Twenty-five Years of APSAC—The Medical Perspective

Lori D. Frasier, MD

This past quarter-century almost precisely parallels my career as a child abuse pediatrician. I ended my pediatric residency in 1986 and approached Dr. Carole Jenny, who had become the medical director of Harborview's Sexual Assault Center, to ask about specialized training in child abuse. She had been my continuity clinic director at Harborview's general pediatric clinic. As I struggled with the direction of my pediatric career, the field of child abuse interested me. In 1988, I became a fellow at the Harborview Sexual Assault Center. No one could have been more surprised than I as to what would happen over the next 25 years.

The Medical Professionals

The publication of "The Battered-Child Syndrome" in 1962 (*JAMA*) by Dr. C. Henry Kempe et al. formed the core focus that would become child abuse pediatrics. This was solidified by Dr. Kempe's partner article in the 1970s about child sexual abuse. However, it was in the 1980s that the field grew from a handful of interested physicians to many more who began seeing and evaluating abused children as a referral specialty. Many pediatricians were recognizing patterns of physical abuse and head trauma. Fewer were involved in the evaluation of child sexual abuse. Some physicians were beginning to be involved in all aspects of child abuse and neglect. It was a tough world with little guidance, few mentors, and no roadmap.

Dr. Carole Jenny recalls, in the mid-1980s, being asked in court, "Aren't girls born without hymens?" Realizing there was really no research on this, she looked at over 1,100 newborns and wrote a seminal paper. Even today, a misconception remains that girls can be born without hymens, despite 25 years of knowledge that this does not occur. The medical professionals (mostly pediatricians, although not exclusively) who were evaluating these children realized that there was a distinct, but not always accurate, body of knowledge and expertise in child sexual abuse. The Cantwell studies of the 1980s, although now no longer valid, were important in recognizing that physicians needed to understand not only normal anatomy but also sequelae of sexual abuse trauma in children.

Although I cringe at my recollections of telling physicians about the "4mm rule," I now realize that we were very much pioneers and had little "evidence-based" knowledge to rely upon. The pediatricians who were really at the frontline of the field were instrumental in training the next generation of child abuse pediatricians such as me. I asked Dr. Jenny in 1988 if I could train as a fellow in her program for a year. No one could believe that I wanted to specialize in this very strange area. Twenty-five years later, there are accredited 3-year fellowships in child abuse pediatrics and a child abuse subboard examination. Each generation of newly trained child abuse physicians has been amazingly intelligent and insightful. Our colleagues from family medicine, radiology, ophthalmology, neurosurgery, pathology, and psychiatry, to name just a few, are increasingly partnering with pediatricians to ask important questions and to find answers through well-designed research. Dr. Jenny is responsible for training the largest number of physicians to be child abuse specialists.

Technology

Colposcopy

The colposcope equipped with a camera was the first tool medical providers had in the area of child sexual abuse to really share and research genital findings in children. There were no studies (except the prescient book by Ambroise Tardieu in 1846) that really described children's anogenital anatomy. The reality is that "normal" was completely misunderstood if not unknown. Providers began taking magnified photos and carefully trying to analyze and understand what various findings meant. The colposcopic and other macro-camera photos became the basis for early study in this area. Teaching sessions developed in which actual cases could be shared. I recall the workshops and case review sessions at the San Diego conference in the 1990s where many people brought their slides and Kodak prints for viewing by colleagues. There were many questions and not so many answers. We became, for want of a better term, *hymenologists*.

During this period, Dr. Joyce Adams was attempting to organize the findings we were seeing into a tool that became the Adams Classification System. Later, it became apparent that medical providers were misusing such systems as a checklist or cookbook for findings. These systems morphed into a consensus-based guidelines statement. We are now at a stage where abnormal findings are considered rare. Photodocumentation with digital systems and distance peer review are the norm. Sexually transmitted infection (STI) assessment has been revolutionized by DNA amplification technologies, and forensic assessment of acute rape victims is changing rapidly as new technologies come online.

Imaging
Recognition of physical abuse, especially serious forms of battered children, had long been known. Caffey, for example, described the concept of shaking babies in the early 1970s. However, the importance of earlier recognition and prevention were concepts that evolved over the past 25 years. These advancements parallel improvements in neuroimaging that have been so critical to our field. CT scans improved and MRIs became standard imaging tools in determining injuries, bleeding, and aging of blood products. Improved understanding of pathophysiology and biomechanics enabled physicians to more accurately diagnose abuse.

The Horizon
Proteomics, serum markers of neurologic injury, may enable us to detect early and prevent more serious injury and even deaths. Primary prevention of infant abuse, primarily head trauma, has become the focus of many advocates and researchers.

Other Healthcare Professionals (SANES, NPs)

The involvement of other health professionals in child abuse and neglect has also been a force for change for the better. Using nurse practitioners as physician extenders and ultimately as experts in their own right with specialist practices has expanded the scope of child abuse services both in tertiary institutions and in rural communities. Sexual Assault Nurse Examiners (who may be RNs or additionally NPs) have provided forensic services to victims of sexual assault in the absence of skilled physicians.

The Child Advocacy Center Model and the Medical Profession
The first child advocacy center (CAC) was formed in Huntsville, Alabama, in the mid-1980s as a response to the treatment of children as victims in the criminal justice system. CACs spread throughout the U.S., becoming accredited by the National Children's Alliance. CACs were envisioned to be community-based agencies that were child friendly, where all members of the investigative and treatment teams were able to meet and discuss cases of child abuse in a collaborative manner. There are now over 900 CACs in the U.S., each reflecting an individual community's needs. Medical providers, long part of this multidisciplinary team, often provide on-site medical care for children and have become a voice for medical issues at team meetings.

Medico-Legal Advancements
Research, clinical care, and forensic practice evolved at the same time for medical providers. The unique role of a clinician (whether physician or nurse) in the court system has advanced significantly. Judges and juries weigh the medical experience of specialty child abuse practitioners heavily. Prosecutors and defense attorneys rely on such expertise. Court testimony has become a skill that these providers have developed and ongoing training programs assist medical practitioners in the development and refining of such skills.

However, some of the legal issues are not supportive of the work of the child abuse researchers over the last 25 years. A backlash against the concept of shaking infants has permeated the courts. The media have taken this up as a significant medical controversy, which it is not. It is a legal controversy. However, the need for additional research has never been more acute.

Where Are We Going in the Next 25 Years?

The major goal of all organizations such as APSAC should be to NOT exist in 25 years. Child abuse should be eradicated through primary prevention efforts combined with earlier detection and intervention with at-risk families. Ideally, children would be wanted and raised in loving homes. Parents would have resources and support from their communities, and their government would have a priority to raise stable and happy children. All families, no matter how they are configured, would have support for raising their children. Beam me up, Scotty!!!!

Short of these laudable, and perhaps unattainable, goals, an emphasis on primary prevention must be the future in order to reduce child abuse in our society and around the world. Governments and health care organizations must realize that preventing child abuse is the single best way to reduce many health consequences in adults, and also a way to reduce prison populations and criminality. This will result in heightened productivity of our work force, an improved standard of living, and a more civil society. A critical issue is the prevention of neglect, which is so deeply rooted in poverty in even in the richest country in the world. I expect APSAC will be around in 25 years, and I hope it asks me as I approach my 82nd birthday what was accomplished in that 25 years and what the future may bring. I will look back fondly at our failures and our successes. I hope to write about how much we have accomplished in the half-century since APSAC was founded and how important APSAC was in achieving those goals.

About the Author
Lori D. Frasier, MD, is Professor of Pediatrics at the University of Utah School of Medicine, and Medical Director of the Medical Assessment Team at Primary Children's Medical Center, Center for Safe and Healthy Families. She has worked clinically in the field of child abuse since 1988 and has lectured and published many articles on child abuse. Dr. Frasier is Chair of the American Board of Pediatrics Subboard on Child Abuse Pediatrics and is a member of the APSAC Board of Directors.
Contact: lori.frasier@ihc.com