“The Child is the Father of the Man”—William Wordsworth

Wordsworth’s observation (forgiving his gender pronouns) is truly one of the core principles of family medicine. Yes, we care for children because we are concerned about them, but also because we are concerned about the adults that those children become. As family physicians we may or may not care for a specific child into adulthood, but we certainly care for adults whose health has been influenced by their experiences as children.

For family physicians, parents are often our patients as well; they do not exist as unidimensional “Moms” and “Dads” but are complex people with strengths and challenges. We know if they have a chronic or acute illness, or are caring for an older parent, or have a difficult relationship with a partner, or a boss, or a substance. This facilitates our ability to help them work on the most positive, nurturing, and supportive plans of care for their children, because we are aware of the particular difficulties that may be confronted by those parents, that family.

Thus, it is unfortunate that we do not do a better job of collecting information on Adverse Childhood Experiences (ACEs) from our patients, as documented by Tink and colleagues in this issue of Family Medicine. The authors note that ACEs, the combination of childhood abuse and household dysfunction first described by Felitti in 1998, “...have a strong and graded relationship...[with] subsequent persistent unhealthy adult behaviors, much intractable adult chronic disease and early death.” They cite studies indicating that 20%–50% of adults have ACE histories and that these people have higher rates of adverse health conditions, including alcoholism, substance abuse, and suicide. However, other studies they cite show that physicians, including family physicians, do a poor job of eliciting these histories. In a survey of community family physicians, Weinreb et al found only 25% and 12.5% screened female patients and male patients (respectively) for ACEs at any time, although 70% believed screening was beneficial to patients, and nearly 80% felt that it was within their role.

The current study adapted the Weinreb instrument, “Screening for Childhood Trauma in Adult Primary Care Patients,” to survey 112 family medicine residents at the University of Calgary, and the results were not encouraging. Only two residents screened patients for ACEs on the first visit and only a few more at subsequent visits. Mental health, addictions, and signs of abuse were correlated with screening, but behaviors such as smoking, overeating, and avoidance of screening tests did not increase ACE screening rates. Female residents were more likely than male to screen, and women were more frequently screened than men. Only 1/3 of the residents correctly identified the prevalence of childhood ACEs in women, and just 10% the prevalence in men.

The authors discovered that residents with a personal history of ACEs were more likely to screen and that this group had a prevalence comparable to that of the overall population;
36% of female and 26% of male residents reported childhood abuse or adult trauma (even though the survey question asking about it was optional). The trauma included physical abuse, witnessing parental violence, sexual touching, and forced sexual practice. Thirty percent of those reporting trauma reported two or more trauma categories.

This is, perhaps, the most interesting, important, and disturbing finding in this paper. I doubt that most family medicine residents or family physicians would imagine that such a high percentage of their colleagues had experienced abuse, and the entire discipline owes a tremendous debt of gratitude to the Calgary residents who shared the fact that they had such trauma, and raised our awareness of the depth and breadth of the problem. If the rate is so high even among us, the low rate of screening our patients is all the more problematic. The residents in this study, like the community physicians in Weinreb’s, cite a variety of reasons for not screening, including inadequate time and lack of resources for addressing problems that were uncovered.

The time issue is real; Yarnall and colleagues, in 2003, showed that it would take 7.4 hours per day for a primary care physician to provide all USPSTF-recommended preventive care (which do not include screening for ACEs) to a standard population. Every recommendation for prevention or screening has advocates who feel it is the most important one, but the family physician who is responsible for all of them can easily feel overwhelmed. Because we are busy trying to manage acute and chronic diseases and document all the prevention recommendations programmed into the EHR, it can be tempting to not “ask for trouble” by inquiring about ACEs. We are increasingly recognizing that the “social determinants of health,” essentially a patient’s life experience, current and past, are a major cause of disease, and ACEs are certainly one. Medical care alone cannot “fix” any of these, but we need to know about them, because even the simple act of acknowledgement can be an important first step in addressing them. Given the high prevalence of ACEs in both the general population and among ourselves, and the correlation they have with adult morbidity, we need to do a better job.

After all, caring for the family is what we do. If part of our reason for providing quality health care for children is to improve the health of the adults that they will become, part of the way we improve the health of the adults we care for is to identify and address the adverse events that occurred to the children they used to be.

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