Protecting Children from Sexual Abuse by Health Care Professionals and in the Health Care Setting

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Sexual abuse or exploitation of children is never acceptable. Such behaviour by paediatricians and health care professionals is particularly concerning because of the trust that children and their families place on adults in the health care profession. The American Academy of Paediatrics stands strongly behind the social and moral prohibition against sexual abuse or exploitation of children by health care professionals.

Paediatricians and health care professionals 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. Everyone 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.

Sexual abuse or exploitation of children or adolescents by anyone, including paediatricians, health care professionals (HCPs), (eg, any provider of health care, including trainees in any of these professions) is unethical and must not be tolerated. The use of “children” in this policy refers to all children younger than 18 years. It is the responsibility of paediatricians to protect and foster the health of their patients. Sexual encounters, including but not limited to, sexual touching, kissing, exposing oneself, or sexual intercourse with patients are destructive and are strictly forbidden and unlawful. This position is consistent with other professional medical societies such as, the American Medical Association,1 Canadian Medical Association,2 and British General Medical Council.3 Paediatric patients are especially vulnerable because of their age, developmental level or disability, race, ethnicity, or English language proficiency. There is an inherent power differential, and, as minors, they can never consent to sexual contact with an adult in a position of power. Any sexual contact with current or former paediatric patients by paediatricians and HCPs is abusive and unethical. Child sexual abuse (CSA) in any context can vary from a single, situational incident to planned, compulsive, and repetitive behaviour.

The aim of this statement is to assist parents, caregivers, and health care professionals in preventing sexual abuse of children in health care settings and to guide the response to patients’ disclosures of sexual abuse. The Centers for Disease Control and Prevention has provided guidance on preventing child sexual abuse within other youth-serving organizations.

Epidemiology of Child Sexual Abuse in Health Care Settings

CSA is a worldwide, preventable problem. Because CSA is underreported,5 prevalence studies show wide variation; data from the United States show that victimization ranges from 15% to 25% for girls and 5% to 10% for boys.6,7 These numbers likely undercount the actual number of victims. Many children never tell, are unable to tell because of their developmental delays, or may only tell a same-aged peer who may not relay the information to a responsible adult.8 Victims of sexual abuse by HCPs represent a subset of all CSA victims.

Literature specifically identifying CSA in health care settings is sparse9 ; more information is available regarding sexual contact between adult patients and physicians.10 What is known about CSA by HCPs largely comes from cases that have been litigated in the courts, reports to medical boards, or media accounts, but not the scientific literature, potentially resulting in an underestimate of the true frequency.11 Cases may not be reported out of disbelief or fear of repercussion or may be settled without legal involvement. Health care is not exempt from sexual predators who may be drawn to the profession by the combination of a position of power and access to children. Recognition of the scope of the problem is critical to prevent it.

The most well-known case of CSA in a health care setting as of this writing is former Michigan State University physician and former USA Gymnastics team physician Larry Nassar, who received international attention after being accused of assaulting at least 265 girls in his care from 1992 to 2014.12 Many of these women reported being abused at every visit, often with their parents in the room, and being told that what he was doing was part of routine medical examinations. Nassar's case shows that the trust placed in a physician can be manipulated to cover predatory behaviour.

There are, unfortunately, a number of examples of paediatricians who have abused children in their practice, including Johnnie Barto, who was convicted in 2019 of abusing 31 children over decades of clinical practice,13 or Earl Bradley, who was convicted in 2011 of 471 charges of child molestation involving 103 paediatric patients.14 Like Nassar, Barto and Bradley were able to insidiously abuse their position of authority as trusted paediatricians to groom both parents and patients as they perpetrated sexual abuse against children. However, physicians are not the only ones known to commit these offenses, and there are likely a multitude of cases of other health care professionals taking advantage of their position of trust in a health care setting to perpetrate such abuse against vulnerable patients.

CSA in health care settings are crimes against children in what should be a protective and safe environment. Although these cases may represent a minority of overall childhood sexual abuse, the devastating effects of the abuse on the victims also involves the repercussions of violated trust in the health care system.

Normal Paediatric Examination Practice

Paediatricians are responsible for assessing the physical health and development of children, including genital health and pubertal development. During physical examinations, it is often appropriate and necessary to perform an examination of sensitive areas of the child. A child's anogenital region is routinely recognized as sensitive. Other body regions—for example, the breasts—may also be recognized as sensitive. Individual children and specific cultural norms will lead to different perceptions of which body areas are sensitive. In addition to the physical examination, the paediatrician's and HCP's history taking and verbal interaction can involve sensitive topics.16 Sensitive examinations should only be conducted in formal clinical settings.

Bright Futures, the common source for guidance on age-appropriate examinations during well-child care, provides recommendations for anogenital examinations throughout childhood.17 Performing routine examinations during preventive annual visits destigmatizes the examination of this organ system. Routine screening intravaginal examinations and Papanicolaou smears are currently not recommended until age 21 years.

Anogenital examinations are also needed for specific complaints and, therefore, should be guided by the specific concern. Certain conditions, such as vaginal, penile, scrotal, and anal anomalies, may require repeated examinations or treatments. When a genital (sensitive) examination is indicated, it is important that appropriate assent be obtained from the patient. The process of obtaining assent includes discussing the need for the examination as well as what that examination will entail. Depending on the age of the child, verbal consent may need to be obtained in a similar way from the parent.

Patients should be provided privacy during disrobing and appropriate draping during examinations. The age of the patient, the child's and family's temperament, and cultural and religious norms will dictate the level of draping and gowning required. The child's comfort should always be considered. Paediatricians and HCPs should wear gloves for the examination of the anogenital structures.

Indicators of Possible Sexual Misconduct by Medical Professionals

As in other situations of CSA, grooming behaviour by a paediatrician or HCP may occur to gain a child's or caregiver's confidence and acquiescence to subsequent abuse. Grooming behaviours occur when the perpetrator performs actions that increase the parent's and/or child's trust and dependence on the perpetrator while gradually obtaining the child's accommodation to sexual contacts. The intrusiveness of sexual activities may slowly escalate. For example, the perpetrator may begin with seemingly harmless touches on the shoulder and thigh and then slowly progress to more overt contact. Other examples include favours or gifts and repeated contact with the child that is unsupervised. Perpetrators may select children who are emotionally vulnerable, developmentally or intellectually delayed, physically disabled, or attention-seeking as their victims.

Prevention of Sexual Misconduct Issues Involving Clinic and Hospital Staff

The prevention of CSA in the health care setting can be framed in the context of error reduction and a "safety culture" that an increasing number of health care organizations have adopted. This makes the use of harm reduction strategies logical to prevent these types of events. Both external and internal measures can be used to increase the safety of children in health care settings.

External measures are those designed to prevent perpetrators from having access to potential victims. All medical and health care staff and volunteers who have access to children in the health care setting should be screened during the recruitment and hiring process for past allegations of abusive behaviour with children. In many states, this is mandatory for those who work with children. This screening should include a careful check of past employment situations as well as criminal and child abuse registry background checks. However, such procedures cannot be relied on to provide protection. Staley et al reported that less than 1% of people who molest children have a criminal record.20 There is no profile of a "typical" sexual offender, and reliance on external measures such as background checks as the only prevention tool is inadequate to ensure children's safety.

An increasing body of literature has shown the importance of internal measures as key to preventing CSA. Internal measures reduce the opportunities for perpetrators who are not otherwise stopped by external measures to gain access to potential victims.22–24 These internal measures can include increasing the perceived effort of committing the abuse, increasing the perceived risk of discovery of the perpetrator, and removing internally generated justifications for the behaviours that are abusive. As explained below, many of these techniques are applicable to health care settings.

Increasing the perceived effort and risk to a potential perpetrator can be accomplished by establishing explicit rules, expectations, and standards of care related to potentially sensitive examinations or care activities, such as hygiene or medical procedures in the perianal area. Making these expectations explicit and part of training for all personnel sends the message to potential perpetrators that this type of crime is recognized and not tolerated. An example of language that could be used during on-boarding of personnel in the health care setting is, "The safety of children in our care is paramount. We do not tolerate inappropriate behaviour, boundary violations, or sexual abuse of children in our care." Perpetrators may internally or externally justify their behaviours as minor infractions or normal, caring behaviour.

Education and training can be another tool to prevent sexual abuse. Paediatricians and HCPs in training as well as those in practice should receive education on appropriate professional boundaries, professional interactions during sensitive or explicit discussions or examinations, and when and how to use chaperones. Trainees have the same behavioural expectations as other HCPs, and any allegations against trainees should be handled accordingly.

It is important to train all employees in the health care setting, including those not directly providing patient care, on their role in the safety of children in the health care setting, and their specific duty to report concerns to Child Protective Services and/or police. By ensuring that all personnel understand their duty to report, a clear message is conveyed that there is not a distributed duty to someone of a higher rank or position, which may lead to missed opportunities to prevent or intervene. Education on the prevalent myths of sexual abuse is also important for all who work with children and is necessary to dispel these commonly held beliefs. See Table 1 for commonly held

myths. Education should be broad and include information on sexual abuse characteristics and prevalence, victims, perpetrators, long-term outcomes, mandated reporting, and prevention strategies. See Table 2 for additional information.

TABLE 1

Commonly Held Myths About Child Sexual Abuse

Myths About Victims	Myths About Perpetrators
Only girls are victims of sexual abuse.	Most children who are sexually abused are abused by a stranger.
A child would tell if they were sexually abused.	Most sexual abuse involves kidnapping a child.
Children often lie about sexual abuse.	You can tell a perpetrator by looking at them.
If a child is sexually abused, there will be physical evidence or changes on physical exam.	Only men sexually abuse children.
Children will try to fight off an abuser.	
Sexual abuse must include physical contact.	
Children who are victims of sexual abuse will go on to become perpetrators of sexual abuse.	
Children are afraid of their abuser or don't love their abuser.	

TABLE 2

Suggested Educational Topics for Employees and Volunteers in Health Care Settings

Overview of Sexual Abuse	Definitions and Prevalence
Victims	Myths and realities
	Disclosure
	Behavioural and trauma responses to abuse
	Sequelae of abuse
	Long term outcomes for victims
Perpetrators	Myths and realities
	Grooming behaviour
Response to abuse	Mandated reporting laws and hospital protocols
	Hospital policies related to reported abuse
Prevention	Use of chaperones
	Professional Boundaries

Institutions should have policies and training in place to provide chaperones for sensitive examinations, investigate, manage, and report complaints, and educate staff and volunteers about appropriate provider-patient boundaries25 (Appendix 1). Violation of these boundaries may be grooming behaviours or a test of the safety of a setting and, therefore, should be treated as serious infractions because of the risk they pose to the patient. Staff should be trained to recognize and defuse eroticized and/or disruptive child behaviour, particularly in settings in which child behavioural issues are likely. Staff policies and procedures should be in place to report concerns of sexual impropriety or possible grooming behaviour (Appendix 3). Staff should be educated about these policies and procedures and their responsibility to expeditiously report concerns. Policies that are explicit and enforced, no matter the position of the potential perpetrator, are an important prevention technique, increasing the risk of discovery of the perpetrator. Unfortunately, research has shown that physicians who are aware of impaired or incompetent colleagues only report two thirds of these cases to the appropriate authorities.26 Staff should be taught that such underreporting will not be tolerated.

The American Academy of Paediatrics (AAP) has a policy on the use of chaperones for paediatric examinations, which was reaffirmed in 2017 and is currently being updated.27 Chaperones are an important tool for protecting both children and paediatricians or HCPs and should be used for all examinations that are determined to be sensitive, such as the inspection or palpation of anorectal or genital areas and/or the breasts of adolescent patients. The use of nonfamily chaperones is important as children age and is preferred whenever possible. There is no evidence to support the need to offer gender-matched chaperones, and in some practice environments, it may be impractical. In instances when a patient is intoxicated, unconscious, or developmentally impaired or is otherwise at greater risk for sexual exploitation or has a history of trauma such as sexual abuse, HCPs should also consider using chaperones, even for non sensitive examinations. The purpose and use of a chaperone should be discussed with the child and family and be a shared decision between the patient and paediatricians or HCP and documented in the medical record.

Chaperones are a necessary prevention technique during certain medical procedures or examinations, such as anogenital examinations,27 because circumstances exist in a health care setting that can create opportunities for sexual abuse, such as children without a parent or guardian present. Institutional practices should consider situations such as heavy sedation, developmental or neurologic impairment, or the need for ongoing intimate care of medically compromised children as situations in which safety measures can be implemented to reduce opportunities for potential perpetrators. In general, a family member is not an adequate safeguard against inappropriate contact with a patient, because they may not be able to question the paediatrician or HCP. Another medical professional such as a nurse or medical assistant is a more appropriate chaperone. Because of the inherent power dynamic between a health care professional and a paediatric patient, the onus to request or permit a chaperone for a sensitive examination should never be placed on the patient. If possible, the gender preference of the patient for the chaperone should be respected.

Response to Concerns About Child Sexual Misconduct by a Paediatrician or Other Health Care Professional

Any report of sexual abuse made regarding a paediatrician or HCP should be taken seriously. Each setting or institution should have a clearly defined process for handling these concerns (Appendix 3). Reports of suspected sexual abuse should be made to appropriate agencies as directed by specific state statutes.

For more information about the status of current individual state laws and related resources, contact AAP State Advocacy at stgov@aap.org. It is important to remember that mandated reporting laws have a low threshold for reporting, requiring only a “reasonable suspicion” or “cause to believe.” Further, all mandated reporting laws have a good faith exception that protects a reporter when a report is not found to be abuse, whereas there may be criminal penalties for failing to report a case of suspected abuse. Although not all states require reporting to the state medical board, reports made that result in adverse actions, such as revocation of license, are required to be reported to the National Practitioner Data Bank by medical boards, serving as an important safety check on physicians who

have been found to have sexually abused their patients.28 During an investigation, there should be strong consideration for temporarily removing the alleged offender from patient care.

Confidentiality for both children and paediatrician or HCPs is essential during sexual abuse investigations because the consequences could be even more traumatic should such information be distributed before a complete investigation. Although there are documented instances of false disclosures and allegations, these are not common and can be mitigated by a properly performed investigation.29 Although institutions should have an internal investigation process to determine whether there is sufficient concern for a mandated report, child protective services and/or the police are responsible for thoroughly evaluating any allegations. Sexual misconduct or sexual abuse should be reported to state medical boards.

Examples of hospital policies on staff-patient boundaries (Appendix 1), chaperones for outpatient care (Appendix 2), and reporting, evaluation, and management procedures for staff allegations (Appendix 3) are available as appendices. These represent the policies developed by Seattle Children's Hospital and are provided with permission as examples of 1 institution's approach to these issues but do not represent AAP policy.

Outcomes of Sexual Abuse

Victims of sexual abuse are at increased risk of a broad range of problems, including emotional, behavioural, cognitive, social, and general health impairments. Child sexual abuse is a known adverse childhood experience (ACE) and can increase the risk for chronic, life-limiting medical conditions.30 In addition, abuse by a paediatrician or HCP has damaging effects on the patient's ability to trust future paediatricians and HCPs or to seek necessary health care.15 Past victims of sexual abuse are at increased risk of further sexual victimization.

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

Summary

It is the responsibility of paediatricians to protect and foster the health of their patients. The sexual abuse of a child in a health care setting is a devastating violation of ethical and legal behaviour that can severely impair the child's future physical and mental health and, therefore, is strictly forbidden. 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 paediatricians and HCPs by recognizing and reporting sexually inappropriate acts by their colleagues or others. In addition, paediatricians need to recognize that victimized children and their families may require emotional support.

Recommendations

1. It is the responsibility of paediatricians to protect and foster the health of their patients. Sexual encounters with patients are destructive and are strictly forbidden.

2. Candidates for employment in paediatric medical facilities should be screened for previous cases of child abuse perpetrated by them, both through formal state registries and through contact with previous employers.

3. Paediatricians should be educated about the indications and techniques of the genital examination and how to discuss the genital examination with the patient and family.

4. Paediatricians must explain to parents and verbal children why they are performing each element of the examination and respect their patients' need for modesty by providing appropriate draping and allowing privacy while changing.

5. Everyone who works in a paediatric medical facility should be trained about staff-patient boundaries, chaperone use, and their personal responsibility to immediately report concerns of patient abuse by other staff members. Institutions should have policies and procedures in place to conduct these trainings.

6. Additional training should include dynamics of sexual abuse, victim and perpetrator characteristics, grooming strategies, and sexual abuse prevention strategies.

7. Patients and parents should be informed of the use of chaperones, and the use of a chaperone should be documented in the medical record. Patients and families should be aware that if they have concerns about sexually inappropriate examinations or paediatrician or HCP actions, they should immediately report to the clinic's or medical facility's administration and may also report to the state's child protective services hotline. A nonfamily member chaperone should be used for the safety of both the patient and the paediatrician or HCP whenever possible.

8. All paediatricians, HCPs, and health care institutions are legally mandated reporters for suspicions of child abuse. If there is reasonable cause to suspect that another paediatrician or HCP has sexually abused a child, there is a legal mandate to report to child protective services and/or the police.

Procedures should be developed and followed such as:

1. Institutions should have policies and procedures in place to receive and evaluate concerns for abuse of a patient.

2. Accused employees should have complaints about them managed confidentially, sensitively, and expeditiously. They should be provided with independent, confidential support and counselling services during the investigation.

3. Individuals and institutions are responsible for following legal guidelines about reporting concerns for child abuse to the appropriate institutional, local, and state authorities.

4. Individuals and institutions should cooperate with appropriate protective, legal, and licensing agencies in their investigation of concerns for sexual abuse by paediatricians or HCPs.

5. Institutions remain responsible for the future protection of patients from abuse. They should not pass problem paediatricians or HCPs along without appropriate notifications.

6. Institutions should assist victims of sexual abuse by staff to receive appropriate assessment and treatment by a physician who specializes in evaluating and treating child sexual abuse and consideration of the need for counselling by a qualified mental health professional.

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The guidance in this statement does not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

All policy statements from the American Academy of Paediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.

Abbreviations

HCP = health care professional
CSA = child sexual abuse

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