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To Report or Not Report: A Physician's Dilemma

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Physicians often encounter childhood injuries and conditions that test their knowledge of what is considered child abuse and neglect and when to report their suspicions. Some situations pose ethical dilemmas that are not easily resolved. Understanding what constitutes child maltreatment and having a plan for making decisions about it can reduce the burden of physicians' duty to report their suspicions effectively and appropriately. In this article we discuss the definitions of child abuse and neglect and offer recommendations to help physicians determine when reporting is necessary.

To illustrate the complexity and uncertainty of reporting child abuse and neglect, consider the example of a 5-year-old boy brought to the pediatrician's office for a well-child checkup. He was accompanied by his father, mother, 7-year-old sister, and 8-year-old brother. He was reported to be healthy, but upon exam the clinician discovered a 2-centimeter linear bruise on his palm. When asked about the cause of the bruise, the father said that a few days earlier he had spanked the boy with a belt and the child had put his hand behind him, resulting in the injury. He had no other bruises. Based on this information, should the pediatrician report this case?

Before one can answer this question, it is necessary to know the definitions of child abuse and neglect as defined by the American Academy of Pediatrics (AAP) and other sources [1, 2]. Physical abuse is any physical injury to a child that is not accidental and may involve, but is not limited to, hitting, slapping, beating, biting, burning, shaking, or strangulating. As a result of these actions, a child may have bruises, broken bones, burns, or internal injuries that document the occurrence, as well as imprints of the specific object used to inflict the injury (e.g., belt buckle, hand, and knuckles). In sexual abuse, an adult or older child engages a child in sexual activities such as fondling, intercourse, oral-genital stimulation, sodomy, observing sexual acts, viewing adult genitals, and looking at, watching, or engaging in pornography. Not all children who are sexually abused are forced or threatened to participate; they may be enticed through bribery, trickery, or persuasion.

Emotional and psychological abuse exposes a child frequently and repeatedly to behaviors that impact his or her psychological well-being, including blaming, threatening, yelling at, belittling, humiliating, name calling, pointing out faults, withholding emotional support and affection, and ignoring a child. In some cases, exposure to domestic violence is considered psychological abuse. Neglect is the chronic failure to meet a child's basic needs—clothing, nutritious food, cleanliness,

educational opportunity, medical and dental care, protection, shelter, and supervision. Though the four forms of maltreatment are defined separately, they often co-occur against one child.

The number of children who are maltreated annually in the United States is difficult to document because: (1) definitions vary across tribal, state, and federal jurisdictions; (2) the standards and methods of collecting data vary considerably; and (3) many cases go unrecognized and unreported [5]. In 2006, the national rate of child maltreatment was 12.1 per 1,000 children under age 18 [2]. Previously, the highest rate was 15.3 child victims per 1,000 in 1993, after which the overall rate of substantiated cases has continued to decline. The rates for neglect have persistently increased, while sexual abuse has steadily declined. Of the nearly one million substantiated cases of maltreatment in 2006, approximately 66 percent involved neglect (586,967); 16 percent, physical abuse (142,041); 9 percent, sexual abuse (78,120); 7 percent, psychological maltreatment (58,577); and 15 percent (133,978) were classified as “other types” of maltreatment (e.g., abandonment, congenital drug addiction, and threats of harm to the child). (Since children often experience multiple forms of neglect, these percentages total more than 100 percent.) The rate of maltreatment was highest for children from birth to age 1 (24.4 per 1,000), followed by ages 1 to 3 (14.2 per 1,000), and ages 4 to 7 (13.5 per 1,000). Boys and girls were equally vulnerable to neglect and physical abuse, but girls were sexually abused four times more frequently than boys (1.7 versus 0.4 per 1,000). African American children had the highest rates of substantiated abuse—24.7 per 1,000 children [2].

Do these definitions and statistics clarify the perception of suspected abuse in the case presented? The decision to report is complicated by the ambiguity of the definitions and their inconsistency across disciplines. Furthermore, accepted cultural practices complicate the decision to report. No specific guidelines distinguish between physical abuse and physical discipline. Spanking a child is one parenting behavior that can fall into this gray area. Nor is there a defining line between neglect and inadequate parenting. For example, children with a chronic illness who miss a series of medical appointments may be victims of medical neglect. Such instances present physicians with difficult decisions.

It is not the physician’s responsibility to determine the intent of the parent or caregiver, or whether abuse or neglect occurred. Their responsibility is to report their suspicions and allow trained professionals to conduct an investigation. Teams across the nation conduct the investigations and make the difficult but necessary decisions. To be substantiated, a case is first referred to a Child Protective Services (CPS) agency, subsequently investigated, and then decided one way or the other based upon the preponderance of evidence [3].

According to the most recent national statistics available (from 2006), an estimated 3.6 million reports of suspected maltreatment were received by state CPS agencies, of which approximately 905,000 were substantiated [2]. In the majority of these cases maltreatment was perpetrated by the child’s caregivers. Despite the statistics,

each case of suspected abuse presents physicians with the dilemma of determining what constitutes abuse and neglect and when to report.

Many factors play a role in physicians' decisions to report. A 2008 study found that pediatricians in an office-based setting do not always report suspicious injuries [4, 5]. Physicians from two national pediatric practice-based research networks were recruited and 434 reported information from more than 15,000 injuries seen in their offices. Approximately 10 percent of all injuries (1,683 injuries) were identified as suspicious, yet only 6 percent of those (95 injuries) were reported to CPS. Among the factors that played a role in reporting or not reporting, four points were commonly mentioned by physicians as contributing to their decision about reporting an injury to CPS.

- *Relationship to the family.* Familiarity with the family and a positive history resulted in physicians being less likely to report suspicious injuries, while meeting families for the first time or having prior concerns pushed physicians toward reporting to CPS.
- *Case-specific elements.* These include presence of pattern injuries, delay in seeking care, and lack of an adequate explanation for the injury.
- *Use of available professional resources.* Physicians reported that discussing the case with a knowledgeable colleague helped them decide whether or not to report suspicious injuries.
- *The clinician's past experiences with CPS.* Clinicians who believed that CPS involvement would result in a negative outcome for the child or family were less likely to report.

This study indicates that decisions to report suspicious injuries were less tied to definitions, statistics, and reporting laws than to a variety of factors related to patient-physician relationships and experiences with CPS [4, 5].

To add to the complexity of our case of the 5-year-old boy, the physician learned that the family had a prior CPS history of neglect for a dirty house and physical abuse for spanking and bruising the children. Should this information sway the physician to report?

A week after the 5-year-old boy visited the pediatrician's office, his 8-year-old brother was brought in for follow-up of an emergency-room visit for a head injury. The father reported that the boy was playing with neighborhood children and fell, hitting his head. The father did not witness the fall but noticed a lump on the left side of his son's head. The father reported that an hour later the boy fell and lost consciousness, again not witnessed directly by the father but reported to him by the boy's playmates. In the emergency room, the boy's exam showed only a bruise to his left temple area, and a CT of the brain was negative for fracture and intracranial bleeding. At the follow-up visit, the boy reported that he had had some headaches over the last few days but they were going away. He was sullen and would not answer other questions. When asked about the falls, he said that he did not

remember. Does this injury cause suspicion of abuse or neglect? Should this added information further persuade the physician to report?

The level of suspicion required to report suspected abuse is not clearly defined. But, with the knowledge that physicians tend to underreport suspected abuse, the following recommendations are made to increase physicians' confidence in making appropriate reports:

- *Obtain continuing education regarding child maltreatment.* Routinely seeking out local and national opportunities for continuing education related to child abuse and neglect can help you maintain a current understanding of child maltreatment.
- *Know reporting laws.* Familiarizing yourself with the reporting laws and to whom reports should be made in your state (i.e., CPS or law enforcement) can lessen the ambiguity in the reporting process.
- *Consult with colleagues.* Establishing collaborative relationships with colleagues to consult with regarding difficult cases can assist in the decision-making process. Physicians in private practice who do not have colleagues readily available may want to create a referral process with local agencies that have teams who make these decisions.
- *Know your local CPS staff.* Forming relationships with your local CPS staff members can facilitate an open line of communication and establish a better sense of the guidelines used by the agency.

Conclusion

The fact that it is often difficult to decide whether to report suspected abuse does not negate one's professional and legal responsibility to protect children by doing so. Physicians are not responsible for determining whether maltreatment occurred, only for reporting reasonable suspicion. The reporting decision is complicated by ambiguous definitions that vary across disciplines and by cultural differences in acceptable parenting practices. Many factors play a role in a physician's likelihood of reporting, including the relationship with the family, details surrounding the injury, consultation with colleagues, and previous experience with CPS. Physicians may reduce their decisional burden and increase appropriate reporting by participating regularly in continuing education related to child maltreatment, familiarizing themselves with reporting laws and local CPS staff, and consulting with colleagues.

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Suggested Reading

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