

# Letters to the Editor

## Congratulations

First of all, a small selection of letters after our inaugural issue.

"Please accept my congratulations on a very fine piece of work..."

*Grahame Feletti, Ke Ola O Hawaii, Inc, Leahi Hospital, Hawaii*

"Congratulations on the first issue of your journal."

*TJC Boulton MD, FRACP, New Zealand*

"I was very impressed with the high quality of this publication, it was certainly worth waiting for, and I subscribed immediately."

*Stephen Weinstein, Gold Coast Hospital, Australia*

"We were pleased to receive your new publication *Pacific Health Dialog* and feel it is an important addition to the information available on the Pacific."

*Pamela Thomas, Director, National Centre for Development Studies, Australia*

"Congratulations on this superb publication."

*Dr. Pashu Ram, Director, National Diabetes Centre, Fiji*

"Congratulations for the launching of the PHD journal. It has been long overdue."

*Dr. N. Kere, Permanent Secretary, Ministry for Health & Medical Services, Solomon Islands*

"The PHD is great - nice layout, good articles. It was worth waiting for."

*William A. Alto, M.D., Associate Director, St Mary's Hospital, Grand Junction, CO, USA*

## Nurses and doctors: towards the year 2000

Congratulations on the inaugural issue of PHD. I found it interesting reading and wish to respond to Finau's perspective on 'Doctors and nurses: union or divorce towards the year 2000'. (*Pacific Health Dialog*, 1994; 1(1): 57-59)

There is nothing simple about the relationship between the medical and nursing professions in the Pacific or anywhere else. The identity of the medical profession is firmly established and its practice is based on scientific principles. In contrast, the identity of nursing is less acknowledged or recognised and there are many who would argue that nursing does not have the status of a profession. I appreciated Finau including nursing as a profession.

In a nutshell, doctors diagnose and treat patients. Often this is difficult to do. Doctors are expected to have the knowledge and the skills to do this well, across a wide range of medical problems. It is a fact that only people with proven academic ability are accepted for medical education and that the years of learning for them are demanding in time and energy. On graduation, doctors have achieved in the longest educational programmes and with that comes socialisation to a 'top dog' position in society. Because of the level of difficulty often involved in diagnosing and treating, it is my view that this position of power within society is extremely difficult to avoid. This position of power is both earned and given by society during the processes of medical education and socialisation.

Finau rightly gives credit to Florence Nightingale providing the conceptual framework for nursing. For years, hospital schools of nursing were modelled on the Nightingale model. However, Nightingale contributed more to nursing than simply create the servant role. She believed that the major function of nursing was to get the patient in the best possible condition for nature to do the healing. This is achieved in many ways, including activities of human caring. It is not possible to discuss this aspect of nursing here.

Nursing education in many parts of the world is currently undergoing a 'curriculum revolution' so that nurses can effectively perform their role within society. There is a move away from the medical model, a move towards working collaboratively with doctors, but more importantly a move towards the empowerment of clients or patients. To assist people to live well with a disease or disability or during a difficult period of diagnosis or treatment requires that nurses have a range of knowledge and skill, some of which will overlap, for example with medicine or psychology. Feminism has acted as a catalyst for this 'curriculum revolution'. Nursing is now involved with theory development and in nursing research.

The future professional relationship between doctors and nurses is complementary. Finau suggests that it is not necessary for nurses to be provided with skills previously confined to doctors, namely diagnosing and treatment. Modern nursing already uses nursing diagnosis and the implementation of nursing care - but this is not the same as 'the skills previously confined to doctors'. Clinical reasoning and problem solving skills have been essential to nursing, as well as medicine for a long time.

The purpose of all health care is on the needs of the consumer. When health care is delivered in a hospital, there is a complex social structure which tends to create more problems in which the doctor/nurse relationship is located. Health professionals do their work within a highly technical and challenging social system where excellent communication and an understanding of power relationships are essential.

Education for all health professionals should occur in educational settings and include generic and specific content. Respect for persons, patterns of communication and team work, economics and ethics are some of the fundamental elements in educational programmes to enable future graduates to contribute to effective working partnerships in health care systems.

*Isabelle Sherrard*

*Dean, Faculty of Health, UNITEC Institute of Technology, Auckland, New Zealand*

Response from the author.

*I am glad Ms Sherrard agrees with my basic tennet that doctors and nurses must be complementary. This means they need to be both client oriented but must have knowledge and skills in different interphasing areas. That is, they should not learn the same thing (medicine) in the same place (schools separate from the hospitals). That, of course is medically speaking. However, if we are talking about health then we need dialogue about a different ball game – an undergraduate and postgraduate health school for community health physicians and nurses rather than the current exclusive medical curriculum for the doctors and their nurses.*

## Domestic violence in Vava'u, Tonga Island

Domestic violence! Is it a problem in Tonga? What is the cost our children have to pay when they see daddy beating up mummy or vice versa? How is that going to affect their basic trust, their ability to relate and interact with other humans? What will be their quality of life? These are worrying questions that deserve mention in your Journal.

Over the last three years, we have seen a trend of increasing number of trauma cases requiring operations at Ngu Hospital, Vava'u. A good percentage of minor injuries were treated as outpatient. The fatal ones bypassed theatre to the morgue. There has been a rise from twenty cases in 1987 – 1988 to more than forty in 1989 – 1990. Note that in all those years about 15% of trauma were due to motor vehicle accident. Among trauma cases were injuries caused by assault. In most cases it involved members of the same family or close relatives, that is, due to domestic violence.

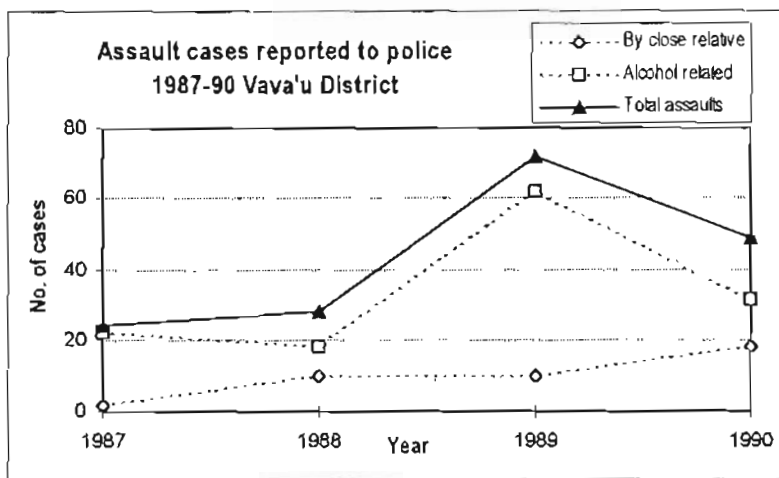
The Ngu Hospital case histories of domestic violence in Vava'u during 1988 – 1990 are listed at the side.

Many wives were complaining of their husbands drinking kava instead of staying with the family. Some have turned up at the hospital with black eyes and broken jaws and probably a broken heart. Fighting between in-laws, and the beating of children in schools and at home are becoming common causes of injury seen at the hospital. One mother stoned her child of four and barely missed injuring his eye. A father was upset and hit his son with a piece of iron bar fracturing his leg. A husband punched his wife's left eye

| <i>Victim (sex/age in years)</i> | <i>Offender (injury)</i>  |
|----------------------------------|---|
| Wife (F/26)                      | Assaulted by brother-in-law (black eye)   |
| Student (M/17)                   | Assaulted by teacher (cut lower lip)  |
| Wife (F/27)                      | Assaulted by husband (cut lip and broken tooth)   |
| Wife (F/40)                      | Hit with belt buckle by husband when she complained about his kava parties (bruising and haematoma)   |
| Wife (F/28)                      | Beaten by husband when wife complained of his kava parties (bilateral black eyes and broken mandible)   |
| Wife (F/35)                      | Punched by husband, angry when wife scolded him when he came home drunk (black eye)   |
| Wife (F/23)                      | Bitten by sister-in-law, fighting over a piece of tapa cloth (ear lobe bites).  |
| Wife (F/36)                      | Bitten over the left eye brow by husband's girl friend (laceration)   |
| Wife (F/28)                      | Punched by husband (ruptured globe, complete blind left eye)  |
| Daughter (F/12)                  | Chased by mother and thrown a piece of fire wood at her (cut on left thigh)   |
| Son (M/19)                       | Hit by father with iron bar on the right leg (compound fracture, 3rd finger, deep laceration shin)  |
| Sister (F/18)                    | Punched by brother (fractured mandible)   |
| Son (M/4)                        | Stoned by mother, child was crying for some money to buy 'Rambo' (laceration right eye brow)  |
| Student (M/5)                    | Child cried from school saying that the teacher had beaten him up. (in tears, stick marks on buttocks and back, refused to go to school, grandma said this is the 4th time in 2 months) |
| Student (M/13)                   | Hit by teacher with stick (fractured right ulna)  |
| Student (M/14)                   | Brought in by mother because child was hit by the teacher over left ear (ringing, blood stained ear)  |
| Child (F/4 month)                | Mother 16 years old and father 70 years old. Mother went to dance and did not return home. Frequently beaten by the old man (no injury noted but signs of neglect)                      |
| Child (F/8)                      | Alleged bicycle accident ('accidental' perineal tear)   |
| Child (F/6)                      | Cut on the edge a piece of cardboard ('accidental' perineal tear)   |
| Grandmother (F/82)               | Hit by grandson with wooden drawer of sewing machine (fractured skull and unconscious)  |

resulting in total blindness of that side. A six year old child was brought in with an 'accidental' perineal tear but sexual and physical abuse could not be ruled out.

There was a definite increase in the number of assault cases reported to the police during 1987 to 1989. Figure 1 shows the number of assault cases reported to the police during two and half years. Note the big difference between



twenty four cases in 1987 and seventy two cases reported in 1989. Note also the number of assault cases with alcohol use at the time of the assault. The number of assault cases caused by close relatives was also on the increase.

What is happening to the human person? Where is the Christian value of love and respect that we as Tongans are so proud of and call our heritage? Culturally, we like to think of ourselves as a family-oriented and caring bunch. What can we do to change this situation? I would suggest that we admit there is a problem and stop hiding behind tradition and religion, bring it out to the open. We must get professional help, and we health workers must work together with other professions.

What I have said so far may not be so scientific, but I hope I am able to generate and stimulate the consciences. As someone has said: "The crises now facing the human race are technically solvable. Yet, these problems may prove fatally insolvable because what is required is a shift in value on the part of each person. For it is the individual's consciousness, that is the problem".

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### Child sexual abuse

A PHD issue on child health will be incomplete without child sexual abuse being at least mentioned.

Health workers find making a diagnosis of sexual abuse difficult for several reasons: the mode of presentation may be unfamiliar to them (e.g. highly sexualised play); their often inadequate training in examining normal female children's genitalia; or their reluctance to countenance such an impalatable possibility.<sup>1</sup>

If they consider the diagnosis then they face further hurdles in obtaining the history in an accurate, unbiased way, performing a competent examination and understand-

ing the complexity of laboratory evidence which may assist in making the diagnosis.<sup>2</sup> Add to this the social and legal ramifications of the diagnosis and it's not surprising that most thoughtful professionals become anxious when faced with the possibility of sexual abuse.

#### *How do these children present?*

Abused children may present with symptoms secondary to the psychological effects of abuse. The range is broad and several areas of functioning may be affected but sexual behaviour problems stand out as being a differentiating factor for these children, particularly coercive sexual behaviour which is outside that expected for age.<sup>3,4</sup> They may present with non-specific genital symptoms.<sup>5</sup> They may also present with a history of assault.

If any of these presentations occur it may be necessary for the health worker to broach the subject of abuse with the caretaker and with the child if a history can be obtained.

**“ Abused children may present with symptoms secondary to the psychological effects of abuse. The range is broad and several areas of functioning may be affected... ”**

#### *The history*

In taking the history it is important that the doctor is able to establish rapport with the child, be interested and appear to be in control of the situation.<sup>6</sup> Questions should be simple and clearly explained so that there is no confusion as to what is meant. One should not use questions which suggest answers, if they can be avoided. In very young children, this may not be possible.<sup>7</sup> In the medical interview, it is particularly important to get details in relation to the abuse, of pain or bleeding, urinary frequency, desire to defecate, taste, if appropriate, and about how the child felt during the abuse. Documentation of the child's affect when retelling the story can be very helpful. Obviously a thorough history of past and present medical symptoms and signs is important. A protocol may be available and should be adhered to.

#### *The examination*

The examination can usually take place at a time which is convenient for everybody unless the assault is very recent (<72 hours) or if there is vaginal bleeding, pain or discharge; then an examination will need to be expedited.<sup>8</sup> Many centres have a protocol for these examinations and if this is the case then it should be followed. The examiner should be familiar with normal female anatomy, know techniques for exposing the hymen and have a good light source. Familiarity with the differential diagnosis of anogenital findings is essential. Photographs using a colposcope are very helpful. Material for taking swabs should be available.

Several studies have been done which have described normal findings.<sup>9,10</sup> The decision to test for sexually transmitted diseases is an individual one based on the history, the risk category of the assailant, prevalence rates in the community, and concern on the part of families.<sup>11</sup>

The examination is best undertaken in conjunction with a general physical examination and the child should be in the supine position normally, or in the knee-chest position if confirmation of suspicious hymeneal findings make this necessary. Taking specimens is facilitated by the use of small wire swabs and irrigation of the vaginal area with saline.<sup>12</sup> In adolescents who have had sexual intercourse, where penetration is alleged or there is evidence of penetration, a speculum examination should be performed for endocervical cultures for *Neisseria gonorrhoea* and *Chlamydia trachomatis* and a pap smear done.<sup>13</sup> A reliable pregnancy test should be done at the visit and repeated two weeks after the last sexual contact in pubertal girls.

The genital examination of boys is routine and familiar to doctors. Examination of the anus is important to look for evidence of discharge, scars, distortion or condylomata.

It is important to talk to parents and adolescents about the examination findings and to emphasise normality and rapidity of healing. Follow-up routines for cultures, blood tests, pregnancy tests should be available on a typed sheet. Good records are important for medico-legal reasons and findings and conclusions should be described simply and clearly. One should be wary of drawing absolute conclusions.

#### Forensic examination

This is beyond the scope of this letter. A useful reference is Jenny, C. Forensic examination: The role of the physician as 'Medical Detective' in Heger, A and Emans, SJ (editors) *Evaluation of the Sexually Abused Child*, Oxford University Press: 1992.

#### Treatment

A crisis is inevitable in a family in which sexual abuse is suspected. It is important that such a family be assessed quickly by a social worker and/or a mental health professional. Doctors are in an ideal position to do this constructively. It is also a legal requirement that suspicion should be reported to a statutory authority in most Australian states.

#### What are the legal requirements in the Pacific countries?

The reason for further evaluation of the child and family is to validate the allegation, do a forensic evaluation and to determine the impact of the abuse on the child and family. It may be necessary to assess the degree of future risk to the child. Unfortunately, as yet, there are no standardised measures of outcome.

I hope this helps to remind health workers to be on the lookout and identify this growing problem early.

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Editors' Note: Please write to the Editor of Pacific Health Dialog about the legal requirements in your country in response to the question Dr Moran has asked above. □

