Handling Child Abuse at Organ Donation Facilities

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Abstract

Japan's revised Organ Transplant Act took effect on July 17, 2010. The Act specifically bans organ donation from abused children, a point that is unique to Japan. This article explains the current status of child abuse, factors relating to child abuse, and the Act concerning child abuse. It also describes the types of child abuse and diagnostic approaches, such as the use of a checklist in cases of suspected abuse. The steps that must be taken by a facility to eliminate abused children from brain-dead children as organ donors are not taken only by the child's attending physician; organizational responses, including those of abuse response committees and ethics committees, are also important. Furthermore, enhancing pediatric end-of-life care is a challenge that needs to be addressed in order to increase the number of organ donations from children in Japan.

Key words Pediatric organ transplantation, Acts concerning child abuse, Factors in child abuse, Responding to child abuse on organ transplant

Introduction

Japan's revised Organ Transplant Act took effect on July 17, 2010. One of the key points in the revisions is organ donation from children, regarding which the Act specifies that abused children must be eliminated from child organ donors. Accordingly, organ donation facilities are required to establish abuse response committees. This article describes the kind of responses that should be taken in such organizations.

Current Status of Child Abuse

In fiscal 2009, child consultation centers responded to 44,210 cases as abuse and 128 children died as a result of abuse (of which 67 were not parent-child suicide).[1] The number of child abuse cases is increasing every year at a rate of 105–108%, and is anticipated to continue increasing.

Obligation to Report Suspected Abuse

Article 25 of the Child Welfare Act makes it an obligation of all citizens of Japan "to give notification upon finding a child for whom the custody of his/her guardian is deemed inappropriate." Furthermore, Article 5 of the Act on the Prevention, etc. of Child Abuse imposes an obligation on physicians and other healthcare providers, who should be aware that they are in a position in which it is easy to discover child abuse, to make efforts to detect child abuse early. This means that there is an obligation to notify a child consultation center or other appropriate authority at the stage abuse is suspected. Accordingly, physicians have a responsibility to protect the rights of children together with the government by training themselves to have an eye for the signs of possible child abuse during daily clinical practice, unrelated to organ transplant, and to discover child abuse early.

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Table 1 Responding to abuse

1. Obligation to report suspected abuse

Cases of suspected abuse must be reported immediately to the municipal welfare office or child consultation center. In some cases the public health center is also acceptable. In this case, there is no need to confirm the fact of abuse; a report must be made at the stage abuse is suspected. Article 6 of the Act on the Prevention, etc. of Child Abuse provides that when suspected abuse is reported, it shall not be deemed a violation of physicians' confidentiality obligation.

2. Circumstances in which to suspect physical abuse

(1) Physical problems

1) Physical problems that must be considered as abuse

① Multiple instances of or repeated presentation with trauma (or scars), burns (or scars), fractures, accidental ingestion, or other accidents (near drowning, etc.)

② Trauma or burn marks with a clear contour, pattern, or small circular form

③ Multiple cavities, mouth burns, infant fractures, subdural hematoma (excluding in situations such as a traffic accident)

④ Trauma, burns, fractures, or accidents that cannot be explained with the cause of injury given by the parent or guardian

2) Physical problems that must be considered as possible abuse

Filthy skin, poor weight gain, short stature, CPA upon hospital arrival (including SIDS)

(2) Behavioral problems: In case there are the following behavior problems in addition to physical problems, the possibility of abuse increases:

1) Behavioral problems that must be considered as abuse

Young children: Remarkable polyphagia or pica, excessive and indiscriminate approaching of others, uncontrolled rough manner, violent speech and conduct

Elementary school students (ages 6–12): Recurrent independent misconduct, cruelty to plants and animals, unrestrained aggressive language and violence

Middle and high school students (ages 12–18): Recurrent running away from home and loitering

2) Behavioral problems that must be considered as possible abuse

Young children: Unconcerned about being separated from a parent or guardian, excessive wariness

Elementary school students: Deviance from group action, rebellious speech and conduct

Middle and high school students: Truancy, violent behavior, sexual deviancy

3. Neglect

Neglect refers to the abandonment of children, nurturing that is so inadequate as to cause loss of health, or serious disregard for a child's safety. In the case of nutritional neglect, it is also a lethally abusive behavior. Examples of neglect include:

① Failure to provide physical care in the form of food, clothing, and shelter (nutritional, clothing, and hygiene neglect)

② Failure to provide emotional care necessary for development (maternal deprivation syndrome, emotional neglect)

③ Failure to provide necessary supervision to protect the safety of children (environmental neglect): This includes going shopping while leaving a child unattended in a vehicle.

④ Failure to provide necessary medical care, infant health checkups, and immunizations (medical and health neglect)

⑤ Failure to provide necessary education, not allowing children to attend day care, kindergarten, or school (educational neglect)

⑥ Abandoned children, parent-child suicide (abandonment, murder)

The following are important for noticing neglect during a medical examination:

(1) Child's physical characteristics

① Poor weight gain, weight loss; ② Poor hygiene, inappropriate clothing; ③ Lethargy, poor complexion, lack of spirits; ④ Delay in being seen at a hospital; ⑤ Leaving chronic conditions untreated, incomplete treatment

(2) Child's emotional characteristics

① Developmental delay during infancy (language delay); ② Problem behavior during infancy (lack of concentration, hyperactivity, aggression, impulsivity); ③ Problems in school age children (learning difficulties, low self-esteem, lack of cooperativeness)

(3) Child's behavioral characteristics

① Frequent injuries, accidents; ② Loitering at night, running away from home; ③ Problems with food (eats greedily, sneaks food); ④ Frequently late to or absent from daycare or school; ⑤ Made to beg from children, steal, work, and perform housekeeping; ⑥Takes drugs and alcohol; ⑦ Hyperactive, antisocial behavior

When such abuses are suspected, it is important for physicians to not try to resolve the issue personally but to notify by telephone or other means the child consultation center or other appropriate authority so that society as a whole can support abused children and their families. Reports must be made to the police in cases such as CPA or a critical condition from trauma, but when it is unclear whether abuse is taking place or not, it is advisable to follow the directions of the child consultation center.

[Extracted and modified from Japan Pediatric Society Child Abuse Project (2006).[4]]

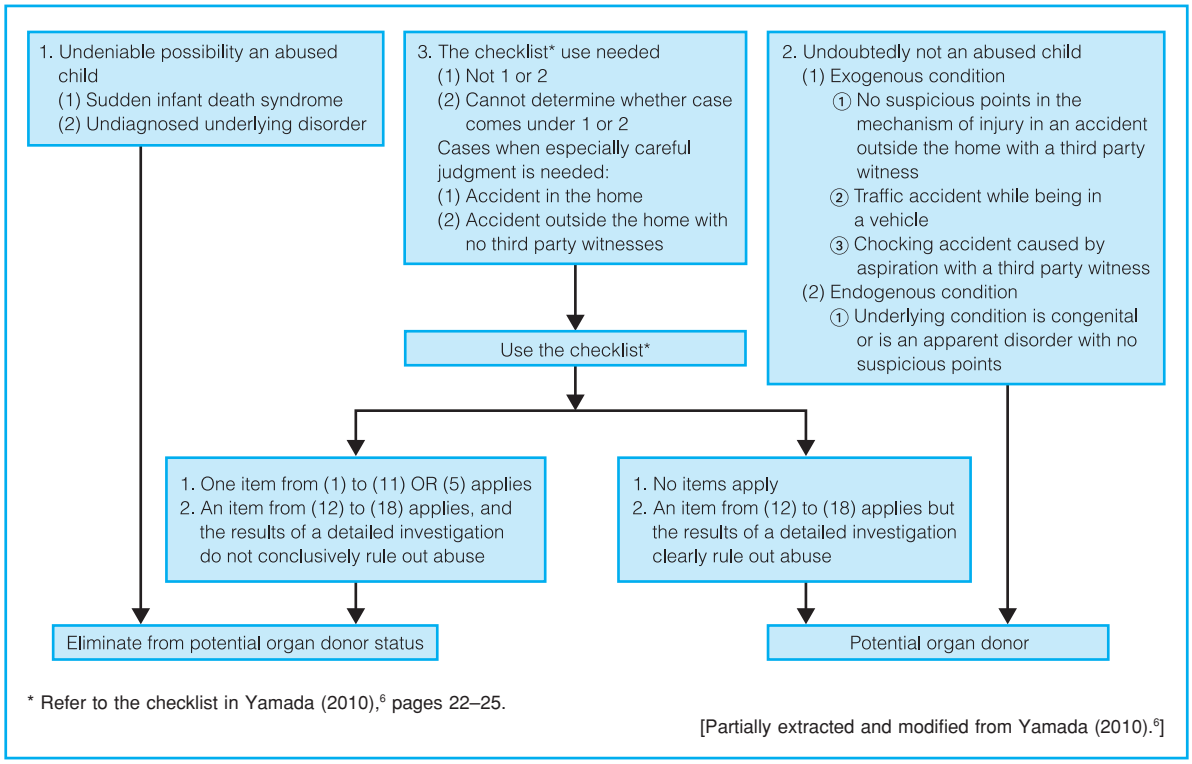

Fig. 1 Manual flowchart for eliminating abused children from brain-dead organ donors

Factor Relating to Abuse

According to Miyamoto, the following are factors relating to abuse[2]:

(1) Personal factors of the abuser: Intellectual capacity, inappropriate view of children, impulsivity, aggression, dependency, low self-worth, experience being abused, substance abuse, personality disorder, psychiatric disorder, etc.
(2) Familial factors: Discord between husband and wife, violence between spouses, large number of children, violent family, crime by family members, unemployment, poverty, isolation, etc.
(3) Social factors: High-crime society, violence-approving society, etc.
(4) Personal factors of the child: Difficult temperament, low birth weight infant, physical disability, developmental disability, congenital disorder or other factor that increases the child rearing burden

Many of these factors are not isolated and are thought to be associated. Also, the person committing the abuse is often the child's real mother. This includes problems that cannot be resolved on the part of the abuser alone, such as in cases when the mother is unable to receive cooperation from the father and other family members with breastfeeding and the many other aspects of childrearing that can only be done by the mother, the brunt of her dissatisfaction is directed toward the child and results in abuse.

Why Was Organ Donation from Abused Children Passed Over in the Revisions to the Organ Transplant Act?

In many foreign countries brain death is established by law as a kind of death of an individual. Accordingly, physicians are the ones who pronounce death in the brain-dead state, and the family members who receive the declaration consider organ donation as one option after death. In Japan, however, brain death is not yet recognized by law as the death of an individual socially even though it is so medically. For that reason, in order to enable the performance of organ trans-

plantation, the Organ Transplant Act establishes brain death as the death of an individual only in cases when organs are to be donated, which means that there is a need to confirm an intention of organ donation prior to the determination of death.

In cases where it is unclear whether a person had an intention, while s/he is alive, to donate organs, the revised Act makes it possible for the deceased's family to establish such intention. However, in the case where the parents, who are supposed to protect the rights of a child, abused the child, the question of whether it is proper for the parent who committed abuse that led to the death of that child to decide on behalf of the child to donate organs is thought to still be socially controversial. Consequently, it was decided to withhold organ donation from abused children for the time being.

Mortality in Children Under Age 15

According to the vital statistics for fiscal 2009, there were 120 deaths of children under age 15 in Shizuoka Prefecture, which is no more than 0.3% of the 34,089 deaths of those aged 15 and older in the prefecture.[3] In view of that, just within Shizuoka it is thought that the offers of organ donation from brain-dead patients under age 15 is markedly lower than those from adults. Sufficient consideration must be given to the fact that the number of pediatric patients who fall into a state of brain death is originally very small, and that the elimination of organ donation from abused children is not inhibiting pediatric organ donation.

Responding to Abuse During Daily Clinical Practice

Child abuse is broadly classified into abuse, which is an aggressive action taken against a child (intentional act), and neglect, which is the failure to meet the needs of a child (failure to act). The basic recognition of these forms of abuse is an opportunity to start helping children and their families and not a prosecution of the perpetrator.

The Japan Pediatric Society has published guidelines for responding to abuse on its website (http://www.jpeds.or.jp/guide/index.html) (in Japanese).[4] The items from that guide thought to be especially essential are given in **Table 1**.

Responding to Abuse in Potentially Brain-Dead Patients with a Critical Condition

Paragraph 5 of the supplementary provisions in the revised Organ Transplant Act establishes that organ donation from abused children under age 18 shall not be performed. For that reason, organ donation facilities need to have abuse response committees functioning habitually.[5] These committees include internal members such as the assistant director or other hospital administrators, a person in charge of the nursing department, and physicians and nurses from the pediatrics and emergency medicine departments as well as psychiatrists and medical social workers, and in some instances staff members from the community's child consultation center are also included. In an emergency, these committees respond to a situation by holding a meeting with just the internal members and then validating the evidence after-the-fact with the external members. In a case that could result in organ transplantation, the results of the examination regarding abuse are submitted to the ethics committee, and the final decision whether organ donation can be performed is made by the ethics committee and the hospital director, who is given the committee's decision.

The "Examination of Criteria for Determining Legal Brain Death in Children," a piece of shared research in the 2009 Health and Labour Sciences Research Grant Special Research Project "Study on the Determination of Brain Death in Children and Organ Donation," reports research on a manual about responding to abused children in regards to organ donation.[6] The criteria presume an extremely rigorous response in cases of abused children, and some are of the opinion that they impose a greater burden on emergency medical care staff. However, in regards to patients in a condition that could result in brain death, it should be relatively easy to diagnose abuse as the cause that led to such a condition, since the existence or nonexistence of abuse is verified during daily clinical practice, independently of the issue of organ transplantation. The difficulty is confirming the fact of past abuse.

Figure 1 is partially extracted from the report,[6] and the items in the checklist include the contents of **Table 1**. Details are given in the Japan Organ Transplant Network's Protocol for Organ

Donation Facilities.[7]

The concept of the act of organ donation is that organs from a patient who has died are donated through the medical procedure of transplantation to a patient who can be saved, and it is the duty of medical professionals to fulfill that noble wish. This means that there are cases that do not go simply, such as the handling of cases in which a child who was abused expressed to a third party, while s/he is alive, an intention to donate organs. However, since a written declaration of intent of a child under age 15 is invalid, even in the revised Organ Transplant Act, the wishes of the family, as the child's legally acceptable representatives, are important. Even if past abuse were a fact, the question of how to handle the situation in the present so as to think serious about the child and respect the child's intentions is a delicate problem. For that reason, deliberation in the ethics committee after being notified by the abuse response committee or other body of the fact of past minor abuse is very important.

Conclusion

Organ transplant is one option in end-of-life care. Accordingly, unless the national government and the people of Japan think seriously about the definition of death and end-of-life medical care, needless confusion ends up being forced upon the medical front. The problem of organ donation from abused children considered in this article is to a great extent caused by the still insufficient Organ Transplant Act. The establishment of a system that enables the organ donation intentions of a family facing death to be reliably fulfilled while also ensuring adequate protection of the human rights of a child donating organs is a task that we medical professional must also engage in.

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