Child abuse pediatrics

Background

According to American Board of Medical Specialties, a pediatrician who specializes in child abuse pediatrics serves as a resource to children, families, and communities by accurately diagnosing abuse. They also connect with community agencies on child safety, serve as experts in court, and treat abuse and neglect. They can be directors of child abuse and neglect prevention programs and can be on multidisciplinary teams that investigate and manage child abuse cases.

According to the Accreditation Council for Graduate Medical Education (ACGME), the subspecialty of child abuse pediatrics is meant to educate physicians to diagnose and treat child abuse and neglect, as well as appropriately serve in other roles and perform such other duties as mentioned above. Physicians in this field also become familiar with administrative, legislative, and policy issues in child abuse.

For example, Nationwide Children’s Hospital offers a training program in child abuse that includes training in the evaluation and management of a medical home to children placed in out-of-home care, and evidence-based treatment within the on-site trauma-focused treatment programs. Understanding the dynamics of family violence and learning about child advocacy efforts are other areas of the program. Fellows are exposed to child care systems, mental health, preparing court testimony, and forensic pathology.

After becoming board certified in pediatrics, the American Board of Pediatrics (ABP) requires that candidates have completed two years of training in this area, if training occurred before 2010, or three years of training in the subspecialty if training began after 2010. Clinical practice amounting to five years, where half the work is focused in this subspecialty area, is required. The American Osteopathic Association (AOA) does not offer certification in this subspecialty.

For more information, please see Clinical Privilege White Paper, Practice area 152—Pediatrics.

Involved specialties

Pediatricians
Positions of specialty boards

**ABP**

According to the ABP, a subspecialty fellow who entered child abuse pediatrics training before January 1, 2010, may apply for certification on the basis of completion of two years of subspecialty fellowship training in child abuse pediatrics in a program under the supervision of a director who is certified in child abuse pediatrics or, lacking such certification, possesses appropriate educational qualifications. Only those child abuse pediatrics training programs that are operated in association with general comprehensive pediatric residency programs accredited by the ACGME or the Royal College of Physicians and Surgeons of Canada (RCPSC) will be considered.

Three years of full-time, broad-based fellowship training in child abuse pediatrics are required for fellows entering training on or after January 1, 2010. A fellow who began part-time training after January 1, 2010, may complete the required training on a part-time basis not to exceed six years.

Physicians who enter training in child abuse pediatrics on or after January 1, 2013, are required to complete their training in a program accredited for training in child abuse pediatrics by the ACGME in the United States, or the RCPSC in Canada if accreditation should exist.

Five years of broad-based practice experience in child abuse pediatrics are required. A minimum of 50% of full-time focused professional activity averaging 20 hours a week must have been spent in the practice of child abuse pediatrics. These five years should be of such type and quality that they substitute for the clinical exposure one might have encountered during subspecialty fellowship training. Practice experience may include:

- Time spent in teaching
- Research and other scholarly work
- Advocacy
- Multidisciplinary team case reviews
- Other activities expected to be important components of fellowship training

All child abuse pediatrics practice experience must be accrued in the United States or Canada.

A combination of subspecialty fellowship training and practice experience equal to five years as outlined below may be utilized:

- A fellow completing less than 12 months of fellowship training in child abuse pediatrics may receive practice credit on a month-for-month basis. For example, a nine-month subspecialty fellowship would be credited for nine months of experience; this, added to four years and three months of child abuse pediatrics practice experience, would total 60 months, or five years.
• A fellow completing 12–23 months of subspecialty fellowship training in child abuse pediatrics may receive credit on a two-for-one basis. For example, an 18-month subspecialty fellowship would be credited for 36 months of experience; this, added to 24 months of child abuse pediatrics practice experience, would total 60 months, or five years.

**AOBP**

The American Osteopathic Board of Pediatrics (AOBP) does not offer subspecialty certification in child abuse pediatrics.

**Positions of societies, academies, colleges, and associations**

**AAP**

The American Academy of Pediatric’s (AAP) Section on Child Abuse and Neglect (SOCAN) offers membership to all fellows of the AAP. Members need not be trained in, have experience or expertise in, or be practicing in the field of child abuse pediatrics. Membership in SOCAN should not be construed as evidence of certification or expertise in child abuse and neglect.

**AOA**

The AOA does not publish standards for the training of pediatricians in child abuse pediatrics.

**ACGME**

According to the *ACGME Program Requirements for Graduate Medical Education in Child Abuse Pediatrics*, the educational program in child abuse pediatrics must be 36 months in length.

Fellows must demonstrate proficiency in the following areas:

• Providing care for patients who exhibit a broad range of manifestations associated with each type of child abuse
• The use of appropriate techniques for examining, evaluating, and managing anogenital trauma, acute and chronic sexual abuse, and sexually transmitted infections, to include prepubertal and pubertal pelvic exams and sexual abuse/rape protocols
• Diagnosing and managing child neglect, including medical, supervisory, and physical neglect
• Managing prenatal and perinatal child abuse, and Munchausen syndrome by proxy (also known as medical child abuse)
• Interpreting and using results from child abuse–related laboratory studies, diagnostic tests, imaging modalities (including x-rays, CT scans, and MRIs), and subspecialty examinations (including ophthalmologic examinations)
• Determining the results of sudden unexpected deaths in children using autopsy, death scene investigation, medical history review, and interagency case reviews
• Child abuse examination skills, including:
  - Using digital photodocumentation systems for image capture and secure storage
  - Using magnification systems including a colposcope (still and video)
  - Documenting injury
  - Collecting evidence and cultures, and maintaining the chain of custody for evidence
• Applying treatment approaches that incorporate both medical and mental health therapies in the context of the family
• Epidemiology of childhood injuries, including risk factors for child abuse/neglect, family violence, and the biomechanics of injury
• Principles of child abuse, partner abuse, psychological abuse, injury prevention, and factors leading to domestic and interpersonal violence
• Typical and atypical child behavior and development as it pertains to child abuse
• Developmental anatomy and pathophysiology of organ systems as they relate to child abuse, including sexual development and anogenital anatomy
• Forensic pathology
• Principles of toxicology
• The elements and functions of community and social services; standards and procedures of child protective services; cultural aspects of child abuse; child welfare services; foster care; home visitation; reunification; mental health services; and child death review teams
• Laws and legal procedures related to child abuse, including:
  - Mandatory reporting
  - Forensic investigation
  - The role of law enforcement
  - Expert witnesses
  - Civil and criminal justice system
  - Ethical issues in expert testimony
  - Child witnesses; courtroom procedures
  - Local and national child abuse statutes
  - Legal definitions of abuse
  - Standards of evidence, and legal implications of organ donation in fatal maltreatment cases
• Child abuse prevention
• Current local and national legislation, funding options for child abuse programs, and public testimony related to child abuse legislation
• The role of the family in prevention, perpetuation, and reunification, with regard to the assessment and management of child abuse
• Medical interviews of victims, suspected perpetrators, and non-offending family members
Child abuse pediatrics

• Providing expert direct medical testimony, including clearly written and understandable media presentations and depositions
• Communicating with nonmedical professionals responding to child maltreatment
• A nonjudgmental and objective approach to child abuse detection and treatment
• Ethical behavior in interactions with the media, including protecting patient rights and maintaining patient confidentiality
• Strategies to foster personal emotional wellness, including debriefing, collegial support, and other techniques and resources
• Using community and social services and a multidisciplinary approach to patients, to include foster care, reunification, home visitation services, mental health services, and child protection
• Advocating for local and national legislation and funding affecting victims of child abuse and their families
• Developing and disseminating strategies to prevent child abuse

Fellows must participate in:
• Multidisciplinary teams to evaluate child abuse
• Local or regional multidisciplinary child protection teams and child fatality review teams
• Court, as either the physician of record or an expert witness

Positions of accreditation bodies

CMS

CMS has no formal position concerning the delineation of privileges for child abuse pediatrics. However, the CMS Conditions of Participation (CoP) define a requirement for a criteria-based privileging process in §482.22(c)(6) stating, “The bylaws must include criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges.”

§482.12(a)(6) states, “The governing body must assure that the medical staff bylaws describe the privileging process. The process articulated in the bylaws, rules or regulations must include criteria for determining the privileges that may be granted to individual practitioners and a procedure for applying the criteria to individual practitioners that considers:
• Individual character
• Individual competence
• Individual training
• Individual experience
• Individual judgment
The governing body must ensure that the hospital’s bylaws governing medical staff membership or the granting of privileges apply equally to all practitioners in each professional category of practitioners.”

Specific privileges must reflect activities that the majority of practitioners in that category can perform competently and that the hospital can support. Privileges are not granted for tasks, procedures, or activities that are not conducted within the hospital, regardless of the practitioner’s ability to perform them.

Each practitioner must be individually evaluated for requested privileges. It cannot be assumed that every practitioner can perform every task, activity, or privilege specific to a specialty, nor can it be assumed that the practitioner should be automatically granted the full range of privileges. The individual practitioner’s ability to perform each task, activity, or privilege must be individually assessed.

CMS also requires that the organization have a process to ensure that practitioners granted privileges are working within the scope of those privileges.

CMS’ CoPs include the need for a periodic appraisal of practitioners appointed to the medical staff/granted medical staff privileges (§482.22[a][1]). In the absence of a state law that establishes a time frame for the periodic appraisal, CMS recommends that an appraisal be conducted at least every 24 months. The purpose of the periodic appraisal is to determine whether clinical privileges or membership should be continued, discontinued, revised, or otherwise changed.

**The Joint Commission**

The Joint Commission has no formal position concerning the delineation of privileges for child abuse pediatrics. However, in its *Comprehensive Accreditation Manual for Hospitals*, The Joint Commission states, “The hospital collects information regarding each practitioner’s current license status, training, experience, competence, and ability to perform the requested privilege” (MS.06.01.03).

In the introduction for MS.06.01.03, The Joint Commission states that there must be a reliable and consistent system in place to process applications and verify credentials. The organized medical staff must then review and evaluate the data collected. The resultant privilege recommendations to the governing body are based on the assessment of the data.

The Joint Commission introduces MS.06.01.05 by stating, “The organized medical staff is responsible for planning and implementing a privileging process.” It goes on to state that this process typically includes:

- Developing and approving a procedures list
- Processing the application
- Evaluating applicant-specific information
• Submitting recommendations to the governing body for applicant-specific delineated privileges
• Notifying the applicant, relevant personnel, and, as required by law, external entities of the privileging decision
• Monitoring the use of privileges and quality-of-care issues

MS.06.01.05 further states, “The decision to grant or deny a privilege(s) and/or to renew an existing privilege(s) is an objective, evidence-based process.”

The EPs for standard MS.06.01.05 include several requirements as follows:
• The need for all licensed independent practitioners who provide care, treatment, and services to have a current license, certification, or registration, as required by law and regulation
• Established criteria as recommended by the organized medical staff and approved by the governing body with specific evaluation of current licensure and/or certification, specific relevant training, evidence of physical ability, professional practice review data from the applicant’s current organization, peer and/or faculty recommendation, and a review of the practitioner’s performance within the hospital (for renewal of privileges)
• Consistent application of criteria
• A clearly defined (documented) procedure for processing clinical privilege requests that is approved by the organized medical staff
• Documentation and confirmation of the applicant’s statement that no health problems exist that would affect his or her ability to perform privileges requested
• A query of the NPDB for initial privileges, renewal of privileges, and when a new privilege is requested
• Written peer recommendations that address the practitioner’s current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism
• A list of specific challenges or concerns that the organized medical staff must evaluate prior to recommending privileges (MS.06.01.05, EP 9)
• A process to determine whether there is sufficient clinical performance information to make a decision related to privileges
• A decision (action) on the completed application for privileges that occurs within the time period specified in the organization’s medical staff bylaws
• Information regarding any changes to practitioners’ clinical privileges, updated as they occur

The Joint Commission further states, “The organized medical staff reviews and analyzes information regarding each requesting practitioner’s current licensure status, training, experience, current competence, and ability to perform the requested privilege” (MS.06.01.07).

In the EPs for standard MS.06.01.07, The Joint Commission states that the information review and analysis process is clearly defined and that the decision
process must be timely. The organization, based on recommendations by the organized medical staff and approval by the governing body, develops criteria that will be considered in the decision to grant, limit, or deny a request for privileges. The criteria must be consistently applied and directly relate to the quality of care, treatment, and services. Ultimately, the governing body or delegated governing body has the final authority for granting, renewing, or denying clinical privileges. Privileges may not be granted for a period beyond two years.

Criteria that determine a practitioner’s ability to provide patient care, treatment, and services within the scope of the privilege(s) requested are consistently evaluated.

The Joint Commission further states, “Ongoing professional practice evaluation information is factored into the decision to maintain existing privilege(s), to revise existing privileges, or to revoke an existing privilege prior to or at the time of renewal” (MS.08.01.03).

In the EPs for MS.08.01.03, The Joint Commission says there is a clearly defined process facilitating the evaluation of each practitioner’s professional practice, in which the type of information collected is determined by individual departments and approved by the organized medical staff. Information resulting from the ongoing professional practice evaluation is used to determine whether to continue, limit, or revoke any existing privilege.

**HFAP**

The Healthcare Facilities Accreditation Program (HFAP) has no formal position concerning the delineation of privileges for child abuse pediatrics. The bylaws must include the criteria for determining the privileges to be granted to the individual practitioners and the procedure for applying the criteria to individuals requesting privileges (03.01.09). Privileges are granted based on the medical staff’s review of an individual practitioner’s qualifications and its recommendation regarding that individual practitioner to the governing body.

It is also required that the organization have a process to ensure that practitioners granted privileges are working within the scope of those privileges.

Privileges must be granted within the capabilities of the facility. For example, if an organization is not capable of performing open-heart surgery, no physician should be granted that privilege.

In the explanation for standard 03.01.13 related to membership selection criteria, HFAP states, “Basic criteria listed in the bylaws, or the credentials manual, include the items listed in this standard. (Emphasis is placed on training and competence in the requested privileges.)”
The bylaws also define the mechanisms by which the clinical departments, if applicable, or the medical staff as a whole establish criteria for specific privilege delineation.

Periodic appraisals of the suitability for membership and clinical privileges is required to determine whether the individual practitioner’s clinical privileges should be approved, continued, discontinued, revised, or otherwise changed (03.00.04). The appraisals are to be conducted at least every 24 months.

The medical staff is accountable to the governing body for the quality of medical care provided, and quality assessment and performance improvement (03.02.01) information must be used in the process of evaluating and acting on re-privileging and reappointment requests from members and other credentialed staff.

**DNV**

DNV has no formal position concerning the delineation of privileges for child abuse pediatrics. MS.12 Standard Requirement (SR) #1 states, “The medical staff bylaws shall include criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to those individuals that request privileges.”

The governing body shall ensure that under no circumstances is medical staff membership or professional privileges in the organization dependent solely upon certification, fellowship, or membership in a specialty body or society.

Regarding the Medical Staff Standards related to Clinical Privileges (MS.12), DNV requires specific provisions within the medical staff bylaws for:

- The consideration of automatic suspension of clinical privileges in the following circumstances: revocation/restriction of licensure; revocation, suspension, or probation of a DEA license; failure to maintain professional liability insurance as specified; and noncompliance with written medical record delinquency/deficiency requirements
- Immediate and automatic suspension of clinical privileges due to the termination or revocation of the practitioner’s Medicare/Medicaid status
- Fair hearing and appeal

The Interpretive Guidelines also state that core privileges for general surgery and surgical subspecialties are acceptable as long as the core is properly defined.

DNV also requires a mechanism (outlined in the bylaws) to ensure that all individuals provide services only within the scope of privileges granted (MS.12, SR.4).

Clinical privileges (and appointments or reappointments) are for a period as defined by state law or, if permitted by state law, not to exceed three years (MS.12, SR.2).
Individual practitioner performance data must be measured, utilized, and evaluated as a part of the decision-making for appointment and reappointment. Although not specifically stated, this would apply to the individual practitioner’s respective delineation of privilege requests.

CRC draft criteria

The following draft criteria are intended to serve solely as a starting point for the development of an institution’s policy regarding this practice area. The core privileges and accompanying procedure list are not meant to be all-encompassing. They define the types of activities, procedures, and privileges that the majority of practitioners in this specialty perform. Additionally, it cannot be expected or required that practitioners perform every procedure listed. Instruct practitioners that they may strikethrough or delete any procedures they do not wish to request.

Minimum threshold criteria for requesting privileges in child abuse pediatrics

Basic education: MD or DO

Minimal formal training: Successful completion of three years of full-time, broad-based ACGME-accredited fellowship training in child abuse pediatrics are required for fellows entering training on or after January 1, 2010, and/or at least five years’ clinical experience in which at least half the work focused on child abuse pediatrics.

Required current experience: Evaluation of at least [n] patients, reflective of the scope of privileges requested, in the past 12 months or successful completion of an accredited clinical fellowship in the past 12 months.

References

If the applicant is recently trained, a letter of reference should come from the director of the applicant’s training program. Alternatively, a letter of reference may come from the applicable department chair and/or clinical service chief at the facility where the applicant most recently practiced.

Core privileges in child abuse pediatrics

Core privileges in child abuse pediatrics include the ability to provide care for patients who exhibit a broad range of manifestations associated with each type of child abuse, as well as the use of appropriate techniques for examining, evaluating, and managing anogenital trauma, acute and chronic sexual abuse, and sexually transmitted infections, to include prepubertal and pubertal pelvic exams and sexual abuse/rape protocols. Practitioners may diagnose and manage child neglect, including medical, supervisory, and physical neglect, and manage prenatal and perinatal child abuse as well as Munchausen syndrome by proxy (also known as medical child abuse). Core privileges also include the
ability to interpret and use results from child abuse–related laboratory studies, diagnostic tests, imaging modalities (including x-rays, CT scans, and MRIs), and subspecialty examinations (including ophthalmologic examinations). Physicians may determine the results of sudden unexpected deaths in children using autopsy, death scene investigation, medical history review, and interagency case reviews, and should exhibit appropriate child abuse examination skills and apply treatment approaches that incorporate both medical and mental health therapies in the context of the family.

Reappointment

Reappointment should be based on unbiased, objective results of care according to a hospital’s quality assurance mechanism. To be eligible to renew privileges in child abuse pediatrics, the applicant must demonstrate current competence and an adequate volume of experience with acceptable results, reflective of the scope of privileges requested, for the past 24 months based on results of ongoing professional practice evaluation and outcomes. Evidence of current physical and mental ability to perform privileges requested is required of all applicants for renewal of privileges. In addition, continuing education related to child abuse pediatrics should be required.

For more information

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