CPT MEDICAL CURRICULUM

Fictitious Profile for Training
Expert knowledge about child abuse is the hallmark of the Child Protection Team system. The following curriculum incorporates materials from many of the top experts in the field. The materials are split into multiple levels to prioritize the acquisition of knowledge. However, expertise is continually added upon by further reading (attached listings) and peer review with others.

The medical provider should gain initial expertise in the basics of child abuse – neglect, physical abuse, and sexual abuse. Visual recognition of injuries is especially important. Child fatalities, Munchausen syndrome by proxy, computer pornography, drug exposed children, and other more specialized subjects can be reviewed in depth thereafter (or earlier if cases present themselves).

It is important that medical providers also learn about the skills of other members of the team. In particular, familiarity with interviewing, cultural aspects of child abuse, psychological outcomes, and a broad overview of child abuse and its health consequences is a next step.

Testimony is also an important component of documenting what has happened to the child. In addition to the specific references in this curriculum, observation of another’s testimony and feedback regarding one’s own testimony (by a member of the CPT team) can significantly aid in developing this important skill.

The list of readings is longer than most can easily assimilate. However, over time these materials will serve as important references.

Questions about these readings or child abuse should be addressed with others on the CPT team – especially with the Medical Director. In addition, the Statewide Medical Director is always available to help with case, readings, and other learning experiences beyond those contained herein.

The curriculum is divided into different levels. These help to focus the new medical provider with key aspects of knowledge necessary to begin child abuse assessments. Ultimately, the references themselves contain more topics and details than the levels alone indicate. Continued study is the best way to achieve ever increasing levels of knowledge.

Level 1: beginning orientation
Level 2: building a solid foundation
Level 3: references and readings

Note that there are other learning opportunities. Conferences are an important means to achieve additional knowledge. Please contact the Medical Director or Statewide Medical Director for suggestions about which conferences may be most beneficial. The Statewide meeting twice a year is an excellent example. In addition, note that memberships in key organizations is highly recommended and subscription to the Medical Quarterly for CPTs is required.
LEVEL 1
(Beginning orientation)


Physical abuse


Neglect


Sexual Abuse


LEVEL 2
(Building a solid foundation)

Neglect


Pediatric Condition Falsification (Munchausen syndrome by proxy)


Physical Abuse


Fatalities


Sexual Abuse


REFERENCES

The following are references that should be in the library of all CPTs.

Books

Strongly recommended


Highly suggested


Brodsky S, Hendricson S, Scott M.  Testifying in court: guidelines and maxims for the expert witness.  1991.  [Available through American Psychological Association (#460-0220) or Amazon.com.  There are several sequels that are good as well.]

**Multi-media**

- Strongly recommended


Felitti, V.  The relationship of adverse childhood experiences to adult health status.  The University of Utah: Primary Children’s Center for Safe and Healthy Families.  2003.

- Suggested

When babies cry.  The Shaken Baby Alliance.  (www.shakenbaby.com)

Elijah’s story.  National Center on Shaken Baby Syndrome.  (www.dontshake.com)

**Subscriptions/Journals**

- Required

The Medical Quarterly.  [This quarterly by Robert Reece is the both excellent and the only source of abstracted articles enabling the reader to keep current with the literature on child abuse.]
Strongly recommended

APSAC membership:

1. The Advisor (APSAC). [This newsletter entails a membership in the American Professional Society on the Abuse of Children. You are then automatically enrolled in FLAPSAC – the Florida chapter.] http://apsac.fmhi.usf.edu/

2. Child Maltreatment. [This a child abuse journal which is also is part of a membership in the American Professional Society on the Abuse of Children]

ISPCAN membership:

1. International Journal of Child Abuse and Neglect. [This is an important child abuse journal which comes with ISPCAN membership.] www.ispcan.org

Internet resources

Additionally, these should be bookmarked:

www.acestudy.org
www.aap.org/
Key Articles Regarding Syndromes

Shaken baby syndrome:

Position papers:


Other


**Pediatric Condition Falsification (Munchausen syndrome by proxy):**


Selected key articles (good and bad)

Because of the impact that a diagnosis – or misdiagnosis, or missed diagnosis – of child physical abuse has on the life of a child and his/her family, it is important that practitioners be well grounded in literature which is scientifically valid and widely recognized as reliable by the medical community. Most of the following articles meet this standard, but others, by virtue of their design or execution, are less compelling. Can you identify them?


   *What explanation does Caffey offer for the association he reports?*


   *Following Caffey’s report, other authors speculated on a variety of possible medical explanations for the metaphyseal changes often seen in such infants. What is the “significance” Wolley attaches to these findings?*


   *This is the article which sparked widespread medical and public awareness of the problem of child abuse. What does this imply about articles published before 1962 on abnormal findings in infants and children?*


   *What does this article indicate about the validity of attempts to date bruises in children?*

Much has been learned about this condition since Caffey first described it, but it is interesting to see how comprehensive his initial report it is.


Following Kempe’s description of the Battered Child Syndrome in 1962 and Caffey’s report of the Shaken Baby Syndrome in 1974, researchers began to study what types of injuries resulted from household falls in order to be able to critique the histories provided by parents of seriously injured children. What types of injuries did Helfer find?


How do Williams’ findings compare to Helfer’s? (See also David Chadwick’s article in the same issue.)


How many children in Lyons’ study died from falling out of bed? What do the Lyons and Helfer studies say about the occurrence of linear skull fractures (without serious brain injury) in falls from heights of 3 – 4 feet?


How many infants suffered serious injuries from falling out of bed or rolling off a couch? How do Tarantino’s findings compare with those of Helfer, Williams and Lyons?


This is a notorious article, one with which it’s important to be familiar. What injuries did Aoki attribute to infants’ simply falling backwards from a sitting position onto woven straw tatami mats?

*This article is frequently quoted by those who testify on the “short fall defense.” How do Aoki’s and Hall’s findings compare with those of Helfer, Lyons, Williams and Tarantino? What may account for the difference? Whom do you find more credible and why?*


*This is another article commonly quoted by “short fall” defense experts. How did Plunkett identify his cases and verify the histories he quotes? How credible do you think his findings are? What does “short” mean, and how was it operationally defined? How would you define it?*


*What did Duhaime find at autopsy on infants suspected of having been shaken? What studies did she perform regarding the biomechanics of head injury in infants, and what did they show? What does she think actually happens to “shaken” babies? Are you convinced? Why or why not?*


*How do Alexander’s findings compare to Duhaime’s? Whom do you believe and why?*


*Are retinal hemorrhages pathognomonic for child abuse? Does the birth process cause retinal hemorrhages? What are some other things that can cause them? Do seizures or CPR produce retinal hemorrhages?*