) for it is always warranted. Likewise, offers of chaperones are recommended, but the decision of whether to use one should be a joint decision of the patient, family, and provider. In general, it is wise for male providers to have a chaperone during female genital examinations. However, even same-gender examinations can be misunderstood and can benefit from chaperoning. The patient's wishes and comfort should determine the gender of the chaperone. Providers should check to determine whether their state or hospital has specific chaperoning mandates and, if so, should abide by them. Providers also should be alert to riskier situations for which they should direct the decision toward chaperone use.[27] Ex-

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amples include the intoxicated adolescent, the child with developmental or behavioral difficulties, or the child who has been a sexual abuse victim. In these cases, normal examination practices may be misinterpreted as assaultive. False allegations of provider sexual abuse of patients do occur.[31] Being attuned to patient and parent cues and appropriately using nonfamily chaperones are the provider's best protections. Documenting the offer and use of chaperones in the medical record is good practice and provides additional practitioner protection.

INDICATORS OF POSSIBLE SEXUAL MISCONDUCT BY, OR PEDOPHILIA IN, PEDIATRICIANS

As in other situations of child sexual abuse, grooming behavior by a physician may occur to gain a child's confidence and acquiescence to subsequent abuse.[22,32] Grooming behavior includes perpetrator actions that increase the child's trust and dependence on the perpetrator while gradually obtaining the child's accommodation to sexual contacts. The intrusiveness of sexual activities may escalate slowly. Grooming may include the use of unusually "child-friendly" settings and unusual social contact beyond or outside the normal clinical interaction. Favors or gifts beyond minimal value may be given to the child. Pedophiles, similar to other sex abusers, may select emotionally vulnerable and needy victims.[22,32]

Practitioners who sexually abuse patients may have unique indications or frequencies for genital examinations. The examination techniques themselves may be idiosyncratic, such as involving inappropriately prolonged or intimate contact, contact intended to sexually stimulate the patient, examinations that lack normal gowning and draping for modesty, unnecessarily invasive examinations, or inappropriately ungloved contact. The examination or clinical interaction may be accompanied by inappropriate sexually suggestive, or sexually complimentary, comments. Parents or chaperones may be excluded from situations in which they would normally be present. For example, caregivers of preadolescent children may be excluded from examinations by the provider. The provider may tell the child not to tell the parents or caregivers about the encounter. Photographs of the child may be taken beyond those normally required for clinical documentation. Providers may share inappropriate details about their own personal, social, or sexual background. During the visit, offers of extracurricular contact and activities may be tendered. Unsolicited phone, e-mail, or text contacts, unrelated to clinical care needs, may be among the initial attempts to establish extracurricular interactions.

PREVENTION AND MANAGEMENT OF SEXUAL MISCONDUCT ISSUES THAT INVOLVE CLINIC AND HOSPITAL STAFF

All medical and health care staff involved in the care of children should be screened for past allegations of abusive behavior with children during the recruitment-and-hiring process, which should include careful checking of past employment situations and criminal and child abuse registry background checks. However, such procedures cannot be relied on to provide protection. Staley et al[33] reported that less than 1% of people who molest children have a criminal record.

Pediatric training programs should include education on appropriate professional boundaries, professional interactions during sexually sensitive or explicit discussions or examinations, and when and how to use examination chaperones. As part of the trainee's expected skills acquisition in the categories of "intrapersonal skills and communication" and "professionalism," programs should assess the success of this training. Assessment for inappropriate behavior will be most successful if it includes a review, which queries peers, parents, and nursing staff as well as physician mentors. Concerns about sexual misconduct or contact between a trainee and a patient should be reported to the appropriate state investigative and licensing authorities and may warrant discharge from the training program.

Institutions should have policies and training in place to educate staff about appropriate provider-patient boundaries[7] (Appendix A). Staff should be explicitly informed that sexual contact with patients and their caregivers is strictly forbidden. Policies about chaperoning of sensitive examinations should be implemented. Such examinations should only be conducted in formal examination or clinical settings.[27] Staff should be trained, particularly in settings in which child behavioral issues are likely, to recognize and defuse eroticized and/or disruptive child behavior. Policies and procedures should be in place for staff to report concerns of sexual impropriety (Appendix B). Staff should be educated about these policies and procedures and their responsibility to report concerns expeditiously. However, DesRoches et al[34] recently reported that physicians who are aware of impaired or incompetent colleagues only report two-thirds of these cases to the appropriate authorities. Staff should be taught that such underreporting will not be condoned. Institutions should have policies and procedures for investigating, managing, and reporting these complaints.[35]

Solo practitioners may present greater potential for both real and false accusations of sexual abuse. Their office staff may be less able to

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provide chaperoning. Likewise, the power imbalance between the provider and his or her staff is more focused, staff exposure to different practice styles is more limited, and staff may be dissuaded from or lack an avenue for reporting concerns. As such, extra efforts to include safeguards are appropriate. Included might be patient handouts that describe examination policies about genital examinations and rigorous chaperone usage.

Examples of hospital policies on staff-patient boundaries (Appendix A); chaperones for outpatient care (Appendix C); and reporting, evaluation, and management procedures for staff allegations (Appendix B) are available at the end of this statement. These appendixes represent the policies developed by Seattle Children's; they are used by permission of Seattle Children's. They do not represent AAP policy. Although they are specific to a single large pediatric-only hospital, the intention is to provide guidance to others for policy development. The Centers for Disease Control and Prevention also provides advice about screening and monitoring staff, safe environments, and complaint evaluation and management for programs that involve youth.[35]

RESPONSE TO CONCERNS ABOUT CHILD SEXUAL MISCONDUCT BY A PEDIATRICIAN OR OTHER HEALTH CARE PROVIDER

Parents and medical staff should bring any suspicions of inappropriate sexual contacts or troubling events to the attention of the office manager or pediatric practice's medical director in cases that arise in pediatric offices. With institutional or hospital cases, concerns should be brought to the attention of the managing nurses and physicians of the involved service, the hospital's child protection program, the hospital administration, or the hospital's patient or parent advocate. Provisions for confidential reporting should be available. Because concerns may arise from misinterpreted but medically appropriate actions, it is preferable that designated hospital evaluators conduct an initial evaluation before reporting to mandated state investigative agencies. However, when there are conflicts of interest between the accused and the manager, lack of an appropriate manager, or fear of retribution, it may be necessary to report directly to mandated state investigative agencies.

When managers receive reports of possible abuse, the concerns need to be evaluated expeditiously, and appropriate steps should be taken to protect other patients from abuse during the investigation (see Appendix A for sample procedures). Likewise, steps should be taken to maintain the confidentiality and reputation of accused practitioners during the time at which complaints are investigated. Institutions should offer accused providers confidential, outside supportive services. The risk of provider psychological morbidity and self-harm can be significant.

In cases with more definite concerns for abuse that rise to the equivalent of a "reasonable cause to believe" that abuse has occurred, institutional staff are legally required to report, and parents can report to their state's protective services and/or the police. A contact listing for state agencies designated to receive and investigate reports of suspected child abuse and neglect is available from the US Department of Health and Human Services Child Welfare Information Gateway (www.childwelfare.gov/pubs/reslist/rl_dsp.cfm?rs_id=5&rate_chno=11–11172). For more information about the status of current individual state laws and related resources, contact the AAP Division of State Government Affairs (800-433-9016, ext 7799, or stgov@aap.org). Once it is determined that abuse concerns rise to this level, it is possible that concerns will become public and end the accused staff member's confidentiality. More substantive complaints also warrant reporting to the appropriate state professional licensing board. When within-hospital complaints are considered substantiated, they constitute a hospital "critical incident," which generally requires reporting to the state's hospital licensing commission and conducting a critical incident review directed at how policies and procedures could be improved to prevent such incidents. It is the responsibility of institutions to warn the public of such provider behavior through these formal channels, not simply to pass the provider and issue on to some other setting. Likewise, if concerns have become public but have been evaluated and found baseless, institutions, with the consent of the accused, should make public the exonerating findings.

OUTCOMES OF SEXUAL ABUSE BY PROVIDERS

The physical and psychological health consequences sustained by children and adults who have been victims of sexual abuse are significant, and children victimized by physicians will require assessment, followed by medical care and counseling, as indicated. Although not all children exposed to sexual abuse go on to experience sequelae, there is increased risk of a broad range of problems including emotional, behavioral, cognitive, social, and general health impairments. Included are both internalizing and externalizing psychiatric disorders.[36] Past sexual abuse is associated with a greater frequency of depression, anxiety, substance abuse, conduct/antisocial personality disorder, and suicidal ideation and attempts.[37] Other childhood associations have included poor self-esteem; posttraumatic stress dis-

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order (PTSD); regressive, withdrawn, or neurotic behaviors; sexually inappropriate behaviors; eating disorders; delinquency; and general behavioral disorders.[38,39] Similar psychological problems remain more common in adults who were victims of childhood sexual abuse.[39,40] In a meta-analysis, childhood sexual abuse was correlated with adult anxiety disorders, depression, eating disorders, PTSD, sleep disorders, and suicide attempts.[41] Past victims of sexual abuse are at increased risk of further sexual victimization in childhood and adult life.[42] The absolute risk for victims of preadolescent sexual assault for some of these consequences of abuse include a 23% risk of PTSD and a 25% to 33% risk of subsequent major depression in young adulthood.[36] Physical and sexual abuse victims experience a doubling of their suicide risk.[42] A New Zealand study attributed 13% of the country's adult mental health burden to sexual abuse.[37] Specific data about the psychiatric morbidity of child sexual abuse in the medical setting are lacking. However, because such sequelae of sexual abuse generally are more common when the sexual abuse has been more frequent and more physically intrusive, is accompanied by other forms of abuse, or occurs in the setting of other family dysfunction,[36,39] isolated assaults by medical providers might result in less future morbidity. Adults who have been exposed to childhood abuse or have witnessed intimate partner violence use more health and mental health services and have poorer health status, more depression, and more interpersonal violence victimization than controls.[43] Although child abuse victimization is associated with the development of criminality and violent criminality, sexual abuse alone or associated with other forms of abuse is not associated with increased violent criminality.[44]

The effects of medical provider sexual contacts or abuse have been most studied in the context of adult psychiatric patients. Patients abused by male providers tend to have increased distrust of and anger directed toward men and to therapists in general and an increase in the number and severity of their mental health and psychosomatic symptoms.[45] In a study of adults who were seeking clinical mental health care after provider sexual contact, posttraumatic stress disorder, major depression, suicidality, misuse of prescription drugs and alcohol, disturbed interpersonal relationships, and employment disruption were all reported.[13] Eighteen percent of these patients were revictimized in subsequent counseling interactions.

Despite these reports of responses to sexual abuse in general and adult responses to sexual abuse by medical and counseling providers, there is no literature on the specific reactions of pediatric patients to medical provider sexual abuse.

Institutions should anticipate that sexual abuse victims and their parents will require assessment and likely will need follow-up counseling. They should assist in referring and financially supporting such efforts.

SUMMARY

It is the responsibility of pediatricians to protect and foster the health of their patients. As such, sexual encounters with patients are destructive and are strictly forbidden. Pediatricians have a responsibility to recognize and report sexually inappropriate acts by their colleagues and other medical staff. When they have "reasonable cause to suspect or believe" (individual states' reporting thresholds vary; providers should check their specific state's law) that abuse has occurred, they are legally required to report to appropriately mandated governmental investigative agencies and licensing boards. The sexual abuse of a child by a pediatrician is a devastating violation of ethical and legal behavior that can severely impair the child's future physical and mental health. When children are abused by those who are entrusted with their medical care, the profession has the responsibility to take the necessary actions to protect future patients from harm by those providers. These actions include helping families affected by abuse by ensuring proper emotional support. Pediatricians should also work with government agencies and licensing bodies to ensure that in the future children are protected from pediatricians and other health care providers who sexually abuse patients.

RECOMMENDATIONS

To protect and foster the health and to earn and maintain the trust of their patients:

1. It is the responsibility of pediatricians to protect and foster the health of their patients. As such, sexual encounters with patients are destructive and are strictly forbidden.
2. Pediatricians and health care providers should know that most sexual offenses of children occur at the hands of adults who have a primary sexual orientation to other adults. However, adults who have a primary sexual attraction to children constitute more risk for planned and multiple-victim child offenses. Sexual offenses are perpetrated by both heterosexual and homosexual offenders. Any sexual abuse of children by medical providers is a profound betrayal of their responsibility for patient well-being, trust, and medical ethics.
3. Medical trainees should be educated about appropriate provider-patient

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boundaries and appropriate use of chaperones for examinations.

4. Employees of medical facilities for children should be screened for previous abuse of a child by them both through formal state registries and through contact with previous employers.
5. Pediatricians should be educated about the indications and techniques of the genital examination, should perform routine genital examinations during annual checkups, and should know the indications for performing genital examinations to evaluate other specific medical concerns.
6. Pediatricians must explain to parents and verbal children why they are performing each element of the examination and respect their need for modesty by providing appropriate draping and allowing privacy while changing. They should offer chaperones and provide them whenever requested or required as part of standard practice and local regulations or when the provider feels that a chaperone is needed.
7. Employees of medical facilities for children should be trained about staff-patient boundaries, chaperone use, and their responsibility to immediately report concerns of patient abuse by other staff members. Institutions should have policies and procedures in place to conduct these trainings.
8. Parents should be informed that they have a right to request chaperoned examinations. They should be aware that if they have concerns about sexually inappropriate examinations or provider actions, they should report to the clinic's or medical facility's administration. If their concerns are sufficient, they themselves have a right to report to their state's protective service for investigation.
9. All health care providers and health care institutions are legally mandated reporters for suspicions of child abuse. If health care providers or institutions have reasonable cause to suspect that another health care provider has sexually abused a child, they are legally mandated to report to protective services and/or the police.
   a. Institutions should have policies and procedures in place to receive and evaluate concerns for patient abuse.
   b. Accused employees should have complaints about them managed confidentially, sensitively, and expeditiously. They should be provided with independent, confidential support and counseling services during the investigation.
   c. Individuals and institutions are responsible for following legal guidelines about reporting concerns for child abuse to the appropriate institutional, local, and state authorities.
   d. Individuals and institutions should cooperate with appropriate protective, legal, and licensing agencies in their investigation of concerns for sexual abuse by medical providers.
   e. Institutions remain responsible for the future protection of patients from abuse. They should not pass problem providers along without appropriate notifications.
10. Institutions should assist victims of sexual abuse by staff to receive appropriate assessment and consideration of the need for counseling.

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REFERENCES

1. Tarabay J. Delaware town misses red flags in pedophilia case. National Public Radio. May 12, 2010. Available at: www.npr.org/templates/story/story.php?storyId=126770855. Accessed August 17, 2010
2. American Medical Association, Council on Ethical and Judicial Affairs. Sexual misconduct in the practice of medicine. *JAMA*. 1991;266(19):2741–2745
3. College of Physicians and Surgeons of Ontario. *Final Report of the Task Force on Sexual Abuse of Patients*. Toronto, Ontario, Canada: College of Physicians and Surgeons of Ontario; 1991
4. General Medical Council. *Good Medical Practice: Maintaining Boundaries*. London, England: General Medical Council; 2006. Available at: www.gmc-uk.org/guidance/current/library/maintaining_boundaries.asp. Accessed January 4, 2008
5. Kellogg N; American Academy of Pediatrics, Committee on Child Abuse and Neglect. The evaluation of sexual abuse in children. *Pediatrics*. 2005;116(2):506–512
6. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV)*. Washington, DC: American Psychiatric Association; 1994
7. American Academy of Pediatrics, Committee on Bioethics. Pediatrician-family-patient relationships: managing the boundaries. *Pediatrics*. 2009;124(6):1685–1688
8. Fallat ME, Glover J; American Academy of

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Pediatrics, Committee on Bioethics. Professionalism in pediatrics. *Pediatrics*. 2007; 120(4). Available at: www.pediatrics.org/cgi/content/full/120/4/e1123

9. Feldman KW, Mason C, Shugerman RP. Accusations that hospital staff have abused pediatric patients. *Child Abuse Negl*. 2001; 25(12):1555–1569
10. Song J, Terry P. A pedophile pediatrician: the conflicting obligations. *J Clin Ethics*. 1999;10(2):142–150
11. Newberger CM, Newberger EH. When the pediatrician is a pedophile. In: Burges AW, Hartman CR, eds. *Sexual Exploitation of Patients by Health Professionals*. New York, NY: Praeger; 1986:99–106
12. Gartrell NK, Milliken N, Goodson WH III, Thiemann S, Lo B. Physician-patient sexual contact: prevalence and problems. *West J Med*. 1992;157(2):139–143
13. Luepker ET. Effects of practitioners' sexual misconduct: a follow-up study. *J Am Acad Psychiatry Law*. 1999;27(1):51–63
14. Rapp MS. Sexual misconduct. *CMAJ*. 1987; 137(3):193–194
15. Dehlendorf CE, Wilfe SM. Physicians disciplined for sex-related offenses. *JAMA*. 1998; 279(23):1883–1888
16. Finkelhor D, Ormrod R, Turner H, Hamby SL. The victimization of children and youth: a comprehensive, national survey. *Child Maltreat*. 2005;10(1):5–25
17. Spencer JW, Knudsen DD. Out-of-home maltreatment: an analysis of risk in various settings for children. *Child Youth Serv Rev*. 1992;14(6):485–492
18. Kardener SH, Fuller M, Mensh IN. Characteristics of "erotic" practitioners. *Am J Psychiatry*. 1976;133(11):1324–1325
19. Groth AN, Birnbaum HJ. Adult sexual orientation and attraction to underage persons. *Arch Sex Behav*. 1978;7(3):175–181
20. Tardif M, Van Gijseghem H. The gender identity of pedophiles: what does the outcome data tell us? *J Child Sex Abus*. 2005;14(1): 57–74
21. Jenny C, Roesler TA, Poyer KL. Are children at risk for sexual abuse by homosexuals? *Pediatrics*. 1994;94(1):41–44
22. Colton M, Roberts S, Vanstone M. Sexual abuse by men who work with children. *J Child Sex Abus*. 2010;19(3):345–364
23. Lee JKP, Jackson HJ, Pattison P, Ward T. Developmental risk factors for sexual offending. *Child Abuse Negl*. 2002;26(1):73–92
24. Salter D, McMillan D, Richards M, et al. Development of sexually abusive behavior in sexually victimized males: a longitudinal study. *Lancet*. 2003;361(9356):471–476
25. Hall RC, Hall RCW. A profile of pedophilia: definition, characteristics of offenders, recidivism, treatment outcomes, and forensic issues. *Mayo Clin Proc*. 2007;82(4):457–471
26. Fagan PJ, Wise TN, Schmidt CW Jr, Berlin FS. Pedophilia. *JAMA*. 2002;288(19):2458–2465
27. Feldman KW, Jenkins C, Laney T, Seidel K. Toward instituting a chaperone policy in outpatient pediatric clinics. *Child Abuse Negl*. 2009;33(10):709–716
28. Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents*. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008
29. American College of Obstetricians and Gynecologists, Committee on Practice Bulletins. ACOG practice bulletin No. 109: cervical cytology screening. *Obstet Gynecol*. 2009; 114(6):1409–1419
30. American Academy of Pediatrics, Committee on Practice and Ambulatory Medicine. Use of chaperones during the physical examination of the pediatric patient. *Pediatrics*. 2011;127(5):991–993
31. Silber TJ. False allegations of sexual touching by physicians in the practice of pediatrics. *Pediatrics*. 1994;94(5):742–745
32. Conte JR, Wolf S, Smith T. What sexual offenders tell us about prevention strategies. *Child Abuse Negl*. 1989;13(2):293–301
33. Staley C, Ranck ER, Perreault J, Newgebauer R. Guidelines for effective staff selection. *Child Care Inf Exch*. 1986;(Jan):22–26
34. DesRoches CM, Rao SR, Fromson JA, et al. Physicians' perceptions, preparedness for reporting, and experiences related to impaired and incompetent colleagues. *JAMA*. 2010;304(2):187–193
35. Saul J, Audage NC. *Preventing Child Sexual Abuse Within Youth-Serving Organizations: Getting Started on Policies and Procedures*. Atlanta, GA: US Department of Health and Human Services; 2007. Available at: www.cdc.gov/ViolencePrevention/pub/PreventingChildAbuse.html. Accessed July 13, 2010
36. Gilbert R, Widom CS, Browne K, Fergusson D, Webb E, Jansen S. Burden and consequences of child maltreatment in high-income countries. *Lancet*. 2009;373(9657): 68–81
37. Fergusson DM, Boden JM, Horwood LJ. Exposure to childhood sexual and physical abuse and adjustment in early adulthood. *Child Abuse Negl*. 2008;32(6):607–619
38. Kendall-Tackett KA, Williams LM, Finkelhor D. Impact of sexual abuse on children: a review and synthesis of recent empirical studies. *Psychol Bull*. 1993;113(1):164–180
39. Andrews G, Corry J, Slade T, Issakidis C, Swanston H. Child sexual abuse. In: Ezzati M, Lopez AD, Rodgers A, Murray CJL, eds. *Comparative Quantification of Health Risks*. Geneva, Switzerland: World Health Organization; 2004:1852–1819 Available at: www.who.int/publications/cra/chapters/volume2/1851-1940.pdf. Accessed August 16, 2010
40. Briere J, Elliott DM. Prevalence and psychological sequelae of self-reported childhood physical and sexual abuse in a general population sample of men and women. *Child Abuse Negl*. 2003;27(10):1205–1222
41. Chen LP, Murad MH, Clobenson KM, et al. Sexual abuse and lifetime diagnosis of psychiatric disorders: systematic review and meta-analysis. *Mayo Clin Proc*. 2010;85(7): 618–629
42. Barnes JE, Noll JG, Putnam FW, Trickett PL. Sexual and physical revictimization among victims of severe childhood sexual abuse. *Child Abuse Negl*. 2009;33(7):412–420
43. Cannon EA, Bonomi AE, Anderson ML, Rivara FP, Thompson RS. Adult health and relationship outcomes among women with abuse experiences during childhood. *Violence Vict*. 2010;25(3):291–305
44. Maxfield MG, Widom CS. The cycle of violence: revisited 6 years later. *Arch Pediatr Adolesc Med*. 1996;150(4):390–395
45. Feldman-Summers S, Jones G. Psychological impacts of sexual contact between therapists or other health care practitioners and their clients. *J Consult Clin Psychol*. 1984;52(6):1054–1061

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POLICY: To foster an atmosphere of safety and healing, Children's staff [including employees, medical staff, post-graduate trainees, agency contractors, students, and volunteers] are required to maintain a professional relationship with patients and families.

PURPOSE: To assist hospital employees, medical staff, trainees, and volunteers to establish relationships with patients and families/significant others that are therapeutic, professional, and which have defined personal and professional boundaries.
To create an environment in which the discussion of what constitutes a professional relationship with families is routine and common within departments.

PROCEDURE: The **ADDENDUM below** describes the current standards and procedures.

Revised by:

Approved by Medical Executive Committee:

APPROVED BY:

Senior Vice President
Chief Nursing Officer

Pediatrician-in-Chief
Chief Medical Information Officer

President
Chief Operating Officer

ORIGINATED:
REVIEWED:
REVISED: 09/09/09

Additional Key Words: Professional Boundaries; Therapeutic Relationship

ADDENDUM:

I. Elements of a Professional Relationship
- A. A professional relationship requires clearly defined and consistently applied boundaries and limit setting in the context of caring for the patient and family.
- B. Staff interventions are defined by the scope of practice, clinical privileges, roles, and responsibilities and by the essential functions defined in Job Descriptions, and approved medical staff credentials or privileges.
- C. Establishing a professional relationship requires that staff maintain a clear sense of their own distinct identity, emotions, moral principles, spirituality, and personal life, while caring for the physical and emotional needs of the patient and family.
- D. A professional relationship respects patient and family rights and cultural differences. This includes consistent adherence to privacy and confidentiality guidelines, and all other relevant Children's policies.
- E. A professional relationship allows staff to advocate for the patient and family, empowering them to achieve their maximum level of independence and decision-making autonomy during and after the patient's hospitalization or illness.

II. Children's Responsibility in Supporting Professional Relationships
- A. The hospital strives to provide an environment that promotes well-defined boundaries for staff relationships with patients and families. Some characteristics of this environment include:
  1. Open communication and dialogue with peers, supervisors, and directors that include the discussion of boundary dilemmas and professional ethical behavior.
  2. Staff bereavement support as appropriate.
  3. Ethical consultation as indicated or requested.

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APPENDIX A Continued

4. Employee Assistance Program consultation to support staff in helping to resolve personal issues contributing to blurred boundaries.
5. Physician Wellness Program to provide support for members of the medical staff and their families as well as residents and fellows.

III. Working with Patients and Families in a Professional Way

A. Some guiding principles to determine professional boundaries and the continuum of professional behavior include, but are not limited to, the following:
   1. Describe your role to the patient and family.
   2. Assess patient and family needs.
   3. Assist with referrals as needed.
   4. Provide care only within the scope of your practice.
   5. Provide care only within regularly scheduled work hours.
   6. Provide consistency in care and support to patients and families without preferential treatment.
   7. Limit communication and contact to subjects related to the care of the patient and services to meet family needs.

B. Refrain from and do not:
   1. Have social contact with patients or families outside of the scope of work.
   2. Provide child care outside of the scope of practice or work hours.
   3. Provide transportation to patients or families in personal vehicles.
   4. Share personal information or problems with patients or families (including home phone numbers, addresses, e-mails, and fax numbers).
   5. E-mail, phone, text, and access patient and/or family personal websites (Facebook, MySpace, Twitter, or other similar electronic sites) for non-clinical or personal use. Use of e-mail for clinical purposes must follow the guidelines outlined in the medical center's Computer User Responsibility.
   6. Directly receive gifts of significant monetary value from patients and families.
   7. Offer gifts or money to families or patients.
   8. Share religious or political beliefs with patients and families.
   9. Enter into a business relationship with a patient or family member outside the scope of one's position, e.g. hiring a patient's parent to landscape a staff person's home.

IV. Additional Rules and Expectations

A. Staff will not engage in a romantic, sexual, or intimate physical relationship with any patient, any member of a current patient's family, or any former patient under the age of 18.

B. Staff will not provide foster care or initiate adoption proceedings for a patient encountered in his or her role as a Children's employee.

C. Staff will continuously evaluate relationships with patients and families using these guidelines.

D. Questions or concerns regarding the appropriateness of relationships with patients and families will be directed to the immediate supervisor, the Director of Human Resources, Seattle Children's Hospital, or anyone in the supervisory chain of command.

E. Should staff or supervisors feel that a staff member's relationship with the patient or family member fails to meet these professional guidelines, counseling or other interventions may be indicated. If need be, the staff person's relationship with the patient or family may be terminated.

F. Failure to maintain a professional relationship with patients and families may lead to corrective action, up to, and including dismissal.

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POLICY: Children's will report, investigate and follow up on any concerns of abuse or neglect of a child arising from the actions of a Children's staff member.

PURPOSE: Children's is committed to maintaining and promoting a safe environment for all patients and families. This policy outlines the process for oversight of investigation of alleged abuse or neglect by a Children's staff member.

PROCEDURE: The **ADDENDUM below** describes the current standards and procedures.

Reviewed by:

Revised by:

Approved by Medical Executive Committee:

APPROVED BY:

Pediatrician-in-Chief Chief Medical Information Officer	Senior Vice President Chief Nursing Officer

ORIGINATED: _
REVIEWED: 10/09
REVISED:

Additional Key Words: CPS, CPT, SCAN, SCPP, Accused Staff, Allegation of Abuse, Child Protective Services, Children's Protection Team, Complaint, Grievance, Human Resources, Patient Safety, Seattle Children's Protection Program, Staff Allegation

ADDENDUM:

I. Applicability. This policy applies to acts by employees, volunteers, members of the medical staff, students, residents, fellows and trainees, all of whom are "staff members".

II. Initial Identification and Response:

A. Any person who becomes aware of a concern of abuse or neglect by a staff member will immediately notify:
   1. During normal business hours, the manager or medical staff leader of the relevant clinical area (unit, floor, clinic, etc.);
   2. Outside normal business hours, the nursing shift administrator.

B. If any person questions whether actions occurring during normal medical procedures or patient restraint are abusive, the manager, medical staff leader or nursing shift administrator will review the concerns and observations of all present to determine if the actions are consistent with normal practice.
   1. The following must be reported directly and immediately to the Seattle Children's Protection Program (SCPP):
      a. If the patient's care management team is not unanimous that the events were within normal procedures;
      b. If more than minor injury resulted; or
      c. If the concern creates **reasonable cause to believe** abuse has occurred.
   2. During regular weekday hours, 8:00 am – 4:30 p.m., contact SCPP at.
   3. After hours and on weekends or holidays, page the on-call SCAN Medical Consultant urgently.
   4. The SCAN Medical Consultant will contact the SCPP Medical Director, Manager or a designee.

C. The manager, medical staff leader or nursing shift administrator should review allegations dealing with unwitnessed events with SCPP.

D. If there are concerns about physical injury or abuse to a child, the attending physician or Suspected Child Abuse or Neglect (SCAN) Medical Consultant should examine the child, recommend treatment of any injuries and document the exam in the patient's medical record.

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APPENDIX B Continued

E. The manager or medical staff leader of the relevant clinical area will, by the end of the business day on which they are notified of the concern:
   1. File an incident report.
   2. Consult with Human Resources.

III. SCPP Investigation and Management

A. The SCPP Manager will assign an appropriate individual to act as Case Manager. Appendices I and II outline the roles of the SCPP Manager and the assigned Case Manager. The Case Manager will usually be a SCAN Social Worker (SW).

B. Disposition of person involved in allegation of abuse:
   1. The supervisor of the involved staff member will immediately remove the person from any duties involving patient care interactions.
      a. If the involved staff member is a member of the medical staff, the SCPP Manager will notify the Department Chair or Division Chief, and the Pediatrician-in-Chief or Surgeon-in-Chief if appropriate, to remove the medical staff member from patient care duties.
      b. In addition, the SCPP Manager will notify the Medical Director of the incident, who will consider whether summary action under the Medical Staff Bylaws is warranted to protect patients. The SCPP Manager will keep the Medical Director informed of the status of the investigation for the same purpose. Upon receiving such notice from the SCPP Manager, the Medical Director will assure notice to:
         i. The Medical Staff Department Director, Division Chief, and Medical Staff President;
         ii. The Department Chair, Pediatrician-in-Chief or Surgeon-in-Chief, if appropriate;
         iii. The physician leader of any practice group where the medical staff member provides patient care;
         iv. The appropriate licensing authority; and
         v. The affected member of the medical staff.
   2. If possible prior to such removal of a Seattle Children's employee, the supervisor will consult with HR. If the supervisor and HR agree, the person may be assigned to non-patient care duties. This consultation will not delay the removal of the person from patient care interactions.
   3. If the person is not assigned to non-patient care duties, the staff member will be placed on immediate paid administrative leave.
   4. The staff member involved in the allegation shall cooperate in the investigation by participating in an interview on request or otherwise as requested by the Case Manager. Failure to cooperate with the investigation on request may be grounds for disciplinary action, up to immediate termination of employment or medical staff privileges or both.
   5. The supervisor of the staff member, working with HR in the case of a Seattle Children's employee, will designate a support person for the staff member.
   6. As a case involving a Seattle Children's employee progresses or is closed, HR will periodically re-evaluate the staff member's status (leave, terms of leave, reassignment, termination or otherwise) and modify it as appropriate.
   7. Any disciplinary action result for a Seattle Children's employee as a result of the investigation shall be documented under normal HR policies.

C. Evaluation:
   1. The Case Manager will conduct an evaluation of the allegation as soon as possible. Evaluation consists of at least the following:
      a. Interview with the person(s) bringing the concern.
      b. Interview with the staff member against whom the allegation has been made regarding the event. The Case Manager will include the person's supervisor in this interview.
      c. Interview with the patient's caregiver/parent(s)/legal guardians. The Case Manager may delegate this interview to an existing assigned social worker if appropriate in the circumstances.
      d. Interview with the patient when indicated. The Case Manager may delegate this interview to an existing assigned social worker if appropriate in the circumstances.

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2. The affected child should have a trusted support person present during any interview.
3. The Case Manager will prepare a written evaluation summary.
4. In conducting the investigation outlined above, the Case Manager shall have the authority to conduct such interviews and engage in such additional investigation as the Case Manager deems reasonably necessary for the purposes of the investigation.

D. Reporting.
1. As soon as possible upon the completion of the evaluation, SCPP Manager will review the evaluation summary to determine whether the incident requires reporting to CPS, law enforcement or the Department of Health (for licensed facilities).
2. The SCPP Manager will also consult with the Associate Medical Director for Patient Safety to determine whether the incident requires reporting to the Department of Health as a sentinel event.
3. The SCPP Manager may consult with others, including the Case Manager, SCPP Medical Director, HR representative, Children's general counsel, and others with expertise in the relevant area.

E. If the SCPP Manager determines that reasonable cause exists to believe that abuse or neglect of a child has occurred, the Case Manager will make the report to CPS or law enforcement.

F. If the Case Manager reports the case to CPS, the staff member will remain or be placed on paid administrative leave by his/her supervisor, in consultation with Human Resources (HR) in the case of a Seattle Children's employee. The employee will remain available for any interviews with CPS or law enforcement.

G. The Case Manager will coordinate any patient interview by CPS, law enforcement and Department of Health (DOH) investigators with the patient's care team. The affected child should have a trusted support person present during any such interview.

H. If CPS or law enforcement determine that the incident was abusive, the SCPP Manager will:
1. Make a report to the DOH at .

I. Consult with the Associate Medical Director for Patient Safety to determine whether the alleged event constitutes a sentinel event requiring a report to the Department of Health.

J. If no report of the incident is made to CPS or law enforcement
1. The Case Manager will advise the family of their right to consult CPS for outside review.
2. The SCPP Manager will advise the person initially identifying the concern of that person's right or obligation to file an independent report with CPS.

IV. Documentation:

A. The Case Manager will:
1. Document the incident in the patient's medical record on CIS in the Child Protection folder without identifying the person alleged to have acted improperly by describing the incident as **allegation of abuse by a third party with access to children**.
   a. The individual bringing the concern will not be identified in the record, but will be referred to as a parent, medical staff member, child, volunteer, etc.
   b. If the case is determined not to require reporting, a statement to this effect will be noted in the medical record.
2. Complete the Patient/Family Risk Assessment Form (PFRA).
3. Document all procedures and communications completed or in progress, including dates and times for each step.

B. The SCPP Manager will:
1. Attach all documentation to the appropriate electronic file in Centerpoint.
2. As appropriate, arrange for the Medical Records Department to secure the medical record or relevant portions of the medical record.
3. Request that CPS, law enforcement or DOH investigators provide Seattle Children's with both verbal and written documentation of their disposition of the case.
4. Coordinate notification of the disposition of the case to all relevant parties.

C. If the allegation will affect the child's on-going treatment or placement, the attending physician at discharge will provide a brief summary of the nature of the incident in the medical discharge summary, without reference to the name of the employee.

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APPENDIX B Continued

V. Consequences – Children's Employee
- A. The SCPP Manager will report to HR any case where a report is made to CPS or law enforcement, or where CPS or law enforcement determines that the incident was abusive. HR shall take immediate action, which may range from continued administrative leave (with or without pay) up to termination of employment.
- B. In any other case, the SCPP Manager shall consult with the supervisor of the staff member involved in the allegation to communicate the results of the investigation. The supervisor shall consult with HR and determine what if any actions to take based on the circumstances of the event.

VI. Consequences – Medical Staff Member.
- A. In any case where a report is made to CPS or law enforcement regarding a member of the medical staff, or where CPS or law enforcement determine that the incident was abusive, the SCPP Manager shall notify the Medical Director, who shall initiate a formal professional investigation under the Medical Staff Bylaws.
- B. Upon receiving such notice from the SCPP Manager, the Medical Director will assure notice to:
  1. The Medical Staff Department Director, Division Chief, and Medical Staff President;
  2. The Department Chair, Pediatrician-in-Chief or Surgeon-in-Chief, if appropriate;
  3. The physician leader of any practice group where the medical staff member provides patient care;
  4. The appropriate licensing authority; and
  5. The affected member of the medical staff.

APPENDIX I: Staff Allegation of Child Maltreatment Supervisor/Manager Checklist

The Seattle Children's Protection Program (SCPP) provides leadership for staff allegation interventions. This includes case management, including further assessment and reporting, if indicated. Every effort will be made to maintain confidentiality for the patient, witness(es), reported and staff member of concern. When a report is made, the following are steps to be taken.

I. Supervisor/Manager of staff person of concern will:
- A. Gather initial information:
  1. Reporter Name
  2. Witness(es) Name
  3. Staff Person of Concern Name
  4. Patient Name
  5. Location
  6. Attending
  7. Nature of Incident
- B. Immediately contact Seattle Children's Protection Program (SCPP) Manager or Medical Director by speaking in person to:
  1. During day shift Monday – Friday, the SCPP manager, at ext. 7-2194
  2. After hours/weekends/holidays, SCAN physician, by calling the switchboard
- C. Complete the following:
  1. Emphasize need for confidentiality with all involved staff; instruct all involved individuals not to discuss the case until SCPP has arranged for the person to be contacted.
  2. Work closely with SCPP Case Manager to support investigation process
  3. Complete an incident report
  4. Obtain signed written statement from reporter and send to SCPP Manager (M/S), not to the medical record
  5. Notify patient's Attending of the incident
     - a. If there is potential physical injury, request that Attending or SCAN physician assess and treat patient, including photo documentation
  6. Place staff member on paid administrative leave, or into a "no patient contact" role when determined by appropriate supervisor, HR and SCPP Manager pending completion of incident review
  7. Working with HR, become or designate a support person for the staff person of concern

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8. Provide support to the reporter and witness(es) of the incident as needed
9. Assist the SCPP Case Manager with interviews of witness(es), reporter, and staff person of concern, and, if appropriate, with parent(s)/caregiver/legal guardians and child
10. Ensure the involved staff member is available as needed for interviews
11. With HR, periodically re-evaluate staff person's employment status (leave, terms of leave, reassignment, or termination) as investigation proceeds
12. Assess and manage transition of employee's return to work if this is outcome of review, reemphasizing the need to maintain confidentiality with all involved

II. Documentation

A. Attending and/or SCAN physician will document any exam results and treatment attributable to the incident in the patient's medical record

B. If the allegation will affect the child's on-going treatment or placement, a brief summary of the nature of the incident will be summarized by the Attending physician in the medical discharge summary without reference to the name of the involved staff member

C. Any patient complaint or grievance will be managed and documented according to Admin. P & P, "Patient Complaint or Grievance"

III. Reporting Considerations

A. SCPP Manager will determine if case is to be reported to CPS, law enforcement and/or DOH

B. If reportable, the SCPP Case Manager will notify CPS and/or law enforcement, and the SCPP Manager will notify DOH.

APPENDIX II: Seattle Children's Protection Program (SCPP) Manager and SCPP Case Manager Roles and Responsibilities

I. The SCPP Manager is responsible for communication (initially and ongoing) with the following:

A. Medical Director
B. Pediatrician-in-Chief or Surgeon-in-Chief, if appropriate
C. SCPP Medical Director
D. Administrator On Call (AOC) (who should notify the appropriate administrative leadership)
E. Clinical on Call (COC) (who should notify the appropriate medical leadership)
F. Chief Nurse
G. Vice President with oversight of SCPP
H. General Counsel
I. Risk Management
J. Human Resources
K. The Department of Health (DOH) (if required)
L. Associate Medical Director for Patient Safety, for consideration of reporting a sentinel event
M. Family and Patient Relations Manager
N. MarComm (if appropriate in the circumstances)
O. Case Manager

II. The Case Manager established under this policy is responsible for communication with the following:

A. Person bringing the concern
B. Any potential witness(es) to the incident
C. Staff member's supervisor
D. Staff member
E. Patient's social worker, if involved
F. Patient's caregiver/parent(s); and provide for, or arrange support as needed
G. Patient, when indicated
H. Patient's attending physician
I. Patient's PMD as appropriate
J. SCAN Medical Consultant, if involved
K. SCPP Manager
L. Child Protective Services (CPS) (if appropriate)
M. Law enforcement (if appropriate)
N. Unit Nursing Director or Clinical Manager

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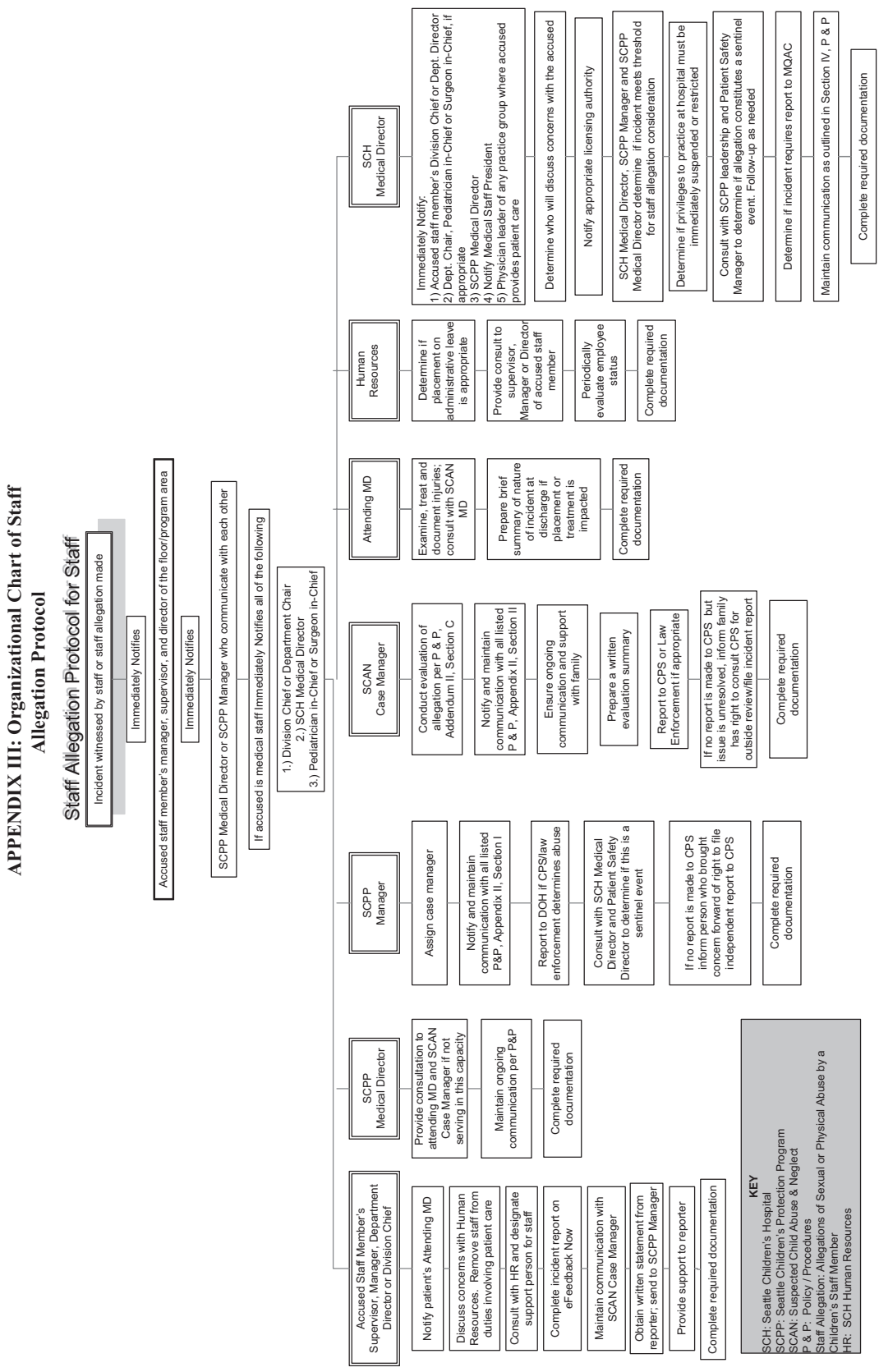
APPENDIX B Continued



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POLICY: Children's Providers will offer a chaperone to patients or their families for all or any part of a physical exam or sensitive procedure occurring in ambulatory care. This policy assures that patients will be interviewed and examined in a secure and professional manner and serves to protect health care providers from misunderstandings, accusations or inappropriate behaviors regarding physical exams and procedures.

This policy applies to all ambulatory care activities occurring within the Children's Health Care System. Any clinical area may in addition adopt more stringent guidelines.

Children's staff will maintain professional relationships with patients and families.

PURPOSE: Children's is committed to providing an environment where patients and staff feel safe and confident that clinical care is provided in a comfortable, secure, and professional manner.

PROCEDURE: The **ADDENDUM below** describes the current standards and procedures.

Reviewed by:

Revised by:

APPROVED BY:

Pediatrician-in-Chief Chief Medical Information Officer	Senior Vice President Chief Nursing Officer

ORIGINATED: __
REVIEWED:: __
REVISED: **12/02/08**

BARRIER TECHNIQUES:

CLASS __I__ **GLOVES** __R__ **EYE** __A__ **MASK** __A__ **GOWN** __A__

Additional Key Words: Confidentiality, Detention, Exam, Examination, Family Centered Care, Genital Exams, Juvenile, Patient Safety, Privacy, Professional Relationship, Staff Safety, Sensitive Exams or Procedures, Touch, Touching

ADDENDUM:

I. Chaperones will be provided in all outpatient activities listed below unless the patient or legally authorized representative requests that a chaperone not be present.
- A. In those circumstances (refusal of chaperone) see **Section IX** below.
- B. Activities requiring chaperones:
  1. Specifically requested by the patient, the parent or legal guardian
  2. Requested by the health care practitioner (i.e. physician, mid-level provider, nurse, or other caregiver) and with the approval of the parent/legal guardian or patient
  3. A potentially sensitive examinations or procedures (i.e. genital, breast, rectal) will be conducted.
  4. See **Sections IV** for considerations applicable in such situations.
  5. Prior to undertaking any such potentially sensitive examination or procedure, the person who will perform it will offer a chaperone to the patient or the legal guardian, as appropriate in the circumstances.

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APPENDIX C Continued

II. The following individuals may be considered as appropriate chaperones:
- A. Clinical staff (i.e. attending or consulting physicians, nurses, medical assistants) or other Children's staff who have specifically been trained in patient contact.
- B. Family members for younger-aged children or at the request of an adolescent; **or**,
- C. Other individuals as designated by the patient or legal guardian.
  - 1. **Note**: Interpreters, office and non-clinical staff are not appropriate for chaperoning sensitive examinations or procedures.
  - 2. Trainees (e.g. students, interns, residents, fellows) may not act as chaperones for any faculty member.
    - a. Trainees may act as chaperones for hospital personnel, such as radiology technologists.
  - 3. The patient or guardian should have the choice of the chaperone's gender.

III. Examinations and patient contacts will be limited to those warranted by the medical issues at hand.
- A. Patients will be draped appropriately for the type of contact and for modesty.
- B. Patients will be provided privacy when they dress or undress, and,
- C. The examiner will wear gloves when conducting genital exams or when there is contact with an older child's genitals, consistent with community standards.

IV. Sensitive exams or procedures are those involving the breasts, genitals or rectum. Practitioners should in addition be alert to patient-or family-specific concerns about other parts of the body that the patient or family considers sensitive.
- A. The practitioner may determine, on an individual basis, that a chaperone will be required for a breast, rectal, genital or other potentially sensitive exam or procedure, taking into account:
  - 1. Physician/practitioner patient relationship.
  - 2. Patient concern or complaint; or,
  - 3. Patient's pertinent mental health or developmental history.
- B. See **Section IX** below for cases where the patient or legal guardian declines a chaperone requested by the practitioner.

V. If a chaperone is utilized, sensitive inquiries and history-taking will respect patient confidentiality (per HIPAA regulations) and will be conducted outside the chaperoned physical exam/procedure.
- A. Medical trainees that are a part of the patient care team can be present as part of the normal care/training process.

VI. Chaperones provided by Children's will be HIPAA trained and will respect patient confidentiality and privacy.

VII. Practitioners will be sensitive to historical cues that may heighten patient or family anxiety about provider contacts.
- A. Risk for misunderstanding or misinterpreting examinations is higher when:
  - 1. Children have experienced past abuse, particularly sex abuse victimization.
  - 2. Children/adolescents have developmental delays or acutely altered mental states (e.g. intoxications) or chronic altered mental states (e.g. mental illness).
  - 3. Patients are young or naïve to medical care, or are having their first clinical encounter with a health care provider.
  - 4. Patients are in juvenile detention settings.
  - 5. There are patient or family ethnic, cultural or religious considerations specific to the examination or procedure.

VIII. Some adolescents may wish to discuss their personal issues and be examined without their parents or a chaperone present.
- A. When possible, it is appropriate to ask adolescents about their chaperone preferences in private.
- B. When adolescents can consent for their own care, they may also make the decision about utilization of a chaperone.
  - 1. For those with impaired competence, the legal guardian will be involved in making the decision about having a chaperone present.

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IX. A patient (who is authorized to consent to his/her own medical care) or the legal guardian may request that a chaperone not be present for a sensitive exam.
- A. Such, a request will be honored.
- B. However, in such a situation, the practitioner may judge the examination too problematic to complete.
- C. In such cases, the practitioner will make arrangements for subsequent evaluation of non-emergent issues or make an effort to transition patient care to another provider.
- D. In any such case involving emergency medical treatment, practitioners will assure that the patient receives a screening history and examination and any medically necessary stabilizing care.
- E. The practitioner will document the refusal for a chaperone in the medical chart.

X. Staff will not leave the exam room door open in lieu of providing a chaperone.

XI. Documentation:
- A. In the medical chart, practitioners will document:
  1. The name of the chaperone, **or**
  2. In case of refusal of a chaperone by the patient or legal guardian in circumstances described in **Section IX**, the fact that a chaperone was offered and that the patient or legal guardian declined the chaperone.
- B. In addition to the provider documentation, in the medical chart under **Add Hoc** charting, the Registered Nurse and/or Medical Assistance will document if a chaperone has been offered and accepted or declined.
- C. Follow steps below for documentation:
  1. Choose **Ad Hoc** charting under the **Chart** tab.
  2. Under the **Clinical Care** tab, click on **Patient Care Information**.
  3. Choose **Chaperone Form**.
  4. Either check **Accepted** or **Declined**.
  5. If accepted, then type in the **Name** of chaperone.
     - a. Click on the binoculars to get a current employee list.
  6. Or, if there was a family member present for the examination, type their name in box.
  7. Type in the name of **Who Accepted** or **Declined** the Chaperone.
  8. Choose the relationship to the patient.

REFERENCES:

AAP Policy. The Use of Chaperones during the Physical Examination of the Pediatric Patient. *Pediatrics*. Vol. 98, No. 6, December, 1996:1202.

Use of Chaperones during Physical Exams. *Report of the Council on Ethical and Judicial Affairs*. American Medical Association June. 1998.

WAC 246-16-100.

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COMMITTEE ON CHILD ABUSE AND NEGLECT

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