Paediatric Ethics Cases:

Case 1. When parents and doctors disagree regarding treatment REQUESTS: the case of Charlie Gard

Charlie Gard was born in the UK in August 2016, apparently healthy at birth. Over the next 2 months he failed to thrive and was diagnosed with a rare fatal genetic disorder, mitochondrial DNA depletion syndrome (MDDS), at the Greater Ormond Street Hospital (GOSH) in October 2016. His treating medical team felt that ongoing treatment was not in his best interests and recommended withdrawal of care. However, his parents located a doctor in the US, Dr Hirano, who said that experimental nucleoside treatment might be of benefit, depending on Charlie's current status. While a request for this experimental treatment was being prepared for the GOSH ethics committee, Charlie developed severe prolonged seizures. At this point his doctors deemed further treatment futile. Charlie's parents disagreed and engaged in a social media campaign (GoFundMe) to raise funds to take Charlie to New York for treatment.

In Feb 2017, GOSH took legal action to prevent his parents taking Charlie to the US. The parents appealed the decision, but the High Court supported the hospital, as did the Court of Appeal, the Supreme Court and the European Court of Human Rights. After interventions from the Pope and President Trump, GOSH returned to court for an affirmation of the orders, but the parents requested review of new evidence, and the court asked Dr Hirano to examine Charlie. Dr Hirano found that Charlie's disease had progressed to the point where treatment would be futile, at which point his parents ceased their legal action. The court made an order for palliative care and withdrawal of ventilation, leading to Charlie's death on 28 July 2017. (Hammond-Browning 2017)

WHO can make decisions for minors who lack the capacity to make treatment decisions?

Consent type	Who can consent	Documentation
Adults & mature minors (sig + minor Rx)	• Patient	***Written consent*** NEEDED
Refusal of treatment or ACD	• Patient (who has capacity at the time)	***Written consent*** or advanced care directive (form on NSW health)
Emergency	• None – doctor does whatever is needed for a child <15 or young person (16 or 17) **without** consent of the child or young person, or RESPECTIVE parent • (Section 174 of the *Children and Young Person's (Care and Protection) Act)*	Patient's health record
≥16 with no capacity to consent	• *Guardianship Act 1987* ➔ appointed guardian (followed by spouse > carer > close friend) • If none can be found ➔ ONLY NSW Civil and Administrative Tribunal	***Written consent***
Minor (<16) – simple or sig. Rx	• Parent/guardian (unless Mature Minor – Gillick Competence, Marion's case, Common law" • If intellectual disability = still need to assess for competence!!!	***Written consent*** (req. for significant treatment → fill out form on NSW health
Minor (<16) – refusal of Rx	• Parent/guardian (unless Mature Minor – Gillick Competence, Marion's case, Common law" • NB: court can override Gillick competence refusal by minor or guardian based on Minor's best interest (well-being)	***Document ALL discussions*** and statements about Rx refusal in patient's health record
< 14 yo child	➢ Parent/guardian ONLY valid	
Cultural barriers	➢ Valid consent can only be obtained if the young person understands what is being presented in a language in which they are fluent ➢ Healthcare interpreters needed (e.g. translating and interpreting service 131 450	

- ***HOW* should these decisions be made?**
  In the best interest of the child.

- ***WHY* might these decisions prove contentious? & *WHAT* are the ethical considerations that arise in this case?**

Using social media to mobilise support – raises awareness of a rare condition BUT also increased criticism and death threats against treating doctors who did not permit decision. Delayed intervention meant in an ability to test whether the new experimental treatment could work. Doing something is better than nothing approach

Crowdfunding to pay for unauthorised treatment – due to finite healthcare resources, potential that this case if successful would set a precedence for other families to follow the same route if doctors and courts consider it is not in the best interest of the child

- ➢ Affects issues surrounding privacy
- ➢ Wider issues on inequitable and fair access to medical treatment?
- ➢ What happens when crowdfunding money runs out?

Fuelling anti-establish sentiment:

- ➢ Shift from "doctor's knows best" attitude to "parents knows best"
- ➢ Shift from best interest of Charlie to politically shifting to best interest of others (e.g. being heard on social media)

Case 2. When parents and doctors disagree regarding REFUSAL OF TREATMENT: the case of Oshin Kiszko

Oshin Kiszko was 5 years old when he was diagnosed with a medulloblastoma on 1 Dec 2015. His tumour was resected on 3 Dec 2015 at the Princess Margaret Hospital (PMH) in Perth. The hospital's treatment protocol for medulloblastoma recommended chemo- and radio-therapy, starting within 28-36 days of surgery. This protocol aimed at maximizing the chance of cure, but risked significant side effects including long term cognitive impairment from the radiotherapy. Oshin's parents, Angela Kiszko and Adrian Strachan, were concerned about the side effects and the suffering that treatment would entail. They withheld permission for treatment to commence, and treated Oshin with natural therapies. Oshin's case was then referred to the PMH ethics committee, which held divided opinions between recommending the radio- and chemotherapy for the best chance of survival, versus palliative chemotherapy only in accordance with the parents' wishes.

In March 2016, the PMH sought an order from the WA Family Court to authorise the urgent instigation of treatment. At this time, full treatment offered a 50-60% chance of 5 year survival, dropping to 30% for chemotherapy alone. Without treatment, Oshin was predicted to die within 6-12 months. The Chief Justice appointed an Independent Children's Lawyer (ICL) and ordered Oshin to receive chemotherapy but not radiotherapy, pending further review. In April 2016, the ICL received an expert report to the effect that radiotherapy was unlikely to be life-saving but would certainly cause harm. The Family Court then determined that Oshin should not receive radiotherapy. Review in July 2016 showed a good response to treatment and the PHM staff recommended consolidation chemo- and radiotherapy. Oshin's parents refused consent and the case came before the WA Family Court for a third time in August 2016, at which point the PMH doctors estimated there was a 30-40% chance of cure. The Chief Justice eventually ruled for palliative care only, noting that the delays and obstruction by the parents had effectively robbed Oshin of the chance of cure. After receiving palliative care from September onwards, Oshin died at home on 28 December 2016.

WHO **can make decisions for minors who lack the capacity to make treatment decisions?**

- Parents are default medical decision-makers for their children (they usu. know best and carry primary burden and carer for their children long term)
- Case highlighted importance of ***improving doctor-parent communication*** (understand parent's views, desires for child etc.)

HOW **should these decisions be made?**

In the *best interest of the child.* Consider "zone of parental discretion" to avoid significant harm RATHER than maximising welfare

- Parents have ethical right to make decision for child based on their own conception of a good life
- Parents are not morally obliged to maximise well being of their child
- Parental decision overridden ONLY if child likely suffers significant harm from decision.

- However, some parents make decisions against best medical advice → doctors may respect BUT may not necessarily agree for instance:
  - Declining artificial feeding of undernourished child with disability as they prefer lighter child to carry
  - Decline diagnostic testing or definitive surgery – may seem it is unnecessary or too risky
  - Refuse cancer treatment → in favour of alternatives

- ***WHY*** **might these decisions prove contentious? &** ***WHAT*** **are the ethical considerations that arise in this case?**

Child's well-being depends on → pain-free, long-life span, having meaningful relationships and being able to play

- Doctors need to compromise final decision and accept that a sub-optimal choice is preferred as long as it not harmful and considers the child's well-being and parent's autonomy

Case 3. Treatment request in a MATURING MINOR: the case of Lisa

Lisa is a 15-year-old girl who lives in country NSW. She comes to see her GP, Dr Morrow, to discuss contraception. Lisa has recently become sexually active with her boyfriend of 8 months. There has been no coercion, and the decision to have sex has been made together by Lisa and her boyfriend after lengthy deliberation. This is her first 'serious' boyfriend and Lisa regards it as a stable relationship. Lisa has no significant past history, is on no medication and does not smoke. She attends secondary school and lives at home with both parents and her older brother and younger sister. She is a reasonably mature girl who does well at school, has supportive friendships, and is good at sports. Her mother is not aware of Lisa's sexual behaviour or her request for oral contraception.
This comparatively straightforward situation is complicated by the fact that Lisa is Dr Morrow's niece, the daughter of her husband's sister. Relationships between Dr Morrow's family and Lisa's family are close, they get on well together and they regularly see each other socially.
Dr Morrow has provided Lisa's mother and her three children with medical care for the past 12 years. The availability of female doctors in their town has been limited over this time and Lisa's family has been happy for Dr Morrow to take this role. On this occasion Lisa has come to Dr Morrow in confidence.

- **WHO can make decisions for minors who lack the capacity to make treatment decisions?**

Mature Minor ("Gillick competence" and Marion's case) is capable of independently consenting to or refusing their medical treatment when they achieve a sufficient level of understanding and intelligence to enable them to understand fully what is proposed. Determined on a case-by-case basis by medical practitioner.

Table 1: Maturity Guide for Minor's Capacity to Consent to Medical Treatment

Level of maturity & understanding	Recommendation for Obtaining Consent
Immature and insufficient understanding (may be 13 and under)	Consent from a parent or guardian must be obtained (Attachment B)
Intermediate understanding (may be 14 and 15)	Consent from the young person may be sufficient. However, the consent of a parent or guardian should also be obtained, unless the young person objects to this (refer discussion above on *Gillick* Competence) (Attachment A or B, depending on the young person's capacity)
Mature understanding (may be 16 and 17)	Consent of the young person will be sufficient in most cases (refer discussion above on *Gillick* Competence) (Attachment A)

What is valid consent?

- Understands general nature of the treatment
- consent must cover the act performed
- must be voluntary

1. **What values do you think are most important to Lisa at present?**
   - Autonomy to make own decisions. Maintain good social and family relationships. Progressing relationship with boyfriend.
   - Excelling in sports and academics.

2. **What questions would you ask Lisa to understand her point of view and work out if she has capacity to make the treatment decision in question?**
   - Understand what types of contraceptions (pill, LARCs) are available. Reason for contraception. Benefits (e.g. contraception), risks (e.g. can still get STIs) and side effects (e.g. breast tender, N/V, mood swings, breakthrough bleed).
     - What do they want?
     - Know how to use contraceptions? Including emergency contraceptives.
   - Current relationship status w/ boyfriend (any power differential, abuse, recent risky behaviour)

- Good knowledge of safe sex practices (e.g. condoms, void after sex, clean before sex)

3. **What are the doctor's ethical and legal obligations?**
   - ***Beneficence/Equity***: The doctor's duty of care to the adolescent patient where confidentiality must be protected unless there are extenuating circumstances
   - ***Beneficence*** = The importance of maintaining a trusting relationship with the adolescent
   - The young person's age, developmental maturity and demonstrated competence
   - ***Non-maleficence = Compelled by law to disclose*** → e.g. evidence of notifiable disease (e.g HIV, AIDS, hepatitis, TB), reporting BAC tests admitted to hospital after MVA and recoding of births and deaths
     - Mandatory reporting of physical, sexual abuse or risk of suicide

4. **What are the ethical tensions in the case and how would you resolve them?**
   - ***Confidentiality and privacy*** = no disclosure of what was spoken → Disagreement between daughter and mother (create a safe space where Lisa is alone and can be assessed for mental capacity with mother out of room)
     - Explain that we are not learning any new secrets but ONLY goal is to give best medical advice
     - *If not ask Lisa to contact me separately at another time*
   - ***Paternalistic and religious/cultural attitudes*** (parents know best until child turns 18) → encourage Lisa to speak with mother
   - ***Advise on correct usage/costs -*** encouraging them to ask their doctor or nurse if they don't know
   - Educate Children can apply for their **own Medicare card (and number) when they turn 15**, WITHOUT parental consent . Those < 15 can apply with parental consent .

5. **How do the personal relationships influence your reasoning?**
   - Compromise patient doctor confidentiality → breaks down rapport → prevents follow up
   - Have to remain vigilant with choice of words and disclosing details of other family member

Case 4: Treatment refusal in an adolescent: the case of Jason

Jason is 14 years old. He has had Crohns disease since the age of six. He is currently experiencing a flare up and at his last clinic visit the consultant commenced him on oral steroids. Jason and his parents are seen in clinic for a follow up appointment two weeks later. Jason is accompanied by his parents who report that he is refusing to take his medication. Last time he had steroids he put on a lot of weight and he does not want this to happen again. His mother is sympathetic to Jason's argument but apparently his father thinks he should be forced to take them if necessary. The consultant's last clinic letter states clearly that Jason is at high risk of developing complications if he does not take oral treatment and may end up requiring surgery.

1. **What values do you think are most important to Jason at present?**

Autonomy. Being well and healthy including projecting a good social image (body image).

2. **What questions would you ask Jason to understand his point of view and work out if he has capacity to make the treatment decision in question?**

Understanding of his Crohn's. Does he understand the benefits vs risks. Does he know of alternatives? What are other reasons for not taking oral steroids? (looks bad taking 'steroid' pills – stigma?, does not feel it works?)

3. **What are the doctor's ethical and legal obligations? & What are the ethical tensions in the case and how would you resolve them?**

Although the Gillick principle allows for a competent minor to consent to treatment , it does NOT allow for a corresponding right to refuse treatment . Can also provide treatment against child's wishes, even if Gillick competent, only when treatment is urgent. May require a court order.

4. **Develop a plan for resolving disagreement.**

Ascertain concerns of Jason, Father and mother separately if possible. Discuss alternatives to steroids for acute flares.

Case 5: Jehovah's witness

Sarah is a 17-year-old patient who has Hodgkin's disease and is about to start her third round of chemotherapy following a relapse of the disease. Sarah and her family are followers of the Jehovah's Witness faith and object to having a blood or platelet transfusion. Sarah and her parents have provided a written, signed document to her Medical Practitioner refusing blood or platelet transfusions. Sarah's Medical Practitioner has over 20 years' experience with patients in similar situations and has advised that Sarah will die without chemotherapy treatment. Sarah has a 70% chance of being cured of the disease with chemotherapy treatment, but this treatment will necessitate a blood transfusion, without which Sarah is likely to die from anaemia. Sarah and her parents seek to have the chemotherapy treatment but refuse to consent to a blood or blood product transfusion. Sarah has been assessed by expert Medical Practitioners as a Mature Minor. She is fully supported by her parents in her decision.

1. **What considerations need to be made by the practitioner?**

- consider any alternative appropriate treatment for which consent would be forthcoming
- consider obtaining a 2nd opinion from suitably qualified doctor to confirm prognosis and treatment plan
- attempt to reach agreement with Sarah and her family by repeat discussions and counselling
- if no agreement can be reached → consider whether there are reasonable grounds to refuse treatment to suspect that Sarah is 'at risk of significant harm' to the degree that a suspected risk of significant harm report must be made to the Department of Communities and Justice pursuant to the mandatory reporting requirement under section 27, Children and Young Persons (Care and Protection) Act 1998.

2. **What are the doctor's ethical and legal obligations?**

- Medical Practitioner should *escalate* the issue within the ***Health Service*** and urgently seek advice from ***Ministry of Health Legal Branch*** to obtain an appropriate court order for guidance on a treatment plan → who may issue *parens patriae jurisdiction* to make an order based on the best interests of *Sarah*
- If multiple providers disclosed in care of young person → e.g. MDT → advisable to seek a patient's permission to disclose any non-urgent communications outside these parameters [**team confidentiality**]

Child Abuse And Neglect (IDENTIFY → CONSULT → RESPOND)

Identify features on history and examination which are concerning for child abuse and neglect, and use the Mandatory Reporters Guide to appropriately report cases to statutory authorities

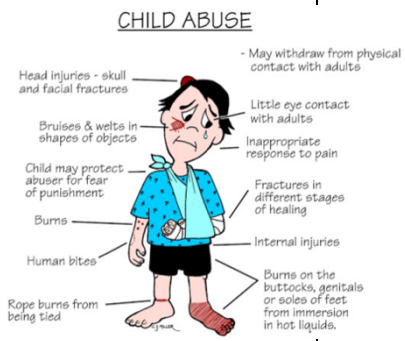
Child Neglect:

Neglect type	Potential indicators	Parents/caregivers
Physical Neglect	• FTT • Inadequate supervision for age • Poor hygiene standard • Chronic complex health care needs • Focus on basic survival	➢ Inadequate food, shelter, safe home, clothing ➢ Physical signs of injuries (e.g. cheek, chest, arm, stomach, groin and feet) ➢ Prioritises work and adult interests ahead of interest of child
Psychological Neglect	Delayed developmental milestones	Poor parent/carer attachment
Medical Neglect	➢ Did not attend appts for child w/ complex health needs ➢ Stays in homes of friends (rather their own)	➢ Does not act on deteriorating signs of child ➢ Does not follow medical advice (even when clearly explained) ➢ Repeatedly does not attend appts w/o acceptable reason
Education Neglect	Unenrolled in school	Does not ensure child goes to school

Domestic and family violence:

- Where child or young person pregnant woman in household subjected to domestic violence causing serious physical and psychological harm

	Children victim indicators	Adult victims	Perpetrators

Physical Abuse
 	
RF - parent:
➢ Poverty
➢ Young parents
➢ DFV
➢ Substance abuse
➢ Divorced
➢ Intergenerational trauma
 	
RF - child:
➢ Pre-term and LBW
➢ Birth defect
➢ Dev. delay
➢ Hyperactive
➢ Intergenerational trauma
	• **Bruise** on face, neck and head (esp. in shape of objected, bite marks, burns)
	• **Unspecified internal pains**
	  ○ Concealing clothing to hide bruise?
	• **Head injuries** – drowsy, vomiting, glassy eyes, fixed pupils
	  ○ Beware swallowing poisonous substances, EtOH, drugs
	• **FTT and delayed developmental milestones** (Lacks age appropriate social skills)
	• **Low self-esteem** (low confidence)
	• Does not value others – apathetic
	• Aggressive and violent behaviours (a bully)
	• Hypervigilance and cowering at sudden movements
	• Self-harm
	• Suicidal attempt
		➢ Explanation does **NOT** match injury OR offered under duress
		➢ Bruising if pregnant
		➢ Concealing clothing
		➢ Unwanted pregnancy or STI through coerced sex
		➢ Unexplained M/C or stillbirth
		➢ EtOH or drug abuse
		
		 
			➢ Explanation inconsistent to type and severity of injury
			➢ Victim fighting back causing facial scratches and injuries to hands
			➢ Non-family member present with child
			➢ FHx of violence
			➢ Aggressive behaviour displayed in presence of child

Sexual abuse • Kissing • Touching/ fondling • Penetration • Sexual coercion • Exploitation	➢ Directly or indirectly discloses sexual abuse (+ describing acts w/ age inappropriate knowledge) ➢ Fear of going home (always running away) ➢ Engaged in prostitution or pornography ➢ Wears baggy clothing to disguise gender, body shape, bruises and injury ➢ Self-harm, suicidal attempt, drug and EtOH dependence	➢ Defers to partner ➢ Minimise disclosure	➢ Tolerates and encourages sexual behaviour ➢ Controlling attitude ➢ Coerces child to engage in sexual behaviour w/ others ➢ Child grooming ➢ Justifies abuse by blaming victim
Social / Psychological Harm	➢ Directly or indirectly discloses domestic violence ➢ Poor sleep and appetite ➢ Frequent school/ work absenteeism ➢ Abusive / dismissive attitude to parent ➢ Homeless / stays away from home ➢ **Suicidal attempts** ➢ Socially isolated, sadness, frequent crying ➢ Feeling worthless, highly self-critical ➢ Distrusts others and apathetic ➢ Submissive to adults	Same as child: ➢ Substantial delay before seeking Rx ➢ Refers to partner's anger/temper ➢ Never makes decisions (controlled by partner) ➢ After-hours presentations ➢ Feeling anxious and depressed ➢ Presence of domestic violence	➢ Presents as victim ➢ Visible rough handling of victim ➢ Cannot control outburst ➢ Always speaks on behalf of partner ➢ Rigid stereotypical roles ➢ Jealousy and distrust to partner (belittles and criticises them) ➢ Downplays violence ➢ Previous criminal convictions

	Physical indicators	Psychological Indicators
Pre-natal concern of pregnant mother	• EtOH or drug misuse • Pregnant women victim of domestic violence • Homeless	Unmanaged psych condition ➢ Risk of suicide ➢ Hx of abuse or neglect in unborn child ➢ Limited social support

Ranking of types of abuse: (it is cumulative!)

1) **Emotional (60%)** - emotional deprivation and trauma
2) Neglect – deprivation
3) Physical - NAI
4) Sexual – if having sexual abuse (most likely experiencing all types of abuse)

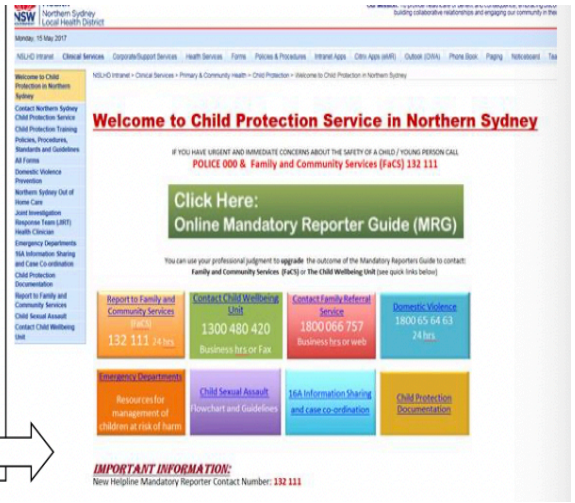
Adverse childhood events (ACEs) are single greatest unaddressed public threat"

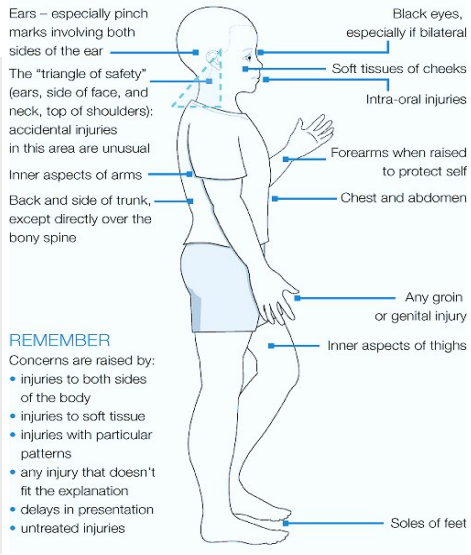
1) Cumulative (ACEs) ➔ increases risk of CVS, cancer, stroke, COPD, #, diabetes
2) Divorced parents= major cause

Management:

- Improving resilience through education for families
- Good role models (aunt, teacher)
- Empathy → Ongoing peer support

Child Protection Helpline:
132 111
Child Wellbeing Unit:
1300 480 420
Family Referral Service:
1800 066 757
Nthn Syd Child Protection Service: 94629266
NSLHD-NSCPSIntake@health.nsw.gov.au
Child Protection link under Quick Links on NSLHD Intranet home page (right hand side):





How should I respond?

*WHO IS A **MANDATORY** REPORTER?:

- *HCW, welfare workers (i.e. social, psychologist,s case worker), education (teacher, counsellor), children's services (child care workers), police, refuge workers*
- ***Child and Young Persons (care and protection) act 1998*:** All HCW providing children or their families legally obligated to make report to DCJ (child protection helpline) if there are reasonable grounds to suspect child is at risk of significant harm (RoSH)

REPORTING PROCESS

1. Continue **providing health services** to patient and answer family's concerns
2. **Consult SENIOR PAEDS or SOCIAL WORKER** in line with info sharing requirements detailed Section 6 of Child Wellbeing & Child Protection Policies and Procedures for NSW health.
3. **Consult Mandatory reporter guide (MRG) to determine course of action**
   a. Phone DCJ (**Child Protection Helpline**) 132 111 *who use SCRPT (Screening and Response Priority Tool) to determine risk of self-harm*
   b. Complete eReport on MRG – nb report is confidential and I will not be defamed or be prosecuted for disclosing
4. **If unsure ➔ Call NSW Health Child Wellbeing Unit (CWU)** to assess risk

Consider where child goes next?* → **next of kin (relative), **foster care**, **home-based care**

Scenarios

ED	• HCW contact 000 for NSW police force • Complete child protection helpline report
Imminent RoSH	• (e.g. perpetrator at home patient returns to) • **Child Protection Helpline immediately**
Non- Imminent RoSH	• **Child Protection Helpline within 24 hrs or** • **NSW Health Child Wellbeing Unit (CWU)**
Below RoSH	• **(err on the side of safety)** • *Consult +collaborate* senior or social worker • **NSW Health Child Wellbeing Unit (CWU)**

Important documentation tips:

- Correct details (as much detail – photos, sketches)
- Name/age/address of child (<16) or young adult (16-18) → to alert whether or not family has been previously involved with CPS
- Avoid medical jargon/acronyms and non-relevant medical info (e.g. do not copy and paste)

Reporting to Child protection dilemma

- **False reporting** - create parental stress, destroy rapport, prolong hospitalisation, expose child to unnecessary tests
- **Not reporting** – child may return to abuse, child may die

Wk 3b: Domestic & Family violence (IDENTIFY → CONSULT → RESPOND)

DFV definition (POWER + CONTROL/INTIMIDATION)

- *What is Domestic?*
  - ***family*** *(Siblings, parents vs child)*
  - ***intimate*** *(defacto, married)*
  - ***carers*** *(aged care, retirement village)*
  - ***shared living*** *(flatmates, foster homes)*
- *DV = Designed and designated behaviour causing:*
  - *Fear*
  - *Psychological*
  - *Physical harm*
- *Gender experience of violence*
  - *Men experience more physical violence than women (usu. public places by stranger)*
  - *Most violence to women @ home*

Dispel myths:

1) There is always conflict in a relationship → conflict vs DV
(DV = where perpetrator of DV uses tactic to shift balance to hold vast majority of rights want their partner to agree with them (brainwashing, gaslighting) → overrules individual rights, freedoms

2) DVs do not happen very often:
1 woman /week and 1 man/ week killed by current/former partner

3) *Common myths*:
- *Happens only at SES, specific ethnicities definition about DV,*
- *Cultural beliefs – ok to hit wife*
- *DV victims hate their abuser,*
- ***Why don't victims leave****?*
  - *a)* ***Leaving relationship = ++ vulnerable = +++ stalking = +++ death***
  - *b)* ***Loss of family and social support***
  - *c)* ***Loss of visa***
  - *d)* ***Cannot access resources*** *(feel unable to support themselves, financial loss)*
  - *e)* ***Attitudes (***Still love their partner)
  - *f)* ***social pressure (****perceived as being weak –* ***self-blame, embarrassment****, it can't be that bad, presumptions)*
  - *g)* ***Threats made by perpetrator (suicide)***
- *Not seen – not DV ➔ Domestic violence is only physical abuse?,*
- ***Perception*** *= Continue DV to avoid divorce and hurting the kids*
  - *Kids see violence (psychological trauma)*

Causes of DFV = Dictate how they behave, their personality

- Individual attitudes
- family experiences,
- peer experiences
- societal attitudes

Complications of DV:

1) Cyclical incidence and apologising scenario
2) reduced self-worth and lives in fear
3) PTSD, hypervigilance, **Higher suicidal attempts**
4) **Substance abuse** = coping mechanism = impaired judgment and more vulnerable, dependent on others
5) **Effect on child** = DV impacts them → psychological (due to hearing, knowing) and drives their learning (developmental trauma, PTSD, poor academics)

Identify, Consult and Respond to DFV:

1) **RISK QUESTIONS**:
   a. *What do you fear might happen in the future?*
   b. *Can you tell me what you usually do when this happens?*
   c. *Do you feel safe leaving here?*
2) **High risk**:
   a. **Recent big event**: separation, pregnancy, new birth
   b. **Perpetrator**: Stalking, threats to kill, coercive control
   c. **Vulnerability factors** (e.g. depressed, mental health)
   d. **Access to weapons OR non-lethal strangulation (even in context of S+M sex)**
   e. **Previous history of high risk** (previous sexual violence)
3) **LISTEN ➔ Start the conversation**
   a. **EVERYTHING WE SAY IS COMPLETELY CONFIDENTIAL AND WILL NOT LEAVE THE ROOM (UNLESS THERE IS A RoSH)**
   b. Is there anything in your life that may be affecting in you?
   c. Many families fight. What does a fight look at? What happens in the end? When it does happen – how do you feel? [NORMALISATION]
   d. Are there places in your life where you feel scared or threatened?
   e. Does anyone else know about this? Are your friends and family aware of what is going on?
   f. Are you worried about children and their safety?
   g. **What's been your biggest worry?**
4) **VALIDATE**
   a. *It can be hard to talk about it. Thank you for telling me*
   b. *This happens to a lot of women but you have a right to feel safe*
5) **ENHANCE SAFETY ➔ SUPPORT**
   a. *Increase safety – safety strategy plan*
   b. *Decrease isolation – referral to services*
   c. *Increase empowerment (respect her decisions – identify things they're doing already to keep safe)*

Consult:

- Consultant, SRMO
- DV services:
  - 1800 RESPECT
  - DV Navigator in the GP space
  - psychosocial support of the local hospital
  - WDVCAS worker
  - PARVAN (prevention and response to violence abuse and neglect) service

Respond:

1. Ensure suitable support and referrals
2. Document
3. Police report (serious injuries, access to weapons, threats)
4. Child protection responsibilities

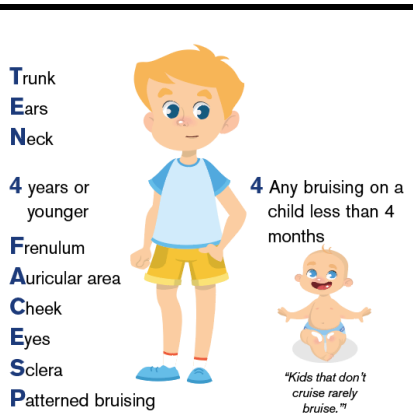
DDx/Red flags of child abuse

- How are thing's going? What's happened to you?
- Who lives in your household? Do you have children in your care?
- Who's looking after children? Any worries?
- Who helps and supports child?

- There are many things happening in your life, Anyone would be stressed.
- What changes have you made?

Red Flags

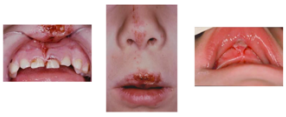
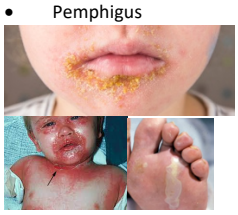
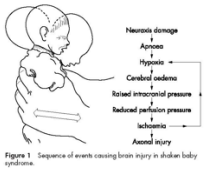
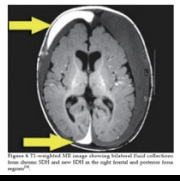
1) Vague details- inconsistent history (did they see it? – vague history despite witnessing it – e.g. what position were they in, mechanism of injury)
2) No explanation and repeated version
3) Inconsistent w/ child development
4) Implausible history
5) *Delayed presentation* (takes time to seek medical attention) → be cautious about it (think context)
   a. **Consider if injury is just modest (e.g. ankle injury)**
   b. Difficult to accept displaced compound transverse #
   c. Delay to point of sig. complications (e.g. fevers) requires a very good explanation
6) Repeated presentation at ED



General work up

1) Consult senior
2) Skeletal survery (acute vs old #)
3) Bone scan (acute vs old #)
4) CT brain (intracranial haemorrhages)
5) Eye review (retinal haemorrhages)
6) Bloods
   a. Bone markers (CMP, Vit D, PTH, EUC, LFT (ALP)
   b. Coagulopathy (FBC, EUC, LFT, + COAG screen plus vWB)

Abdo pain/injury (lipase/amylase, B-HCG, CRP, LFT)

	Bruises (phys. Inj.)	Fractures	Burns (10%)	Abusive head trauma
Abuse signs	• *Cheeks ,chest, arm,* • *stomach, groin, feet,* • *Hands* (due to protection postures and ↑ nerve endings in hands/ feet → pain responses) 	More worried about rib # AND no sig. high velocity/impact accidents • Check incident w/ Scapula and spine (e.g. MVA vs small fall) • **Midshaft humerus (in <15/12 month old)** • CML – classic ***Metaphyseal and rib fracture*** =	• **Splash/splatter** • **Flow** (Common on buttocks/genitalia) • **Immersion burns** (usu bum spared) • **Donut sign burns** (child immersed in hot water, sparing buttocks region) • **Stocking and glove burns** • **Contact imprint burns** (hot object)	• Shaken baby syndrome → ruptures cranial BVs → ICH → Sx worsens in 24-72 hrs • <12 months, • no explanation/hx, poor quality story, • delayed seeking of care
DDx	Normal = bony prominences (if mobile) • **Platelet or Vitamin C def** • **Connective Tissue Disorder** • **Coagulopathies (** vWF, Haem A /B) • Vitamin K def or Liver Disease	NORMAL = **Usu. supracondylar fracture** (FOOSH): **RIBs > Humerus > femoral or skulls** • **Osteogenesis imperfecta** = blue sclera, osteopenia, bone deformity, poor dentition • **Osteopenia of prematurity** = pre-term and LBW • **Scurvy =** vit C def, osteopenia • **Rickets =** X-ray changes (not solely Vit D def.) • **Congenital Syphilis** • **Osteopenia =** frequent #	• **Impetigo** (esp. bullous impetigo) • **SSSS [like a burn]** • Toxic epiderma necrolysis • **Epidermolysis bullosa [EB = blisters on skin]** • Herpes zoster • Pemphigus 	• Most linear skull # are accidental • Missing injury you cannot see • Falling from large height  

SEXUAL ABUSE:

*can include:

- violation of social taboos – genital manipulations (in some cultures is normal but abnormal here),
- penetrative sex,
- touching genitalia/breasts,
- cyber harassment,
- stalking,
- distributing pornography,
- sex trafficking

- **Perpetrator** = usu. someone who knows the child (most now on cyberbullying)
- **Grooming** = slowly building trust (desensitise child)
- **Heterosexual men abuse boys** (paedophilia – gender does not matter)

EMOTIONAL ABUSE:

XS of persistent & cumulative harm/impact caused by:

- Criticism, belittling, name-calling
- Hostility intimidation
- Withhold praise
- Rejection and scapegoating
- Belief child is bad or evil
- Inappropriate physical or social isolation as punishment
- Co-occurrence with
  - Domestic and family violence (DFV)
  - Child abuse and neglect + child sexual abuse
  - Fhx of abuse
  - Sexual assault

Case Studies

	ED – mother w/ flu brings 3/12 old with unusual rash (possible bruising) - says that baby slipped from dad's hands during bath the day prior to presentation		***ED – 15yo girl bib mother w. abdominal pain and missed period***
	Mother focused	**Child Focused**	Obtain 2x sets of histories (1 w/ both, 1 alone)
What to ask? **DDX:**	**Resp.** ➢ SOB, coryza, rhinorrhoea ➢ ?sick contacts, day care ➢ PMHx **DFV:** ➢ restrained marks and bruises, track marks (IVDU) ➢ Reason for presentation ➢ PSHx: social stresses, home environment	➢ **Malignancy (leukaemia) =** *fever, NS, wt loss, poor feeding* ➢ **Coagulopathy** = epistaxis, FHx ➢ birth complications) → any other injuries or rashes ➢ **Vasculitis =** red eyes ➢ **Allergies (?** *Ingestion, ? contact)* ➢ **NAI (physical abuse) =** understand mechanism of injury, reason for delayed presentation ○ *Did you go to see GP about baby's injury* ○ safe bathing techniques, is it just a misunderstanding?	(beware of ≥ 14yo – mature minor) ➢ **GI** = appendicitis, mesenteric adenitis, SBO/LBO ➢ **GU** = UTI, renal colic (stone) ➢ **Gynae** = ectopic, true pregnancy, fibroids, endometriosis, PID ➢ **Sexual abuse**: *Disclose that it consult may not be fully confidential = may have to disclose if harmful to child or others (e.g. sexual, violence, mental health) ➢ Relationship status ➢ How does she identify herself? ➢ Age of partner – statutory rape? (in NSW: ≥ 2 year gap (Romeo and Juliet law) – charged w/ rape) ➢ *HEEAADDSSS* - ?sexual abuse ○ *OTHER children at home* ○ *Understand home environ* –child at higher risk of injury
Exam findings	CVS, RESP	(head-toe exam – remove clothing and expose all skin) – CVS, RESP • "kids that don't cruise rarely bruise" • Cachectic, FTT (sign of neglect) • Check for other bruises/fractures • Poor attachment between mother and baby (esp. when baby crying) • If Mobile (abnormal) = soft tissue areas (stomach, cheeks, thighs) ➔ Facial bruising = warning sign of occult brain trauma	• GI – pale, sweat, cachectic, bruises • Abdo exam Genital exam – **usu. normal** (but does NO mean no injury has occurred • Pre-puberty – hymen has degree of elasticity • post puberty – vagina designed for stretch)
Ix			➢ FBC (↓Hb), EUC, LFT, CRP ➢ B-HCG, STI ➢ DASS 21 = depression/anxiety
Mx	Do you let them take the child home? • You cannot accuse or find the cause of harm (responsibility of statutory agencies)		**NSW = Crimes ACT 1900 (Section 66C) – Romeo and Juliette law** ➢ 2 year gap (can charge a 14yo sexually abusing 11 year old) ➢ No crime if Child < 10yo ➢ Consent is 18 if person in position of power/authority

Disclosure: = is a process

- Involuntary (attempt) = use clues, words, hints and behaviour (need to remove harm to encourage disclosure esp. those who deny abuse)
- Voluntary (purposeful) = will detail if asked

Further ethical considerations

Why do children need health rights?

- Vulnerable population at risk of exploitation by adults
- Young child cannot speak for themselves
- Disabled children have incapacity to make decisions for themselves

Gillam's zone of parental discretion (ZPD)?

Aim to act in patient's best interest (beneficence) – may not align w/ parents:

1) Parents have ethical right to make medical decisions for their children (vegan diets, school selection)
2) Parents are **NOT** morally obliged to maximise well being of child
3) Limit to parental authority is when there is likely significant harm to children (non-maleficence)

*What is significant harm or 'best' interest? Mismatch in treatment opinion from either parent?

Issues with young children:

***WHO** can make decisions for child who lacks capacity?*

(1) Parents / carer (1st point of call)
(2) Appointed legal guardian
(3) Doctors

***HOW** should decision be made?*

- Evidence based plan given transparently
- Consider all relevant stakeholders ➔ Understand context of child and family (i.e. previous experience, attitudes and values)
- Team-based discussion -ethics committee, social workers, parent, physician
  - Minimise significant harm (non-maleficence)
  - Best interest of child (beneficence)
  - Escalate to courts if cannot bring together individuals (e.g. difference in opinions)
  - Doctors May feel victimised if decision goes against you in court
- Parent's autonomy and right to seek a 2nd opinion, preferred treatment option
  - Compromise between natural therapies and pharmacotherapies (e.g. esp. non-evidence based)
  - What medical therapies can be agreed upon
- Minimise coercion

***HOW** can decision be controversial?*

- Possible delay in treatment
- May not align w/ what is deemed 'best' interest of child
- Doctor's failure to understand context of decision

WHAT are the general ethical considerations?

- Patient autonomy – child's healthcare spoken on behalf of a parent
- Conflict in parental opinion towards treatment
- Delay in treatment is "not" in best interest
- *Location of healthcare workplace* – if rural → doctors may be the only healthcare professional patients will interact with (no 2nd opinion) → creates conflict of interest and breaks confidentiality

** Beware of public announcements*

> Sensationalised view – provocative Underdog story (parents/families going against large institution)

Issues with older children /adolescents:

***WHAT** are barriers to seeking help?*

- Cost and accessibility (opening hours, location)
- Embarrassment
- Lack of knowledge about services

***WHAT** values are important for adolescence?*

- **Social acceptance** (body image)
- **What is normal**? (10-14yo) ➔ **identity/belonging (15-17yo)** ➔ **career (>17yo)**
- **Confidentiality issue** – should not disclose any information
- **Social rebellion – independent thinker**
  - **Need to explore barriers w/ psychologists**
- Coping w/ stress, school issues, mental health

***WHAT** can we ask to understand their POV?*

- Ask to speak w/ child alone by **NORMALISATION**
  - ***E.g. "I** always examine children on their own. Could you please leave now?" OR I normally run through what the child knows about their medical condition"*
- Elicit their **ideas, concerns** and **expectations**
  - **HEEAADDSS**
  - **understand reason for refusal & personal circumstances**
  - Assess body language / clothing (NAI, DVO)
- **Determine competency level** – do they understand the benefits or risks of Rx and the complications or A/E of being treated/untreated & discussed alternatives
  - E.g. for Crohn's = lifelong stoma bag if not using steroids for flares
  - E.g. for sexually active F → Check for vulnerability (e.g. homeless), contraception knowledge, complications - pregnancy, assess for coercion and abuse
  - **For Gillick competence →** *esp. for under 16 yo displays competent ability to understand BUT is decision dependent*
  - **Double standard = Can consent but cannot refuse Rx (e.g. blood transfusion in teenager Jehovah's witness)**
  - **@ 15 yo** = can obtain Medicare card

***WHAT** are the ethical and legal responsibilities of a doctor?*

- Clear *confidentiality* agreement made w/ patient (however, must disclose need to break confidentiality if it could harm to others)
  - Public interest (measles, COVID, gonorrhoea)
- Report to relevant authorities – if DVO, sexual abuse
- Sexual abuse of vulnerable → report and notify but not your decision → child protection services decision ((statutory rape > 2 year gap with male OR school teacher))

***WHAT** plan to resolve disagreement?*

- Team-based discussion -ethics committee, social workers, parent, physician
- Bargaining and negotiation (can be difficult if patient is 13-14 yo or have parents with conflicting opinions) – *what is achievable?*

Issues faced w/ treating family members:

- Hard to be completely objective when family members – may skew treatment (over or under-investigate)
- Poor hx and exam on patient (not in normal medical setting) – avoid intimate examination w/ family member present
- Lack of documentation = e.g. writing simple Abx script for UTI
- Conflicts of interest and loyalties
- Causing harm to one – destroys rapport with entire family
- If there is no alternative healthcare professional -