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Child Abuse

TUTOR GUIDE

Case Materials:

Tutor's Guide

Case

Handout #1: Differential Diagnosis of Child Abuse & Specificity of Skeletal Injuries

Handout #2: Specificity of Skeletal Injuries

Handout #3: Principles of Effective Brief Interventions

AAP Child Abuse Slide Set (Available for Loan (email ronald.samuels@tch.harvard.edu) or may be purchased from the AAP)

References

Evaluation Tools

Tutor's evaluation/prior to presentation

Tutor's evaluation/post presentation

Student evaluations

Objectives:

By the end of this session, clinicians will:

1. Recognize the signs and symptoms of child physical abuse.
2. Know the provisions of state law regarding mandated reporting of *suspected* abuse or neglect.
3. Describe the role of the pediatrician in management of child abuse.

Overview of Child Abuse Case:

A significant number of children suffer physical abuse by parents and other caregivers. Many children so injured will be seen in offices and emergency rooms for initial treatment. Health care providers should know how to recognize families at risk for child maltreatment, and be familiar with state laws on reporting suspected abuse. These cases may be emotionally difficult. However, properly trained clinicians can both protect the child and assist families in receiving the treatment and support they need.

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Teaching Guide

Introduction

Physical abuse constitutes about 25% of cases reported to child protective service agencies. Also, in the U.S., approximately 11-20% of children suffer “severe” parent-child violence, characterized by parental kicking, biting, punching, hitting with an object, beating, threatening, or using a gun or a knife. Bright Futures Guidelines for the nine month old visit suggest screening questions that may help identify families at risk for abuse or neglect:

“How are things going in your family?”

“Have there been any major changes or stresses in your family since your last visit?”

“Now that [Lisa] can move on her own more, what changes have you made in your home to insure her safety?”

“How does it feel to have Lisa becoming more independent?”

“What are your thoughts about discipline?”

In addition, pediatricians must be vigilant when examining children, particularly injured children. Physical findings that are not consistent with history should always arouse suspicion. In this case, the findings do match the historical account. Mr. White, however, has unrealistic expectations regarding his daughter's behavior, and does not understand the importance of child-proofing the home.

When a physician who has a prior professional relationship with a family suspects that a child is being abused by the parent(s), conflict will likely arise between the physician's duty to report the abuse and the parents' desire to keep that concern between the physician and family. Physicians resolve this problem by calling parents' attention to the reporting mandate and by being neutral in their attitudes and supportive of a needed interview. Referral of the family to a new primary physician may be necessary. The problem cannot legally be resolved by failing to report the suspected abuse because this can endanger the child.

GUIDING QUESTIONS FOR DISCUSSION

1. Is this child abuse? How do you weigh parent education and different cultural child rearing practices in making your decision?
2. What types of injuries should make one suspect abuse?
3. Are there other studies, consults, or evaluations indicated?
4. What is your plan for follow-up?
5. What is your role in filing a mandatory report to state authorities?
6. What is your interpretation of these findings?
7. What will you say to Mrs. White?

1. Is this child abuse? How do you weigh parent education and different regional/cultural child rearing practices in making your decision?

These are common and difficult questions, and the answers are seldom clear-cut. Physical abuse is defined as inflicted injury to a child and can range from minor bruises and laceration to severe neurologic trauma and death. Child abuse is relatively easy to diagnose in situations of inflicted injury, but may become more of a judgment call in situations where the parent was apparently disciplining a child. According to the Diagnostic and Statistical Manual for Primary Care, Child and Adolescent Version (DSM-PC), harsh discipline or improper parenting may be considered a "Quality of Nurture Problem". This phenomenon requires provider intervention in the form of parental guidance, but does not necessarily require a mandated report of physical abuse. In matters of discipline, one may consider the cultural context, but in the end, clinicians should adopt a concept of "reasonableness," (i.e., were these actions those of a reasonable parent?) A spanking might be within the bounds of accepted discipline for some families, but is not reasonable in an infant. Clinicians should also consider whether or not there is a pattern of abusive behavior. In Lisa's case, initial history suggested that the spanking given by Mr. White was an isolated occurrence.

2. What types of injuries should make one suspect abuse?

- bruises, especially if excessive given the proffered explanation, or in unusual locations
- bruises and welts forming regular patterns, perhaps resembling the shape of the article used to inflict the injury (hand, belt buckle, electrical cord)
- cigar or cigarette burns, especially on the soles, palms, back, and buttocks
- immersion burns (stocking or glove-like without splash burns on extremities, doughnut-shaped on buttocks or genitals)
- patterned burns resembling an electrical appliance (e.g., iron, burner, grill) rope burns, particularly on wrist, ankles, neck, torso
- skull, rib, long bone, metaphyseal (corner) fractures (*see Handout 1*)
- abdominal injuries such as intramural hematoma of the duodenum or proximal jejunum, intestinal perforation, splenic rupture, pancreatic injury, abdominal wall bruising
- subdural hematoma (often caused by blunt trauma or violent shaking), subarachnoid hemorrhage, cerebral infarction (secondary to cerebral edema)
- retinal hemorrhages
- a pattern of recurrent injuries, even if each individual event seems to have an adequate explanation

3. Are there other studies, consults, or evaluations indicated? (See Handout 1)

In making the diagnosis, the physician must conduct a thorough health assessment, including a history, physical examination (with particular attention to the skin), and developmental assessment, on any child who may be a victim of abuse. One should also consider laboratory studies (e.g., skeletal survey, bone scan, coagulation studies) which are useful in delineating the nature and extent of current trauma, in defining the presence of previous trauma, and in excluding other medical causes. Skeletal survey is mandatory in children under 2 years who are thought to have been abused, and in children less than 1 year who have been severely neglected. Finally, an assessment by a social worker may be indicated to obtain information about family stressors. There are many factors thought to increase the risk of child abuse:

- child with disabilities, prematurity, behavioral problems (crying)
- domestic violence
- substance abuse
- parental immaturity
- parental expectations inconsistent with child development
- social isolation
- family stress from illness, poor finances, divorce
- adult caretakers who themselves were abused

4. What is your plan for follow-up?

In this case, the family should return to your clinic within 2-3 weeks, when a social worker can be available to meet with them. In the interim, a visiting nurse could be assigned to assess their home environment and work on further educating the parents.

5. What is your role in filing a mandatory report to the States Child Protection Service?

Just about every state jurisdiction requires that a report be filed with the State's Child Protection Service whenever there is suspected child abuse or neglect. (The clinician must have "reasonable cause to believe" that the child is being abused; "proof" is not required.) Reporters acting in good faith are given immunity from parental lawsuits. (Presenters should be aware of state specific issues, such as to whom a report is filed with, what number to call for such a report, etc - a handout with this information should be considered for the class.) The physician has several objectives when child abuse is suspected:

- To understand the historical antecedents of the child's injury and to assess the plausibility of the explanation provided (particularly worrisome is a lack of explanation).
- To determine the magnitude of the ongoing risk to the child, guiding the choice between protective or family supportive interventions.
- To form a relationship with the family that fosters and supports their participation in subsequent diagnostic and therapeutic work with other professionals.
- To explain to the family the case report and protective service process - what the pediatrician and others will be doing to protect the child and to help his or her parents

6. What is your interpretation of these findings?

The nature of Lisa's femur fracture is highly suspicious for abuse, especially as there is no corresponding history of injury and she is not yet walking or capable of climbing up on top of high objects at age 9-months. The presence of other healing fractures is confirmatory.

What should you do now? An important part of the outpatient assessment is the gathering of information to assess the ongoing risk to the child if she returns home. Is the child or the caretaker who brought the child in at risk for further violence, particularly now that there is an allegation of physical abuse? Will the child, if she is old enough to report abuse herself, be threatened or harassed by family members? In this case, Lisa should be admitted to the hospital directly. She has a serious medical condition (the femur fracture) requiring treatment. In addition, admission to the hospital will give the pediatrician and other professionals time to assess whether or not it is safe for Lisa to go home.

7. What will you say to Mrs. White?

Parents should always be told when a report of suspected abuse or neglect is made. Clinicians must not avoid this difficult but necessary aspect of management. The "FRAMER" and "ATTUNE" mnemonics summarize the important principles that should guide this process. Have another person present as "there is strength in numbers." In case there is confusion or disagreement later about what was said, you will have someone to back you up. Begin by listing the facts that have led to your concern (the hand prints, the fracture, etc.) This should be a monologue, not a dialogue or debate. If interrupted, ask the parent to please let you finish what you have to say; you will then be happy to listen to them without interrupting. When you suspect child abuse, avoid accusation. State your concern about the nature of injury, and that "someone may have abused your child." Explain that you are obligated to file a report with the Department of Social Services *on behalf of the child*, not *against* the parents. Tell the parents you would like to work with them; all of you have the child's best interest at heart. If other professionals

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are involved, they must all communicate with each other and one person should be designated to act as spokesperson. Do not avoid the family once the child is hospitalized. Keep them informed about what is going on. Acknowledge how difficult this process is for them.

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Part 1

Mr. and Mrs. White come to your clinic for nine month old Lisa's first visit. They have just moved into your area. Lisa was the product of a NSVD at 40 weeks, with no prenatal complications. She has had no hospitalizations or surgeries, and is on no medication. She is behind one set of immunizations. Developmental milestones are appropriate for her age. Her parents state that they have been moving around quite a lot as Mr. White has been looking for steady work. He has just found a job at a local gas station as an automobile mechanic. He is 20 years old, and a high school dropout. Mrs. White is 18 years old, and left high school to get married three years ago. They are presently living in an apartment with Mrs. White's sister and her three children.

On physical examination, Lisa is 25th percentile for height and weight, and 50th for head circumference. She is an alert, difficult to examine female who clings to her father during most of the exam. The only physical finding of note are echymotic areas on both buttocks, which appear to be hand prints. When you ask her parent how this happened, Mr. White states quite openly "We had to give her a little spanking. She's been opening up the cabinet under the kitchen sink even though we told her "NO". We have to teach her what's right. What else could we do?" When questioned further, the Whites deny any prior physical punishments.

Part 2

After discussion with your attending, you decide not to file a mandated report to the state authorities at this time. Instead, the plan will include:

- parent education regarding developmental expectations, child-proofing the home, and appropriate disciplinary methods
- weekly VNA visits to assess child safety within the home
- a follow-up appointment in three weeks with both you and the clinic social worker (she was out sick today)

The parents seem genuinely surprised when you tell them Lisa is too young to understand the danger posed by her “explorations”, and agree to install safety latches on all the cabinets. They also agree to try alternatives to spanking, and to cooperate with the remainder of your plan.

The Whites do not keep their scheduled follow-up appointment in three weeks. Since they have no phone, you call the visiting nurse. She tells you that “things looked fine” during the first visit, but the family has not been home for her visits for the last two weeks. She had set appointment times with them in advance. She shares your concern, and agrees to visit them unannounced the next day and insist they bring Lisa back to your clinic right away.

Three days later, Lisa and her mother show up in your clinic. Mrs. White apologizes for missing the appointment and tells you she is worried about Lisa's right leg. “She woke up this morning crying a lot and won't move it. I don't know what's wrong with her.” Lisa is lying quietly on the examination table. Her right thigh appears larger than the left, and is painful on passive range of motion. An x-ray reveals a midshaft spiral fracture of the right femur. Skeletal survey is positive for periosteal new bone formation on the left femur and also on the left proximal tibia.

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Epilogue

Lisa was admitted to the hospital for her femur fracture. The investigator from the state's child protection services agency (DSS) met with the medical team and family. Both of Lisa's parents denied injuring her, and were unable to explain how the fracture might have happened. As Lisa has had multiple caretakers, including several teenage cousins, no one could establish with certainty how the injuries occurred.

DSS attempted to place Lisa with a family member (e.g., grandmother), but could find no suitable relative in your state. Lisa was therefore placed temporarily in a foster home. As part of the service plan, Lisa's mother and father attended parenting classes and counseling. After two months, Lisa's parents separated and Mr. White moved out of state. Mrs. White disclosed to her family worker that he had struck her on more than one occasion and that she planned to file for divorce. She denied ever seeing him abuse Lisa.

After six months, Lisa was returned to her mother.

Lisa comes to your clinic for catch-up immunizations and well care. There have been no further injuries.

Handout #1: Differential Diagnosis of Child Abuse

Clinical Findings	Differential Diagnosis	Differential Tests
<i>Cutaneous Lesions</i>		
Bruising	Trauma Hemophilia Von Willebrand's disease Henoch Schonlein purpura Purpura fulminans Ehlers-Danlos syndrome	Rule out other disease Prothrombin time, partial thromboplastin time Von Willebrand's panel Typical distribution of lesions Rule out sepsis Hyperextensibility
Local erythema or bullae	Burn Staphylococcal impetigo Bacterial cellulitis Pyoderma gangrenosum Photosensitivity and phototoxicity reactions Frostbite Herpes, zoster or simplex Epidermolysis bullosa Contact dermatitis, allergic or irritant	Clinical history and characteristics Culture, Gram stain Culture, Gram stain Culture, Gram stain History of sensitizing agent, oral or topical Clinical history and characteristics Scraping, Culture Skin biopsy Clinical characteristics
OCULAR FINDINGS		
Retinal hemorrhage	Shaking or other trauma Bleeding disorder Neoplasm Resuscitation	Coagulation studies History
Conjunctival hemorrhage	Trauma Bacterial or viral conjunctivitis Severe coughing	Culture, Gram stain History
Orbital swelling	Trauma Orbital or periorbital cellulitis Metastatic disease Epidural hematoma	Complete blood count, culture, sinus radiographs Radiograph, CT scan; CNS examination Radiograph, CT scan; CNS examination
<i>Hematuria</i>	Trauma Urinary tract infection Acute or chronic forms of glomerular injury (e.g., glomerulonephritis) Hereditary or familial renal disorders (e.g., familial benign recurrent hematuria) Other (e.g., vasculitis, thrombosis, neoplasm, anomalies, stones, bacteremia, exercise)	Rule out other disease Culture Renal function tests, biopsy History History, cultures, radiologic studies

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Clinical Findings	Differential Diagnosis	Differential Tests
<i>Acute abdomen</i>	Trauma Intrinsic gastrointestinal disease (e.g., peritonitis, obstruction, inflammatory bowel disease, Meckel's diverticulum) Intrinsic urinary tract disease (infection, stone) Genital problems (e.g., torsion of spermatic cord, ovarian cyst) Vascular accident, as in sickle cell crisis Other (e.g., mesenteric adenitis, strangulated hernia, anaphylactoid purpura, pulmonary disease, pancreatitis, lead poisoning, diabetes)	Rule out other disease Radiographs, stool tests, and others Culture, ultrasound, intravenous pyelogram History, physical examination, radiograph, ultrasound, laparoscopy Angiography, sickle cell studies As appropriate
<i>Osseous lesions</i> Fractures (multiple or in various stages of healing)	Trauma Osteogenesis imperfecta Rickets Birth trauma Hypophosphatasia Leukemia Neuroblastoma Status after osteomyelitis or septic arthritis Neurogenic sensory deficit	Radiograph and blue sclerae Nutritional history Birth history Decreased alkaline phosphatase Complete blood count, bone marrow Bone marrow, biopsy History Physical examination
<i>Metaphyseal lesions, epiphyseal lesions, or both</i>	Trauma Scurvy Menkes syndrome Syphilis "Little League" elbow Birth trauma	Nutritional history Decreased copper, decreased ceruloplasmin Serology History History
<i>Subperiosteal ossification</i>	Trauma Osteogenic malignancy Syphilis Infantile cortical hyperostosis Osteoid osteoma Scurvy	Radiograph and biopsy Serology tests No metaphyseal irregularity Response to aspirin Nutritional history
<i>Sudden infant death syndrome</i>	Unexplained Trauma Asphyxia (aspiration, nasal obstruction, laryngospasm, sleep apnea) Infection (e.g., botulism) Immunodeficiency Cardiac arrhythmia Hypoadrenalism Metabolic abnormality Hypersensitivity to cow's milk protein	Autopsy Autopsy "Near-miss" history Cultures, bacterial and viral Immunoglobulins Autopsy Electrolytes, ACTH stimulation test Ca++, Mg++, other

Adapted from Newberger EH. *Child Physical Abuse. Primary Care* 1993;20(2):317-27.

Handout #2: Specificity of Skeletal Injuries as Evidence of Child Abuse

Specific Fractures

Metaphyseal-epiphyseal (<2 years of age)	
Thoracic cage	Rib
	Sternum
Shoulder	Scapula
Clavicle	Medial (sternoclavicular)
	Lateral (acromioclavicular)
Spine	Vertebral body (anterior compression)
	Spinous process

Highly suggestive fractures/patterns

- Multiple: bilateral, symmetric
- Repetitive/different age of fractures
- Hands, feet
- Skull, complex fracture line
- Associated nonskeletal injury; intracranial, visceral

Nonspecific fractures

- Diaphyseal (shaft of long bone)
- Clavicular, midshaft
- Skull, linear

Handout #3: Principles of Effective Brief Interventions

When you suspect abuse:

- F** Give parents a listing of the **FACTS** that have led to your concern.
- R** Explain that you are legally **REQUIRED TO REPORT** your concern to child protection authorities on behalf of the child.
- A** State that a formal **ASSESSMENT** is needed to determine the exact nature of the problem and need for treatment.
- M** Present a **MENU** of alternatives for evaluation and treatment services.
- E** **EMPATHY**. Acknowledge how difficult this process is for everyone involved.
- R** Insist that you receive a **REPORT BACK** from the assessment and insist on open communication with the child protection worker. This will let you know it has been done and help you better care for the child.

While the child is hospitalized:

- A** **AVOID ACCUSATION**. State your concern about the nature of the injury and that someone may have abused their child
- T** **TELL THE TRUTH**. Explain that you are obligated to file a report with the child protection authorities on behalf of the child, not *against* the parents.
- T** **TEAM APPROACH**. Tell the parents you would like to work with them; all of you have the child's best interest at heart.
- U** **UNITED FRONT**. There must be open communication among all professionals, with one designated to act as spokesperson. Avoid splitting.
- N** **NEWS**. Do not avoid the family. Keep them informed about what is going on.
- E** **ENSURE SAFETY**. Determine whether or not it is safe to let the child return home.

REFERENCES

1. Green M. (Ed.). *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. 1994, Arlington, VA. National Center for Education in Maternal and Child Health.
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SUGGESTED READINGS (ANNOTATED)

American Academy of Pediatrics, Section on Child Abuse and Neglect. *A Guide to References and Resources in Child Abuse and Neglect*. 1994.

This soft cover book produced by the AAP is a comprehensive reference on child physical abuse, sexual abuse, neglect, and factitious illnesses. There are specific sections on topics such as abdominal injuries, head injuries, fractures, etc. Each section includes an annotated bibliography of recently published scientific articles.

Newberger EH, Child physical abuse. *Primary Care* 20(2):317-27. June 1993.

This is a comprehensive review article, which covers history, ethical considerations, interviewing guidelines, and diagnosis of child physical abuse. There is a very useful table on differential diagnosis including a guide to laboratory and radiological studies.

Sirotnak AP, Krugman RD. Physical abuse of children. *Peds in Review* 15(10):394-9. October 1994.

This article is a concise review of child physical abuse which includes brief tables on diagnosis, social/environmental factors, and suspicious fractures. There are several useful photographs illustrating injuries and a discussion of reporting and management strategies.

Module Evaluation

For presenter to fill out before the teaching session

A. I consider myself

- | | | | | |
|---|--|--|--|--------------------|
| 1. A nationally known expert on this topic | 2. A locally known expert on this topic | 3. Very knowledgeable on this topic | 4. to have learned about this topic to teach it | 5. Not sure |
|---|--|--|--|--------------------|

B. I spent approximately _____ minutes preparing for teaching this topic.

C. Of the time I spent preparing to teach this topic, I used material provided to me as part of the Serving the Underserved Curriculum

- 1. 100% of the time**
- 2. 75-99% of the time**
- 3. 50-74% of the time**
- 4. 25-49% of the time**
- 5. <25% of the time**

D. How appropriate were the educational objectives?

- | | | | | |
|---------------------|----------------|-------------------|----------------|--------------------|
| 1. Excellent | 2. Good | 3. Average | 4. Poor | 5. Not sure |
|---------------------|----------------|-------------------|----------------|--------------------|

E. How appropriate were the tutor notes?

- | | | | | |
|---------------------|----------------|-------------------|----------------|--------------------|
| 1. Excellent | 2. Good | 3. Average | 4. Poor | 5. Not sure |
|---------------------|----------------|-------------------|----------------|--------------------|

F. How appropriate were the references?

- | | | | | |
|---------------------|----------------|-------------------|----------------|--------------------|
| 1. Excellent | 2. Good | 3. Average | 4. Poor | 5. Not sure |
|---------------------|----------------|-------------------|----------------|--------------------|

G. If your answer to any of the above questions (except A) was 3, 4 or 5, please comment.

Please feel free to write further comments on the back of this sheet.

Thank you for taking the time to fill out this evaluation.

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Module Evaluation

(For Presenters to use after the teaching session)

Presenter: _____

Your responses will help us refine and develop this case.

A. Please rate the overall quality of this material as a stimulus for learning.

1. **Excellent** 2. **Good** 3. **Average** 4. **Poor** 5. **Not sure**

B. Please rate the classes participation in the learning

1. **Excellent** 2. **Good** 3. **Average** 4. **Poor** 5. **Not sure**

C. How comfortable were you with case based teaching

		Not at All			Very Much	
1.	Prior to this teaching session	1	2	3	4	5
2.	During the teaching session	1	2	3	4	5
3.	After the teaching session	1	2	3	4	5

D. Please list how long you spent on this topic, and how the time was divided

Total Time _____ **minutes**

Time spent on case discussion _____ **minutes**

Please describe how you spent the rest of the time

E. Please Rate each of the following

		Poor			Excellent	
1.	The Educational Objectives	1	2	3	4	5
2.	The Case Vignette	1	2	3	4	5
3.	The Tutor Guide, including guiding questions	1	2	3	4	5
4.	Reference List	1	2	3	4	5
5.	Handouts	1	2	3	4	5
6.	Audiovisual Materials	1	2	3	4	5

If you answered 1-3 on any of the above, please comment further

F What were the cases strengths

- 1.
- 2.
- 3.

G What were the cases weaknesses

- 1.
- 2.
- 3.

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H What is the single most important thing that you learned from the case discussion?

I Case Evaluations

1. Do you think facts or data should be added? **1. Yes** **2. No**
If **yes**, what should be added?

2 Do you think facts or data should be deleted? **1. Yes** **2. No**
If **yes**, what should be deleted?

J. Tutor notes evaluation

1. Did you use the **tutor notes**? **1. Yes** **2. No**
If **no**, why not?

2. What were the **tutor notes** strengths? 1.
2.

3. What were the **tutor notes** weaknesses? 1.
2.
3.

4. How would you suggest improving the **tutor notes**?

5. Do you think facts or data should be added to the **tutor notes**? **1. Yes** **2. No**
If **yes**, what should be added?

6. Do you think facts or data should be deleted from the **tutor notes**? **1. Yes** **2. No**
If **yes**, what should be deleted?

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K Slide Evaluation – Not Applicable – Slide Set created by the AAP

L Did you use any other materials **1. Yes** **2. No**
If **yes**, what other materials?

If supplied by the Serving the Underserved
Project, how would you improve the material

M. What did you as a teacher learn about this topic?

#1

#2

#3

Please feel free to write any further comments on the back of this form

Thank you for taking the time to fill out this evaluation.

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Module Evaluation

Presenter: _____

Your responses will help us refine and develop this educational material. The person completing this form is:

PGY1 PGY2 PGY3 Fellow Faculty Other _____

A. What is the single most important thing you learned from the case discussion today.

B. Please rate the overall quality of this case as a stimulus for learning.

1. **Excellent** 2. **Good** 3. **Average** 4. **Fair** 5. **Poor**

C. The facilitator

		Not at All			Very Much	
1.	Encourages student direction of teaching	1	2	3	4	5
2.	Stimulated interest in the subject matter	1	2	3	4	5
3.	Encouraged Group Participation	1	2	3	4	5

D. I consider the facilitator

1. A nationally known expert on this topic 2. A locally known expert on this topic 3. Very knowledgeable on this topic 4. a teacher who learned about this topic to teach it 5. **Not sure**

E. Please rate each of the following components of the teaching session (N/A for not applicable)

		Poor		Good		Excellent	
1.	Case Vignette	1	2	3	4	5	N/A
2.	Case Based/Learner Centered Format	1	2	3	4	5	N/A
3.	Handouts/Supplemental Materials	1	2	3	4	5	N/A
4.	Teacher/Facilitator	1	2	3	4	5	N/A

F. Do you think information should be added? 1. **Yes** 2. **No** 3. **Not Sure**
If **yes**, what should be added?

G. Do you think information should be deleted? 1. **Yes** 2. **No** 3. **Not Sure**
If **yes**, what should be deleted?

H. Comments

Please feel free to write any comments on the back of this sheet.

Thank you for taking the time to fill out this evaluation.

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