Attitudes and child abuse reporting behaviours among Hong Kong GPs

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Background. GPs are often the first contact for injured children and hence play a crucial role in early identification and intervention of child abuse cases in the community.

Objectives. To investigate Hong Kong GPs’ attitudes and behaviours towards child abuse reporting and their opinions on the introduction of a mandatory reporting system.

Methods. A cross-sectional survey was conducted in 2006 among GPs who were attending or had attended a local postgraduate family medicine course.

Results. One hundred and seventy-one GPs participated in this study, among which only 8.9% received formal child abuse training. Only 35.8% of those GPs who had encountered suspected cases reported every case. GPs who considered reporting could produce more harm than good to the family or child, who concerned about maintaining anonymity and who were reluctant to get involved with legal system were less likely to make a report [odds ratio (OR) 0.21–0.27; 95% confidence interval (CI) 0.06–0.11, 0.67–0.86]. ‘Concern on own anonymity’ was the only significant independent predictor for reporting (OR 3.47; 95% CI 1.11–10.87). Despite the low satisfaction with the present reporting system, 67.3% would not support the introduction of a mandatory reporting system. Logistic regression showed previous training could predict supportive attitude towards mandatory reporting (OR 4.84, 95% CI 1.01–23.27).

Conclusions. This study shows low reporting behaviour among Hong Kong GPs. The major barriers to report are identified and can only be addressed by education and a carefully designed support system for GPs. Further research engaging a multidisciplinary approach is required to work towards an optimally beneficial system for the children.

Keywords. Abuse reporting, child abuse, GP, Hong Kong.

Introduction

Evidence suggest that severity of child abuse tends to escalate over time,\textsuperscript{1,2} making early detection and intervention crucial in preventing victims from suffering severe abuses. GPs, the first professional group from whom parents may seek help for their injured children, can play a significant role in prevention. Arguably, doctors have moral and legal responsibilities to report these cases to relevant governmental authorities or social welfare organizations in order to provide early interventions for victims and perpetrators and prevent further abuse.

In practice, even where reporting suspected abuse is a legal responsibility, such as in the USA\textsuperscript{3} and most states of Australia,\textsuperscript{4} many medical professionals fail to do so despite potential criminal and civil penalties.\textsuperscript{5} Studies have shown that up to 43% of GPs in Australia\textsuperscript{6} and 28% of paediatricians in the USA\textsuperscript{7} did not report suspected cases they encountered. Common barriers found to prevent reporting included lack of knowledge and training on identifying child abuse, lack of knowledge on reporting laws and process and previous negative experience with Child Protection Services (CPS), concerns regarding maintaining anonymity and a reluctance to get involved in litigation.\textsuperscript{5,7–10}

In Hong Kong, there is no legal requirement to report suspected abuse cases; however, the Hong Kong Social Welfare Department (SWD)’s ‘Procedural Guidelines on Handling Child Abuse’\textsuperscript{11} suggests doctors to report all suspected cases to senior medical professionals or to the SWD. The total number of
newly reported cases has risen from 622 in 2004 to 944 in 2007, 55% were physical, while 30% were sexual abuse cases. However, these figures are likely to represent a serious underestimation, as low as 1–2% of total cases. Many scholars and professionals have urged the Hong Kong Government to consider the introduction of a mandatory reporting system. It is believed that, despite concerns over potential drawbacks such as conflicting interests in confidentiality and autonomy issues, such system would assist with the early identification of victims.

Previous studies found that corporal punishment and child physical abuse was common in Hong Kong. The present study aimed to investigate the reporting behaviours of child abuse among Hong Kong GPs. The relationships between attitudes and behaviours of reporting were also examined in order to identify those barriers to report. Another goal of this study was to engage GPs with the relatively novel idea of mandatory reporting of child abuse in Hong Kong. GPs’ attitudes and concerns about mandatory reporting system were also surveyed.

Methods

Participants
The participants were qualified GPs who enrolled in the Diploma of Family Medicine (DFM) at the Chinese University of Hong Kong as their further specialized training. Based on sample size calculation, with a 95% confidence interval (CI), 0.15% width of CI and ~52% expected to support the implementation of mandatory reporting system, a total of 170 respondents were required. With an estimated 50% response rate, 339 GPs studying in the academic years of 2001–07 were invited to participate in this cross-sectional survey.

Procedures
Having obtained permission from the DFM Course Director, data were collected between June and November 2006. The demographic and contact details of all 339 GPs were obtained from the course database. Questionnaires were distributed with a cover letter, consent form and pre-paid self-addressed envelope either during class (for current studying GPs) or by post (for graduated GPs). The participants took 15 minutes to complete the questionnaire. Participants were informed of issues regarding confidentiality, anonymity and voluntary participation. Two follow-up mail-outs were conducted at three weekly intervals. A lucky draw worth HK$200 (~GBP 16) was used as an incentive, with participants able to supply contact details on a separate form voluntarily. Ethics approval was obtained from the Survey and Behavioural Research Ethics Committee at the Chinese University of Hong Kong.

Measures
The questionnaire was pilot tested by six local GPs, having been based on a number of variables and validated scales modified to suit the local context. These included the following:

1. Attitude towards corporal punishment: Adapted from Feng and Levine’s study, this six-item scale required GPs to indicate how much they would agree on the use of corporal punishment in a six-point Likert scale. Good validity and reliability of the scale had been reported with Cronbach alpha as 0.80.

2. Barriers to reporting: A validated 10-item scale was adapted from King et al.’s study. It comprised two subscales, 4 items for professional and 6 items for case-related concerns on reporting (Cronbach alphas as 0.65 and 0.66, respectively). GPs were asked to rate how important these barriers were in deterring them from making a report in a five-point Likert scale. To avoid bias of providing socially desirable responses, the questions were framed in the third person perspective, i.e. why ‘other GPs’ chose not to report.

3. Choice of reporting system in Hong Kong: GPs were asked to choose the best reporting system for Hong Kong among (i) a highly regulated mandatory system for all suspected cases; (ii) a partially mandatory system applying to severe cases only (both adapted from Delaronde et al.’s study) or (iii) the current system in which reporting was by voluntary basis.

4. Level of satisfaction towards local reporting system and previous experience on handling abuse cases: Satisfaction towards local reporting system was asked by a single item using a five-point Likert scale. The latter included the number of suspected and reported child physical and sexual abuse cases in their past practice.

5. Choice of organizations: Participants were asked to indicate their choice of organization to which they would make a report in a hypothetical situation in the future. The options included governmental bodies (police, SWD and paediatrics departments in hospitals), non-governmental organizations (NGOs) or others.

6. Demographic information: These included age, gender, parental status and years of child abuse training.

Data analysis
Data were entered and cleaned using SPSS 16 and descriptive statistics were obtained. With the demographic details provided by the respondents, their characteristics could be compared with the rest of the
non-respondents based on the information in the course database. The relationships between a number of independent variables and outcomes were examined by chi-square tests for ordinal variables and independent samples \( t \)-test for continuous variables. Fisher’s exact test was used in cases where the expected count was fewer than five. GPs’ reporting behaviours and degree of support for a mandatory reporting system were transformed into dichotomous variables and further tested in a logistic regression model. Factors found to be significantly related to outcome variables in bivariate associations were entered into the regression model in order to determine whether they could independently predict the occurrence of these outcomes.

Results

Among the 339 GPs approached, 171 (50.4%) completed and returned the questionnaire. The average completeness of data of each questionnaire was satisfactory at >97%. When compared the respondents with non-respondents, GPs <30 years old were more likely to participate in this survey [odds ratio (OR) 5.61, 95% CI 3.18–9.91] (Table 1).

Characteristics and training needs of the responding GPs

Among participating GPs, 114 (66.9%) were male and one-third (38.5%) were parents (Table 1). Their age ranged from 25 to 71 years (mean: 35.0 years; SD: 9.62 years), with average 8.1 years of practice. They saw an average of 12.4 child patients per day. Surprisingly, very few participating GPs (15/114; 8.9%) reported receiving education on child abuse issues.

Attitudes towards corporal punishment

The mean total score of GPs’ attitudes towards corporal punishment was 17.12, (score range from 6 to 36; higher scores for more tolerant attitudes), implying participants were somewhat opposed to the use of corporal punishment. Some thought that corporal punishment was not ‘effective in educating children’ (67.3%) or considered it ‘abusive’ (60.8%). Most did not intend to use it on their own children (65.5%). GPs who were parents \( (P = 0.00) \), older \( (P = 0.01) \) and more clinically experienced \( (P = 0.02) \) were significantly less tolerant towards corporal punishment (Table 2).

Reporting behaviours among GPs who had encountered child abuse cases

In total, 95 GPs had encountered at least one child abuse case in their history of practice. Among them, approximately one-third (35.8%) made reports for every suspected case, while 38 (40.0%) had never reported. Seventy-nine of the 171 GPs (46.2%) had encountered suspected physical abuse cases, with only 29 of them (36.7%) reporting all the cases and 33 (41.8%) never having done so. Forty of the 171 GPs (23.4%) reported encountering suspected sexual cases: 19 of them (47.5%) had reported all cases, while 16 (40%) had reported none.

Among the 95 GPs, those >30 years old were more likely to have reported suspected sexual abuse cases \( (OR 4.75, 95\%\ CI 1.11–20.39; Table 2) \). Moreover, a higher proportion of GPs who had received child abuse training had made a report in the past compared with those without such training \( (90.0\% \text{ versus } 56.3\%\) (Table 2). However, the 95% CI range is relatively large probably due to the small number of trained GPs in our sample \( (OR 7.00, 95\%\ CI 0.85–57.89)\) (Table 2). Therefore, care must be taken when interpreting the effects of training on reporting. On the other hand,

### Table 1  Demographic information of responding (N = 171) and non-responding doctors

<table>
<thead>
<tr>
<th></th>
<th>Overall</th>
<th>Respondents</th>
<th>Non-respondents</th>
<th>OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>( n ) ( % )</td>
<td>( n ) ( % )</td>
<td>( n ) ( % )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age (mean = 35.00; SD = 9.62)</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(&lt;30)</td>
<td>87</td>
<td>68</td>
<td>19</td>
<td>5.61 (3.18–9.91)</td>
</tr>
<tr>
<td>( \geq31)</td>
<td>252</td>
<td>98</td>
<td>154</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>233</td>
<td>113</td>
<td>120</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>106</td>
<td>56</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td>Are you a parent?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>NA</td>
<td>65</td>
<td>38.5</td>
<td>NA</td>
</tr>
<tr>
<td>No</td>
<td>NA</td>
<td>104</td>
<td>61.5</td>
<td>NA</td>
</tr>
<tr>
<td>Any child abuse training?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>NA</td>
<td>15</td>
<td>8.9</td>
<td>NA</td>
</tr>
<tr>
<td>No</td>
<td>NA</td>
<td>153</td>
<td>91.1</td>
<td>NA</td>
</tr>
<tr>
<td>Number of years in practice</td>
<td>Mean = 8.11; SD = 7.42</td>
<td></td>
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</tbody>
</table>

NA, data not available.
attitudes towards corporal punishment were not associated with reporting behaviours.

Perceived importance of barriers and relationships with reporting behaviours
The most important barrier to reporting was ‘lack of sufficient evidence’, with 65.5% of 171 GPs considered it as ‘very’ or ‘extremely’ important barrier, followed by ‘reluctance to get involved with the court or legal systems’ (42.9%) and thinking that the ‘reporting process was too time consuming’ (42.1%).

‘Reporting may produce more harm than good to the family’, ‘concern about maintaining anonymity’, ‘reporting may produce more harm than good to the child’ and ‘unwilling to get involved with legal system’ were significantly associated with a lower likelihood to make a report (OR 0.21–0.27; 95% CI 0.06–0.11, 0.67–0.86; Table 3). In the regression model (Table 4), only concern about maintaining anonymity was shown to be an independent predictor of the GPs’ reporting behaviour (OR 0.29; 95% CI 0.09–0.90).

Attitudes towards local reporting system
Only 13.9% of 171 GPs were satisfied with the present reporting system. In the hypothetical question that if a report was to be made in the future, nearly half the participants would choose to report to the police (48.2%), followed by paediatricians (40.9%), SWD (38.6%) and NGOs (12.3%).

The GPs’ choice of organization was also associated with levels of perceived importance of various barriers

| Table 2 | Significant bivariate associations of doctor’s demographic variables with their attitudes towards corporal punishment and reporting behaviours |
| Total score on attitudes towards Corporal Punishment scale* | t | P value |
| Age | Mean | SD |
| ≤30 | 18.56 | 5.48 | 2.86 | 0.01 |
| >31 | 16.00 | 5.80 |
| Are you a parent? | | | |
| Yes | 15.34 | 5.41 | 3.24 | 0.00 |
| No | 18.30 | 6.00 |
| Years in practice | | | |
| <5 years | 18.42 | 5.75 | 2.44 | 0.02 |
| ≥6 years | 16.19 | 5.92 |
| Ever report child sexual abuse? | OR | 95% CI |
| Yes | | |
| No | | |
| Age | | |
| ≤30 | 4 (33.3%) | 8 (66.7%) | 4.75 | 1.11–20.39 |
| >31 or above | 19 (70.4%) | 8 (29.6%) |
| Ever report child abuse? | OR | 95% CI |
| Yes | | |
| No | | |
| Any child abuse training? | | | |
| Yes | 9 (90.0%) | 1 (10.0%) | 7.00b | 0.85–57.89 |
| No | 45 (56.3%) | 35 (13.8%) |

*A higher score stands for more tolerant attitudes towards corporal punishment.

bFisher’s exact test was used because one cell had expected count <5.

| Table 3 | Associations of doctors’ reporting behaviours with their perceived importance of barriers |
| Ever report child abuse? | OR | 95% CI |
| Yes | | |
| No | | |
| Concern about own anonymity | | |
| Not important | 30 (76.9%) | 9 (23.1%) | 0.27 | 0.11–0.67 |
| Important | 24 (47.1%) | 27 (52.9%) |
| Reporting may do more harm than good for the child | | |
| Not important | 49 (65.3%) | 26 (34.7%) | 0.27 | 0.08–0.86 |
| Important | 5 (33.3%) | 10 (66.7%) |
| Reporting may do more harm than good to the family | | |
| Not important | 50 (65.8%) | 26 (34.2%) | 0.21 | 0.06–0.73 |
| Important | 4 (28.6%) | 10 (71.4%) |

| Table 4 | Logistic regression for ever reporting child abuse |
| Variables | OR | 95% CI |
| Older age | 0.96 | 0.90–1.04 |
| Female gender | 1.48 | 0.48–4.56 |
| With previous child abuse training | 5.87 | 0.62–56.08 |
| Years in practice | 3.20 | 0.84–12.23 |
| Satisfaction towards present reporting system | 0.81 | 0.27–2.43 |
| Tolerant attitudes towards corporal punishment | 0.96 | 0.88–1.05 |
| Unwilling to jeopardize the relationship with the child or his/her parents | 1.96 | 0.55–6.92 |
| Concern about maintaining anonymity | 0.29 | 0.09–0.90 |
| Reporting a suspected case may produce more harm than good for the child | 1.72 | 0.32–9.33 |
| Reporting a suspected case may produce more harm than good for the family | 0.56 | 0.11–2.95 |
| Unwilling to get involved with legal system | 0.64 | 0.18–2.31 |

(5). Those who were ‘unwilling to jeopardize the relationship with the client’s family’ were more likely to report to NGOs (OR 4.18, 95% CI 1.62–10.81) and SWD (OR 2.79, 95% CI 1.38–5.64). Conversely, those who ‘respect for cultural differences in child rearing’ were more likely to report to NGOs (OR 4.24, 95% CI 1.56–11.58) but less likely to the police (OR 0.39, 95% CI 0.16–0.94). GPs who concerned ‘reporting may do more harm than good’ were less likely to report to both SWD (OR 0.38, 95% CI 0.15–0.94) and police (OR 0.41, 95% CI 0.18–0.93).

Despite their dissatisfaction with the current system, only one-third (32.7%) of the 171 GPs would support the implementation of mandatory reporting system. Specifically, 26.5% would support mandatory reporting for severe cases, such as sexual and severe physical abuse. After controlling for factors previously found to be significant, such as gender, past reporting behaviours and the perceived importance of lack of
sufficient evidence, 'previous child abuse training' could still significantly predict support for the mandatory reporting system (OR 4.84, 95% CI 1.01–23.27) (Table 6). However, as mentioned before, the results of training effects should be interpreted with caution due to the small number of GPs with such training.

Discussion

This study found that most participants had low tolerance towards both child physical and sexual abuse and generally opposed the use of corporal punishment. Failure to report abuse was common and ‘concern about their own anonymity’ was found to predict reporting behaviours. If a report was to be made, police and paediatric departments were their preferred organizations. Few GPs (13.9%) were satisfied with current reporting systems in Hong Kong, but only one-third supported the implementation of a mandatory reporting system, especially in those who had not had any child abuse training.

Despite the strong study design, which utilized a multifaceted pilot-tested questionnaire with validated culturally adjusted scales, the generalizability of our results was potentially sacrificed to a degree in order to overcome low response rates reported in previous surveys of GPs. Following the example of Wong et al. in earlier studies, we approached GPs that we considered more likely to respond to research questionnaires. Although there was no child abuse training module in the DFM curriculum, it was possible that the participants were arguably more interested in acquiring higher skills and more likely to adapt to new ideas or changes in policy than other local practising GPs. Another limitation, as in all retrospective studies, could be the recall bias on their previous clinical experience, raising the possibility of an inaccurate recollection of events.

Contradictory to traditional Chinese teaching, most participating GPs disagreed with the common belief of ‘sparing the rod would spoil the child’ and opposed the use of corporal punishment. The finding of more tolerant attitudes towards corporal punishment among younger GPs was in line with both local and international findings. One possible explanation is that younger GPs may lack effective parenting skills with which to discipline children, relying instead on corporal punishment to achieve immediate effects.

<table>
<thead>
<tr>
<th>Table 5  Significant associations between perceived importance of barriers and their choice of organizations to which they would make a report</th>
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<tbody>
<tr>
<td><strong>Prefer reporting to NGOs</strong></td>
</tr>
<tr>
<td>Unwilling to jeopardize the relationship with the child or his/her parents</td>
</tr>
<tr>
<td>Not important</td>
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<td></td>
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<tr>
<td>Important</td>
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<tr>
<td>Prefer reporting to SWD</td>
</tr>
<tr>
<td>Unwilling to jeopardize the relationship with the child or his/her parents</td>
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<tr>
<td>Not important</td>
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<tr>
<td>Important</td>
</tr>
<tr>
<td>Prefer reporting to NGOs</td>
</tr>
<tr>
<td>Respect for cultural differences in child rearing practices</td>
</tr>
<tr>
<td>Not important</td>
</tr>
<tr>
<td>Important</td>
</tr>
<tr>
<td>Prefer reporting to police</td>
</tr>
<tr>
<td>Respect for cultural differences in child rearing practices</td>
</tr>
<tr>
<td>Not important</td>
</tr>
<tr>
<td>Important</td>
</tr>
<tr>
<td>Prefer reporting to NGOs</td>
</tr>
<tr>
<td>Concern about maintaining anonymity</td>
</tr>
<tr>
<td>Not important</td>
</tr>
<tr>
<td>Important</td>
</tr>
<tr>
<td>Prefer reporting to police</td>
</tr>
<tr>
<td>Concern about maintaining anonymity</td>
</tr>
<tr>
<td>Not important</td>
</tr>
<tr>
<td>Important</td>
</tr>
<tr>
<td>Prefer reporting to SWD</td>
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<tr>
<td>Reporting may do more harm than good to the family</td>
</tr>
<tr>
<td>Not important</td>
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<tr>
<td>Important</td>
</tr>
<tr>
<td>Prefer reporting to police</td>
</tr>
<tr>
<td>Reporting may do more harm than good to the family</td>
</tr>
<tr>
<td>Not important</td>
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<tr>
<td>Important</td>
</tr>
</tbody>
</table>
Under-reporting was common among local GPs. Direct comparison with foreign figures is difficult as most published figures are concerned with countries with mandatory reporting laws. The high non-reporting rates obtained in the present study may be attributed to the complex interaction of a lack of mandatory reporting requirements and cultural values, in that Chinese society emphasises the non-disclosure of sensitive family issues in the public.

Lack of sufficient evidence, ‘unwillingness to involve with the legal system’ and thinking that ‘reporting process is too time consuming’ were the three most important barriers that deterred GPs from reporting. The latter two barriers implied that the main concerns were the time and effort required for their reports and potential legal proceedings given their heavy workloads. Article 2 of the United Nations Convention on the Rights of the Child, to which China and Hong Kong are signatory members, suggests that we should take all appropriate measures to protect a child against all forms of abuse and Article 18 further elaborates that such measures can be legislative, administrative, social and educational in nature. Therefore, failure to report simply to avoid time loss or due to unwillingness to engage with legal systems is unacceptable. Providing support, guidance and/or financial incentives for GPs can be considered to promote reporting behaviours.

The present results implied that while the welfare of the abused child and family is a crucial consideration in reporting, GPs feared that a failure to remain anonymous could not only cause hostility and damaged relationships but also result in litigation. Consistent results have been reported in a number of studies, with this concern found to be the strongest predictor of the GPs’ lifetime reporting proportion. Therefore, training on how to manage child abuse cases and sensitive handling by relevant organizations such as SWD and NGOs to maintain confidentiality of the identity of reporters are essential attributes of any future successful intervention strategies.

Child abuse training, an independent factor found to predict their support for the implementation of mandatory reporting system, was uncommon among GPs. In the USA, mandatory reporters were found to have a higher lifetime reporting proportion if they had received >10 hours of child abuse training. The training should not only include the introduction of child abuse and the role GPs can play in its management but also describe reporting issues such as the relevant regulations, procedures and what information they should prepare for future investigations and court cases.

When the implementation and effectiveness of the mandatory reporting policy comes into question. Ainsworth found that although more child abuse victims were identified after the policy was introduced in New South Wales, considerably more effort and resources were invested on unsubstantiated cases when compared to Western Australia. Consistently, Melton also regarded this system as ‘a policy without reason,’ since child protection was viewed as equating reporting and investigation, and CPS agency was largely engaged in gathering evidence and preparing court cases rather than promoting the safety of children.

In reality, GPs can have several choices of organizations to which they can make a report to for a suspected child abuse cases, such as police, public hospitals and SWD. Their impression on these organizations can be reflected by the significant relationships between their choices of organizations and perceived importance of barriers. For example, GPs who emphasized ‘maintaining own anonymity’ were less likely to report to the police, simply because reporting to police was likely to lead to detailed investigation and involvement in legal system, and GPs could be easily identified by the family during this process.

Among GPs who respect for cultural differences in child rearing and ‘unwillingness to damage the relationship with the family’, they were more likely to report to NGOs, which are expected to help resolve the conflicts between family members with dual consideration of their long-term relationship. Reporting to SWD was more common among GPs who considered the relationships with family as important, but less so among those who considered ‘reporting may do more harm than good to the family,’ which suggests their concern about the negative effects of reporting, such as removal of the child from the family as a means to prevent further abuse.

In conclusion, the present study shows the problem of under-reporting of suspected child abuse cases among GPs in Hong Kong, and several important barriers to report, such as confidentiality issue and welfare of the victims, are identified. More support and clearer guidelines should be provided for GPs to address this issue. Further training on child abuse can be
another option to increase awareness and knowledge in reporting and such training should be made mandatory. Finally, more research on a multidisciplinary approach is required to explore an optimally beneficial reporting system for the children in Hong Kong.

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Declaration

Funding: The School of Public Health Grant at The Chinese University of Hong Kong.

Ethical approval: Survey and Behavioural Research Ethics Committee at the Chinese University of Hong Kong.

Conflict of interest: none.

References