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# Doing the Right Thing: A Primary Care Pediatrician's Perspective on Child Abuse Reporting

Claire McCarthy, MD

Department of Pediatrics, Martha Eliot Health Center, Jamaica Plain, Massachusetts; Department of Pediatrics, Harvard Medical School, Boston, Massachusetts

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## ABSTRACT

The Child Abuse Recognition Experience Study (CARES) demonstrated that primary care physicians and nurse practitioners who treat injured children find the decision of whether to report suspected abuse difficult. This commentary briefly summarizes and responds to the papers presented at the Child Abuse Recognition, Research, and Education Translation (CARRET) Conference. The commentator traces her own changing views of child protective services as she became more involved in a multidisciplinary assessment team. Pediatricians are called on to advocate for more effective collaborations to better protect vulnerable maltreated children. *Pediatrics* 2008;122:S21–S24

WHEN I READ in the Child Abuse Recognition Experience Study (CARES) that primary care providers do not consistently report possible child abuse to child protective services (CPS), I was not surprised at all. If anything surprised me, it was that people found it surprising.

It is reasonable to assume, I suppose, that primary care providers would report any injury to a child that may have been caused by abuse, especially when reporting is mandated by law in all states. However, it turns out that most reports do not actually come from primary care providers, and retrospective studies that examined children who were ultimately found to have been abused showed that, in many cases, primary care providers did not report previous injuries. The CARES was the first to gather prospective data on how primary care providers decided whether injuries they saw were a result of abuse and then whether they reported suspicious injuries to their state CPS agency.

What they found was alarming: experienced providers did not report three quarters of the injuries they thought were possibly a result of abuse and, even more worrisome, did not report more than one quarter of those they thought were likely to have been caused by abuse.

Understandably concerned by these results, the Agency for Healthcare Research and Quality (AHRQ) convened the Child Abuse Recognition, Research, and Education Translation (CARRET) Conference, at which professionals who work in child abuse treatment and prevention tried to understand the findings of the CARES. Sadly, I understand them only too well.

I have been doing primary care pediatrics at an urban neighborhood health center for 17 years. All sorts of families bring their children there, but we have more than our share of single parents, stressed parents, poor parents, and parents struggling with addiction. We have disorganized families and families affected by violence. We are a little microcosm of risk factors for child abuse.

I have sat in examination rooms with those families, looking at injuries, listening to stories, wondering if they are true, wondering what I should do, wanting to do the right thing: the very best, most responsible, most helpful thing. I am sure that every one of my primary care colleagues who has been in one of those examination rooms has wanted to do the right thing, too.

“Happy families are all alike; every unhappy family is unhappy in its own way,” wrote Tolstoy,<sup>1</sup> and I found myself thinking of that quote as I read the CARES. Don’t get me wrong; just because I did not find the CARES surprising does not mean I do not think that things need to change. Clearly, we are not protecting children as well as we need to, but primary care—good primary care—is intrinsically about understanding context and complexity. Good primary care is about relationships. And, when you see the context and complexity, when the relationships are crucial, things that look black and white in hindsight or from the outside can look stubbornly gray in that examination room. I have reported many cases of possible child abuse, and there have been cases of possible child abuse that I have not reported.

*A child sits in front of you with a bruise. The story is plausible—or is it? The father seems angry; did it seem in that moment that the child was afraid? That glance, that gesture, what did they mean? The mother seems so affectionate now; is it true affection or guilt? You’ve known them for years, but do you really know them at all?*

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### Key Words

child abuse, child protective services, CARES

### Abbreviations

CARES—Child Abuse Recognition Experience Study  
CPS—child protective services

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Address correspondence to Claire McCarthy, MD, Department of Pediatrics, Martha Eliot Health Center, 75 Bickford St, Jamaica Plain, MA 02130-1401. E-mail: clairemccarthy@comcast.net

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Some of it is training, sure. And, there's the fact that I am allotted 15 minutes for most office visits, which makes true delving, painstaking examinations, and exhaustive thought processes particularly challenging. However, there is also a cost/benefit calculation that happens when it comes to reporting, one that every pediatrician approaches differently.

There is a high perceived cost of reporting in terms of the relationship with the family. People do not generally take it well when you report them to CPS. There are ways to spin it, but it is hardly a compliment, and parents, afraid their children will be taken away from them, often get panicked and furious. This is not just about not wanting to upset parents. Those of us in primary care see ourselves as protectors of our patients, and if we get fired or parents no longer trust us, we cannot protect our patients. If I might ruin any chance I have of watching over a child, I need to be sure that the people to whom I am reporting will do it for me.

This leads to the benefit part of the equation. All of us primary care folks, even when we are fully cognizant of laws and obligations, cannot help but ask the question, "What will reporting offer this patient and this family?" When the injury is serious, almost certainly a result of abuse, when we are worried about a child's safety, and when we know a family needs more monitoring and intervention than we can provide, the math is simple and we report the situation. But, when we are not sure that an injury was caused by abuse, when we are not as worried about a family and see viable options for helping them, and when we have had a previous bad experience with CPS, the math sometimes works out the other way, which is what the CARES illustrated starkly.

*If you report, they may be gone forever, and all those years of building trust are down the drain. You are not sure it is abuse, after all. You can find—or invent—reasons to see them back soon, and frequently. At the next visit, you will see if you can talk the mother into some counseling; she seems a bit depressed. Of course, if there is an injury that you are sure is abuse, you'll report it then.*

More pediatricians need to report cases of possible child abuse, absolutely, and we need to work toward that goal. However, the bigger goal, one with which every single pediatrician can agree, is to keep all children safe. That, of course, is much harder. However, every time we come together to brainstorm about child protection, as was done at the Child Abuse Recognition, Research, and Education Translation Conference, we get a little closer.

Dr Cindy Christian, co-director of Safe Place: The Center for Child Protection and Health, stressed the need for education.<sup>2</sup> I could not agree more with Dr Christian that physicians, especially pediatricians, need more education about child abuse and neglect. It is shameful that the median time spent on this in medical schools is 2 hours and that there is not any residency accreditation requirement for training in this important topic. It is somewhat absurd to expect that anybody will competently identify something they have not been trained to identify.

There is only so much that PowerPoint presentations

can teach, though. We learn best when we see actual cases, when we hear the histories and examine the children—and not just one child here and there but many of them. Although child abuse is common (according to the Centers for Disease Control and Prevention, 899 000 children [1210 per 100 000] were classified as victims of abuse or neglect by CPS in 2005), the presentations tend to be scattered among all sorts of different offices and emergency departments. Dr Carol Berkowitz,<sup>3</sup> past president of the American Academy of Pediatrics, discussed establishing multidisciplinary centers of excellence to which cases of abuse could be referred; not only would these centers give those children more complete and better assessments, but they would be places where students and doctors could learn. Such centers, by offering educational opportunities and role models, might also encourage more pediatricians to pursue the Certificate in Special Qualifications in Child Abuse Pediatrics, which is another step toward keeping all children safe.

Dr Berkowitz is right in saying that medical consultation is a concept with which pediatricians are familiar and comfortable. She is also correct in believing that many pediatricians do not report because they are uncertain of the diagnosis of child abuse. Having the ability to discuss with and refer cases to experts would be wonderful. However, it is important to remember that in the CARES, all the clinicians (except for 3 who did not respond to the question) reported some access to consulting colleagues. Even more interesting was the fact that although 82% of the clinicians who reported injuries consulted someone, only 18% of the clinicians who had a high suspicion of abuse yet did not report discussed the case with a colleague, which means that the vast majority of those who saw a really suspicious injury and chose not to report it did not consult anyone. We cannot know what was going on in the heads of all those people, but when you use the cost/benefit calculation paradigm, it makes sense: if a pediatrician has decided that there is not enough benefit from reporting to risk the cost, why talk to someone who may make you report?

Thus, although regional centers are undeniably a good idea and would help significantly when it comes to prosecution, expertise needs to be disseminated as well as consolidated. Pediatricians in the examination rooms are at the front line, and they need to have enough of a knowledge base to identify cases that need reporting. Having requirements for continuing education in child abuse and neglect is a great idea, and the experts at regional centers could be charged with providing solid curricula and evaluating their impact, but how do we alter that cost/benefit calculation?

I agree with Dr Christian that it could make a difference if the medical community could think of child abuse and family violence as public health problems such as asthma or obesity. As she pointed out, public health problems demand medical intervention. They demand education of health professionals and communities, and they demand a comprehensive approach. They demand funding for research and treatment, which is

sorely needed when it comes to child abuse and neglect. The other thing they demand is prevention. If we not only train doctors to identify child abuse but also give them evidence-based tools to prevent it, it changes everything. Reporting then has a different context; it becomes like prescribing prednisolone when the inhaled steroids did not hold off the wheezing. Not only that, pediatricians could be empowered to identify risk factors and intervene earlier, before there is abuse that needs reporting.

It was clear from the CARES that distrust by medical providers of CPS is a big part of the problem—possibly the biggest part. This did not surprise me either, because I spent my early years as a pediatrician in my own dysfunctional relationship with Massachusetts' child protection system, the Department of Social Services. As far as I was concerned, they were overworked and undertrained and did not have a whole lot to offer my patients. Similar to many of the pediatricians in the CARES, I had negative experiences: reports I felt strongly about not being investigated, children being returned to homes I thought were unsafe, and workers being unreachable, changing all the time, and unaware of the details I thought were important. I felt like I was excluded from all the decisions that happened after I reported.

Then, approximately 10 years ago, I started to work with the Department of Social Services. I joined a multidisciplinary assessment team at the office near my health center. I went to meetings, listened to cases, and realized that I had been wrong. They did know things about families; by sitting in living rooms and going to schools and spending more time that I ever did, they learned all sorts of truths and explanations I would have never found out. They did have something to offer: they could reach out and watch in ways that I could not, and they could provide parenting help, day care slots, in-home mental health services, connections with community programs, and sometimes concrete things such as furniture or money to pay an electric bill. Often, they were just as upset about a judge's decision to send a child home as I was. I realized that they were more than happy to include me in making decisions.

Why did I not know all this before? As Mr Goad, former Illinois Deputy Director of Child and Family Services, discussed extensively in his article,<sup>4</sup> health care providers and CPS do not interact or collaborate well. There are confidentiality issues: once the initial reporting period is past, families need to sign consent forms for CPS to let providers know what's happening, and families that are upset and angry are often not in the mood to sign consent forms. However, it is way more than that. Some of the issues Mr Goad mentions, all of which I have experienced, include unclear roles and expectations, power struggles (on both sides), perceived class distinctions between health care providers and social workers, and abundant distrust and misunderstanding all around.

I wasn't wrong about all my perceptions of CPS, though. As Mr Goad writes, "Those responding are universally very busy and often overwhelmed. CPS agencies

are notoriously underfunded, which results in CPS workers frequently having workloads that preclude thorough investigations." Add to that the fact that many different workers might be involved with a particular family because of both institutional policies (eg, moving from investigation to assessment) and attrition. Each worker might have a different view of the case and a different relationship with not just the family but also the health care provider. And, because record-keeping is an evolving process in child protection, it can be difficult for one worker to pick up where the other left off.

There is also an inescapable problem: there is only so much that CPS can do. They can monitor and support, but they cannot eliminate waiting lists for mental health services. They cannot create drug treatment programs, jobs, or affordable housing. They cannot hand out high school diplomas. When the resources that the community has to offer are limited, so is the impact of CPS, and yet CPS gets the blame.

Collaboration between health care providers and CPS may be the best way to change the cost/benefit calculation to increase reporting. It may also be the best way to improve education and assessment and the best way to work toward keeping all children safe.

A wonderful example is the Educating Physicians in Their Communities on Suspected Child Abuse and Neglect (EPIC-SCAN) program described by Dr Christian.<sup>2</sup> This program, run by the Pennsylvania chapter of the American Academy of Pediatrics and the Pennsylvania Department of Public Welfare, teams physicians and child protection social workers together to give educational presentations that are not only informative but practical and that help providers identify community resources for families at risk. The program also provides additional training in child protection to local pediatricians who can then serve as resources for other health care providers.

Working together, we could learn from each other. CPS workers could gain more expertise in the medical and developmental aspects of child abuse, and pediatricians could learn more about family dynamics, family support strategies, and the legal aspects of child protection. Working together, we could perform complete evaluations that help us truly understand what is happening to a child and how best to intervene. If we worked together, doctors would be better trained and more likely to report abuse because they would have a better understanding of what CPS could do and because they would feel more involved and invested in the decision-making process.

There is another crucial reason for us to collaborate: advocacy. Our country desperately needs to devote more attention, and more resources, to supporting families and keeping children safe. I absolutely believe that the money and resources exist; it is just a matter of getting them where they need to be. If health care providers and CPS worked closely together as one strong voice, just think what we could do. We could bring attention to the problem of child abuse and neglect. We could write and promote legislation that supports children and families. We could fight for funding, not only for CPS but for day

care, job training, drug treatment, home-visiting programs, and other interventions that have been proven to prevent child abuse and improve the lives of families. Together, as one strong voice, one strong force, we could keep children safe.

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