

## Child Abuse and Neglect

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## AMA Journal of Ethics®

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### FROM THE EDITOR

#### Child Abuse and Neglect

Jeanne Elkin, MD, MBE

I did not realize how common child abuse and **neglect** are until I actually began my clerkships. Like most physicians and trainees, I was privileged to grow up in a safe community. In **medical school**, we had only one lecture on child abuse and neglect. So, I considered it rare, like Rocky Mountain Spotted Fever or methylmalonic acidemia. But I met adult patients with enduring **psychological trauma**, women in labor who refused to have pelvic exams because it reminded them of childhood assault, babies who had somehow ingested opiates, parents living in such impoverished conditions that they could not satisfy their children's basic needs, a middle schooler stabbed by an uncle, a mom with postpartum depression so severe that she forgot to feed her newborn, and children with so many injuries.

These experiences point to the fact that child abuse and neglect are not rare at all, but common. **Child protective services** agencies receive roughly 4.4 million reports per year, and more than 600 000 are substantiated.<sup>1</sup> A child is 40 times more likely to be a confirmed victim of child abuse and neglect than to be diagnosed with any kind of cancer.<sup>2</sup> Yet students in the health professions learn far more about pediatric cancer than they do about abuse and neglect.

This issue of the *AMA Journal of Ethics* considers clinical, legal, and ethical questions related to child abuse and neglect that are rife with ambiguity and uncertainty—questions that are all the more difficult for clinicians, who are called upon to recognize their seemingly clear-cut duties to protect children. This issue also considers how clinicians might navigate this important tension and draw attention to everyday practice realities that are too often overlooked.

#### References

1. Children's Bureau. *Child Maltreatment 2019*. US Department of Health and Human Services; 2021. Accessed October 11, 2022. <https://www.acf.hhs.gov/sites/default/files/documents/cb/cm2019.pdf>
2. Childhood Cancer Awareness Month. American Childhood Cancer Organization. Accessed October 11, 2022. [www.acco.org/childhood-cancer-awareness-month/?gclid=CjwKCAjw97P5BRBQEiwAGflV6Q3REPqvqOFSdmwqBeL65ROUIT3j0aFC5qaRH9j7ihSKQqZmz4RCTxoCVqgQAvD\\_BwE](http://www.acco.org/childhood-cancer-awareness-month/?gclid=CjwKCAjw97P5BRBQEiwAGflV6Q3REPqvqOFSdmwqBeL65ROUIT3j0aFC5qaRH9j7ihSKQqZmz4RCTxoCVqgQAvD_BwE)

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## AMA Journal of Ethics®

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### CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

#### How Should Clinicians Minimize Bias When Responding to Suspicions About Child Abuse?

Megan M. Letson, MD, MEd and Kristin G. Crichton, DO, MPH

##### Abstract

Clinicians have ethical and legal obligations to report suspected maltreatment of children. A decision to report suspected abuse is one of great ethical, clinical, and legal importance and can weigh heavily on clinicians who have established relationships with a family. Mandated reporting is done inequitably, however, with overreporting of families with low socioeconomic status and minoritized families and underreporting of families with high socioeconomic status and White families. This article canvasses evidence-based approaches to evaluating and reporting suspicion of child maltreatment in ways that minimize bias and promote equity.

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##### Case

A 9-month-old boy is brought to an emergency department (ED) by his mother. The baby's mother reports that she slipped in an icy parking lot while lifting the baby from the car seat. She reports that, as she fell to the ground, the baby slipped out of her hands, hitting his head on the icy concrete. Physical examination of the baby reveals right-sided scalp swelling and multiple bruises on the torso and extremities. When asked about the bruises, the mother panicked, stating, "I didn't think to check under my baby's clothes. It was too cold. I just drove right here." The ED physician and nurse caring for the baby are distressed by the severity of the baby's injuries. The physician reviews the baby's electronic health record (EHR). Notes from an ED visit 6 months ago include photographic and narrative documentation of 2 bruises on the then-3-month-old baby's right arm. The physician and nurse confer quietly about what they observed, what they know, and how to respond.

##### Commentary

The federal Child Abuse Prevention and Treatment Act (CAPTA) of 1974 and Victims of Child Abuse Act Reauthorization Act of 2018 seek to protect children from abuse and neglect. This federal legislation provides funding to support the prevention, assessment, investigation, prosecution, and treatment of child abuse and neglect and establishes a

federal definition of child abuse and neglect.<sup>1</sup> CAPTA also requires states to implement reporting procedures.<sup>2</sup> Forty-four states, the District of Columbia, and US territories have designated professionals and other persons, including clinicians, to report suspected child abuse and neglect to community agencies in accordance with federal law.<sup>2</sup> Standards for reporting vary by state, but a **mandated reporter** who suspects, has knowledge, or believes that a child has been abused or neglected is required to report.<sup>2</sup> A reporter does not need to be certain or to prove that abuse or neglect occurred. This threshold for reporting is intended to identify children who are being abused, minimize harm, and prevent further abuse. Thus, individual mandated reporters may act without evidence-based protocols based on their own interpretation of CAPTA criteria, often relying on their intuition and “gut” feelings.

### **Gut Feelings as Sources of Bias**

The Centers for Disease Control and Prevention cites a combination of individual, relational, community, and societal factors that contribute to the risk of child abuse and neglect. These risk factors include caregiver characteristics such as substance use, mental health issues, low educational attainment, young age, and low income.<sup>3</sup> However, clinicians must interpret social risk factors and apply them in practice in ways that do not perpetuate bias.

Overrepresentation of children of color in the child welfare system, possibly due to racism, has been well documented.<sup>4,5,6</sup> Racial inequity can occur at any step along the child welfare continuum, starting with the initial reporting of suspected child abuse and neglect to child protective services (CPS). Black children are more likely than White children to be reported (excepting those of low socioeconomic status).<sup>4,7</sup> Additionally, once reported to CPS, Black children are more likely to have their cases opened for investigation and are at a greater risk of being placed in out-of-home care than White children.<sup>6</sup> For example, in 2019, Black children accounted for 23% of the foster care population but represented only 14% of the child population, while White children accounted for 44% of the foster care population but made up half of the child population.<sup>6</sup>

Although children may be removed from their birth family to prevent abuse or neglect, foster care system involvement can have adverse outcomes. For children, removal from their home is traumatic. Often children enter foster care with unmet health needs and are at increased risk for medical, developmental, and behavioral health problems related to their **childhood trauma**.<sup>8</sup> Additionally, they have poor educational outcomes, with more than 40% of school-aged children in foster care having educational difficulties.<sup>9</sup> Unfortunately, many of these needs persist while the children are in foster care.

In the case example, the clinicians must decide if mandated reporting is warranted and if a medical evaluation for additional injuries is indicated. Despite the existence of evidence-based clinical guidelines for child maltreatment, several studies have demonstrated clinician bias in the clinical evaluation of symptoms.<sup>10,11</sup> Abusive head trauma has been shown to be unrecognized more often in young White infants than in minority infants and in infants from “intact” families than in families in which the parents were not living together.<sup>12</sup> Additionally, underrepresented minority children are more likely than White children—and children without private insurance are more likely than those with private insurance—to be evaluated with a skeletal survey and reported for suspected abuse.<sup>13,14,15</sup>

## Responding to Suspicion

In addition to weighing complex decisions about initiating a medical evaluation to identify occult injury and engaging CPS, clinicians may also face the moral distress of realizing that they do not believe the history provided by the caregiver to account for the injuries. Clinicians who work with young children are accustomed to obtaining a medical history by proxy from caregivers. In most cases, these histories are reliable and can be trusted. However, when a caregiver provides a history of an injury that does not account for the injury, when the history of the injury changes, or when a child with no history of injury presents for an injury, clinicians may be hesitant to challenge the caregiver or report this concern to CPS due to fear of disrupting their relationship with and trust in the caregiver. Clinicians may also be concerned about negative professional consequences, such as testifying in court or being sued, despite US immunity statutes protecting mandated reporters.<sup>16,17</sup>

These factors, if present, could tempt clinicians to avoid discussing suspected abuse with family members. It is critical for the safety of the patient and other children sharing the same care environment that clinicians persevere through their discomfort and **explain their concerns** using clear and nonjudgmental language. While clinicians might be uncomfortable saying the word *abuse* to caregivers, **family-centered care** continues to be a priority and is important in fostering trust and partnership with families. Caregivers have a right to know and understand their child's medical condition, including concerns about physical abuse. As clinicians, we are ethically bound to clearly convey concerns about physical abuse so that caregivers can partner with us in protecting their child. In the case example, the clinicians could share their concerns with the mother to provide anticipatory guidance about next steps and help her understand potential safety risks for her child.

Determining whether one's suspicion for abuse is just can be complex. Failure to recognize or report abuse can result in dire consequences for children; however, reporting concerns of child maltreatment inappropriately can lead to unnecessary stress for children and their families, unwarranted removal of a child from their caregiver, and overburdening of an already strained child welfare system. Several strategies may be helpful as a self-check, including consulting with a child abuse pediatrician or another clinician for an independent assessment. When considering the clinical history, clinicians must focus on the factual, specific details provided by caregivers and on identified injuries while minimizing attention to subjective information or potential risk factors. Patient safety tools, such as STAR (stop, think, act, review), can provide a framework for clinicians to reflect on cases. For example, Nationwide Children's Hospital, with which we are affiliated, used STAR as an approach to child abuse cases in conjunction with a clinical guideline.

- Stop: Have you considered child abuse?
- Think: What is known and what is uncertain.
- Act: Call social work or child abuse team.
- Review: Did you follow guidelines?

Without STAR, clinicians may fall into the habit of relying on risk factors, such as socioeconomic status—which has long been used as a red flag for identifying populations of children at high risk of physical abuse—rather than considering each patient's unique clinical history and physical examination findings. In the case highlighted, the physician and nurse discussed that the bruising would not be expected

from the reported accidental history because the boy also had bruises on his abdomen, back, and posterior extremities. Given that he reportedly fell and hit his head and that the mother denied any other accidental injuries, the patterned bruising on his torso and extremities remained unexplained and raised concerns about physical abuse. The clinicians' response should not be affected by the mother's race, ethnicity, marital status, income, or educational attainment.

Clinicians must understand the types and patterns of injuries indicative of physical abuse, including how presentations vary by age and plausible accidental injury mechanisms, in order to determine whether the injuries warrant concerns about physical abuse.<sup>11</sup> Medical education on the identification of child abuse varies widely, and clinicians cite a lack of certainty about when to be concerned about abuse as a barrier to their recognition of suspicious injuries.<sup>18,19,20,21</sup> Ethical and evidence-based evaluation begins with a foundational knowledge of potential signs and symptoms of physical abuse and, like so many other diagnoses, a thorough history of how the injury occurred. Additionally, clinicians must be aware of how both injuries and mimics of injury can appear differently on different skin tones to avoid misdiagnosis.<sup>22</sup>

### **Recommendations for Minimizing Bias**

Many institutions have pursued practice standardization by implementing screening tools, clinical guidelines and pathways, and EHR alerts to support clinical decision making about child abuse.<sup>23,24,25,26</sup> Recently, to facilitate such decisions, one institution combined a routine screen using a brief series of questions asked by nursing staff with an EHR-embedded clinical decision support tool with triggers based on age-related chief complaints, documented exam findings, orders, and discharge instructions. The researchers found that the screen improved identification of suspected child abuse but that there was no relation between race and odds of a positive screen, which suggests that this approach might improve racial disparities in abuse evaluations.<sup>27</sup> While many of these tools are promising, they need to be validated across multiple clinical settings.<sup>28</sup> Furthermore, successful use of such tools requires clinician education and buy-in to ensure clinicians' compliance and effective use of the tools.

In addition to using an evidence-based approach, clinicians must be aware of explicit and implicit biases that everyone brings to their interactions with others. When making decisions about how to act on their concerns about child maltreatment, clinicians should reflect on what evidence exists to support or contradict their suspicion. Incorporating a multidisciplinary team with heterogeneous backgrounds and perspectives can help address bias in medical decision making.<sup>29</sup> In this case, the multidisciplinary team should include a social worker to engage caregivers in completing holistic psychosocial evaluations that highlight family strengths and opportunities for support. Social workers are instrumental in partnering with clinicians to ensure that mandated reporting is prompt and accurate and to support clinicians' communications with the family and community agencies. A hospital child protection team—specifically, a child abuse pediatrician who has specific expertise in injuries in children—can help clinicians review the clinical information, including identified injuries, and gauge the level of concern for physical abuse. This approach could be applied to provide an ending to the case scenario.

*A social worker met with the mother and learned that her boyfriend had been caring for the boy while she worked because she could not afford childcare. A skeletal survey was completed and revealed healing rib fractures, which a child abuse pediatrician, after*

consultation, described as concerning for physical abuse. Social work facilitated a report to CPS, and CPS established a safety plan with the family as part of its ongoing investigation.

### Conclusion

Although it is imperative for clinicians to recognize injuries indicative of child abuse in order to engage appropriate community agencies to protect children, they also must be mindful that involvement of these agencies is not benign and that racial and cultural bias results in disproportionate reporting and investigation of families of color. Evidence-based screening, diverse interprofessional team collaboration, and expert consultation can improve diagnostic accuracy of child abuse and neglect.

Finally, we cannot underestimate the toll that identifying and caring for children with suspected child abuse and neglect takes on health care professionals. Understanding the impact these cases have on individuals and teams will reduce compassion fatigue and burnout so that clinicians can continue to work for their most vulnerable patients.

### References

1. Child Welfare Information Gateway. About CAPTA: a legislative history. Children's Bureau, US Department of Health and Human Services; 2019. Accessed October 12, 2022. <https://www.childwelfare.gov/pubpdfs/about.pdf>
2. Child Welfare Information Gateway. Mandatory reporters of child abuse and neglect. Children's Bureau, US Department of Health and Human Services; 2019. Accessed October 12, 2022. <https://www.childwelfare.gov/pubPDFs/manda.pdf>
3. Risk and protective factors. Centers for Disease Control and Prevention. Updated April 6, 2022. Accessed October 19, 2022. <https://www.cdc.gov/violenceprevention/childabuseandneglect/riskprotectivefactors.html>
4. Dettlaff AJ, Boyd R. Racial disproportionality and disparities in the child welfare system: why do they exist, and what can be done to address them? *Ann Am Acad Pol Soc Sci.* 2020;692(1):253-274.
5. Cénat JM, McIntee SE, Mukunzi JN, Noorishad PG. Overrepresentation of Black children in the child welfare system: a systematic review to understand and better act. *Child Youth Serv Rev.* 2021;120:105714.
6. Child Welfare Information Gateway. Child welfare practice to address racial disproportionality and disparity. Children's Bureau, US Department of Health and Human Services; 2021. Accessed March 11, 2022. [https://www.childwelfare.gov/pubpdfs/racial\\_disproportionality.pdf](https://www.childwelfare.gov/pubpdfs/racial_disproportionality.pdf)
7. Putnam-Hornstein E, Needell B, King B, Johnson-Motoyama M. Racial and ethnic disparities: a population-based examination of risk factors for involvement with child protective services. *Child Abuse Negl.* 2013;37(1):33-46.
8. Szilagyi MA, Rosen DS, Rubin D, Zlotnik S; Council on Foster Care, Adoption, and Kinship Care; Committee on Adolescence; Council on Early Childhood. Health care issues for children and adolescents in foster care and kinship care. *Pediatrics.* 2015;136(4):e11131-e11140.
9. Jee SH, Szilagyi M, Ovenshire C, et al. Improved detection of developmental delays among young children in foster care. *Pediatrics.* 2010;125(2):282-289.
10. Palusci VJ, Botash AS. Race and bias in child maltreatment diagnosis and reporting. *Pediatrics.* 2021;148(1):e2020049625.

11. Christian CW, Crawford-Jakubiak JE, Flaherty EG, et al; Committee on Child Abuse and Neglect, American Academy of Pediatrics. The evaluation of suspected child physical abuse. *Pediatrics*. 2015;135(5):e1337-e1354.
12. Jenny C, Hymel KP, Ritzen A, Reinert SE, Hay TC. Analysis of missed cases of abusive head trauma. *JAMA*. 1999;281(7):621-626.
13. Lane WG, Rubin DM, Monteith R, Christian CW. Racial differences in the evaluation of pediatric fractures for physical abuse. *JAMA*. 2002;288(13):1603-1609.
14. Paine CW, Wood JN. Skeletal surveys in young, injured children: a systematic review. *Child Abuse Negl*. 2018;76:237-249.
15. Hymel KP, Laskey AL, Crowell KR, et al; Pediatric Brain Injury Research Network (PediBIRN) Investigators. Racial and ethnic disparities and bias in the evaluation and reporting of abusive head trauma. *J Pediatr*. 2018;198:137-143.e1.
16. Flaherty EG, Sege R. Barriers to physician identification and reporting of child abuse. *Pediatr Ann*. 2005;34(5):349-356.
17. Child Welfare Information Gateway. Immunity for reporters of child abuse and neglect. Children's Bureau, US Department of Health and Human Services; 2018. Accessed July 20, 2022.  
<https://www.childwelfare.gov/pubPDFs/immunity.pdf>
18. Mandadi AR, Dully K, Brailsford J, et al. A national survey of pediatric emergency medicine physicians on improving education in child maltreatment recognition and reporting child abuse and neglect. *Child Abuse Negl*. 2021;122:105324.
19. Baker AJL, LeBlanc S, Adebayo T, Mathews B. Training for mandated reporters of child abuse and neglect: content analysis of state-sponsored curricula. *Child Abuse Negl*. 2021;113:104932.
20. Eismann EA, Shapiro RA, Makoroff KL, et al. Identifying predictors of physical abuse evaluation of injured infants: opportunities to improve recognition. *Pediatr Emerg Care*. 2021;37(12):e1503-e1509.
21. Eismann EA, Shapiro RA, Thackeray J, et al. Providers' ability to identify sentinel injuries concerning for physical abuse in infants. *Pediatr Emerg Care*. 2021;37(5):e230-e235.
22. Ngo V. A closer look: medical conditions that mimic physical abuse. *Pediatr Ann*. 2020;49(8):e341-e346.
23. Crumm CE, Brown ECB, Thomas-Smith S, Yu DTY, Metz JB, Feldman KW. Evaluation of an emergency department high-risk bruising screening protocol. *Pediatrics*. 2021;147(4):e2020002444.
24. Rumball-Smith J, Fromkin J, Rosenthal B, et al. Implementation of routine electronic health record-based child abuse screening in general emergency departments. *Child Abuse Negl*. 2018;85:58-67.
25. Chen CJ, Chen YW, Chang HY, Feng JY. Screening tools for child abuse used by healthcare providers: a systematic review. *J Nurs Res*. 2022;30(1):e193.
26. Pierce MC, Kaczor K, Lorenz DJ, et al. Validation of a clinical decision rule to predict abuse in young children based on bruising characteristics. *JAMA Netw Open*. 2021;4(4):e215832.
27. Suresh S, Heineman E, Meyer L, et al. Improved detection of child maltreatment with routine screening in a tertiary care pediatric hospital. *J Pediatr*. 2022;243:181-187.e2.
28. Stilwell L, Golonka M, Ankoma-Sey K, et al. Electronic health record tools to identify child maltreatment: scoping literature review and key informant interviews. *Acad Pediatr*. 2022;22(5):718-728.

29. Baird J, Ashland M, Rosenbluth G. Interprofessional teams: current trends and future directions. *Pediatr Clin North Am.* 2019;66(4):739-750.

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#### Editor’s Note

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The author(s) had no conflicts of interest to disclose.

*The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental. The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.*

**CASE AND COMMENTARY: PEER-REVIEWED ARTICLE**

**How Should Race and Resource Context Influence How Neglect Is Considered by Clinicians?**

David Kelly, JD, MA and Jerry Milner, DSW

**Abstract**

Separation of children from their parents is one possible traumatizing consequence of a mandated report, which is not to be taken lightly. This commentary on a case considers how racism and poverty should influence clinicians' construal of their duties as mandatory reporters of abuse and offers recommendations about how to respond in similarly difficult cases.

**Case**

AB, age 1 year, is accompanied to a visit with pediatrician, Dr K. AB's grandmother apologizes for missing prior scheduled appointments and explains that she and her daughter both work many hours beyond full-time. Dr K asks about AB's caregiver when they're at work. AB's grandmother pauses and explains that neighbors "check in on" AB during the day. Dr K, recording AB's below-normal weight, certainly feels there's enough evidence to suspect that AB is neglected, although AB's lack of regular adult supervision and insufficient caloric intake are due to poverty, not to insufficient parental impulse or love.

Dr K hesitates, therefore, to "suspect" neglect. Dr K learned that one result of a recent mandatory report to the state's child welfare agency led to a 3-year-old patient's removal from a home in which the parents live in poverty. When that child returned to Dr K for an annual visit, the child was in a third foster care home, could not sustain eye contact with Dr K, would not engage in any kind of play Dr K tried to initiate, and was still underweight.

Dr K worries, "Neglect is obvious, so, yes, I suspect it. This means I'm mandated by federal law to report this to the state. But, ethically, that hasn't helped some of my patients before and might do more harm than good for AB." Dr K doesn't speak with anyone else and wonders what to do.

**Commentary**

Federal law requires that all 50 states have procedures for mandatory reporting by certain individuals when they suspect child abuse and neglect.<sup>1</sup> This case illustrates a common dilemma in child welfare for mandatory reporters and caregivers who seek help

for children with profound vulnerabilities. Dr K clearly recognizes what constitutes neglect from a medical perspective (ie, the child is underweight and alone for a good portion of the day). However, after asking the grandmother one question about childcare arrangements, Dr K did not ask additional questions to better understand what was happening in the life of the family or to evaluate what the improper weight may be due to—for example, the child’s having a medical condition or not being fed properly or regularly, or something else. We do not know whether **differences of language** or culture or racial dynamics affected the ability of the grandmother and Dr K to communicate effectively and truly understand one another. Regardless, Dr K is justified in being concerned by the mere fact of a 1-year-old child being left alone for long periods of time. Whether Dr K took the extra step of considering the cause of AB’s neglect—specifically, whether it is attributable to intentionally inadequate caretaking or perhaps to financial hardship, lack of access to childcare, unstable housing, or food insecurity—is not stated in the case. In short, Dr K was left with many unknowns about what could be contributing to his concerns about the health and well-being of the child, but he seems worried that help is needed.

For mandatory reporters, especially medical doctors who are trained to examine the totality of a patient’s well-being, the dilemma is whether to make a diagnosis of neglect or child maltreatment generally and **report the family** to a child abuse hotline or to dig deeper into the circumstances of the family’s life to learn more about the root causes of the warning signs. A deeper dive might result in recognizing the problem as poverty or hardship and lead to efforts to connect the family to concrete support as opposed to labeling the problem as child maltreatment.

The next section outlines the grounds for this assertion and places Dr K’s dilemma within the larger context of a system that is doing harm. We then explain ethical concerns stemming from definitions of neglect and mandatory reporting. Finally, we discuss distinguishing between hardship and neglect and describe an ethical approach to child welfare.

### **Report or Look Closer?**

As Dr K recognizes, the dilemma of whether to report or to probe for signs of abuse or neglect is heightened by the limitations of the likely responses from child protective services (CPS). Dr K remembers a specific case with a similar fact pattern in which CPS involvement did not lead to positive outcomes for the child. In fact, the overall health and well-being of that child may now be worse as a result of the call to the hotline and placement in 3 foster homes. The child that Dr K recalls now has great instability in life and is separated from family, which is affecting the child’s development and has interfered with healthy bonding, not to mention that the child remains underweight. This information adds to the ethical challenge that he faces in reporting what he suspects is neglect and risking further harm or taking an alternative approach.

In the case, the physician reveals his ambivalence about the child’s circumstances, noting on the one hand that the child’s being underweight and left alone “are due to poverty” and, on the other, that “neglect is obvious.” Is it obvious? While hardship can be harmful, is hardship that causes harm de facto child maltreatment? We assert it is not and that a closer look is warranted. Is it critical to connect families struggling with hardship to supportive and concrete services? Absolutely. Is a call to a child abuse hotline necessary in this case or even what would be helpful? Could other supportive or protective steps be taken in lieu of a hotline call? Does Dr K feel this is truly the most

appropriate or only way to address the situation? Or is it that, as a mandatory reporter, Dr K feels compelled to report to avoid culpability? Too often, we believe it is the latter.

The case raises several difficult ethical questions for clinicians.

- Do clinicians have the necessary information to reasonably suspect neglect and report it as such?
- Could mandatory reporting impair clinicians' ability to do what they feel is in the best interest of their patients' overall health and well-being?
- Does harm caused by reporting constitute a violation of clinicians' oath?
- Is a decision to make a report in any way influenced by race or social standing or any other factors in the family's situation other than the child's condition?

These questions result from, reflect, and contribute to an approach to child welfare in the United States that places many parties in ethical conflict. For mandatory reporters, such as Dr K, ethical conflict centers on legal reporting requirements vs gathering more information about possible causes of signs of abuse or neglect. For the family itself, the conflict is whether to seek medical attention for the child and risk being reported.<sup>2</sup>

### **Ethical Concerns**

The need for ethical clarity in child welfare is demonstrated by persistent racial disparities in outcomes—such as children of color being “more likely to experience multiple placements, less likely to be reunited with their birth families, more likely to experience group care, less likely to establish a permanent placement and more likely to experience poor social, behavioral and educational outcomes” than White children<sup>3</sup>—and it is clear in the words used by those who have experienced the system to describe it.<sup>4</sup> Recognition of the **harm that the child welfare system causes** is reflected in the case, which describes the negative impacts on a child reported for neglect (ie, withdrawn and underweight) and the child's subsequent treatment by the system designed to protect the child (ie, 3 foster home placements). The origins and evolution of the child welfare system are well documented<sup>5</sup> and deserve to be discussed at greater length, but 3 key flaws are noteworthy: (1) the system is reactive rather than proactive and causes trauma; (2) it offers few alternatives to separating families; and (3) it disproportionately intrudes in the lives of families with low income and families of color.<sup>6,7,8</sup> These flaws are highlighted in the following discussion of ethical concerns.

*Mandatory reporting.* Mandatory reporting<sup>1</sup> has been recognized as a structure of oppression, especially for Black and Indigenous populations.<sup>9</sup> Mandated reporters may fear that they will be sued for not reporting suspected child abuse, as some states allow such tort claims.<sup>10</sup> This fear of liability places tremendous pressure on mandated reporters and may increase the chances that a report is made when it is not necessary. For example, reporters may make a call for neglect for what they recognize as poverty-driven circumstances. Insofar as they are aware of mandatory reporting requirements, families experiencing vulnerability may be disincentivized to seek help.<sup>11</sup> In such instances, family integrity hangs in the balance, and trauma to children often follows.

*Neglect.* Neglect is the most common reason children are separated from their families and placed in foster care.<sup>12</sup> The term *neglect* is not defined in federal child welfare statute, except in the broadest terms.<sup>13</sup> Rather, it is left to the states to define, resulting in inconsistent definitions across the nation. What may be considered neglect that rises to the level of maltreatment in one state may not be neglect at all in another.<sup>14</sup> Unlike

criminal law, in which offenses are categorized by count and require a mental state as an element of a crime, no such requirements exist in child protection law definitions.<sup>15</sup>

Ambiguity in legal definitions of neglect increases the likelihood that decisions to report will be made subjectively.<sup>15</sup> In the case, what constitutes neglect is front and center (ie, Dr K says on the one hand that the problems “are due to poverty” and on the other that “neglect is obvious”). Potential criminal liability or loss of professional licensure for not reporting can increase stress for mandatory reporters, as they seek to avoid underreporting due to fear of legal liability and to avoid overreporting out of an abundance of caution. Should medical professionals, especially pediatricians, be trusted to make sound professional judgments without facing potential criminal liability? We suggest the answer to both questions is yes.

*Harm.* In the case, Dr K has concerns about 2 harms to the child that arise at 2 levels: the harm of the child’s being underweight and home alone at times if the child remains in the family and the harm of the child’s experiencing instability and disruption as a result of separating the family. Both harms require contemplation and weighing both the short- and long-term consequences. On the one hand, we know that very young children are especially vulnerable to factors that impede their healthy development, including the lack of consistent care and attention to their physical and emotional needs.<sup>16</sup> On the other, we also know that very young children are particularly sensitive to disruption in their attachments to and bonds with their parents and that changing caretakers and making frequent moves can impair them for life, physically and psychologically.<sup>16,17</sup>

The ethical dilemma of having to choose one form of harm over another should have no place in a system intended to protect children. Nonetheless, the child welfare system’s primary response to a report of child abuse and neglect, when the report is substantiated, is to investigate a family and separate the child from that family. Separation causes trauma to children and their parents, even when it is necessary.<sup>17,18</sup> Accordingly, there is growing concern about harms that traditional child welfare approaches and vague definitions of neglect cause children.<sup>19</sup> For example, the child welfare system continues to surveil and police poor families and families of color, exposing them to increased reporting and the harm of separation, even when poverty, not neglect, is the main concern.<sup>20</sup> Decades of poor outcomes for children and youth in the child welfare system, including more than 20 000 young people exiting care annually<sup>21</sup> without the permanency of a family and the supports and connections needed for their well-being, provide additional evidence of the system’s harmful results.<sup>22,23,24,25</sup>

### **How to Respond**

Dr K must work within the system of which he is a part and in accordance with the laws that govern his professional behavior, which include reporting obligations when he has good reason to suspect that a child is being neglected. While it is not his job to determine if neglect has occurred, it should be his job to understand enough of the facts to warrant a report and risk the further harm that reporting can bring. Dr K has an opportunity to engage with the child’s parent and grandparent to explore age-appropriate childcare arrangements and proper nutrition. He has an opportunity to ask for more frequent appointments and possibly link the family with a home visiting nurse.

Through activities such as these, Dr K would have an opportunity to ascertain whether it is indeed the family’s poverty that is responsible for the child’s being underweight and

left alone or whether the caretakers are intentionally neglectful. In either case, help will be needed, but the additional information and insight could help Dr K determine where that help should come from and what form it should take. Nevertheless, the nature of the dilemma will not change until child welfare changes how it responds to both poverty and neglect. We assert that, in the face of the known harms and dangerous effects of common child welfare practices, the continuation of those practices—and the vast funding of those practices—constitute a lack of systemic ethics and will continue to put reporters, such as Dr K, squarely in ethical dilemmas.

As a field, we allow preventable harm to occur with little and sometimes no consideration of transforming the system that causes the harm. In fact, we require harm to occur before most interventions, services, or supports are made available, and then we exacerbate harm to children and their parents by causing additional trauma in our responses, which include unnecessary family separation—often without reasonable efforts to keep family members safely together.<sup>26</sup>

### **What Should Child Welfare Practice Look Like?**

An ethical approach to child welfare in the United States requires explicit acknowledgement and ownership of the harms that have been caused and a corresponding duty to stop causing harm and to dismantle harm-causing structures and approaches.<sup>7</sup> The child welfare system can and should be reconceived and restructured, at minimum, to do no harm. Ideally, like whole health and wellness approaches to medicine, child welfare could become a framework for a preventative approach and, when needed, be restorative and healing. This framework would clearly distinguish hardship from child maltreatment and contain safeguards to prevent the confusion of the two.<sup>27</sup> It would incentivize efforts to understand child and family needs and provide critical services and supports as opposed to clinicians' fear of criminal liability making intervention the default. This type of approach would allow a medical professional like Dr K to stay focused on what the child needs to be healthy and what can be done to help the parent or caretaker better ensure the child's needs are met. Dr K would—and should—retain the ability to call child protection services in any instance when abuse is suspected or the child is in immediate danger, but this option should be fully at the discretion of the pediatrician based on their professional judgment.

Overall, an ethical approach requires investments in historically disadvantaged communities and in robust networks of familial support (ie, primary prevention).<sup>28</sup> Such an approach should be designed and driven by families and communities. Partnerships with community members enable trust that is essential for families to make stigma-free and threat-free requests for help, admitting their vulnerabilities along with their openness to help and support without fearing the loss of their children. With appropriate community investment, could the family of the child in the case find support for reliable childcare? For proper nutrition? For transportation to medical appointments? Resoundingly, yes.

In the absence of immediate danger or harm, an ethical approach demands alternatives to separating families that do not threaten the integrity of family relationships and unity. There is growing research demonstrating that community-based, universally available family supports diminish the need for formal intervention by CPS.<sup>29</sup> Place-based approaches that provide an array of services and concrete supports within the communities where families live and work are showing promise.<sup>30</sup> These approaches are consistent with research demonstrating the positive impact of providing material

supports to families to prevent the greater harm of not attending to those needs.<sup>31,32</sup> Family resource centers are one example of a form of community support that is nonthreatening and nonstigmatizing. Compassionate community responses that recognize and can meet cultural and familial needs—including basic human and material needs—before a physician or other mandatory reporter faces a dilemma of whether to report or call for help can make a difference.<sup>33</sup> They can also serve as an alternative to a referral by a physician who sees need or feels concern but does not suspect maltreatment.

It is time for an overarching systemic commitment to nonmaleficence in child welfare and a corresponding duty to invest in families and communities to help them thrive as a first step to repairing historic and ongoing harm. Failure to make such commitments affirmatively and to redesign child welfare accordingly represents a profound moral and ethical shortcoming and abnegation of justice for families. However, reform will not replace the need for state intervention in instances of severe physical, sexual, and emotional abuse or intentional neglect. It would, however, dramatically reduce the trauma that occurs when families are subjected to state intervention when other, less intrusive measures could alleviate stress and risk, help to keep children safe, and preserve the integrity of families and children's relational health.

## References

1. Child Welfare Information Gateway. Mandatory reporters of child abuse and neglect. Children's Bureau, US Department of Health and Human Services; 2019. Accessed September 9, 2022. <https://www.childwelfare.gov/pubpdfs/manda.pdf>
2. Hager E. A mother needed welfare. Instead, the state used welfare funds to take her son. *ProPublica*. December 23, 2021. Accessed August 9, 2022. <https://www.propublica.org/article/a-mother-needed-welfare-instead-the-state-used-welfare-funds-to-take-her-son>
3. Disproportionality and race equity in child welfare. National Conference of State Legislatures. January 26, 2021. Accessed September 12, 2022. <https://www.ncsl.org/research/human-services/disproportionality-and-race-equity-in-child-welfare.aspx>
4. Children's Bureau. Engaging, empowering, and utilizing family and youth voice in all aspects of child welfare to drive case planning and system improvement. US Department of Health and Human Services; 2019. Accessed March 26, 2022. <https://www.acf.hhs.gov/sites/default/files/documents/cb/im1903.pdf>
5. Roberts DE. *Shattered Bonds: The Color of Child Welfare*. Basic Books; 2002.
6. Howard K, Martin A, Berlin LJ, Brooks-Gunn J. Early mother-child separation, parenting, and child well-being in Early Head Start families. *Attach Hum Dev*. 2011;13(1):5-26.
7. Milner J, Kelly D. The need for justice in child welfare. *Child Welfare J*. 2021;9(3&4). Accessed September 21, 2022. <https://www.cwla.org/the-need-for-justice-in-child-welfare/>
8. Sugrue E. Evidence base for avoiding family separation in child welfare practice: an analysis of current research. *Alia*; 2019. Accessed March 28, 2022. [https://www.ncsc.org/\\_\\_data/assets/pdf\\_file/0031/18985/alia-research-brief.pdf](https://www.ncsc.org/__data/assets/pdf_file/0031/18985/alia-research-brief.pdf)
9. Merkel-Holguin L, Drury I, Gibley-Reed C, et al. Structures of oppression in the US child welfare system: reflections on administrative barriers to equity. *Societies*. 2022;12(1):26.

10. Bexis. Does state law really allow tort claims for failure to report to government agencies? Drug and Device Law blog. March 5, 2018. Accessed October 14, 2022. <https://www.druganddevicelawblog.com/2018/03/does-state-law-really-allow-tort-claims-for-failure-to-report-to-governmental-agencies.html>
11. Fong K. "Like a trap": mandatory reporting and dilemmas of help-seeking. *Fam Integr Just Q.* 2022;1(2):70-79.
12. Protecting children from abuse and neglect: trends and issues. Legislative Analyst's Office. August 8, 2013. Accessed September 29, 2022. <https://lao.ca.gov/reports/2013/ssrv/child-neglect/child-neglect-080813.aspx>
13. Child Abuse Prevention and Treatment Act, 42 USC 5101, note (2022).
14. Redleaf DL. The challenge of changing amorphous, limitless neglect laws in a family surveillance society. *Fam Integr Just Q.* 2022;1(2):120-131.
15. Gupta-Kagan J. Confronting indeterminacy and bias in child protection law. *Stanford Law Pol Rev.* 2022;33:217-287. Accessed January 17, 2023. [https://scholarship.law.columbia.edu/cgi/viewcontent.cgi?article=4873&context=faculty\\_scholarship](https://scholarship.law.columbia.edu/cgi/viewcontent.cgi?article=4873&context=faculty_scholarship)
16. Securing a bright future: maltreated infants and toddlers. Zero to Three. March 23, 2016. Accessed Sept 14, 2022. <https://www.zerotothree.org/resource/securing-a-bright-future-maltreated-infants-and-toddlers/>
17. Complex trauma. National Child Traumatic Stress Network. Accessed October 19, 2022. <https://www.nctsn.org/what-is-child-trauma/trauma-types/complex-trauma>
18. Frank Myers A. Harm caused by the Adoption and Safe Families Act. *Fam Integr Just Q.* 2022;1(1):84-91.
19. Sankaran V, Church C, Mitchell M. A cure worse than the disease? The impact of removal on children and their families. *Marquette Law Rev.* 2019;102(4):1161-1194.
20. Roberts D. Child protection as surveillance of African American families. *J Soc Welfare Fam Law.* 2014;36(4):426-437.
21. Children's Bureau. The AFCARS report no. 27. US Department of Health and Human Services; 2020. Accessed September 30, 2022. <https://www.acf.hhs.gov/sites/default/files/documents/cb/afcarsreport27.pdf>
22. Youth in transition (aging out). Annie E. Casey Foundation. Accessed March 26, 2022. <https://www.aecf.org/topics/youth-in-transition>
23. 51 useful aging out of foster care statistics/social race media. National Foster Youth Initiative. May 26, 2017. Accessed March 26, 2022. <https://nfyi.org/51-useful-aging-out-of-foster-care-statistics-social-race-media/>
24. Child Trends. Fostering youth transitions: using data to drive policy and practice decisions. Annie E. Casey Foundation; 2018. Accessed March 28, 2022. <https://assets.aecf.org/m/resourcedoc/aecf-fosteringyouthtransitions-2018.pdf>
25. Courtney ME, Dworsky A, Brown A, Cary C, Love K, Vorhies V. *Midwest Evaluation of the Adult Functioning of Former Foster Youth: Outcomes at Age 26.* Chapin Hall, University of Chicago; 2011. Accessed October 14, 2022. <https://www.chapinhall.org/wp-content/uploads/Midwest-Eval-Outcomes-at-Age-26.pdf>
26. Milner J, Kelly D. Reasonable efforts as prevention. American Bar Association. November 5, 2018. Accessed March 26, 2022. [https://www.americanbar.org/groups/public\\_interest/child\\_law/resources/child\\_law\\_practiceonline/january-december-2018/reasonable-efforts-as-prevention/](https://www.americanbar.org/groups/public_interest/child_law/resources/child_law_practiceonline/january-december-2018/reasonable-efforts-as-prevention/)

27. Milner J, Kelly D. It's time to stop confusing poverty with neglect. *Children's Bureau Express*. 2020;20(10). Accessed March 26, 2022. <https://cbexpress.acf.hhs.gov/article/2020/december-january/its-time-to-stop-confusing-poverty-with-neglect/953840031b92c150517620efe54bcbd9>
28. Milner J, Kelly D. Investing in communities is an act of justice. *Fam Integr Justice Q*. 2022;1(3):6-9.
29. Wulczyn F, Lery B. Do family support centers reduce maltreatment investigations? Evidence from Allegheny County. Center for State Child Welfare Data; 2018. Accessed September 21, 2022. <https://fcda.chapinhall.org/wp-content/uploads/2019/03/FSC-Allegheny-County-Dec2018.pdf>
30. Do place-based programs, such as family resource centers, reduce risk of child maltreatment and entry into foster care? Casey Family Programs. Updated June 2019. Accessed March 26, 2022. [https://www.casey.org/media/SComm\\_Family-Resource-Centers.pdf](https://www.casey.org/media/SComm_Family-Resource-Centers.pdf)
31. Weiner D, Anderson C, Thomas K. Addressing economic hardship key to preventing child welfare system involvement. Chapin Hall, University of Chicago; 2021. Accessed March 28, 2022. <https://www.chapinhall.org/research/economic-supports-child-welfare/>
32. Paxson C, Waldfogel J. Work, welfare, and child maltreatment. National Bureau of Economic Research working paper 7343. September 1999. Accessed March 26, 2022. [https://www.nber.org/system/files/working\\_papers/w7343/w7343.pdf](https://www.nber.org/system/files/working_papers/w7343/w7343.pdf)
33. Children's Bureau. Strengthening families through primary prevention of child maltreatment and unnecessary parent-child separation. US Department of Health and Human Services; 2018. Accessed March 26, 2022. <https://www.acf.hhs.gov/sites/default/files/documents/cb/im1805.pdf>

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### MEDICAL EDUCATION: PEER-REVIEWED ARTICLE

#### How Should Clinicians and Students Cope With Secondary Trauma When Caring for Children Traumatized by Abuse or Neglect?

Colleen E. Bennett, MD, MSHP and Cindy W. Christian, MD

##### Abstract

When health care professionals encounter child abuse and neglect, they can experience a range of emotions, such as anger, sadness, and frustration. Such feelings can cloud judgment, compromise care, or even undermine one's capacity to complete evaluation of a child. This article discusses key ethical values of honesty, objectivity, compassion, professionalism, respect for persons, and justice, which can be used to guide one's approaches to navigating secondary trauma during and after clinical interactions with children who have suffered abuse or neglect. Strategies for coping with intense feelings, especially during interactions with abused and neglected children's families, are also offered herein.

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##### Witnessing Abuse and Neglect

In fiscal year 2020, child protective services agencies received 3.9 million referrals alleging child abuse and neglect.<sup>1</sup> Approximately 618 000 children were identified as victims, with the highest rates for infants. Roughly 12% of reports to child protective services were made by medical personnel.<sup>1</sup> As mandatory reporters in all 50 states, health care professionals are often required to complete child abuse education training in mandated reporting.<sup>2,3</sup> However, there is no universal training program for teaching health care professionals—including students and trainees—how to manage and cope with their emotions in these cases, which can make it difficult to adhere to ethical standards, including honesty, objectivity, and respect and empathy for caregivers who might be **suspected perpetrators of child abuse** and neglect. Here, we offer recommendations for communication strategies health care professionals can employ in cases of suspected child abuse and neglect and discuss approaches to managing secondary trauma that such cases might evoke.

##### Honesty

When child abuse or neglect is being considered, it is best practice for health care professionals to communicate this concern to families in an open and honest way. For instance, the statement, "I am concerned someone may have harmed your child," is an

appropriate expression of concern, especially if a diagnosis of abuse is not certain. Alternatively, if the child is battered or has pathognomonic, multiorgan injury that can only be the result of abuse, it is appropriate to clearly state that the child is a victim of abuse. Sometimes staff do not know the appropriate language to use to convey concern, or they might worry about angering or offending parents or other caregivers or simply feel uncomfortable with confrontation. In consequence, staff might not communicate appropriately with families or might avoid communication with families, which can affect families' perceptions of how they are treated. In a study that examined parental perceptions of care during young children's hospitalization for traumatic injuries, parents who were evaluated for possible abuse by the hospital child protection team—even when the injury was determined to be nonabusive—reported feeling less informed by staff and were less likely to feel that they were treated honestly or respectfully than parents for whom abuse was not considered.<sup>4</sup> Additionally, parents of children who were abused were more likely to feel that the diagnosis of abuse changed the way they were treated by hospital staff. These perceptions may be due to parents thinking that they are being negatively judged by the hospital staff or to their recognizing the hesitancy of staff who are uncomfortable caring for families of children who might have, or who have, been abused. Potentially, both factors contribute to these perceptions, highlighting the need for repeated communication with families. It is often helpful for clinicians to begin the conversation with concerns about possible abuse and ask parents whether they have any concerns that someone might have hurt their child. This is a nonjudgmental way to begin an open dialogue.

It is also ethically important not to “hide” behind one's mandate to report child abuse when discussing concerns with families. That is, clinicians blaming a decision to report on the law (eg, “I don't think it's abuse, but I am mandated to report”) rather than taking full responsibility for acting on their discernment and concern obscure the best reasons they have for reporting. Transparency with families is too important for professionals to invite such obfuscation into an already complex and emotionally fraught discussion. In fact, families in most cases likely deserve to know the specific roles clinicians play on a team—whether consultant or admitting physician, trainee, or supervising clinician. Families should be introduced to the various members of the medical team, just as in any other patient-clinician interaction, and know that the team members take their responsibilities seriously. It is also important to educate trainee team members to be forthcoming about their role as a trainee.<sup>5</sup>

Expressing concerns about child abuse and neglect to a family can be unsettling for any health care professional, but it is especially unsettling for trainees. Trainees may never have encountered child abuse and neglect before and may have minimal experience with challenging patient interactions. Just as mentors would not send trainees independently to deliver bad news without modeling how to do so, so they should not send trainees independently to discuss child abuse and neglect concerns without adequate preparation. To better prepare trainees for these patient encounters, we recommend **modeling communication** with families prior to having trainees lead the discussion. We also recommend emphasizing the importance of explaining medical terminology using language that is easily understood by patients and families. In addition, trainees should be taught to inform families that a report of suspected abuse is needed to further investigate the cause of the child's injury or condition. We often tell families that we will evaluate for underlying medical explanations while asking child protective services to investigate the possibility of abuse or neglect. In general, health care professionals are **expected to report** those cases in which there is reasonable

suspicion that a child was a victim of abuse or neglect by an individual whose care they were under.<sup>2,6</sup>

### **Objectivity**

Medical professionals cannot allow their disgust or horror at a patient's clinical presentation to affect how they treat the patient or the patient's caregivers. Regardless of their degree of concern about child abuse and neglect, trainees and medical professionals must take an objective approach to evaluating children for child abuse and neglect and making decisions regarding mandated reporting. Trainees should be educated on mandated reporting laws and clinical guidelines that inform appropriate medical evaluations in child abuse and neglect cases.<sup>3</sup> It is important to note that while there is a minimum federal definition of child abuse and neglect for purposes of reporting, each state has its own definition.<sup>6</sup> Nonetheless, health care professionals are mandated reporters in all 50 states.<sup>7</sup> Although medical school curricula exist to teach students about child abuse and neglect, it is critical to continue educating clinicians along the training continuum beyond medical school.<sup>3</sup>

The threshold for reporting requires only a reasonable suspicion of child abuse and neglect. However, there are no clear-cut, universal guidelines on what constitutes a reasonable suspicion. Each individual likely has their own threshold to report based on clinical experience, culture, religious background, personal upbringing, and knowledge. How do you teach trainees where and how to draw the line? Health care professionals can educate trainees and students to use a consistent framework to approach cases of child abuse and neglect, such as Leventhal's triangle, which acknowledges that there is a continuum between accident or medical condition and child abuse or neglect and that there is a threshold for a presentation to warrant reporting.<sup>2</sup> We know that racial bias—implicit or explicit—exists both in reporting practices and in investigative outcomes.<sup>8,9,10</sup> As health care professionals, we have an obligation to recognize our individual potential for bias, work diligently to address our biases, and educate trainees to be careful, thorough, and objective in their approach to child abuse and neglect.<sup>2</sup>

A number of resources are available to assist in making evaluations. The American Academy of Pediatrics provides recommendations for evaluations in cases of suspected child abuse.<sup>11,12</sup> Some institutions have created clinical pathways for providing an objective, evidence-based evaluation to reduce bias in medical evaluations.<sup>13</sup> Such pathways can also serve as tools to bolster clinician confidence in reporting when a concern for child abuse and neglect is identified, as health care professionals miss cases of abuse and do not always report cases when they have suspicion.<sup>14,15,16</sup> Several reasons for not reporting have been identified, including familiarity with the family, perceptions of what would be the outcomes of child protective services reports, and consistency of the injury with elements of the patient's history.<sup>15,17</sup> Moreover, some clinicians elect not to report suspected child abuse and neglect because of their concern that it might harm families. However, we do not recommend this approach, as there is significant potential for children who remain with their family to return to the health care facility with signs of additional, more severe abuse or neglect. Cases of child abuse and neglect are challenging for a myriad of reasons. When cases are ambiguous or complicated, clinicians can seek consultation and recommendations from pediatricians who specialize in child abuse and neglect or others who have expertise in this area, such as social workers.

### **Compassion and Respect**

One responsibility of health care professionals is to treat each patient with compassion and respect. This ethical standard holds for caregivers who may be perpetrators of child abuse and neglect. While it might be easy for health care professionals to feel sympathy for victims of abuse and neglect and to provide compassionate care to such children, it is more challenging to show compassion for potential perpetrators of or accomplices in child abuse and neglect. It is essential to teach trainees and students to refrain from apportioning blame to parents or caregivers, as there may be extenuating factors in a given case. Various stressors can lead to a child's victimization, such as lack of support, isolation, fractured family structure, or poverty. We know that poverty, for example, is a potent risk factor for child abuse and neglect; however, most impoverished caregivers do not neglect their child's needs.<sup>18</sup>

We also must recognize that perpetrators often still love their child, despite their abusive acts. Additionally, we often do not know the identity of the perpetrator when talking with families, and we must recognize that the person at the bedside may be a nonoffending parent who was unaware of the abuse. Abuse can also be perpetrated by other adults, such as daycare workers, teachers, clergy, or relatives. It is not our role to be investigators in cases of child abuse and neglect. Rather, our role is to render a medical opinion and communicate the medical information to investigators. We should educate caregivers on what to expect through the child protection and criminal processes and support families through the initial investigation and hospitalization.

Health care professionals should build rapport with patients and caregivers. Toward this end, health care professionals should teach students and trainees to use the "Ask-Tell-Ask" approach to deliver concerns about abuse.<sup>19,20</sup> Trainees and students can also be taught to respond to caregivers' strong emotions—including anger, frustration, sadness, or confusion—using open-ended, nonjudgmental language. One useful strategy is the NURSE mnemonic: naming, understanding, respecting, supporting, and exploring.<sup>19,20</sup> These basic communication skills are essential in all aspects of medicine but can be especially helpful in cases of child abuse and neglect.

### **Coping With Secondary Trauma**

Health care professionals are at risk for secondary trauma as a result of these interactions and the feelings that they evoke. Secondary trauma occurs from indirectly being exposed to another person's trauma, such as through caring for a patient who is a victim of child abuse or listening to a caregiver's own history of domestic violence or sexual abuse.<sup>21</sup> Secondary trauma is distinct from second victim syndrome, which describes the psychological harm that occurs to a clinician who makes a recognized mistake, such as when abuse goes unrecognized and the child sustains further injury.<sup>22</sup>

For a variety of reasons, child abuse and neglect may be challenging for students and trainees to address and may arouse a range of emotions—from sadness and disbelief to anger and abhorrence—in a given clinical situation. For many students and trainees, the clinic may be their first exposure to family violence and child abuse. Some students and trainees have been victims of sexual and physical abuse as children. Others may feel a sense of guilt when diagnosing abuse or filing a report to child protective services due to potential sequelae, such as criminal investigation or placement of the child in kinship or foster care. Some mandated reporters have had previous experiences with child protective services and believe that their report will fail to make a positive difference for the child and thus hesitate or fail to report suspected abuse and neglect.<sup>15,17</sup>

Secondary trauma can affect clinicians' well-being. One study of child abuse pediatric clinicians demonstrated a positive association between secondary trauma and burnout.<sup>23</sup> Another study found that pediatricians and trainees caring for patients with suspected abuse and neglect had high average scores of secondary traumatic stress and low average compassion satisfaction scores.<sup>24</sup> When educating trainees and students, mentors must acknowledge this challenging aspect of the work and offer strategies to cope with and mitigate secondary trauma.

One potential strategy to help trainees and students cope with secondary trauma is to debrief after difficult cases—for example, after caring for a child with severe polytrauma or fatal injury, as well as after interactions with families who express anger or frustration toward the medical team. Emotional debriefing may reduce burnout and promote resilience.<sup>25</sup> Debriefing tools used in other care environments, such as the emergency department or the critical care unit, could be employed to help teams process challenging clinical situations or family conversations.<sup>26,27</sup> Our institution's child protection team uses a debriefing tool for difficult interactions, as well as for severe cases or fatalities. It can be helpful to debrief in all cases of child abuse and neglect and to create trauma-informed health care environments for both patients and health care professionals.<sup>24</sup> Additionally, educating trainees on positive coping strategies, providing peer support, promoting self-care, and helping them find hope and meaning in their work may reduce secondary traumatic stress and risk of burnout.<sup>23,28</sup>

### Conclusion

Cases of child abuse and neglect can evoke a range of emotions in health care professionals, especially in inexperienced students and trainees. It is important to educate learners to maintain objectivity, to speak honestly, and to treat patients and their families with compassion and respect. Additionally, it is critical to support students and trainees in cases of child abuse and neglect and to provide strategies to mitigate the effects of secondary trauma through activities such as debriefing.

### References

1. Children's Bureau. *Child Maltreatment 2020*. US Department of Health and Human Services; 2022. Accessed September 23, 2022. <https://www.acf.hhs.gov/cb/report/child-maltreatment-2020>
2. Asnes AG, Leventhal JM. Managing child abuse: general principles. *Pediatr Rev*. 2010;31(2):47-55.
3. Christian CW. Professional education in child abuse and neglect. *Pediatrics*. 2008;122(suppl 1):S13-S17.
4. Ince EE, Rubin D, Christian CW. Parental perceptions of hospital care in children with accidental or alleged non-accidental trauma. *Child Abuse Negl*. 2010;34(6):403-406.
5. Leventhal JM. Thinking clearly about evaluations of suspected child abuse. *Clin Child Psychol Psychiatry*. 2000;5(1):139-147.
6. Child Welfare Information Gateway. About CAPTA: a legislative history. Children's Bureau, US Department of Health and Human Services; 2019. Accessed September 23, 2022. <https://www.childwelfare.gov/pubpdfs/about.pdf>
7. Child Welfare Information Gateway. Mandatory reporters of child abuse and neglect. Children's Bureau, US Department of Health and Human Services; 2019. Accessed September 23, 2022. <https://www.childwelfare.gov/pubPDFs/manda.pdf>

8. Palusci VJ, Botash AS. Race and bias in child maltreatment diagnosis and reporting. *Pediatrics*. 2021;148(1):e2020049625.
9. Lane WG, Rubin DM, Monteith R, Christian CW. Racial differences in the evaluation of pediatric fractures for physical abuse. *JAMA*. 2002;288(13):1603-1609.
10. Wood JN, Hall M, Schilling S, Keren R, Mitra N, Rubin DM. Disparities in the evaluation and diagnosis of abuse among infants with traumatic brain injury. *Pediatrics*. 2010;126(3):408-414.
11. Christian CW. The evaluation of suspected child physical abuse. *Pediatrics*. 2015;135(5):e1337-e1354.
12. Bennett CE, Christian CW. Clinical evaluation and management of children with suspected physical abuse. *Pediatr Radiol*. 2021;51(6):853-860.
13. Stavas N, Paine C, Song L, Shults J, Wood J. Impact of child abuse clinical pathways on skeletal survey performance in high-risk infants. *Acad Pediatr*. 2020;20(1):39-45.
14. Sheets LK, Leach ME, Koszewski JJ, Lessmeier AM, Nugent M, Simpson P. Sentinel injuries in infants evaluated for child physical abuse. *Pediatrics*. 2013;131(4):701-707.
15. Flaherty EG, Sege RD, Griffith J, et al; PROS Network; NMAPedsNet. From suspicion of physical child abuse to reporting: primary care clinician decision-making. *Pediatrics*. 2008;122(3):611-619.
16. Jenny C, Hymel KP, Ritzen A, Reinert SE, Hay TC. Analysis of missed cases of abusive head trauma. *JAMA*. 1999;281(7):621-626.
17. Jones R, Flaherty EG, Binns HJ, et al; Child Abuse Reporting Experience Study Research Group. Clinicians' description of factors influencing their reporting of suspected child abuse: report of the Child Abuse Reporting Experience Study Research Group. *Pediatrics*. 2008;122(2):259-266.
18. Farrell CA, Fleegler EW, Monuteaux MC, Wilson CR, Christian CW, Lee LK. Community poverty and child abuse fatalities in the United States. *Pediatrics*. 2017;139(5):e20161616.
19. Back AL, Arnold RM, Baile WF, Tulskey JA, Fryer-Edwards K. Approaching difficult communication tasks in oncology. *CA Cancer J Clin*. 2005;55(3):164-177.
20. Hashim MJ. Patient-centered communication: basic skills. *Am Fam Physician*. 2017;95(1):29-34.
21. Meadors P, Lamson A, Swanson M, White M, Sira N. Secondary traumatization in pediatric healthcare providers: compassion fatigue, burnout, and secondary traumatic stress. *Omega (Westport)*. 2009;60(2):103-128.
22. Scott SD, Hirschinger LE, Cox KR, McCoig M, Brandt J, Hall LW. The natural history of recovery for the healthcare provider "second victim" after adverse patient events. *Qual Saf Health Care*. 2009;18(5):325-330.
23. Passmore S, Hemming E, McIntosh HC, Hellman CM. The relationship between hope, meaning in work, secondary traumatic stress, and burnout among child abuse pediatric clinicians. *Perm J*. 2020;24:19.087.
24. O'Hara MA, McCann TA, Fan W, Lane MM, Kernie SG, Rosenthal SL. Child abuse taking its toll on the emotional well-being of pediatricians. *Clin Pediatr (Phila)*. 2020;59(4-5):450-457.
25. Osta AD, King MA, Serwint JR, Bostwick SB. Implementing emotional debriefing in pediatric clinical education. *Acad Pediatr*. 2019;19(3):278-282.
26. Mullan PC, Wuestner E, Kerr TD, Christopher DP, Patel B. Implementation of an in situ qualitative debriefing tool for resuscitations. *Resuscitation*. 2013;84(7):946-951.

27. Zinns LE, Mullan PC, O'Connell KJ, Ryan LM, Wratney AT. An evaluation of a new debriefing framework: REFLECT. *Pediatr Emerg Care*. 2020;36(3):147-152.
28. Smith J, Cho R, Martin C, Cory E, Smith T, Shouldice M. Building skills and resilience in child abuse pediatricians: a novel program to address secondary traumatic stress. *Child Abuse Negl*. 2021;117:105082.

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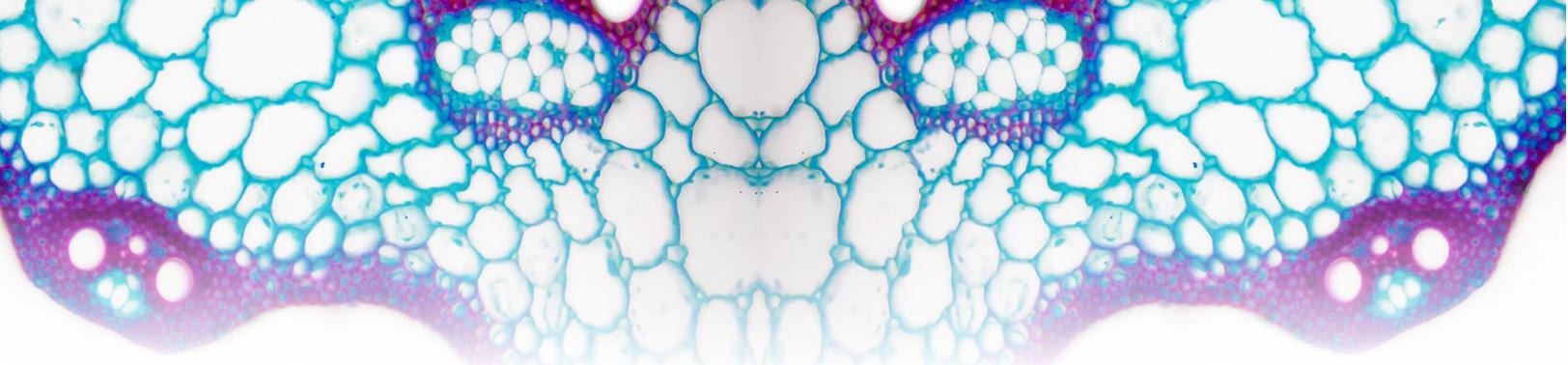
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Dr Bennett reports providing expert witness testimony in cases for which she is subpoenaed, and Dr Christian reports performing medical-legal expert work in child abuse cases.

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## AMA Journal of Ethics®

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### IN THE LITERATURE: PEER-REVIEWED ARTICLE

#### Key Updates to Understanding Roles of Childhood Trauma in Overall Health

Jeremy Weleff, DO and Dawn Potter, PsyD

##### Abstract

While adverse childhood experiences and trauma, including childhood abuse and neglect, have often been viewed from the lens of psychiatry, their influence on physical health, health behaviors, and factors that moderate health now garner more attention. This article reviews recent literature that has changed clinical and social viewpoints on child abuse and neglect and can be used as a primer to better understand (1) influences of child abuse and neglect on physical illness; (2) critical diagnostic advances relevant to persons who have experienced child abuse and neglect; and (3) ethical, research, and practical questions generated by these new understandings.

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##### Trauma's Roles in Health

Increasing attention is being paid to the impact of child abuse and neglect on health. The rapidly growing knowledge base on long-term outcomes of those exposed to child abuse and neglect in the form of both trauma and adverse childhood experiences (ACEs), such as childhood economic hardship,<sup>1</sup> neglect, sexual abuse, emotional abuse, discrimination, racism, household dysfunction, exposure to violence, parental **mental illness**, and parental substance use has warranted this attention.<sup>2</sup> These types of maltreatment have often been viewed only from the lens of psychiatry, but it is now clear that, beyond their impact on mental health, these experiences affect biological mechanisms that influence physical health,<sup>3,4</sup> health behaviors, and other factors that moderate good health, making it a general concern for all of health care and for those invested in improving health outcomes at large.

Given these wide-ranging health impacts, health care systems and individual practitioners must be prepared to evaluate childhood maltreatment-related health concerns. Many clinicians feel unprepared to do this sort of work, and it was likely absent from their training.<sup>5</sup> This article aims to review recent core literature that has broadened medicine's understanding of the forms of child abuse and neglect. It also

provides a primer to better understand (1) the impact of child abuse and neglect on physical health; (2) critical diagnostic advances relevant to those who have experienced ACEs; and (3) the ethical, research, and practical issues that arise from this new understanding of child abuse and neglect.

### **Physical Impact of Child Abuse and Neglect**

In 1998, a Kaiser Permanente survey of adults revealed that ACEs were common among patients undergoing routine medical evaluations and were related to serious health risks and conditions in later life.<sup>6</sup> More specifically, the researchers found that over half of 13 000 respondents had been exposed to at least one ACE, with risk for substance use, suicide attempts, and serious medical conditions—such as ischemic heart disease, cancer, and liver disease—increasing with the breadth of exposure to ACEs. The lifetime health effects of child abuse and neglect have since been researched and characterized in depth.<sup>7</sup>

In 2017, the American Heart Association published a scientific statement outlining the downstream effects of ACEs, which included trauma, on cardiac disease.<sup>8</sup> Increased cardiac disease and cardiac disease risk factors in adults who experienced maltreatment as children are seen in mostly high-income countries.<sup>9,10,11,12,13,14,15,16</sup> This cornerstone publication gave further scientific credence to the critical role of child abuse and neglect in physical health more generally. Specifically, it highlighted that ACEs affect physical health through 3 mechanisms: (1) change in health behaviors (eg, decreased physical activity, tobacco use), (2) biological embedding (eg, inflammation, abnormal endocrine function), and (3) increases in mental health problems. Given this broadened understanding, efforts are needed to mitigate the impact of child abuse and neglect on people's overall health.

### **Diagnostic Advances**

Currently, a patchwork of diagnostic concepts and standard methods of documenting trauma exist. Here, we focus on **posttraumatic stress disorder** (PTSD), which was first included in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)-III* in 1980.<sup>17,18</sup> As a construct, PTSD presents with diverse symptoms, creating diagnostic challenges in clinical work. There are over 630 000 different combinations of symptoms within the primary symptom clusters of PTSD (intrusive, avoidance, cognitive/affective, and arousal) in *DSM-5*.<sup>19,20</sup> This level of heterogeneity has led many to question the validity of PTSD in its current form, and different phenotypes have been suggested based on biological studies and brain imaging.<sup>21</sup> Moreover, it has been argued that existing *DSM-5* diagnostic categories should include a code to specify presence of trauma exposure.<sup>22</sup> The identification of clinically relevant subgroups would contribute to more accurate diagnoses and better-tailored treatment modalities.

Two new diagnoses that are potentially relevant to child abuse and neglect have been proposed: complex PTSD (cPTSD)<sup>23</sup> and developmental trauma disorder (DTD).<sup>24</sup> However, these diagnoses have not been formally included in the *DSM*, seemingly due to ongoing debate about whether they should be separate from PTSD.<sup>25,26</sup> The Table compares criteria for a diagnosis of PTSD and borderline personality disorder (BPD) to these newly proposed constructs.

**Table.** Comparison of PTSD, cPTSD, DTD, and BPD

	PTSD	cPTSD	DTD	BPD
<b>Core criteria</b>	Exposure to actual or threatened death, serious injury, or sexual violence	Exposure to event(s) of an extremely threatening/horrific nature, commonly prolonged/repetitive events from which escape is difficult/impossible	Exposure to repeated & severe interpersonal violence for at least 1 year & disruption in caregiving	Frantic efforts to avoid abandonment
	Intrusive Symptoms (minimum 1/5)	Development of 3 core elements of PTSD (re-experiencing, avoidance, hypervigilance)	Affective & physiological dysregulation symptoms (minimum 2/4)	Unstable and intense relationships
	Avoidance (minimum 1/2)	Severe & pervasive problems with affect regulation	Behavioral or attentional dysregulation symptoms (minimum 3/5)	Identity disturbance
	Negative alterations in cognition & mood (minimum 2/7)	Persistent beliefs about self as diminished, defeated, or worthless with feelings of shame, guilt, or failure related to stressor	Self & relational dysregulation symptoms (minimum 3/6)	Impulsivity
	Negative alterations in arousal & reactivity (minimum 2/6)	Persistent difficulties sustaining relationships/feeling close to others	At least 1 symptom in at least 2 PTSD symptom clusters	Recurrent suicidal/self-harm behavior
				Affect instability
				Chronic feelings of emptiness
				Inappropriate anger
				Transient stress-related paranoid ideation/dissociation (minimum 5/9 of the above)
<b>Comparisons</b>				
Concerns interpersonal or chronic trauma	No	Yes	Yes	No
Interpersonal problems	No	Yes	Yes	Yes
Disturbance of self-regulation or identity	No	Yes	Yes	Yes
Affect Dysregulation	Yes	Yes	Yes	Yes
<b>Diagnostic system</b>	DSM & ICD <sup>20,23</sup>	ICD only <sup>23</sup>	Proposed for inclusion in diagnostic systems <sup>24</sup>	DSM only <sup>20</sup>

Abbreviations: BPD, borderline personality disorder; cPTSD, complex posttraumatic stress disorder; DSM, *Diagnostic and Statistical Manual of Mental Disorders*; DTD, developmental trauma disorder; ICD, *International Classification of Diseases*; PTSD, posttraumatic stress disorder.

While not included in *DSM-5*, cPTSD is recognized in the 11th revision of the *International Classification of Diseases*<sup>23</sup> and was previously under consideration for inclusion in *DSM-IV* as disorders of extreme stress not otherwise specified.<sup>27</sup> It is intended to characterize symptoms experienced by survivors of prolonged or repeated trauma, especially trauma of an interpersonal nature. DTD is also intended to capture sequelae of interpersonal trauma, especially for children and adolescents,<sup>28</sup> as criteria for PTSD are not met by many children affected by abuse and neglect.<sup>22</sup>

Although both cPTSD and DTD require the individual to meet some criteria for PTSD, these diagnostic categories place greater emphasis on the relational impact of trauma. Specifically, DTD requires the person to have experienced a disruption in caregiving and either self or relational dysregulation. cPTSD requires persistent difficulties in feeling close to others or in sustaining relationships. In contrast, while PTSD includes interpersonal symptoms, such as detachment from others and negative beliefs about others, one can meet criteria for the diagnosis without these.

Although having no criteria regarding trauma exposure, the diagnosis of BPD shares symptoms with PTSD, cPTSD, and DTD—namely, affect dysregulation, altered sense of self/identity, and relational issues. The possible role of child abuse and neglect in the development of this condition, as well as evidence of symptom overlap and comorbidity among these conditions, has led experts to conclude that they are related but distinct, creating additional layers of complexity in clinical work.<sup>29</sup>

### **Expanded Understandings**

An understanding of child abuse and neglect that transcends psychiatry and psychology means embracing an increasing amount of complexity and accepting pluralistic approaches to explanations and mechanisms of disease while striving for the highest level of application of our medical understanding of these conditions and related processes.<sup>30</sup> In order to promote justice for those affected by child abuse and neglect across health systems, Teicher et al<sup>22</sup> recently advanced 5 recommendations: (1) that clinicians screen all patients with mental illness for child abuse and neglect, (2) that diagnosis include a code to differentiate between those with abuse and neglect histories and those without, (3) that all treatment trials collect child abuse and neglect data for use as a moderator, (4) that research on biological bases of psychiatric disorders collect child abuse and neglect data, and (5) that concerted efforts be made to reduce child abuse and neglect and prevent development of related disorders in those exposed to it.

For public health professionals, upstream factors that precondition, precipitate, and perpetuate child abuse and neglect must be addressed if we are to effectively prevent serious medical illnesses such as cancer<sup>31</sup> and heart disease.<sup>32</sup> Preventing psychological trauma caused by racial-, ethnic-, gender-, and identity-based violence and victimization, hate crimes, and political violence should become a focal point, and structural factors that can be acted on to prevent trauma should receive more clinical and research attention.<sup>33</sup>

For health care systems and individual clinicians, serious consideration should be given to mechanisms to screen for and treat the sequela of ACEs and trauma, given that the risks and dangers of “therapeutic mislabeling”<sup>34</sup> and misdiagnosis (with the potential for mismanagement) are high. A concerted effort needs to be made to screen patients effectively and empathically (without causing undue harm) while respecting the uniqueness and treatment wishes of each individual, since the extent to which these experiences affect the development, severity, or course of physical and mental illness—let alone how the individual will respond to specific treatments or treatment modalities—is unknown. Once widespread screening for ACEs has been implemented, efforts should be taken to ensure that such screening is thoughtful, considerate, and careful.<sup>35</sup> Because responses to adverse experiences vary widely, some argue that screening for trauma symptoms, rather than for traumatic experiences alone, is preferable because it would identify children who would most benefit from trauma-specific treatment.<sup>36</sup>

Large-scale efforts are underway to improve **trauma-informed care** within primary care and pediatrics.<sup>37,38</sup> Applying updated treatment recommendations for trauma-related conditions remains prudent.<sup>39,40,41</sup> In clinical settings, screening for child abuse and neglect might help target interventions more effectively, and, in research on interventions, exposure to trauma should be regarded as a critical variable.

## References

1. Braveman P, Heck K, Egerter S, Rinki C, Marchi K, Curtis M. Economic hardship in childhood: a neglected issue in ACE studies? *Matern Child Health J*. 2018;22(3):308-317.
2. Finkelhor D, Shattuck A, Turner H, Hamby S. Improving the Adverse Childhood Experiences Study Scale. *JAMA Pediatr*. 2013;167(1):70-75.
3. Min MO, Minnes S, Kim H, Singer LT. Pathways linking childhood maltreatment and adult physical health. *Child Abuse Negl*. 2013;37(6):361-373.
4. Mehta D, Kelly AB, Laurens KR, et al. Child maltreatment and long-term physical and mental health outcomes: an exploration of biopsychosocial determinants and implications for prevention. *Child Psychiatry Hum Dev*. Published online September 29, 2021.
5. Pletcher BA, O'Connor M, Swift-Taylor ME, DallaPiazza M. Adverse childhood experiences: a case-based workshop introducing medical students to trauma-informed care. *MedEdPORTAL*. 2019;15:10803.
6. Felitti VJ, Anda RF, Nordenberg D, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: the Adverse Childhood Experiences (ACE) Study. *Am J Prev Med*. 1998;14(4):245-258.
7. Kendall-Tackett KA. Treating the lifetime health effects of childhood victimization. 2nd ed. Civic Research Institute; 2013.  
<https://www.civicrosearchinstitute.com/toc/LHE%202nd%20TOC.pdf>
8. Suglia SF, Koenen KC, Boynton-Jarrett R, et al. Childhood and adolescent adversity and cardiometabolic outcomes: a scientific statement from the American Heart Association. *Circulation*. 2018;137(5):e15-e28.
9. Pierce JB, Kershaw KN, Kiefe CI, et al. Association of childhood psychosocial environment with 30-year cardiovascular disease incidence and mortality in middle age. *J Am Heart Assoc*. 2020;9(9):e015326.
10. Soares AG, Howe LD, Heron J, et al. How does childhood abuse and neglect influence cardiovascular disease? A sequential causal mediation analysis. *Int J Epidemiol*. 2021;51(2):555-556.
11. Basu A, McLaughlin KA, Misra S, Koenen KC. Childhood maltreatment and health impact: the examples of cardiovascular disease and type 2 diabetes mellitus in adults. *Clin Psychol (New York)*. 2017;24(2):125-139.
12. Chandan JS, Okoth K, Gokhale KM, Bandyopadhyay S, Taylor J, Nirantharakumar K. Increased cardiometabolic and mortality risk following childhood maltreatment in the United Kingdom. *J Am Heart Assoc*. 2020;9(10):e015855.
13. Soares ALG, Hammerton G, Howe LD, Rich-Edwards J, Halligan S, Fraser A. Sex differences in the association between childhood maltreatment and cardiovascular disease in the UK Biobank. *Heart*. 2020;106(17):1310-1316.
14. Power C, Li L, Pinto Pereira SM. An overview of child maltreatment (neglect and abuse) associations with developmental trajectories and long-term outcomes in the 1958 British birth cohort. *Longit Life Course Stud*. 2020;11(4):431-458.
15. Widom CS, Czaja SJ, Bentley T, Johnson MS. A prospective investigation of physical health outcomes in abused and neglected children: new findings from a

- 30-year follow-up. *Am J Public Health*. 2012;102(6):1135-1144.
16. Rogers NT, Power C, Pinto Pereira SM. Child maltreatment, early life socioeconomic disadvantage and all-cause mortality in mid-adulthood: findings from a prospective British birth cohort. *BMJ Open*. 2021;11(9):e050914.
  17. Crocq MA, Crocq L. From shell shock and war neurosis to posttraumatic stress disorder: a history of psychotraumatology. *Dialogues Clin Neurosci*. 2000;2(1):47-55.
  18. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 3rd ed. American Psychiatric Association; 1980.
  19. Galatzer-Levy IR, Bryant RA. 636,120 ways to have posttraumatic stress disorder. *Perspect Psychol Sci*. 2013;8(6):651-662.
  20. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders: DSM-5*. 5th ed. American Psychiatric Publishing; 2013.
  21. Liberzon I. Searching for intermediate phenotypes in posttraumatic stress disorder. *Biol Psychiatry*. 2018;83(10):797-799.
  22. Teicher MH, Gordon JB, Nemeroff CB. Recognizing the importance of childhood maltreatment as a critical factor in psychiatric diagnoses, treatment, research, prevention, and education. *Mol Psychiatry*. 2022;27(3):1331-1338.
  23. 6B41 Complex post traumatic stress disorder. In: *International Classification of Diseases*. 11th rev. World Health Organization; 2022. Accessed September 26, 2022. <https://icd.who.int/browse11/l-m/en#/http://id.who.int/icd/entity/585833559>
  24. Morelli NM, Villodas MT. A systematic review of the validity, reliability, and clinical utility of developmental trauma disorder (DTD) symptom criteria. *Clin Child Fam Psychol Rev*. 2022;25(2):376-394.
  25. Resick PA, Bovin MJ, Calloway AL, et al. A critical evaluation of the complex PTSD literature: implications for DSM-5. *J Trauma Stress*. 2012;25(3):241-251.
  26. van Der Kolk B, Ford JD, Spinazzola J. Comorbidity of developmental trauma disorder (DTD) and post-traumatic stress disorder: findings from the DTD field trial. *Eur J Psychotraumatol*. 2019;10(1):1562841.
  27. Herman JL. Complex PTSD: a syndrome in survivors of prolonged and repeated trauma. *J Trauma Stress*. 1992;5(3):377-391.
  28. Ford JD, Spinazzola J, van der Kolk B, Grasso DJ. Toward an empirically based developmental trauma disorder diagnosis for children: factor structure, item characteristics, reliability, and validity of the developmental trauma disorder semi-structured interview. *J Clin Psychiatry*. 2018;79(5):17m11675.
  29. Ford JD, Courtois CA. Complex PTSD and borderline personality disorder. *Borderline Personal Disord Emot Dysregul*. 2021;8(1):16.
  30. American Medical Association. AMA principles of medical ethics. *Code of Medical Ethics*. Adopted June 1957. Revised June 2001. Accessed December 6, 2022. <https://code-medical-ethics.ama-assn.org/principles>
  31. Fuller-Thomson E, Brennenstuhl S. Making a link between childhood physical abuse and cancer. *Cancer*. 2009;115(14):3341-3350.
  32. Suglia SF, Koenen KC, Boynton-Jarrett R, et al. Childhood and adolescent adversity and cardiometabolic outcomes: a scientific statement from the American Heart Association. *Circulation*. 2018;137(5):e15-e28.
  33. Magruder KM, McLaughlin KA, Elmore Borbon DL. Trauma is a public health issue. *Eur J Psychotraumatol*. 2017;8(1):1375338.
  34. Boissy AR, Ford PJ. A touch of MS: therapeutic mislabeling. *Neurology*. 2012;78(24):1981-1985.
  35. Finkelhor D. Screening for adverse childhood experiences (ACEs): cautions and

- suggestions. *Child Abuse Negl.* 2018;85:174-179.
36. Keeshin B, Byrne K, Thorn B, Shepard L. Screening for trauma in pediatric primary care. *Curr Psychiatry Rep.* 2020;22(11):60.
  37. Green BL, Saunders PA, Power E, et al. Trauma-informed medical care: CME communication training for primary care providers. *Fam Med.* 2015;47(1):7-14.
  38. Duffee J, Szilagy M, Forkey H, Kelly ET. Trauma-informed care in child health systems. *Pediatrics.* 2021;148(2):e2021052579.
  39. Ford JD, Courtois CA, Herman JL, van der Kolk BA. *Treating Complex Traumatic Stress Disorders in Adults: Scientific Foundations and Therapeutic Models.* 2nd ed. Guilford Publications; 2020.
  40. Martin A, Naunton M, Kosari S, Peterson G, Thomas J, Christenson JK. Treatment guidelines for PTSD: a systematic review. *J Clin Med.* 2021;10(18):4175.
  41. Stone MH. Borderline personality disorder: clinical guidelines for treatment. *Psychodyn Psychiatry.* 2022;50(1):45-63.

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## AMA Journal of Ethics®

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### HEALTH LAW: PEER-REVIEWED ARTICLE

#### ***McGirt v Oklahoma* and What Clinicians Should Know About Present-Day Child Abuse and Legacies of Forced Migration**

Amy D. Hendrix-Dicken, MA, Sarah J. Passmore, DO, Michael A. Baxter, DO, and Lauren K. Conway, DO

##### **Abstract**

In 1997, Jimcy McGirt was convicted by the State of Oklahoma for sex crimes against a minor. McGirt appealed his conviction, citing that Oklahoma lacked jurisdiction over the case due to his tribal citizenship, since the crime took place on tribal territory. On July 9, 2020, the Supreme Court of the United States (SCOTUS) reversed the Oklahoma Court of Criminal Appeals' original decision for the case, citing that Congress had failed to disestablish reservations with regard to the Major Crimes Act, which gave the federal government jurisdiction over major felony crimes perpetrated by Native Americans on reservations. This ruling has already caused sweeping changes in the investigations and prosecutions of child maltreatment in eastern Oklahoma, as such cases may fall under the jurisdiction of federal agencies or tribal law enforcement. This article details the historic significance of the decision and the experiences of 3 child abuse pediatricians working as part of a multidisciplinary team while jurisdictional changes were implemented following the SCOTUS ruling.

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##### **Forced Migration and Child Abuse**

Mistreatment of Indigenous peoples happened long before the creation of the United States and has continued to the present day. In the 1830s, the ruling of the Supreme Court of the United States (SCOTUS) in *Worcester v Georgia*, which held that states could not impose regulations on Native American lands, was openly defied by then-president Andrew Jackson, making way for the forced migration of tribes—including Cherokee, Creek, Chickasaw, Choctaw, and Seminole peoples—to Oklahoma.<sup>1,2</sup> During these removals, each tribe was promised lands in the West, via treaties.<sup>3,4,5</sup>

Knowledge of this history is invaluable for understanding the implications of SCOTUS' decision in *McGirt v Oklahoma*—a case involving sex crimes committed against a minor

on tribal land—for child maltreatment cases in Oklahoma.<sup>6,7</sup> This article details the significance of this decision and the experiences of 3 child abuse pediatricians (CAPs) working as part of a multidisciplinary team when jurisdictional changes that followed the *McGirt* decision first influenced child maltreatment cases' prosecution.

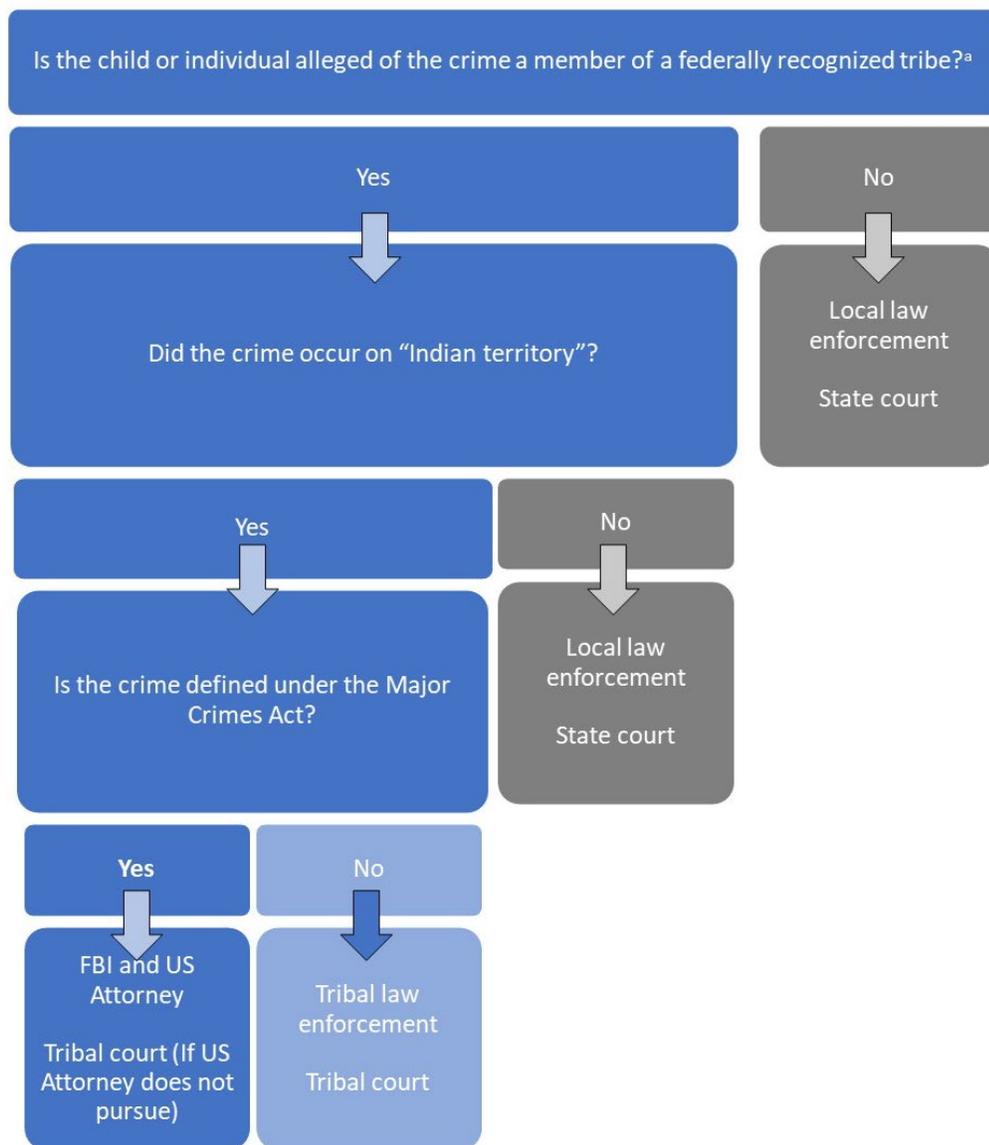
### ***McGirt* Overview**

Jimcy McGirt was convicted by the State of Oklahoma for first-degree rape by instrumentation, lewd molestation, and forcible sodomy in Wagoner, Oklahoma, in 1997.<sup>6,8,9</sup> McGirt, a member of the Muscogee (Creek) and Seminole nations, first appealed his conviction to the Oklahoma Court of Criminal Appeals. After the court declined to review his case, he petitioned SCOTUS, arguing that the state lacked jurisdiction over the case due to his status as a tribal citizen, since the crime took place in what the US federal government calls “Indian Country” (eg, territory belonging to a tribal nation).<sup>6</sup> The State of Oklahoma argued that the Creek Reservation was disestablished by Congress through federal statutes enacted to further strip the Creek government and its people of their rights after they settled in Oklahoma.<sup>6</sup>

On July 9, 2020, SCOTUS reversed the Oklahoma Court of Criminal Appeals' decision, citing that Congress had failed to disestablish Indian reservations with regard to the Major Crimes Act, which gave the *federal* government—not *state courts* like the one that convicted McGirt—jurisdiction over major felony crimes perpetrated by Native Americans on reservations.<sup>6,8,10</sup> In his majority opinion, Justice Neil Gorsuch cited the 1832 Treaty With the Creeks, Article XIV, which states: “[no] State or Territory [shall] ever have a right to pass laws for the government of such Indians, but they shall be allowed to govern themselves.”<sup>6</sup> He further contended that Congress had never formally disestablished the Creek Reservation (by divesting it of its land and diminishing its boundaries) regardless of the number of promises broken by the federal government to the tribe.<sup>6</sup> This ruling reaffirmed the commitment the United States made to tribes when the parties signed treaties hundreds of years ago, while also opening the door to sweeping changes in the investigation and prosecution of child maltreatment-related crimes in eastern Oklahoma. As of April 2022, the *McGirt* decision applies to the Creek, Cherokee, Choctaw, Chickasaw, Seminole, and Quapaw nations.<sup>11</sup>

The SCOTUS *McGirt* decision fundamentally changed the way cases falling under the Major Crimes Act are investigated. Previously, maltreatment crimes were prosecuted primarily by the State of Oklahoma regardless of the crime's location. Now, when a major crime (eg, homicide, **rape**, maltreatment) occurs, local law enforcement agencies, who remain the immediate response group for crimes, generate a police report looking at the factors outlined in the Figure to determine if the investigation will stay with local law enforcement or should be transferred to the Federal Bureau of Investigation (FBI) and the US Attorney's Office or to tribal law enforcement. In some cases, in which the jurisdiction is unknown, the investigation will be concurrent with all 3 parties.

**Figure.** Jurisdiction Decisions After the US Supreme Court *McGirt* Decision



Adapted from Mckkanen AQ.<sup>12</sup>

<sup>a</sup> In some cases, young children may be eligible for tribal enrollment but not be officially enrolled with a tribe. When one or more parent is an enrolled member of a tribe and the child is eligible for enrollment, this ruling still applies. On June 29, 2022, SCOTUS ruled in favor of Oklahoma in *Oklahoma v Castro-Huerta*,<sup>13</sup> further complicating jurisdictional procedures when a non-Native individual is alleged to have committed a crime on a member of a federally recognized tribe on Indian territory. Those changes are not included within this figure.

Unlike legislative processes, the *McGirt* decision did not come with a case processing framework, leaving tribal governments and multidisciplinary teams to navigate these unprecedented jurisdictional changes. Tribal governments have relied on the FBI and US Attorney’s Office to handle cases, in part because the Indian Civil Rights Act severely limited the sentencing power of tribal courts.<sup>14</sup> This reliance is not without issue, as federal agents’ and prosecutors’ refusal to become involved in cases has been a point of contention among tribes and their members for some time.<sup>15</sup> Tribal members’ mistrust of the federal government’s handling of cases is not without merit, given the **historical mistreatment** orchestrated by the federal government that Indigenous peoples have endured, including genocide and ethnocide.

### **Child Abuse Pediatrics After *McGirt***

The Tulsa County Children’s Advocacy Center (CAC) is located in the second-largest city in Oklahoma, which is one area that has been greatly affected by the SCOTUS *McGirt* decision. Tulsa County contains part of the Cherokee Nation reservation in its northern half and part of the Muscogee (Creek) Nation reservation in its southern half. In 2021, 18.45% of the 1767 children utilizing services at the CAC were Native American (S. Beilke, written communication, January 18, 2022). The CAC is home to the Tulsa County Multidisciplinary Team, a team created under a State of Oklahoma statute to investigate suspected child maltreatment.<sup>16,17</sup> The team includes local, federal, and tribal law enforcement agencies, federal and state prosecutors, forensic interviewers, social workers, and CAPs.<sup>16</sup>

*Jurisdictional change.* The unprecedented nature of the SCOTUS *McGirt* decision and its lack of processing framework have created unique challenges. Multidisciplinary teams involved in child maltreatment investigations in Oklahoma were not prepared for the seismic shift in cases and workflow. While the CAC’s client database was not created to track jurisdiction, the center typically saw less than 10 cases of child maltreatment per year involving the FBI and/or tribal or federal courts before the *McGirt* decision (B. Sarah, written communication, April 22, 2022). That number has risen into the hundreds since then, highlighting the impact of jurisdictional changes (B. Sarah, written communication, April 22, 2022).

*Overwhelming case numbers.* After the *McGirt* decision, the FBI faced unprecedented caseloads and lacked the workforce to investigate; as such, local law enforcement was deputized under the federal government.<sup>18,19</sup> Although federal prosecutors and FBI agents were sent to Oklahoma, most federal investigators were only there for 6 to 12 weeks.<sup>18</sup> This period of time did not allow investigators to become familiar with the workings of maltreatment investigations, the geography of Oklahoma, the inner workings of the child abuse multidisciplinary team, or the cultural considerations of working with tribal authorities. All of these factors have played a significant part in the disruption of investigative processes.

*Evaluation delay.* Of this paper’s 4 authors, 3—M.A.B., S.J.P, and L.K.C—have practiced child abuse pediatrics in northeastern Oklahoma. Based on the experiences of CAPs working in eastern Oklahoma, the jurisdictional changes related to the SCOTUS *McGirt* decision initially resulted in team members changing for some cases, which led to a delay in case investigations. New team members, in many cases, had not previously been involved in child maltreatment investigations. In addition to new investigators, political power struggles playing out in the courts regarding jurisdiction<sup>20,21</sup> also considerably affected the functioning of the team.

### **Negotiating Delays Caused by *McGirt***

The CAPs have responded to these challenges by providing education to new team members and advocating for the needs of the children they serve. The education focused on the core functions of every member’s role and what is required of new team members for those roles to be fulfilled. During the 18 months following the SCOTUS *McGirt* decision, the CAPs held continuing education training sessions on the medical aspects of child maltreatment for staff of both the Eastern and the Northern District US Attorney’s Offices, which included federal prosecutors, FBI agents, other Department of Justice employees, as well as for social workers and tribal police departments. These trainings, which were approved by the Council on Law Enforcement Education and

Training (CLEET), consisted of PowerPoint lectures with handouts. An additional CLEET-approved training delivered through a partnership with the Oklahoma Commission on Children and Youth was given to the Assistant US Attorney's Office. The Tulsa County Multidisciplinary Team has also provided these groups with protocol training, which included discussions of how each agency functions within the CAC.

Since the SCOTUS *McGirt* decision applies to Native Americans who either are alleged to have committed a crime or have had a crime committed against them, the implications of the decision are wide-ranging and apply to the general public. It is imperative that other members of the multidisciplinary team understand the risks associated with and ramifications of delayed evaluations of child maltreatment. Based on the authors' experiences, it is crucial that investigations be handled in a timely manner. Early and comprehensive training for new federal and tribal team members is recommended. Additionally, child protective service workers' and federal investigators' joint response is vital for the safety and well-being of children. When investigations aren't conducted in a timely manner, children may be left vulnerable to further maltreatment, increasing their risk of morbidity and mortality. Delays could also result in a child being placed in a foster home for a prolonged period of time.

The authors urge others working in maltreatment-related fields—particularly in areas of the United States that may one day see jurisdictional changes—to prepare appropriate case processing and training frameworks to prevent delays in investigations. Timely and appropriate preparation for potential jurisdictional changes has the potential to increase the safety and welfare of all children. As such, medical professionals who interact with children they suspect of being maltreated should be prepared to educate investigators with whom they interact.

## References

1. Editors of Encyclopaedia Britannica. *Worcester v Georgia*. Britannica. Updated October 2, 2022. Accessed March 4, 2021. <https://www.britannica.com/topic/Worcester-v-Georgia>
2. Prine Pauls E. Trail of Tears. Britannica. Updated October 6, 2022. Accessed March 4, 2021. <https://www.britannica.com/event/Trail-of-Tears>
3. Treaty with the Cherokee, 1835. In: Kappler CJ, ed. *Laws and Treaties*. Vol 2. Government Printing Office; 1904:439-449.
4. Treaty with the Chickasaw: 1830, unratified. Avalon Project, Yale Law School. Accessed March 4, 2021. [https://avalon.law.yale.edu/19th\\_century/nt008.asp](https://avalon.law.yale.edu/19th_century/nt008.asp)
5. Treaty with the Creeks, 1832. Smithsonian National Museum of the American Indian. Accessed March 4, 2021. <https://americanindian.si.edu/nk360/removal-muscogee/transcription-creek-treaty.html>
6. *McGirt v Oklahoma*, 140 S Ct 2452 (2020).
7. TeSelle DK. Review of *McGirt v Oklahoma*—how the Supreme Court and Justice Gorsuch's revolutionary textualism brought America's "Trail of Tears" promise to the Creek Nation back from the dead. *Natl Law Rev*. 2020;10(218). Accessed March 4, 2021. <https://www.natlawreview.com/article/review-mcgirt-v-oklahoma-how-supreme-court-and-justice-gorsuch-s-revolutionary>
8. *McGirt v Oklahoma*. Ballotpedia. Accessed March 5, 2021. [https://ballotpedia.org/McGirt\\_v.\\_Oklahoma](https://ballotpedia.org/McGirt_v._Oklahoma)
9. Jimcy McGirt sentenced to life imprisonment. US Attorney's Office Eastern District of Oklahoma. August 30, 2021. Accessed February 25, 2022.

- <https://www.justice.gov/usao-edok/pr/jimcy-mcgirt-sentenced-life-imprisonment>
10. The Major Crimes Act—18 USC §1153. US Department of Justice Archives. Updated January 22, 2020. Accessed April 25, 2022. <https://www.justice.gov/archives/jm/criminal-resource-manual-679-major-crimes-act-18-usc-1153>
  11. Herrera A. Supreme Court lets ruling stand on “*McGirt v Oklahoma*” retroactivity; no decision yet on reconsideration. *KOSU*. January 10, 2022. Accessed February 1, 2022. <https://www.kosu.org/local-news/2022-01-10/u-s-supreme-court-lets-prior-court-ruling-stand-on-mcgirt-v-oklahoma-retroactivity-no-decision-yet-on-reconsideration>
  12. Mikkanen AQ. Indian Country criminal jurisdictional chart. US Department of Justice; 2020. Accessed March 3, 2021. <https://www.justice.gov/usao-wdok/page/file/1300046/download>
  13. Fletcher MLM. In 5-4 ruling, court dramatically expands the power of states to prosecute crimes on reservations. *SCOTUSblog*. June 29, 2022. Accessed October 21, 2022. <https://www.scotusblog.com/2022/06/in-5-4-ruling-court-dramatically-expands-the-power-of-states-to-prosecute-crimes-on-reservations/>
  14. SANE Program development and operation guide. Office for Victims of Crime Training and Technical Assistance Center. Accessed March 5, 2021. <https://www.ovcttac.gov/saneguide/legal-and-ethical-foundations-for-sane-practice/tribal-law/>
  15. Lussenhop J. The woman in search of Indian Country’s missing. *High Country News*. March 25, 2019. Accessed March 2, 2021. <https://www.hcn.org/articles/tribal-affairs-the-woman-who-searches-for-indian-countrys-missing>
  16. Multidisciplinary team. Child Abuse Network. July 22, 2019. Accessed February 1, 2022. <https://www.childabusenetwork.org/who-we-are/multidisciplinary-team/>
  17. 2016 Oklahoma Statutes: Title 10A. Children and Juvenile Code §10A-1-9-102. Multidisciplinary teams—intervention in reports of abuse or neglect—duties. Justia US Law. Accessed February 25, 2022. <https://law.justia.com/codes/oklahoma/2016/title-10a/section-10a-1-9-102/>
  18. Oklahoma FBI case volume unprecedented. Federal Bureau of Investigation. July 8, 2021. Accessed April 26, 2022. <https://www.fbi.gov/news/stories/oklahoma-fbi-case-volume-unprecedented-070821>
  19. *McGirt* misconceptions. *Biskinik*. June 2021:2. Accessed September 9, 2022. <https://www.choctawnation.com/wp-content/uploads/2022/05/jun2021-biskinik.pdf>
  20. Brief for cities of Tulsa and Owasso, Oklahoma, as amici curiae supporting petitioner, *State of Oklahoma v Victor Manuel Castro-Huerta*, (2022) (No. 21-429). October 21, 2021. Accessed September 20, 2022. [https://www.oag.ok.gov/sites/g/files/gmc766/f/documents/2021/2021.10.21\\_amicus\\_brief\\_of\\_tulsa\\_and\\_owasso.pdf](https://www.oag.ok.gov/sites/g/files/gmc766/f/documents/2021/2021.10.21_amicus_brief_of_tulsa_and_owasso.pdf)
  21. Howe A. Justices will review scope of *McGirt* decision, but won’t consider whether to overturn it. *SCOTUSblog*. January 21, 2022. Accessed February 1, 2022. <https://www.scotusblog.com/2022/01/justices-will-review-scope-of-mcgirt-decision-but-wont-consider-whether-to-overturn-it/>

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**POLICY FORUM: PEER-REVIEWED ARTICLE**

**What the COVID-19 Pandemic Teaches US About Pediatric Iatrogenic Risk**

Katherine Pumphrey, MD, MHA and Jessica Hart, MD, MHQS

**Abstract**

Iatrogenic morbidity and mortality are pediatric public health risks. This article considers how the COVID-19 pandemic illuminates these risks, as clinicians have been forced to navigate increased diagnostic uncertainty and changes to pediatric health care systems, including closures, limited staffing, and new infection control guidelines.

**Diagnostic Uncertainty and Inequity**

Patient harm resulting from treatment by a member of the medical team is referred to as iatrogenesis. This harm may be secondary to an adverse outcome of evaluation or treatment, or it may be due to medical error<sup>1,2,3</sup>; both iatrogenic morbidity and mortality are associated with medical error.<sup>4</sup> Over the last two-and-a-half years, the COVID-19 pandemic has resulted in increased diagnostic uncertainty and diagnostic error and, therefore, an increased risk of iatrogenic morbidity and mortality for certain populations.<sup>5</sup> More specifically, the COVID-19 pandemic highlighted iatrogenic morbidity and mortality as public health risks for pediatric patients.

Throughout the COVID-19 pandemic, physicians were forced to navigate diagnostic uncertainty. Physicians practiced within a rapidly changing health care system (eg, facility closures, limited staffing, telehealth delivery) while experiencing increased fatigue and stress, as well as emotionally charged scenarios. This changing environment resulted in increased opportunities for diagnostic error, defined by the National Academy of Medicine as “the failure to (a) establish an accurate and timely explanation of the patient’s health problem(s) or (b) communicate that explanation to the patient.”<sup>6</sup> Diagnostic error increases risk of iatrogenic morbidity and mortality, secondary to availability bias, diagnostic momentum, and premature closure in the diagnostic process.<sup>7,8</sup> For example, the diagnosis of COVID-19 for pediatric patients was complicated by multisystem inflammatory syndrome in children (MIS-C), a postinflammatory disease related to SARS-CoV-2 infection, which presents similarly to severe pediatric diseases, including bacterial sepsis, toxin-mediated disease, and viral syndromes.<sup>7</sup> Referred to as the “COVID trap,” diagnostic error during the COVID-19 pandemic was identified by Fatemi and Coffin as an especially salient cause of preventable harm in a series of pediatric cases.<sup>7</sup>

## Diagnostic Error as a Source of Iatrogenic Harm to Children

Although highlighted during the COVID-19 pandemic, diagnostic error is not new and is estimated to account for 5% to 15% of diagnoses.<sup>9,10</sup> Previous work has demonstrated that a significant number of admissions to pediatric intensive care units (PICUs) were due to iatrogenic events, with diagnostic error being identified as one area with potential for improvement.<sup>11,12</sup> Furthermore, diagnostic error has been identified as a priority research topic by the Children's Hospitals' Solutions for Patient Safety Network, with experts noting a lack of large, high-quality pediatric studies on the subject.<sup>10,13</sup>

Although diagnostic error continues to be a common—and often serious—risk to patients, unlike other foci of patient safety, such as health care-associated infections or medication errors, few gains have been made, perhaps because diagnostic error may be more challenging to address via a systems solution. Nevertheless, researchers must be willing to examine the complex, multifaceted diagnostic process to reduce diagnostic error. This examination will require the health care system to ensure a culture of psychological safety, as physicians will need to discuss their own role in contributing to diagnostic error via **cognitive errors**. Recently, researchers have identified frameworks for improving reporting of diagnostic error, as it is believed that physician reporting could be a promising method for identifying risks of diagnostic error.<sup>14,15</sup> However, reducing diagnostic error remains an uphill battle, as a culture of fear and low psychological safety still exists within many health care organizations.<sup>15</sup> Until we can address these issues, diagnostic error is likely to continue.

## Conclusion

In 2019, Congress authorized \$2 million for the Agency for Healthcare Research and Quality to investigate and solve the problem of diagnostic errors.<sup>16</sup> The timing of the COVID-19 pandemic likely impeded this research, although it also highlighted why this work may be more important than ever before. In 1999, the Institute of Medicine's report, *To Err is Human: Building A Safer Health System*, challenged us to build a safer health care system<sup>4</sup>; however, **pediatric iatrogenic harm** continues to occur commonly without clear evidence of improvement.<sup>17</sup> A changing health care landscape in the setting of the COVID-19 pandemic highlighted the ongoing risk of pediatric iatrogenic morbidity and mortality due to diagnostic error. However, before diagnostic error can be reduced, physicians must feel safe addressing their own role in contributing to diagnostic errors so that the diagnostic process can be improved.

## References

1. Silber TJ, Hilliard MA. Iatrogenesis: ethical and legal aspects. *Adolesc Med State Art Rev*. 2011;22(2):289-300, x-xi.
2. Sharpe VA, Faden AI. *Medical Harm: Historical, Conceptual, and Ethical Dimensions of Iatrogenic Illness*. Cambridge University Press; 1998.
3. Matlow A, Stevens P, Harrison C, Laxer RM. Disclosure of medical errors. *Pediatr Clin North Am*. 2006;53(6):1091-1104.
4. Kohn LT, Corrigan JM, Donaldson MS, eds; Institute of Medicine. *To Err Is Human: Building a Safer Health System*. National Academy Press; 2000.
5. Muhrer JC. Risk of misdiagnosis and delayed diagnosis with COVID-19. *Nurse Pract*. 2021;46(2):44-49.
6. Balogh EP, Miller BT, Ball JR, eds; Institute of Medicine. *Improving Diagnosis in Health Care*. National Academies Press; 2015.
7. Fatemi Y, Coffin S. The COVID trap: pediatric diagnostic errors in a pandemic world. *Diagnosis (Berl)*. 2021;8(4):525-531.

8. Camporesi A, Díaz-Rubio F, Carroll CL, González-Dambrauskas S. Protecting children from iatrogenic harm during COVID19 pandemic. *J Paediatr Child Health*. 2020;56(7):1010-1012.
9. Isparo AJ, Patel SJ, Warner DC, et al. Declaring uncertainty: using quality improvement methods to change the conversation of diagnosis. *Hosp Pediatr*. 2021;11(4):334-341.
10. Marshall TL, Rinke ML, Olson APJ, Brady PW. Diagnostic error in pediatrics: a narrative review. *Pediatrics*. 2022;149(suppl 3):e2020045948D.
11. Reed RC, Buchino JJ. Pediatric iatrogenic deaths. In: Collins KA, Byard RW, eds. *Forensic Pathology of Infancy and Childhood*. Springer; 2014:775-805.
12. Salvini R, Frey B. Iatrogenic events contributing to paediatric intensive care unit admission. *Swiss Med Wkly*. 2021;151:w20414.
13. Hoffman JM, Keeling NJ, Forrest CB, et al. Priorities for pediatric patient safety research. *Pediatrics*. 2019;143(2):e20180496.
14. Marshall TL, Isparo AJ, Le M, et al. Increasing physician reporting of diagnostic learning opportunities. *Pediatrics*. 2021;147(1):e20192400.
15. Unal A, Seren S. Medical error reporting attitudes of healthcare personnel, barriers and solutions: a literature review. *J Nurs Care*. 2016;5(6):377.
16. Brady J. With increased funding, AHRQ to explore scope and causes of diagnostic errors. Agency for Healthcare Research and Quality blog. March 25, 2019. Accessed July 8, 2022.  
<https://www.ahrq.gov/news/blog/ahrqviews/diagnostic-errors-exploration.html>
17. Stockwell DC, Landrigan CP, Toomey SL, et al. Adverse events in hospitalized pediatric patients. *Pediatrics*. 2018;142(2):e20173360.

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**MEDICINE AND SOCIETY: PEER-REVIEWED ARTICLE**

**How Should Clinicians and Health Care Organizations Promote Equity in Child Abuse and Neglect Suspicion, Evaluation, and Reporting?**

Wendy G. Lane, MD, MPH and Rebecca R. Seltzer, MD, MHS

**Abstract**

Victims of child abuse and neglect come from every racial, ethnic, and socioeconomic background, yet clinical evaluation, reporting to child protective services, and responses to reports inequitably harm Black children and malign families of color. Racial bias and inequity in suspicion, reporting, and substantiation of abuse and neglect and in services offered and delivered, foster care placement, and criminal prosecution are widely documented. In response, clinicians and health care organizations should promote equity by educating clinicians about racial bias, standardizing evaluation using clinical decision support tools, and working with policy makers to support prevention services. If we decide that it is ethically justifiable for clinicians to err on the side of overreporting, we must ensure fair distribution of associated benefits and harms among all children and families.

**Vulnerability**

The term *vulnerable* is often used to refer to a population at risk of being harmed and worthy of society's protection.<sup>1</sup> Children are inherently vulnerable due to their dependency on others to survive and flourish.<sup>2</sup> This dependency puts them at risk of maltreatment, which includes neglect, abuse, and exploitation. States' mandated reporter laws, which require clinicians to report suspected abuse and neglect to child protective services (CPS), were created as a way to protect children from such harm. Kim et al estimate that over one-third (37%) of all US children experience a CPS investigation by 18 years of age; the rates are higher for African American children (53%) and lower for Asians/Pacific Islanders (10%).<sup>3</sup> While the benefit of protecting a child from abuse and neglect is clear, the harms of over- vs underreporting must also be considered, particularly when certain harms are experienced disproportionately among children from certain racial and ethnic groups.

Unwarranted reports—one consequence of overreporting—not only threaten the therapeutic relationship between the patient or family and clinician but also can result in significant emotional and financial hardships for children and families, including traumatic separation, stigmatization due to CPS involvement, missed workdays, and legal costs associated with the investigation.<sup>4,5</sup> Such reports also increase the workload

of already overburdened child welfare workers, creating a barrier to identifying and addressing true cases of abuse and neglect or arranging support services for families.<sup>5,6,7</sup> Even if a report is unwarranted, children are at risk of both removal from their families and longer-term harms of foster care due to the bias that exists at every step of the child welfare decision-making process. Racial and ethnic differences have been identified in acceptance rates of reports for investigative response, substantiation of maltreatment, referral to services, and out-of-home placement.<sup>8,9,10,11</sup> If we decide that these known harms of overreporting are ethically justifiable due to the benefit of protecting children from further maltreatment, we must ensure that the benefits and harms are fairly distributed among all children and families.

### Inequity in Suspicion, Evaluation, and Reporting

Currently, clinicians are taught to report when they have reason to suspect that abuse or neglect has occurred. Yet, of 3.9 million referrals to CPS involving 7 million children, only 618 000 (15.8%) children were substantiated as victims of abuse or neglect in 2020.<sup>12</sup> While CPS findings do not identify all victims, and while many families receive services without a formal finding, there is nonetheless a notable margin of error in rates of reporting and substantiation of maltreatment. In particular, national child welfare data show higher rates of abuse and neglect reporting and substantiation among underrepresented minority families, leading some to conclude that minority children are more likely to be abused or neglected than White children.<sup>12</sup> However, research that includes children with suspected abuse and neglect who are not reported to CPS has shown either that there are no differences in rates of abuse and neglect by race or ethnicity or that the differences depend on socioeconomic status.<sup>13,14</sup> These data indicate that a clinician’s decision to evaluate and report suspected abuse and neglect is influenced by factors other than the actual presence of abuse or neglect. Implicit **bias and racism** have been postulated to explain these differences, although evidence from multiple research studies examining racial or ethnic disparities in evaluation and reporting of child abuse and neglect is not entirely consistent (see Table).<sup>9,10,15,16,17,18,19,20</sup>

**Table.** Research Studies Examining Child Maltreatment Disparities

Reference	Step in process	Type of Injury	Age	Racial/ethnic and class disparities
Hymel (2018) <sup>15</sup>	Evaluation	AHT	0-3 years	Black and Hispanic infants with low likelihood of AHT were more likely to be evaluated than White cohorts. Findings limited to 2 of 18 hospital sites.
	Reporting	AHT	0-3 years	Black and Hispanic infants with low likelihood of AHT were more likely to be reported than White cohorts. Findings limited to 2 of 18 hospital sites.
Jenny (1998) <sup>16</sup>	Diagnosis	AHT	0-3 years	Diagnosis of AHT more likely to be missed in White children than children of color.
Johnson (2007) <sup>9</sup>	Substantiation	All types	All ages	<ul style="list-style-type: none"> <li>Increased likelihood of substantiation for African-American, American Indian, and Asian/Pacific Islander children compared to White children</li> <li>No difference in substantiation between Hispanic and non-Hispanic children.</li> </ul>
	Referral to services	All types	All ages	<ul style="list-style-type: none"> <li>Increased likelihood of referral for multiracial children compared to White children.</li> <li>No difference in referral rates between Hispanic and non-Hispanic children.</li> </ul>
	Out-of-home placement	All types	All ages	<ul style="list-style-type: none"> <li>Fewer placements for African-American than White children.</li> <li>More placements for American Indian than White children.</li> <li>No differences in placement rates between Hispanic and non-Hispanic children.</li> </ul>

Keenan (2008) <sup>17</sup>	Prosecution	AHT	0-2 years	Minority perpetrators more likely to receive severe sentence than White perpetrators.
Lane (2002) <sup>18</sup>	Evaluation	Fracture	0-3 years	Minority children aged 1-3 years more likely to have skeletal survey than White cohorts.
	Diagnosis/reporting	Fracture	0-3 years	Minority children aged 1-3 years more likely to be reported than White cohorts.
Putnam-Hornstein (2013) <sup>10</sup>	Reporting	All types	0-3 years	<ul style="list-style-type: none"> <li>Black children more likely to be reported than White children overall, but Black children receiving public health insurance less likely to be reported than White cohorts.</li> <li>Foreign-born Hispanic children less likely to be reported than White children; US-born Hispanic children more likely to be reported than White children. Among children receiving public health insurance, all Hispanic children had lower likelihood of being reported than White children.</li> </ul>
	Substantiation	All types	0-5 years	<ul style="list-style-type: none"> <li>Black children more likely to be substantiated than White children.</li> <li>Hispanic children less likely to be substantiated than White children.</li> </ul>
	Out-of-home placement	All types	0-5 years	<ul style="list-style-type: none"> <li>Black children more likely to be removed than White children.</li> <li>Hispanic children less likely to be removed than White children.</li> </ul>
Putnam-Hornstein (2016) <sup>19</sup>	Reporting	SEN	0-28 days	Black and Hispanic infants equally likely or less likely to be reported than White infants.
Wood (2010) <sup>20</sup>	Evaluation	AHT	0-1 year	<ul style="list-style-type: none"> <li>Infants with public or no insurance more likely to receive skeletal survey than those with private insurance.</li> <li>Effect modified by race, with a greater performance difference for White infants than for Black or Hispanic infants.</li> </ul>
	Diagnosis	AHT	0-1 year	White infants with skeletal survey more likely to be diagnosed with abuse than Hispanic and Black infants.

Abbreviations: AHT, abusive head trauma; SEN, substance exposed newborn.

Child abuse and neglect identification bias can occur when minority children are overidentified—or when White children are underidentified—as victims. One of the first to describe this bias in the medical literature was Jenny et al, who found that the diagnosis of abusive head trauma (AHT) was more likely to be missed in White children than in Black children.<sup>16</sup> Relatedly, Lane et al found that minority children aged 1 to 3 years were nearly 9 times as likely to be evaluated for abuse with a skeletal survey than White children after adjusting for insurance status, likelihood of abuse, and appropriate ordering of skeletal survey and that minority children at least 12 months old with accidental injuries were more than 3 times as likely to be reported to CPS than White children.<sup>18</sup> Using a multicenter administrative database of children’s hospitals, Wood et al found that, while Black children were more likely than White children to be evaluated with skeletal surveys, White children with skeletal surveys were more likely to be diagnosed with abuse.<sup>20</sup> These findings suggest a potential higher threshold for ordering a skeletal survey in White children.<sup>20</sup> More recently, Hymel et al found that minority children with low risk for AHT were more frequently screened for occult injury (ie, skeletal survey, retina exam) and reported to CPS than White children with low risk for AHT.<sup>15</sup> Other studies have shown no differences in evaluation and reporting rates by race/ethnicity after adjusting for social factors (see Table).

As clinicians, one of our professional and ethical obligations is to “do no harm.” We must ask ourselves whether the existing structure of reporting is truly accomplishing this goal. How can we prevent one harm (maltreatment) without introducing other harms (eg, mistrust, trauma, stigmatization) in the evaluation and reporting process? Instead of focusing on simply more reporting, we should be focusing on more accurate and equitable reporting. Additionally, in order to promote good and to avoid unintended

harm, there is a need to shift from tertiary prevention of abuse and neglect toward more primary and secondary **prevention strategies**, such as improving access to services that support families in caring for their children.

### **Reducing Inequity Through Health Care System Changes**

*Promote accuracy in evaluation and reporting through clinician training.* In order to improve clinicians' accuracy in child abuse and neglect evaluation and reporting, we should expand clinician education in bias, **inequities**, and social determinants of health. We should also utilize the expertise of child abuse pediatricians. Child Abuse Pediatrics (CAP) is a fairly new subspecialty of general pediatrics in which physicians assess the likelihood of maltreatment, help identify or rule out conditions that may mimic maltreatment, and make recommendations about additional assessment, reporting, and treatment. CAP fellowship training requires education on social determinants of health and ethical issues related to diagnosis and reporting.<sup>21</sup> Most CAPs staff work within a hospital or community-based multidisciplinary team (MDT), which, in addition to CAPs, may include CPS, law enforcement, social workers, family advocates, and mental health clinicians. Studies examining the role of CAP and MDT consultation have demonstrated reductions in the unwarranted reporting of noninflicted injuries to CPS,<sup>22,23</sup> although the authors of these studies did not assess whether child race or ethnicity contributed to these effects.<sup>22,23</sup> Nevertheless, the higher frequency of reporting of minority children with noninflicted injuries suggests that CAP and MDT involvement could benefit these children more than White children and could reduce disparities in reporting by race and ethnicity.

*Promote equity in evaluation and reporting through the use of clinical decision support tools.* Clinical guidelines, clinical pathways, standardized electronic medical record (EMR) tools, and prediction rules can decrease the likelihood of bias in the evaluation and reporting of maltreatment. For example, at one institution, the implementation of a clinical guideline for unwitnessed head injury in infants eliminated racial disparities in ordering of skeletal surveys.<sup>24</sup> At another institution, the use of standardized child abuse EMR order sets led to compliance with American Academy of Pediatrics' evidence-based guidelines that specify which children should be screened for physical abuse and with which tests.<sup>25</sup> Clinical pathways can also increase the likelihood of consultation and evaluation by a hospital-based child protection team, as well as reduce socioeconomic disparities in the medical evaluation of suspected physical abuse.<sup>26</sup> Several validated clinical prediction rules may also decrease bias. The TEN-4-FACESp clinical rule for predicting bruises caused by physical abuse had high sensitivity (ie, few false negatives) and high specificity (ie, few false positives) when used in children younger than 4 years who were seen in the emergency department.<sup>27</sup> The Pediatric Brain Injury Research Network has also developed and evaluated a clinical prediction rule for identifying AHT.<sup>28,29</sup> Best practice alerts or pop-up reminders in the EMR could trigger clinicians to use decision-making support tools (eg, standardized order sets, prediction tools, standardized report templates) when a child with signs of abuse and neglect presents in the clinical setting. These tools can help clinicians conduct thorough evaluations and make accurate determinations of the likelihood of abuse.

### **Expanding Prevention**

While improving accuracy and equity in evaluation and reporting of abuse and neglect is important, there is also a need to think about more upstream prevention solutions. The Centers for Disease Control and Prevention has published a technical report on evidence-based abuse and neglect prevention strategies, which focuses on 5 strategies:

strengthening economic support for families, supporting positive parenting, providing quality early child care and education, augmenting parenting skills to facilitate healthy child development, and intervening to mitigate harms and prevent future risk.<sup>30</sup> Interventions such as home visiting programs and parenting programs that promote positive parenting and enhance parenting skills have been shown to decrease maltreatment. The Nurse Family Partnership, a home visiting program in which specially educated nurses provide support to first time moms from pregnancy through the child's second birthday, has been shown to significantly reduce child abuse and neglect, as well as risk factors for maltreatment.<sup>31,32</sup> Long-term participation (4 to 6 years) in child-parent centers—an enrichment program with family engagement—was associated with a 33% reduction in substantiated maltreatment.<sup>33</sup> Additionally, policies and supports that economically strengthen families, such as tax credits, subsidized child care, housing assistance, livable wages, and paid parental leave, have been shown to decrease the risk of child maltreatment.<sup>30,34,35,36,37</sup> One study showed that paid parental leave was associated with reductions in hospitalization rates for AHT.<sup>35</sup> Another study found that lack of waitlists to access subsidized child care decreased rates of child abuse and neglect, even after adjusting for known risk factors (eg, poverty, education level, unemployment).<sup>34</sup>

## Conclusion

While all children are inherently vulnerable to abuse and neglect and deserving of protection, we need to acknowledge that our efforts to protect them can introduce unintended consequences when we overreport minority children and underreport White children. Decades of research reveal the existence of evaluation and reporting bias and the need to implement changes that promote accuracy and equity. At the same time, investing in evidence-based interventions that support families and prevent abuse and neglect would reduce the need for assessment and reporting and reduce demands on the child welfare system. Through such interventions, including expanded clinician education on maltreatment; utilization of child abuse pediatricians; development of abuse and neglect clinical pathways, guidelines, and prediction tools; and investment in upstream prevention services and supports, we can more equitably protect our children.

## References

1. Luna F. Identifying and evaluating layers of vulnerability—a way forward. *Dev World Bioeth.* 2019;19(2):86-95.
2. Bagattini A. Children's well-being and vulnerability. *Ethics Soc Welf.* 2019;13(3):211-215.
3. Kim H, Wildeman C, Jonson-Reid M, Drake B. Lifetime prevalence of investigating child maltreatment among US children. *Am J Public Health.* 2017;107(2):274-280.
4. Tufford L, Lee B, Bogo M, et al. Decision-making and relationship competence when reporting suspected physical abuse and child neglect: an objective structured clinical evaluation. *Clin Soc Work J.* 2021;49(2):256-270.
5. Raz M. Calling child protectives services is a form of community policing that should be used appropriately: time to engage mandatory reporters as to the harmful effects of unnecessary reports. *Child Youth Serv Rev.* 2020;110:104817.
6. How can child welfare leaders safely decrease investigation backlogs? Casey Family Programs. April 3, 2020. Accessed March 17, 2022. <https://www.casey.org/child-welfare-leaders-safely-decrease-investigation-backlogs/#:~:text=Prioritize%20leadership%20involvement&text=Successful%2>

Oleadership%20strategies%20to%20reduce,the%20details%20of%20backlogged%20cases

7. Child Welfare Information Gateway. Caseload and workload management. Children's Bureau, US Department of Health and Human Services; 2016. Accessed March 10, 2022.  
[https://www.childwelfare.gov/pubpdfs/case\\_work\\_management.pdf](https://www.childwelfare.gov/pubpdfs/case_work_management.pdf)
8. Church WT II, Gross ER, Baldwin J. Maybe ignorance is not always bliss: the disparate treatment of Hispanics within the child welfare system. *Child Youth Serv Rev*. 2005;27(12):1279-1292.
9. Johnson EP, Clark S, Donald M, Pedersen R, Pichotta C. Racial disparity in Minnesota's child protection system. *Child Welfare*. 2007;86(4):5-20.
10. Putnam-Hornstein E, Needell B, King B, Johnson-Motoyama M. Racial and ethnic disparities: a population-based examination of risk factors for involvement with child protective services. *Child Abuse Negl*. 2013;37(1):33-46.
11. Choi MJ, Kim J, Roper A, LaBrenz CA, Boyd R. Racial disparities in assignment to alternative response. *Child Youth Serv Rev*. 2021;125:124.
12. Children's Bureau. *Child Maltreatment 2020*. US Department of Health and Human Services; 2022. Accessed January 23, 2022.  
<https://www.acf.hhs.gov/sites/default/files/documents/cb/cm2020.pdf>
13. Sedlack A, Mettenburg J, Basena M, et al. *Fourth National Incidence Study of Child Abuse and Neglect (NIS-4): Report to Congress*. US Department of Health and Human Services; 2010. Accessed January 23, 2022.  
[https://www.acf.hhs.gov/sites/default/files/documents/opre/nis4\\_report\\_congress\\_full\\_pdf\\_jan2010.pdf](https://www.acf.hhs.gov/sites/default/files/documents/opre/nis4_report_congress_full_pdf_jan2010.pdf)
14. Sedlack A, McPherson K, Das B. *Fourth National Incidence Study of Child Abuse and Neglect (NIS-4): Supplementary Analyses of Race Differences in Child Maltreatment Rates in the NIS-4*. US Department of Health and Human Services; 2010. Accessed January 23, 2022.  
[https://www.acf.hhs.gov/sites/default/files/documents/opre/nis4\\_supp\\_analyses\\_race\\_diff\\_mar2010.pdf](https://www.acf.hhs.gov/sites/default/files/documents/opre/nis4_supp_analyses_race_diff_mar2010.pdf)
15. Hymel KP, Laskey AL, Crowell KR, et al. Racial and ethnic disparities and bias in the evaluation and reporting of abusive head trauma. *J Pediatr*. 2018;198:137-143.e1.
16. Jenny C, Hymel KP, Ritzen A, Reinert SE, Hay TC. Analysis of missed cases of abusive head trauma. *JAMA*. 1999;281(7):621-626.
17. Keenan HT, Nocera M, Runyan DK. Race matters in the prosecution of perpetrators of inflicted traumatic brain injury. *Pediatrics*. 2008;121(6):1174-1180.
18. Lane WG, Rubin DM, Monteith R, Christian CW. Racial differences in the evaluation of pediatric fractures for physical abuse. *JAMA*. 2002;288(13):1603-1609.
19. Putnam-Hornstein E, Prindle JJ, Leventhal JM. Prenatal substance exposure and reporting of child maltreatment by race and ethnicity. *Pediatrics*. 2016;138(3):e20161273.
20. Wood JN, Hall M, Schilling S, Keren R, Mitra N, Rubin DM. Disparities in the evaluation and diagnosis of abuse among infants with traumatic brain injury. *Pediatrics*. 2010;126(3):408-414.
21. Subboard of Pediatric Child Abuse. Content outline: child abuse pediatrics subspecialty in-training, certification, and maintenance of certification (MOC) examinations. American Board of Pediatrics; 2021. Accessed July 22, 2022.  
<https://www.abp.org/sites/abp/files/pdf/chab.pdf>

22. Wallace GH, Makoroff KL, Malott HA, Shapiro RA. Hospital-based multidisciplinary teams can prevent unnecessary child abuse reports and out-of-home placements. *Child Abuse Negl.* 2007;31(6):623-629.
23. Anderst J, Kellogg N, Jung I. Is the diagnosis of physical abuse changed when child protective services consults a child abuse pediatrics subspecialty group as a second opinion? *Child Abuse Negl.* 2009;33(8):481-489.
24. Rangel EL, Cook BS, Bennett BL, Shebesta K, Ying J, Falcone RA. Eliminating disparity in evaluation for abuse in infants with head injury: use of a screening guideline. *J Pediatr Surg.* 2009;44(6):1229-1234.
25. Suresh S, Saladino RA, Fromkin J, et al. Integration of physical abuse clinical decision support into the electronic health record at a tertiary care children's hospital. *J Am Med Inform Assoc.* 2018;25(7):833-840.
26. Powers E, Tiyyagura G, Asnes AG, et al. Early involvement of the child protection team in the care of injured infants in a pediatric emergency department. *J Emerg Med.* 2019;56(6):592-600.
27. Pierce MC, Kaczor K, Lorenz DJ, et al. Validation of a clinical decision rule to predict abuse in young children based on bruising characteristics. *JAMA Netw Open.* 2021;4(4):e215832.
28. Hymel KP, Willson DF, Boos SC, et al. Derivation of a clinical prediction rule for pediatric abusive head trauma. *Pediatr Crit Care Med.* 2013;14(2):210-220.
29. Hymel KP, Armijo-Garcia V, Foster R, et al. Validation of a clinical prediction rule for pediatric abusive head trauma. *Pediatrics.* 2014;134(6):e1537-e1544.
30. Fortson BL, Klevens J, Merrick MT, Gilbert LK, Alexander SP. Preventing child abuse and neglect: a technical package for policy, norm, and programmatic activities. Centers for Disease Control and Prevention; 2016. Accessed September 22, 2022. <https://www.cdc.gov/violenceprevention/pdf/can-prevention-technical-package.pdf>
31. Eckenrode J, Campa MI, Morris PA, et al. The prevention of child maltreatment through the nurse family partnership program: mediating effects in a long-term follow-up study. *Child Maltreat.* 2017;22(2):92-99.
32. Macmillan HL, Wathen CN, Barlow J, Fergusson DM, Leventhal JM, Taussig HN. Interventions to prevent child maltreatment and associated impairment. *Lancet.* 2009;373(9659):250-266.
33. Reynolds AJ, Robertson DL. School-based early intervention and later child maltreatment in the Chicago Longitudinal Study. *Child Dev.* 2003;74(1):3-26.
34. Klevens J, Barnett SB, Florence C, Moore D. Exploring policies for the reduction of child physical abuse and neglect. *Child Abuse Negl.* 2015;40:1-11.
35. Klevens J, Luo F, Xu L, Peterson C, Latzman NE. Paid family leave's effect on hospital admissions for pediatric abusive head trauma. *Inj Prev.* 2016;22(6):442-445.
36. Raissian K, Bullinger L. Money matters: does the minimum wage affect child maltreatment rates? *Child Youth Serv Rev.* 2017;72:60-70.
37. Yang MY, Maguire-Jack K, Showalter K, Kim Y, Slack K. Child care subsidy and child maltreatment. *Child Fam Soc Work.* 2019;24(4):547-554.

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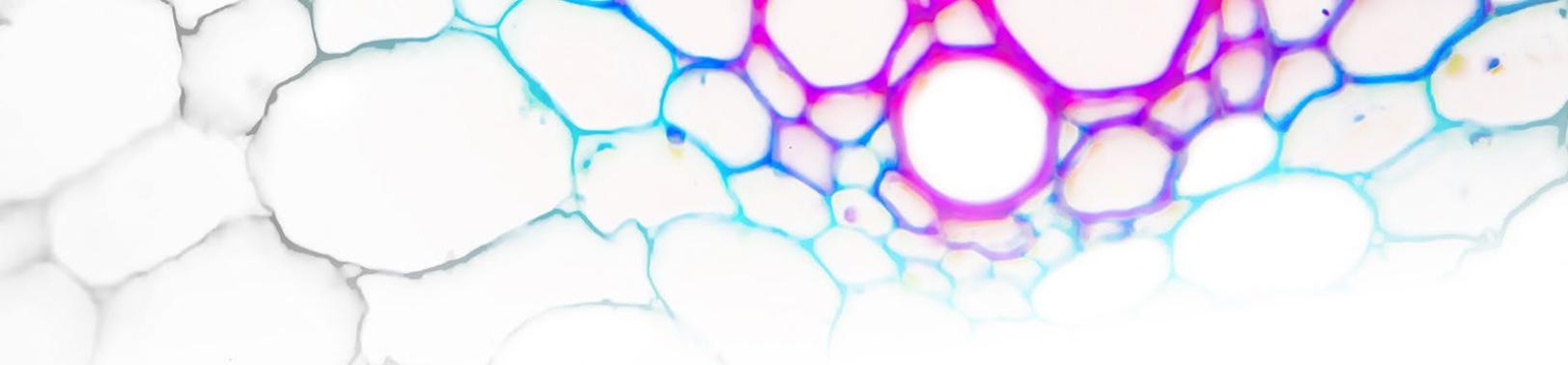
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### MEDICINE AND SOCIETY: PEER-REVIEWED ARTICLE

#### Papal Doctrines' Deep Trauma Legacies in Minoritized Communities

Michael J. Oldani, PhD, MS

##### Abstract

Understanding papal documents from the 15th century and the nature and scope of their authority is important when working with Black, Indigenous, and people of color communities influenced by forces and structures of colonialism. Intergenerational trauma has deep roots, which require clinicians to understand historical and cultural context when working with vulnerable patients—in particular, young victims of child abuse and neglect.

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##### Child Abuse and Intergenerational Trauma

Child abuse and neglect remain a global crisis, and, as the articles in this special volume illustrate, health and social care professionals play a critical role in identifying, intervening on, reporting, and ultimately treating the biopsychosocial symptoms of neglect and abuse in their young patients. Clinicians recognize abuse in the clinical encounter, where the stakes are high for all the parties involved—in particular, for Black, Indigenous, and people of color (BIPOC) communities. Fortunately, our understanding of abuse and neglect has been transformed over the last several decades through trauma-informed theory and practices. More specifically, public health researchers have come to understand that **historical traumas** (eg, war, slavery, and genocide) can impact the current health status of living groups.<sup>1</sup> Related to child abuse and neglect, ethnographic work by medical anthropologists has clearly shown how the legacy of forced removal of Aboriginal children to residential schools, as well as dispossession of First Nation and Inuit land, has caused significant intergenerational trauma for individuals and their families.<sup>2,3</sup> Intergenerational trauma remains an important phenomenon for clinicians to understand and grapple with as they deal with day-to-day cases of abuse and neglect.<sup>4</sup>

##### Conquest and Doctrines of “Discovery”

Issued by Pope Alexander VI in 1493, the controversial *Inter Caetara*, or Doctrine of Discovery, was deployed by colonial powers as a fundamental and divinely authoritative set of instructions for the dispossession, exploitation, abuse, and ethnocide of Indigenous peoples. The document was translated into action and practice by European

colonizers (eg, Spain, Portugal, France, and England) and the US government to subjugate non-Europeans and non-Christians throughout the so-called “New World.”<sup>5</sup>

Traumas of colonization began with words inscribed in the doctrine that provided what was called a *divine decree* and an authorization to conquer the “lands discovered by Columbus” in 1492.<sup>5</sup> The doctrine begins with wishes of health and “apostolic benediction” (papal blessings) “to the illustrious sovereigns,” King Ferdinand and Queen Isabella of Spain. By the second sentence, Pope Alexander proclaims his hope that “the Catholic faith and the Christian religion be exalted and be everywhere increased and spread,” ensuring that “the health of souls be cared for and that barbarous nations be overthrown and brought to the faith itself.”<sup>5</sup> Not coincidentally, 1492 was also the year that Christian Spain recovered the Kingdom of Granada from “the Saracens”—the Islamic Moors—who had inhabited and controlled much of the Iberian Peninsula for over 700 years.<sup>6</sup> The papacy saw this reconquest of Spain and Columbus’ encounters as divine signs to justify King Ferdinand’s and Queen Isabella’s “spread of the Christian rule to carry forward ... [their] holy and praiseworthy purpose.”<sup>5</sup> Spain had failed to convert the “infidels” (the Moors), who chose to flee the country rather than convert. Nevertheless, the papacy also saw opportunities for mass conversion of Indigenous peoples, described as heathens at that time— some whose own spirituality recognized one God or Creator.

The Doctrine of Discovery plants seeds of early capitalism and reads in part as a territorial claim to the Western Hemisphere and as a prospector’s guide to securing “gold, spices, and very many other precious things of divers kinds and qualities.”<sup>5</sup> It notes that many Indigenous peoples at the time were living “in peace” but nonetheless required colonizers “to bring [them] under your sway ... to the Catholic faith ... to embrace the Christian religion.”<sup>5</sup> It grants the Spanish sovereigns “full and free power, authority, and jurisdiction of every kind” as long as they insert God-fearing men throughout the colonies to “instruct ... inhabitants and residents in the Catholic faith and train them in good morals.”<sup>5</sup>

It has been noted by journalists, scholars, and Indigenous communities that the Doctrine of Discovery, at the very least, provided the justification and motivation for Europeans’ claiming new lands and early Catholic missionaries (eg, the Jesuits in New France, now Canada) expanding their conversion work.<sup>7,8,9</sup> The doctrine was also treated as a primary source by jurists and was cited in an 1823 Supreme Court case allowing the US government to dispossess Native people of their lands: “Discovery is the foundation of title, in European nations, and this overlooks all proprietary rights in the natives.”<sup>10</sup> Perhaps more importantly, it has been argued that the doctrine inspired the later Monroe Doctrine (claiming US hegemony over the Western Hemisphere) and the US notion (and practice) of Manifest Destiny, which justified violent dominion over Native lands—from the Atlantic to the Pacific—by Euro-Americans.<sup>11</sup>

Papal decrees, which helped to drive European colonial expansion and imbue early forms of capitalism with divine intent and authority, also affected other Indigenous peoples of that time— namely, Africans. The *Romanus Pontifex* of 1455 was specifically written for the Portuguese sovereign, whose armies had successfully explored and established colonial ports from North Africa (now Morocco) to West Africa (including part of modern-day Guinea).<sup>12</sup> This doctrine laid the then-legal groundwork for early human trafficking between Africa and Europe and eventually between Africa and the Americas:

King Alfonso [may] invade, search out, capture, vanquish, and subdue all Saracens and pagans whatsoever, and other enemies of Christ wheresoever placed, and the kingdoms, dukedoms, principalities, dominions, possessions, and all movable and immovable goods whatsoever held and possessed by them and to reduce their persons to perpetual slavery, and to apply and to appropriate [them] to himself and his successors ... and to convert them to his and their use and profit.<sup>12</sup>

By 1530, it is estimated that between 4000 to 5000 African slaves were being exported from the Kongo annually.<sup>13</sup>

### **Trauma Legacy**

Dispossession of Indigenous lands and the traumatic destruction of Native cultures continues today throughout the Americas. Brazil's conservative government continues to push legislation to cut federal funding to Amazonian tribes and "open up the Amazon" for mining and farming.<sup>14</sup> There are also more subtle forms of dispossession of land when it is hijacked for commercial projects. For example, although President Biden ended the Keystone oil pipeline project in the United States, the Obama administration had previously approved replacing other pipelines that run through Native American communities in the upper Great Lakes region. These replacement lines often create new routes (rather than using the original pathways) and run over and under pristine waterways.<sup>15</sup> The projects are described as "cultural genocide" by Native activists in these communities who argue they are also a violation of Native treaty rights.<sup>15</sup>

Historically, dispossession was combined with forced conversion, which took the form of so-called "civilizing projects."<sup>16,17</sup> In North America, religious institutions administered some Native American boarding schools and the Canadian residential school system, both of which were funded by government agencies.<sup>18</sup> It can be hard to fathom that the last residential school in Canada closed in the mid-1990s.<sup>19</sup> In Central America, similar projects arose in the 20th century in order to "modernize" Indigenous peoples, such as the Maya. In this case, the Maya, like other Indigenous groups, have been able to reclaim some of their lost lands as well as their cultural autonomy through political movements and structural reforms.<sup>20</sup>

A thread of traumatic dispossession of lands and other colonial practices can be pulled through the Doctrine of Discovery to our current times. My work within the Aboriginal community in Manitoba in the early 2000s demonstrated how a legacy of residential school abuses was perpetuated across generations through the stories, psyches, and bodies of First Nation Peoples.<sup>2</sup> Clinicians who developed productive partnerships within the community took time to listen to these stories and to more fully understand colonial practices' traumatic legacy and their current embodiment.

In the United States, the recent and tragic discovery of mass graves at boarding schools has reconnected families with their traumatic past. National Public Radio's StoryCorps recently covered the case of an Oneida man from Wisconsin who traveled to the Carlisle school in Pennsylvania to see where his grandparents had been sent. He spent the next 2 years working to reclaim the remains of Oneida children buried on the grounds who had passed away while far from home. These children, including an orphan with the same last name as one of his relatives, have been reburied "at home" on the Oneida reserve, where they have been reconnected with their families.<sup>21</sup> These kinds of intergenerational traumas run deep and are still being felt and lived through by Indigenous peoples throughout the world.

Scholars examining the historical roots of modern-day diagnostic forms and biopsychosocial outcomes of trauma often point to the industrialization of Europe in the

1860s (eg, urban train accidents both experienced and witnessed), as well as to soldiers who experienced various forms of “trauma neurosis” (eg, posttraumatic stress disorder) during World War I, as modern starting points.<sup>22</sup> For BIPOC communities, the historical roots of trauma begin much earlier. Their modern-day traumas stem from the orders and practices believed (by some) to be divinely sanctioned by papal documents and that Europeans (and later Americans) ruthlessly carried out. Colonization, dispossession, forced conversion, and human trafficking were brought to bear on unsuspecting and often peaceful BIPOC communities.

### **Reconciliation and Healing**

These somewhat obscure papal documents from the late 15th century had devastating consequences. Hierarchies and **racialized structures** were put into place that are being felt by BIPOC peoples and seen in clinical encounters today.<sup>23</sup> Perhaps Canada remains the exemplar of working through this history, forming a Truth and Reconciliation Commission in 2008 for residential school survivors.<sup>24</sup> Canada also is the first country to initiate the kind of structural reform that literally allowed for the sovereign return of a homeland to Indigenous people. In 1999, the Northwest Territories were divided to form Nunavut, which retains its own Tribal legal system as well as an autonomous government, run by the Inuit.<sup>25</sup> The United States is behind Canada in terms of structural reforms and initiatives, but recent developments, including the US Department of the Interior Indian Boarding School Initiative, are encouraging.<sup>26</sup>

One very recent positive development has been a papal apology, the first of its kind, by Pope Francis after a contingent of First Nation Peoples visited the Vatican in March of 2022. The pope recognized Catholic complicity and stated: “Listening to your voices, I was able to enter into and be deeply grieved by the stories of the suffering, hardship, discrimination and various forms of abuse that some of you experienced, particularly in the residential schools.”<sup>27</sup> One commentator understood the apology as part of the healing process: “This opens a door for us to continue on our healing journeys, and it opens a door for us to continue to fight for action.”<sup>28</sup>

Clinicians who work with BIPOC patients can be part of these healing journeys. In Winnipeg, where I conducted clinical ethnography between 2002 and 2004, the Aboriginal Healing Foundation (now defunct) supported healing circles for survivors, which also led many people to engage in sweat lodge and fasting ceremonies as forms of communal healing. Several clinicians I worked with understood cultural context and discussed these opportunities for healing with their patients and children suffering from trauma and abuse. The clinicians worked directly with local institutions, such as the Thunderbird House, to connect patients with Aboriginal-inspired resources, elders, and spiritual healers. Unfortunately, other clinicians I observed were not integrating this history and context into their treatment.<sup>29</sup>

Understanding traumatic histories is part of understanding patient context. Recent research assessing global health rotations for physician assistant students offers a valuable reminder about how understanding local and historical context can shape the clinical experience of both students and patients.<sup>30</sup> These students specifically were part of a South African clinical rotation that focused on primary care. The student feedback was clear: students felt their futures as caregivers were going to be changed for the better by the work they did in South Africa. They were struck by how the lack of technology and diagnostic testing, which is central to the US system, was supplanted by a “three-stage assessment” that focused on “clinical, personal, and contextual

characteristics” of their patients. This assessment involved talking, listening, and taking comprehensive notes. The author underscored what was “remarkable” to these students was the “deliberate clinician focus on patients’ perspectives of their illness and treatment.”<sup>30</sup>

Clinicians throughout the world who engage in **trauma-informed practices** and work with victims of abuse and neglect understand that history is both remembered and felt. Many BIPOC communities have demonstrated incredible resilience during centuries of dispossession, exploitation, and trauma. Nevertheless, historical traumas remain a persistent threat to patient and community health. Clinicians’ patient-centered approaches should incorporate sociocultural context, (deep) history and knowledge of colonial practices, and the patient’s perspective in the diagnostic process.

### References

1. Soltero M. A conceptual model of historical trauma: implications for public health practice and research. *J Health Dispar Res Pract*. 2009;1(1):93-108.
2. Oldani MJ. Uncanny scripts: understanding pharmaceutical emplotment in the Aboriginal context. *Transcult Psychiatry*. 2009;46(1):131-156.
3. Stephens L. *Life Beside Itself: Imagining Care in the Canadian Arctic*. University of California Press; 2014.
4. DeAngelis T. The legacy of trauma. *Monitor on Psychology*. 2019;50(2):36. Accessed February 12, 2022. <https://www.apa.org/monitor/2019/02/legacy-trauma>
5. Pope Alexander VI. Demarcation bull granting Spain possession of lands discovered by Columbus. May 4, 1493. Gilder Lehrman Institute of American History. Accessed February 12, 2022. <https://www.gilderlehrman.org/sites/default/files/inline-pdfs/T-04093.pdf>
6. Blakemore E. Who were the Moors? *National Geographic*. December 12, 2019. Accessed October 10, 2022. <https://www.nationalgeographic.com/history/article/who-were-moors>
7. Blakemore E. This 500-year-old Catholic decree encouraged colonization. Will the pope revoke it? *National Geographic*. July 22, 2022. Accessed September 14, 2022. <https://www.nationalgeographic.com/history/article/doctrine-of-discovery-how-the-centuries-old-catholic-decree-encouraged-colonization>
8. Winyan MT. Doctrine of Discovery. *Lakota Times*. August 10, 2022. Accessed September 16, 2022. <https://www.lakotatimes.com/articles/doctrine-of-discovery/>
9. “Doctrine of Discovery,” used for centuries to justify seizure of Indigenous land, subjugate peoples, must be repudiated by United Nations, permanent forum told. United Nations. May 8, 2012. Accessed September 14, 2022. <https://press.un.org/en/2012/hr5088.doc.htm>
10. *Johnson and Graham’s Lessee v William M’Intosh*, 21 US 543 (1823). Accessed September 14, 2022. <https://www.law.cornell.edu/supremecourt/text/21/543>
11. Miller RJ. American Indians, the Doctrine of Discovery, and Manifest Destiny. *Wyoming Law Rev*. 2011;11(2):329-349.
12. *Romanus Pontifex* (granting the Portuguese a perpetual monopoly in trade with Africa). January 8, 1455. Papal Encyclicals Online. Updated February 20, 2020. Accessed September 14, 2022. <https://www.papalencyclicals.net/nichol05/romanus-pontifex.htm>
13. Wolf ER. *Europe and the People Without History*. University of California Press; 1982.

14. Londono E, Casado L. As Bolsonaro keeps Amazon vows, Brazil's Indigenous fear "ethnocide." *New York Times*. April 19, 2020. Updated April 24, 2020. Accessed April 7, 2022.  
<https://www.nytimes.com/2020/04/19/world/americas/bolsonaro-brazil-amazon-indigenous.html>
15. Regan S. "It's cultural genocide": inside the fight to stop a pipeline on tribal lands. *Guardian*. February 19, 2022. Accessed April 8, 2022.  
<https://www.theguardian.com/us-news/2021/feb/19/line-3-pipeline-ojibwe-tribal-lands>
16. Smith DG. The "policy of aggressive civilization" and projects of governance in Roman Catholic industrial schools for native peoples in Canada, 1870-95. *Anthropologica*. 2001;43(2):253-271.
17. Shweder RA. On the return of the "civilizing project." *Daedalus*. 2002;131(3):117-121.
18. Pember MA. A history not yet laid to rest. *Atlantic*. November 24, 2021. Accessed October 11, 2022.  
<https://www.theatlantic.com/ideas/archive/2021/11/native-american-boarding-schools/620760/>
19. Miller JR. Residential schools in Canada. Canadian Encyclopedia. Updated June 1, 2021. Accessed October 11, 2022.  
<https://www.thecanadianencyclopedia.ca/en/article/residential-schools>
20. Hernández Castillo RA, Nigh R. Global processes and local identity among Mayan coffee growers in Chiapas, Mexico. *Am Anthropol*. 1998;100(1):136-147.
21. Gampa V, Bernard K, Oldani MJ. Racialization as a barrier to achieving health equity for Native Americans. *AMA J Ethics*. 2020;22(10):E874-E881.
22. Born J. Carlisle Indian Industrial School forced Native American children to assimilate. *NPR*. March 18, 2022. Accessed March 11, 2022.  
<https://www.npr.org/2022/03/18/1087448526/carlisle-indian-industrial-school-forced-native-american-children-to-assimilate>
23. Fassin D, Rechtman R. *The Empire of Trauma: An Inquiry Into the Condition of Victimhood*. Gomme R, trans. Princeton University Press; 2009.
24. Truth and Reconciliation Commission of Canada. National Centre for Truth and Reconciliation. Accessed April 3, 2022. <https://nctr.ca/about/history-of-the-trc/truth-and-reconciliation-commission-of-canada/>
25. Kulchyski P. The creation of Nunavut. Canada's History. August 11, 2017. Accessed September 14, 2022.  
<https://www.canadashistory.ca/explore/politics-law/the-creation-of-nunavut>
26. How historical trauma impacts Native Americans today. American Psychiatric Association blog. November 15, 2021. Accessed September 14, 2022.  
<https://www.psychiatry.org/News-room/APA-Blogs/How-Historical-Trauma-Impacts-Native-Americans>
27. Udienza alle delegazioni dei popoli Indigeni del Canada. News release. The Vatican; January 4, 2022. Accessed September 14, 2022.  
<https://press.vatican.va/content/salastampa/it/bollettino/pubblico/2022/04/01/0232/00500.html#en>
28. Shivaram D. The pope apologizes for abuse of Indigenous children in Canada's residential schools. *NPR*. Updated April 1, 2022. Accessed April 15, 2022.  
<https://www.npr.org/2022/04/01/1090213962/pope-francis-apology-indigenous-people-canada>

29. Oldani MJ. *Filling Scripts: A Multi-sited Ethnography of Pharmaceutical Sales Practices, Psychiatric Prescribing, and Family Life in North America*. Dissertation. Princeton University; 2006.
30. Toppe M, Nkombua L. Three-stage assessment as reverse innovation in interprofessional student clinical rotations. *AMA J Ethics*. Forthcoming 2023.

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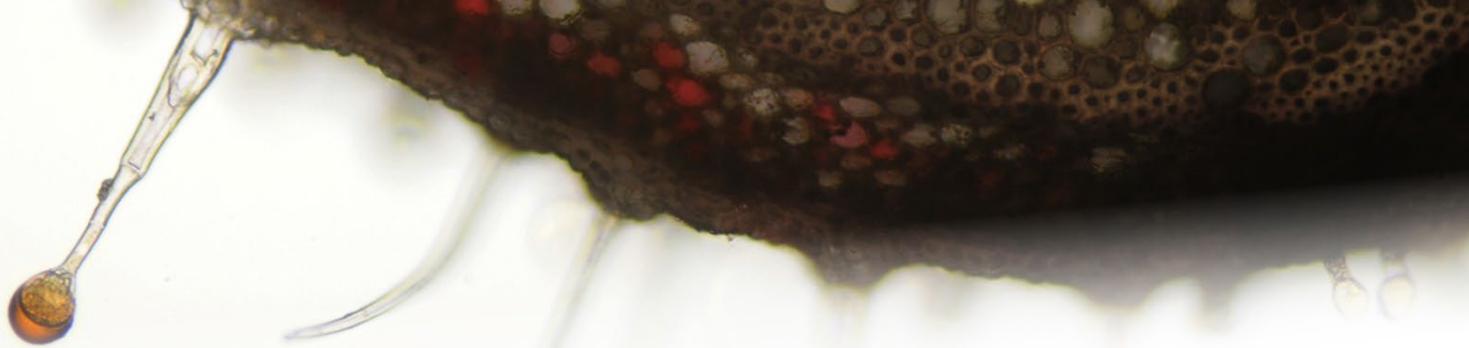
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## AMA Journal of Ethics®

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### HISTORY OF MEDICINE

#### Why 1962 Matters in the History of Clinicians' Responses to Abused and Neglected Children

Jorie Braunold, MLIS

##### Abstract

Although scientific literature about child abuse dates back to the 1850s, how society and medicine discussed and responded to this set of concerns changed dramatically in 1962. Since that time, the problem's fuller scope has been revealed and reforms have been implemented.

##### Battered-Child Syndrome

Abuse of children has a long history, regardless of whether such abuse was publicly sanctioned or restricted to domestic, private spheres. Examples of abuse of children go back to biblical times,<sup>1</sup> and laws dating from America's colonial period acknowledge the need to remove some children from unsafe home environments.<sup>2</sup> But 1962 is when our modern understanding of child abuse seemed to emerge,<sup>2,3</sup> as it was the year that physician C. Henry Kempe and colleagues published their landmark article, which coined the term *battered child syndrome*, in the *Journal of the American Medical Association (JAMA)*.<sup>4</sup> This article reviews the influence of this turning point in the history of discussions and responses to child abuse in America.

##### Early Clinical Reports

In 1857, the French forensic physician Auguste Ambroise Tardieu began describing forms of child mistreatment we'd recognize today, including sexual abuse and child labor.<sup>5</sup> He pointed out not only the prevalence of child abuse, but also how it could be diagnosed by a physician.<sup>6</sup> His findings were roundly ignored by the medical establishment and society at large,<sup>6</sup> and the topic doesn't appear in the scientific literature again until 1929, when a Colombian physician, Jose Martinez, reidentified child abuse in clinical terms.<sup>7</sup> Over the next 70 years, Martinez's work continued to be generally ignored by medicine.<sup>7</sup>

Despite the emergence of nongovernmental child protection societies across America as early as 1875<sup>2</sup> and the codification of abusive child labor practices in the 1938 Fair Labor Standards Act,<sup>8</sup> injuries to children were not documented in the US medical literature until 1946.<sup>9</sup> That year, in the *American Journal of Roentgenology*, the pediatric radiologist John Caffey reported that though it was possible that the "chronic subdural hematomas in association with multiple fractures"<sup>6</sup> that he observed were not injuries caused by abuse, they "appear[ed] to be of traumatic origin."<sup>10</sup>

A 1955 *JAMA* article written by Paul V. Woolley and William A. Evans considered whether some childhood injuries could only be the result of repeated abuse. In their conclusion, they wrote: “It is difficult to avoid the over-all conclusion that skeletal lesions having the appearance of fractures—regardless of history for injury or the presence or absence of intracranial bleeding—are due to undesirable vectors of force.”<sup>11</sup> The article makes euphemistic references to adults’ abusive behavior toward children in referring to “injury-prone environments,” which they describe as sites of “neurotic or frankly psychotic behavior on the part of at least one adult.”<sup>11</sup> Between 1956 and 1962, “at least ten medical reports were published stating that children were being seen with inflicted injuries.”<sup>12</sup>

### **Policy Responses**

*Mandatory reporting.* The appearance of “The Battered-Child Syndrome”<sup>4</sup> in *JAMA* in 1962 finally provoked responses. In 1971, Kempe was quoted as saying: “I coined the term ‘The Battered Child Syndrome’ in 1962 despite its provocative and anger-producing nature. I had for the preceding 10 years talked about child abuse, non-accidental, or inflicted injury but few paid attention.”<sup>7</sup> The roles of physicians in identifying abuse patterns were mentioned in Woolley and Evans’ 1955 article,<sup>11</sup> but Kempe et al plainly asserted physicians’ unique responsibilities to diagnose, report, and prevent abuse of children. The same year that “The Battered-Child Syndrome” was published, Kempe attended a meeting of the US Children’s Bureau and recommended “passage of laws requiring doctors to report suspicions of abuse to police or child welfare,”<sup>2</sup> the first four of which were enacted in 1963.<sup>2</sup> By 1967, all states had reporting laws.<sup>2</sup>

In 1967, Vincent De Francis, an early leader along with Kempe, lamented: “No state and no community has developed a Child Protective Service program adequate in size to meet the service needs of all reported cases of child neglect, abuse and exploitation.”<sup>2</sup> Even in 1973, US Senator Walter Mondale wrote: “Nowhere in the Federal Government could we find one official assigned full time to the prevention, identification and treatment of child abuse and neglect.”<sup>2</sup> De Francis, Mondale, and many collaborators forged the passage of the Child Abuse Prevention and Treatment Act of 1974 (CAPTA),<sup>13</sup> which authorized use of federal funds to improve states’ capacity to respond to physical abuse, neglect, and sexual abuse.

Echoing concerns of many physicians, the American Medical Association (AMA) House of Delegates in 1964 approved a position statement,<sup>14</sup> which argued against placing the primary burden of protecting children on health professionals. Some physicians hesitant to report did not feel equipped to interpret a law that could hurt families or discourage adults from seeking medical help for a child.<sup>15</sup> In the context of states’ passage of reporting laws, however, in 1965, the AMA supported legislation requiring physicians to report suspected abuse that mitigated their criminal or civil liability for reporting.<sup>16</sup> In 1984, the AMA released guidelines for diagnosing child abuse.<sup>17</sup>

*Diagnosis and prevention.* By 1976, a new field devoted to child abuse and neglect had emerged, marked by the *Journal of Home Economics* urging development of regional and local child abuse detection, treatment, and prevention.<sup>18</sup> By 1980, however, the number of cases reported exceeded 1 million,<sup>2</sup> generating a vast foster care crisis. Alarmed, the US Congress passed the Adoption Assistance and Child Welfare Act of 1980,<sup>2</sup> which required states to make “reasonable efforts”<sup>19</sup> to avoid removing children from the custody of their birth parents. But by the 1990s, some argued that overreliance

on family preservation also led to tragedy.<sup>2</sup> Congress responded again by creating the Adoption and Safe Families Act of 1997, which prioritized children’s safety but did not abandon family preservation.<sup>2</sup>

*Bias management.* Racial bias in the handling of child abuse cases has dogged advocates for years.<sup>20</sup> Efforts to promote community-based support for struggling parents have been complemented by amendments to CAPTA that, as the Child Welfare Information Gateway emphasized in 2017, enhance the “role[s] of communities in strengthening protective factors in a child’s environment and providing prevention services targeted toward different segments of the population.”<sup>3</sup> But as child protection systems move from physician-led child abuse reporting to community-based strategies, some states, such as Texas, have taken actions that could compel physicians to report families of minors seeking [gender-affirming care](#).<sup>21</sup>

### Slow Progress

Even when the child protection system functions the way it is intended to do, nearly 3.5 million children are the subject of at least one [child abuse referral](#) each year.<sup>22,23</sup> Physicians systematically underreport child abuse,<sup>24</sup> and reporting was further hindered by the COVID-19 pandemic, as doctors and teachers—two of the most likely reporters of abuse—were unable to assess children in person.<sup>25</sup> Nevertheless, the fact that “substantiated physical abuse ... declined 52% from 1992 to 2007; [and] substantiated sexual abuse ... declined 53% in the same period”<sup>26</sup> signals that physician-researchers and activists’ efforts to push child abuse into public view over time has motivated progress.

### References

1. Gallagher BD. A brief legal history of institutionalized child abuse. *Boston College Third World Law J.* 1997;17(1):1-30.
2. Myers JEB. A short history of child protection in America. *Fam Law Q.* 2008;42(3):449-463.
3. Child Welfare Information Gateway. Child maltreatment prevention: past, present, and future. Children’s Bureau, US Department of Health and Human Services; 2017. Accessed March 20, 2022. [https://www.childwelfare.gov/pubPDFs/cm\\_prevention.pdf](https://www.childwelfare.gov/pubPDFs/cm_prevention.pdf)
4. Kempe CH, Silverman FN, Steele BF, Droegemueller W, Silver HK. The battered-child syndrome. *JAMA.* 1962;181(1):17-24.
5. Labbé J. Ambroise Tardieu: the man and his work on child maltreatment a century before Kempe. *Child Abuse Negl.* 2005;29(4):311-324.
6. Chadwick DL. *The Child Abuse Doctors.* STM Learning; 2011.
7. Krugman RD, Korbin JE, eds. *C. Henry Kempe: A 50 Year Legacy to the Field of Child Abuse and Neglect.* Springer Science + Business Media; 2013.
8. Donovan SA, Shimabukuro JO. The Fair Labor Standards Act (FLSA) child labor provisions. Congressional Research Service; 2016. Accessed September 6, 2022. <https://sgp.fas.org/crs/misc/R44548.pdf>
9. Greeley CS. The evolution of the child maltreatment literature. *Pediatrics.* 2012;130(2):347-348.
10. Caffey J. The classic: multiple fractures in the long bones of infants suffering from chronic subdural hematoma. *Clin Orthop Relat Res.* 2011;469(3):755-758.
11. Woolley PV Jr, Evans WA Jr. Significance of skeletal lesions in infants resembling those of traumatic origin. *J Am Med Assoc.* 1955;158(7):539-543.

12. Fischer H. The sixtieth anniversary of the “battered child syndrome.” *Hektoen Int J*. 2022;14(1). Accessed October 12, 2022. <https://hekint.org/2022/04/04/the-sixtieth-anniversary-of-the-battered-child-syndrome/>
13. National Child Abuse and Neglect Training and Publications Project. *The Child Abuse Prevention and Treatment Act: 40 Years of Safeguarding America’s Children*. Children’s Bureau, US Department of Health and Human Services; 2014. Accessed March 21, 2022. [https://www.acf.hhs.gov/sites/default/files/documents/cb/capta\\_40yrs.pdf](https://www.acf.hhs.gov/sites/default/files/documents/cb/capta_40yrs.pdf)
14. Council on Medical Service. AMA statement of position on protecting children against physical abuse. In: *Proceedings of the House of Delegates*. American Medical Association; 1964:112-113. Accessed October 12, 2022. [https://ama.nmtvault.com/jsp/PsImageViewer.jsp?doc\\_id=1ee24daa-2768-4bff-b792-e4859988fe94%2Fama\\_arch%2FHOD00001%2F00000076](https://ama.nmtvault.com/jsp/PsImageViewer.jsp?doc_id=1ee24daa-2768-4bff-b792-e4859988fe94%2Fama_arch%2FHOD00001%2F00000076)
15. Sangoi L, Ronayne J, Shabazz B, Brico E. Your family or its health: intersections between the healthcare and foster care systems. Shriver Center on Poverty Law webinar. January 14, 2021. Accessed October 12, 2022. <https://www.povertylaw.org/article/webinar-your-family-or-its-health/>
16. Student American Medical Association. Remarks of J.P. Moss, president. In: *Proceedings of the House of Delegates*. American Medical Association; 1965:18-20. Accessed October 12, 2022. [https://ama.nmtvault.com/jsp/PsImageViewer.jsp?doc\\_id=1ee24daa-2768-4bff-b792-e4859988fe94%2Fama\\_arch%2FHOD00001%2F00000079](https://ama.nmtvault.com/jsp/PsImageViewer.jsp?doc_id=1ee24daa-2768-4bff-b792-e4859988fe94%2Fama_arch%2FHOD00001%2F00000079)
17. Council on Scientific Affairs. AMA diagnostic treatment guidelines concerning child abuse and neglect: report I. In: *Proceedings of the House of Delegates*. American Medical Association; 1984:285-307. Accessed October 12, 2022. [https://ama.nmtvault.com/jsp/PsImageViewer.jsp?doc\\_id=1ee24daa-2768-4bff-b792-e4859988fe94%2Fama\\_arch%2FHOD00001%2F00000119](https://ama.nmtvault.com/jsp/PsImageViewer.jsp?doc_id=1ee24daa-2768-4bff-b792-e4859988fe94%2Fama_arch%2FHOD00001%2F00000119)
18. Schmidt R. What home economists should know about child abuse. *J Home Econ*. 1976;68(3):13-20.
19. Adoption Assistance and Child Welfare Act of 1980, Pub Law No. 96-272, 94 Stat 500 (1980).
20. Lane WG, Rubin DM, Ragin M, et al. Racial differences in the evaluation of pediatric fractures for physical abuse. *JAMA*. 2002;288(13):1603-1609.
21. Dolan K. Texas is engaged in state-sanctioned child abuse. *Newsweek*. March 11, 2022. Accessed March 25, 2022. <https://www.newsweek.com/texas-engaged-state-sanctioned-child-abuse-opinion-1687232>
22. Children’s Bureau. *Child Maltreatment 2019*. US Department of Health and Human Services; 2021. Accessed September 1, 2022. <https://www.acf.hhs.gov/sites/default/files/documents/cb/cm2019.pdf>
23. Child Welfare Information Gateway. Child maltreatment 2019: summary of key findings. Children’s Bureau, US Department of Health and Human Services; 2021. Accessed September 6, 2022. <https://www.childwelfare.gov/pubpdfs/canstats.pdf>
24. Flaherty EG, Sege R. Barriers to physician identification and reporting of child abuse. *Pediatr Ann*. 2005;34(5):349-356.
25. Teherani MF, Pickering LK. ED visits for child abuse drop during pandemic; hospitalizations increase. *AAP News*. March 1, 2021. Accessed December 7, 2022. <https://publications.aap.org/aapnews/news/8933>
26. Bergman AB. Child protective services has outlived its usefulness. *Arch Pediatr Adolesc Med*. 2010;164(10):978-979.

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## AMA Journal of Ethics®

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### ART OF MEDICINE

#### ILLUMINATING PSYCHOLOGICAL TORMENT OF CHILD ABUSE

Paul R. Abramson, PhD and Tania L. Abramson, MFA

##### Abstract

What would it mean for our imaginations to fathom, or even just approximate, subjective experiences of people who have endured chronic abuse as children? This article considers the usefulness of 3 works by artists who were directly or indirectly affected by this type of trauma.

##### Fathoming Subjective Experiences of Child Abuse

*Agamemnon* is a Greek tragedy known for one especially notorious act. The father, Agamemnon, kills his daughter. How were viewers supposed to understand this convoluted play? They weren't. Incomprehensibility, according to the philosopher G.W.F. Hegel, was intrinsic to Greek tragedy.<sup>1</sup> Viewers of this play could nonetheless grasp at least some measure of the fallout from atrocity, Hegel declared, by comprehending characters' underlying internal struggles. What, for instance, were the repercussions for Agamemnon after learning he killed his daughter? Articulating and representing those struggles, Hegel believed, are jobs for philosophy and for art.<sup>2</sup>

Some playwrights, such as Shakespeare, seem to have the ability to depict such internal processes, but a question remains whether and to what extent artists do so faithfully. The philosopher Thomas Nagel further wondered whether any subjective experiences could have sufficient objective character to be responsibly represented by another.<sup>3,4</sup> If subjective experience doesn't have an objective foundation, Nagel reasoned, we're then left to our imaginations—which raises yet another question. Can our imaginations ever bring us close enough to represent encounters outside the range of "normal" human experiences? We can, of course, supplement our imaginations with data, if indeed they exist; and perhaps personal narratives and archival resources might be useful as well. But if, like the Greek tragedy noted above, the event is highly unusual, we are ultimately left trying to comprehend an unfathomable human experience.

Which now brings us to the topic of child abuse—namely, children who have been sexually, physically, or emotionally abused or neglected. Usually, abuse is committed by a parent, stepparent, relative, or family friend; sexual abuse is often committed by an adult authority figure.<sup>5</sup> Teachers, coaches, priests, lawyers, scoutmasters, doctors, police officers, foster parents, clergymen, babysitters, and preschool owners—to mention just a few categories of perpetrators, both male and female—are all drawn from the 4-

decades-long forensic caseload of the first author.<sup>5</sup> We also know that child abuse occurs regularly and that it is a crisis of epidemic proportions.<sup>6,7,8</sup>

How then, can we, as health care professionals, better understand this inscrutable tribulation, given that it also appears at the border of intelligibility? The answer for us has always been through scrutinizing artistic visions that were manifested in the wake of this unrelenting trauma, particularly as conceived by **artists who are survivors** but also, to some extent, by artists who intimately connect to this kind of emotional upheaval.<sup>9,10,11</sup>

### Three Artworks

With this background in mind, we introduce 3 artworks. Two are by the second author (T.L.A.), who is a survivor of chronic childhood sexual abuse, and one was done in collaboration with the first author (P.R.A.).<sup>12,13</sup> The third artwork is by an artist who was not a survivor of child abuse but who nevertheless has a relevant connection to this tragedy. Trina McKillen is an Irish artist who was raised in a devout Catholic family in Belfast and, upon hearing the many stories of sexually abusing Catholic priests, she conceived her assemblage. Taken together, these 3 artworks represent cardinal features of the child abuse crisis—namely, its historical anchoring (*Dr Payne's Electroshock Apparatus*), its ubiquity (*Color Coded*), and its institutional preservation (*Bless Me Child for I Have Sinned*).

**Figure 1.** *Dr Payne's Electroshock Apparatus*, 2022, by Tania Love Abramson and Paul R. Abramson



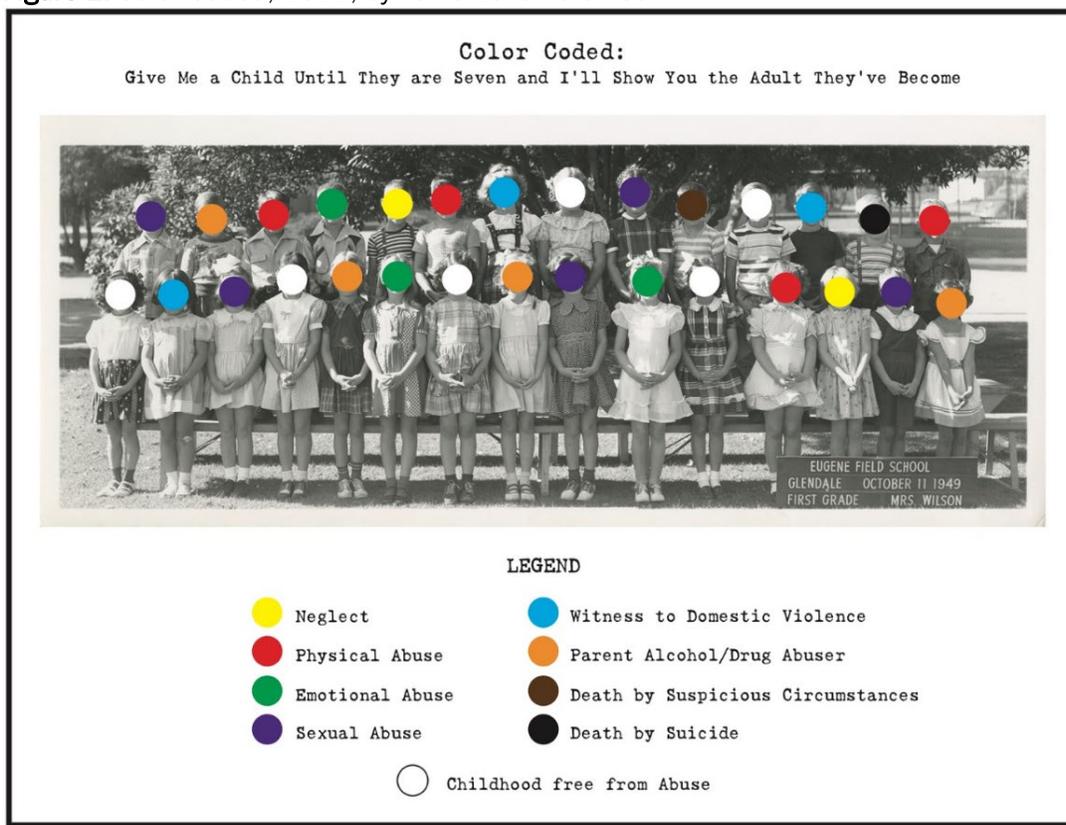
## Media

Child's mannequin head, facsimile electroshock therapy device, text panel, 16" x 24" x 16".

*Dr Payne's Electroshock Apparatus* is a case in point of exhibiting the unconscionable harm done to victims of child physical abuse. This effect is achieved largely through the historically driven signage, referring as it does to the purported 1955 Division of Juvenile Justice's "Spare the Rod, Spoil the Child" slogan.<sup>14</sup> This signage, which is meant to signify the justification of physical abuse as a credible form of parental instruction, also draws power from being harnessed to a facsimile 1950s electroshock unit.

What makes this artwork especially unsettling is that it serves as a reminder that the harm done to children of a previous era continues to this day. Even in the 21st century, hitting children with objects and beating them, as well as shaking infants, persists throughout the world.<sup>15</sup> The overriding message of this activist artwork is that our public health efforts are by no means complete. Parents continue to believe that they are the masters of their own domain and thereby can administer physical punishment at their sole discretion.<sup>16</sup> The adage that "There's no place like home" apparently also means that there's no place like home for harming your child. It also doesn't help matters that corporal punishment has been codified in the New King James version of the Bible—Proverbs 13:24, to be exact: "He who spares his rod hates his son. But he who loves him disciplines him promptly."

**Figure 2.** *Color Coded*, 2022, by Tania Love Abramson



## Media

Digitally manipulated found photograph; dimensions vary.

The second artwork, titled *Color Coded*, is able to achieve its power instantaneously. Using a found vintage elementary school photograph, *Color Coded* is an allegorical representation of the ubiquity and gravity of child abuse, without ever relying on representative samples, national statistics, or even descriptive language, such as legal definitions. The viewer, nonetheless, readily gets the point. Child abuse does **monumental damage** to countless victims.

The artwork is introduced by a gender-neutral version of a quote often attributed to Aristotle: “Give me a child until he is seven and I will show you the man,” which attests that early childhood experiences are formative. With this adage in mind, the colored dots covering the faces of the children serve 2 purposes. They eliminate the identification of each classmate, while simultaneously introducing the various traumas of child abuse—physical, emotional, sexual, and **neglect**—as well as 4 additional adverse events: witnessing domestic violence, parental alcohol/drug abuse, suspicious death, and death by suicide. It is clearly not a pretty picture by any means. On the other hand, it’s also a sincere rendering of the emotional adversities experienced by children of this or any other era throughout the world. Finally, if indeed there is an additional operative element in this artwork, it’s the choreographed positioning of the little girls’ hands in the first row. They are the charming counterpoint to the torment represented herein, further suggesting that, despite the idylls of childhood, innocence doesn’t come with a guarantee.

**Figure 3.** *Bless Me Child for I Have Sinned*, 2010-2013, by Trina McKillen



Used with permission of the artist.

## Media

Glass, marble, wood, nails, metal, nickel-plated composite, linen, plexiglass, 102" x 94" x 58".

Lastly, representative of the institutional preservation of child abuse, is Trina McKillen artwork, *Bless Me Child for I Have Sinned*, which is part of a larger installation titled *Confess*. It is a magnificently crafted and meticulously designed sculptural edifice that operates on several dynamic levels. Although neither priest nor child is visible, the viewer nonetheless immediately grasps that it is the priest who has been exposed as the confessor of the crime of child sexual abuse, and it is he (presumably on his knees) who is asking for forgiveness from a child (sitting in the white chair) who has been a victim of his crime.

This confessional box also functions as a symbol of a fervent departure from Catholic Church policy, whereby the crime of child sexual abuse is no longer banished from sight but instead is now transparent, literally, for all to see. And, as such, this artwork becomes a powerful metaphor of public reckoning, whose therapeutic value cannot be emphasized enough. It gives voice to a particular category of victims of child sexual abuse using an iconic Catholic symbol, the confessional.

## A Take-Home Message

What these 3 artworks have in common is a commitment to using narrative devices—metaphor and allegory—to represent different aspects of the unrelenting trauma of child abuse.<sup>17</sup> There are several advantages to this strategy. First and foremost, each of these artworks effectively illuminates, on both conscious and unconscious levels, the vestiges of anguish experienced by victims of child abuse. By depicting this haunting nightmare, these artworks also serve as effective pedagogic mediums and as persuasive vessels for disseminating the subjective experience of severely traumatized children. That is, they teach—while at the same time spreading the word about—child abuse in a format that is seamlessly absorbed. They're also replete with “aha!” moments, without ever unduly offending the viewer. Lastly, by relying on metaphor and allegory rather than on perception alone, these artworks tell compelling stories about child abuse that make a greater cognitive demand on the viewer. In that case, what the viewer gets is more than what the viewer sees.

## References

1. Hegel GWF. *Phenomenology of Spirit*. Miller AV, trans. Oxford University Press; 1977.
2. Pippin R. *Philosophy by Other Means: The Arts in Philosophy and Philosophy in the Arts*. University of Chicago Press; 2021.
3. Nagel T. What is it like to be a bat? *Philos Rev*. 1974;83(4):435-450.
4. Nagel T. *The View From Nowhere*. Oxford University Press; 1986.
5. Abramson PR, Bland-Abramson S. Hiding under the color of authority: Eric Wess Uller and his decades-long rampage of child sexual abuse. *J Child Sex Abuse*. 2022;31(3):353-372.
6. Johnson CF. Child sexual abuse. *Lancet*. 2004;364(9432):462-470.
7. Jenny C, Crawford-Jakubiak JE; Committee on Child Abuse and Neglect, American Academy of Pediatrics. The evaluation of children in the primary care setting when sexual abuse is suspected. *Pediatrics*. 2013;132(2):e558-e567.

8. Kellogg N; Committee on Child Abuse and Neglect, American Academy of Pediatrics. The evaluation of sexual abuse in children. *Pediatrics*. 2005;116(2):506-512.
9. Abramson TL, Abramson PR. Charting new territory: the aesthetic value of artistic visions that emanate in the aftermath of severe trauma. *Contemp Aesthetics*. 2019;17:1-2.
10. Abramson PR, Abramson TL. Should art about child abuse be exhibited in corridors of health professional schools? *AMA J Ethics*. 2020;22(6):E525-E534.
11. Abramson PR, Abramson TL. Visual and narrative comprehension of trauma. *AMA J Ethics*. 2020;22(6):E535-E543.
12. Abramson TL. *Shame and the Eternal Abyss*. Asylum 4 Renegades Press; 2017.
13. Abramson TL. Unchain my anguish: a feminist take on art and trauma. *Fem Rev*. 2019;122(1):189-197.
14. Barnosky J. The violent years: responses to juvenile crime in the 1950s. *Polity*. 2006;38(3):314-344.
15. Runyan DK, Shankar V, Hassan F, et al. International variations in harsh child discipline. *Pediatrics*. 2010;126(3):e701-e711.
16. Grogan-Kaylor A, Ma J, Graham-Bermann SA. The case against physical punishment. *Curr Opin Psychol*. 2018;19:22-27.
17. Holyoak KJ. *The Spider's Thread: Metaphor in Mind, Brain, and Poetry*. MIT Press; 2019.

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## AMA Journal of Ethics®

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### PERSONAL NARRATIVE

#### How Should We Respond When Clinicians' Calls to CPS Are Punitively Weaponized Against Families?

Arielle Schechter, MD

##### Abstract

This narrative illuminates need for students and clinicians to be well prepared to face ethically and structurally complex realities of identifying and responding to children who might have been abused. The commentary considers how to draw on equity as an ethical value when communicating with children's family members in clinical settings.

##### Reflections on Mandatory Reporting

"Does anyone know how this baby might have sustained these leg lesions?" Our pediatrics professor asks this question while projecting a photograph during a lecture to first-year medical students, including me. We squirm. "Notice the symmetrical, well-demarcated lesions," the professor continues. We avert our eyes. Finally, one student offers, "Child abuse?"

The professor nods, continuing to click through a slide deck of photographs documenting children's abuse injuries—wounds, scars, misshapen anatomy—and explaining for each its likely provenance. "As medical professionals, we are responsible," the professor informs us, "to be alert to how some caregivers might mistreat their children. We are *mandatory reporters* with legal and ethical duties to document and report our suspicions that a child is or has been abused."

*What happens, I wondered during that class, and what should happen to children and to their caregivers after a mandatory reporter makes a report? If we need to report, shouldn't we care that what happens is what should happen?* Perhaps I know the importance of these questions because, for years before this lecture, I was employed in Louisiana's nonprofit social services sector. Having graduated college in the middle of the Great Recession with a liberal arts degree, I worked doggedly at jobs that paid \$9.13 an hour in the hope that I was somehow building a meaningful career.

##### Experience in Social Services

One of my jobs after college was at a residential treatment center for substance use, where I was tasked with providing parenting skills education to clients of a residential treatment program for women and their children. Clients were typically court-ordered to the treatment center and, in many cases, were allowed to have their children live with

them at the facility. Most were in the middle of protracted child custody conflicts, and their successful participation in our program was intended to demonstrate to the courts that they were indeed capable, responsible, and loving mothers, deserving of a chance to raise their own children.

It took me about 20 minutes on my first day to realize that I was not going to provide the solution to any of these women's problems. These women's lives were complicated by the compounded **traumas of poverty**, housing instability, and violence. They had chronic health problems and nutritional deficiencies caused by years of food insecurity and inadequate health care. I don't think any of them had finished college, and some of them didn't know how to read. Their drug use created significant instability in their lives. Their children would tell stories that began, "When the cops came to get Daddy..."

My worksheets about "communication strategies" and "bonding with your baby" seemed woefully inadequate and, frankly, condescending. The women felt that their parenting skills were perfectly adequate; rather, life stressors that were largely unaddressed in our treatment program made parenting challenging. The women and I seemed to get along best when I helped them with what kept them connected to their roles in their families: I spent most of our sessions together proofreading letters to their incarcerated romantic partners and watching cartoons with their kids so they had time to clean, cook, or rest. After several months of apparently impressive work, I was promoted to a position in a different department.

Despite my lack of formal training, I spent years working similar jobs within the grievously underfunded Louisiana social service landscape. Somehow, I was supposed to achieve the "measurable outcomes" of getting marginalized people to reengage with the health care system, embrace sobriety, resolve legal problems, maintain housing, and prove their worth as parents, despite the monumental structural challenges that landed them, usually punitively, in a social services program to begin with. With every anger management workshop I led and every food stamp application denial I appealed, I became increasingly convinced that my work was missing the point entirely on what might lift a person or family out of their struggles. I wanted to offer tangible, hands-on support to people during their times of struggle.

I did some soul-searching, as one does in their 20s, and decided to shift to medicine, a career path that I felt would better enable me to support people as they advance towards their own life goals. After digging my Scholastic Aptitude Test scores out of microfilm archives and sweating through a year of physics and organic chemistry, I was admitted to medical school.

### **Is "Better Safe Than Sorry" Safer?**

My work experiences influenced how I conceived of my new role in the medical field. I was eager to learn the technical skills and structural knowledge that I imagined would support the people like the women I used to work with. However, on the topic of **mandated reporting** for child mistreatment, I was surprised to find that parents and caregivers, many of whom had the same challenges my clients faced, were often villainized through the process of mandated reporting and left out of decisions that affected their families. I was also surprised that doctors receive very little formal training about how to identify and report child mistreatment. My medical school class had that one lecture on common physical findings of abuse, as well as a follow-up didactic a year later featuring many of the same graphic photographs. We were required to

electronically sign the student handbook, which contains a sentence or two about our state's particular reporting mechanisms. And we of course learn to tend to the physical wounds of our patients in the clinical setting.

During pediatrics clerkship, we learned about mandated reporting by observing a physician make a child protective services (CPS) report about a patient's family. We were sometimes encouraged to participate in writing the report or to speak with a hospital social worker about our observations. We were taught that we cannot always be sure if what we are seeing is child abuse but that, in such circumstances, we are never to hesitate to make a report if we have even the slightest suspicion. "It's better to be safe than sorry," we were counseled by the more experienced members of the treatment team. "We have to advocate for the children."

This formulation makes me uncomfortable. Of course, I want to advocate for the children. And there are situations in which a child's safety is acutely threatened and immediate intervention is required to bring the child out of harm's way. But in those "better-to-be-safe-than-sorry" situations, it seems that the task of child protection demands a snap and potentially underinformed judgment of the adequacy of someone else's parenting skills. There is no concurrent demand to have basic familiarity with the historical, ethical, and material realities of child abuse and with the disruptive and often traumatic downstream effects that mandated reporting can have on families. In the same way that doctors interrogate the etiologies of disease to make informed judgments about treatment, I would hope that doctors would have the knowledge to identify mistreatment and a mechanism to report it without causing additional and undue harm to families in distress.

We do not learn, for example, that "neglect" was determined to be the form of maltreatment in the majority of child protective investigations.<sup>1</sup> *Neglect* is a nebulous category that is often conflated with the effects of poverty (eg, inadequate public transportation, employment) that impede parents' abilities to provide for their children. We do not learn that, nationwide, allegations of parental alcohol and drug use account for more than 35% of all removals of children from their homes and, for pregnant women, are typically not accompanied by health care services.<sup>2</sup>

We do not learn that allegations of maltreatment involving Black children are more likely to be reported to child welfare agencies and more likely to be substantiated as valid reports than those involving White children (although substantiation rates are roughly equivalent for children covered by public health insurance).<sup>3</sup> Black children are more likely to be removed from their homes after CPS investigations and less likely to be legally reunited with their families.<sup>4,5</sup> The literature is inconclusive as to the reasons for this inequity: both race and poverty are significant and often intertwined factors in how a CPS-involved family might fare.<sup>3,6</sup> But it is certainly true that Black families are inequitably disrupted and harmed by CPS involvement.

If a medical student were to ask about these data, she might be told that making a CPS report helps a family access valuable social services. However, the majority of CPS referrals do not result in the provision of new services for families, as 45.5% of all reports nationwide in 2019 were not even investigated by CPS and, as such, did not require follow-up; of the reports that were investigated, 16.7% had evidence of abuse or neglect.<sup>7</sup> Nationally, it takes an average of 33 days before supportive services are even initiated for a CPS-involved family.<sup>7</sup> Evidence suggests that CPS-involved children have

worse outcomes than their uninvolved peers on academic and mental health measures.<sup>7,8</sup> Furthermore, fear of CPS involvement itself can deter a family from requesting services that might be helpful. Parents might not want to admit to mandated reporters (including medical professionals, teachers, social workers, and librarians) that they need certain supports at home to keep their children safe for fear that their vulnerability can be used against them.<sup>9</sup> The literature suggests that these fears are warranted, as parents and advocates have noted that threats to call CPS are often used by mandated reporters to regulate behavior.<sup>9</sup>

### **Punitive CPS Calls**

On my pediatrics clerkship, I cared for a young girl with severe chronic health problems. Her parents, fatigued by multiple hospitalizations over the course of their child's life, alternated between expressing gratitude, frustration, relief, and confusion towards the treatment team. On one morning after a failed intervention for the child's gastrointestinal distress, the patient's father shouted at the attending physician, informing her quite colorfully that she was "the worst doctor in this hospital." After several minutes of heated back-and-forth dialogue, the physician ended the conversation brusquely and left the room. The father followed her to the doorway, continuing to loudly express his dissatisfaction with the care she provided for his daughter. "He can't talk to me like that!" the physician said to the team, within earshot of the father. "Next time I'm calling CPS!"

As a medical student and a former caseworker, I was shaken. I empathized with the father, who felt powerless to soothe his daughter's discomfort. I also empathized with the doctor, who I knew was trying to make the best clinical decisions for the child's care. But the specter of alerting CPS was clearly intended as a form of punishment and control over the parent's behavior: the physician likely just wanted the father to calm down. Making the call had nothing to do with child protection—after all, the child was already in the hospital under the care of medical professionals. Rather, it had mainly to do with subjective views of a mandated reporter deciding whether to identify and report child abuse and the potentially devastating consequences that could befall this family. In short, the call was an exercise of power, a misuse of authority, which was wrong.

But I was in a bind: as a medical student, I was learning that such power was mine to wield. And I was learning this from the very physicians whose profession I had been begging to join for years, the same physicians who evaluate and grade me and hopefully will promote me through my training. I felt actively discouraged from thinking about the particular challenges faced by this father, because I was supposed to be training to be the physician in this situation. I wrestled with my initial instinct to ask her what would have been the indication to call CPS on this family. But, ultimately and shamefully, I was afraid to ask, for fear that she would think I was undermining her authority and questioning her judgment.

### **Creating Possibilities**

When I was in medical school, my formal education on child abuse was less than substantial, and the hidden curriculum, for better or worse, seemed to offer the most powerful lessons. A physician might call CPS to report a child with poor dentition, hoping this action will result in a dental evaluation. However, this physician is in effect attributing what might be barriers to care to a symptom of bad parenting. Perhaps the child has behavioral disabilities that make dentist trips nightmarish. Perhaps the family does not have dental insurance and cannot afford regular cleanings. Whatever the case,

the investigation is outside the physician's responsibility and falls to CPS. Even if CPS is able to secure dental care for the child, the legacy of CPS involvement with a family can be devastatingly punitive, especially in cases involving drug use.

In some states, when physicians decide to drug-test a postpartum patient and the patient's newborn baby, they are in effect agreeing to make an automatic CPS referral should the test results be positive for certain substances. The patient is not consulted on this decision but will certainly face the consequences of it.<sup>8</sup> But what if there is no evidence of distinct harm to the newborn? Is this child abuse, or, in the language of Louisiana's child protection laws, "prenatal neglect"?<sup>10,11</sup> Does the physician need to consider that CPS involvement might cause significant disruption to this family's homelife, including court involvement and placement of the newborn baby in foster care? Is this ethical patient care? Does this actually protect any children?

I would argue that the more effective and ethical method of child protection is building a stable partnership with the family around optimizing the health and safety of the home. In cases of suspected or known drug use, the physician and other members of the care team should be open to asking the caregivers what they need to thrive, be it targeted treatment, economic supports, or other resources. The physician's mandate is not only to do no harm, but also to do good. Certainly, these principles of nonmaleficence and beneficence conflict in many cases. The real question is how to be responsible, thoughtful, and creative about approaching such conflicts.

Alongside the slideshows of the physical evidence of child abuse, medical students should be taught about the personal and social toll of surveillance, investigation, and child removal by CPS. We should learn to be advocates for children and their families, as well as their communities. Of course, we do not want any children to get hurt. And what should we do when they are? Are we really well-prepared to offer trauma-informed health care that helps children heal? Roles of rehabilitative or restorative justice for perpetrators of harm remain unsatisfyingly unclear.

When we remove a child from their family home—purportedly for their own well-being—we then put the child in another home with temporary caregivers who receive money from the government to help with expenses related to the child's care. If poverty is an indicator for CPS involvement,<sup>9,10,12,13,14</sup> why don't we just give money directly to the child's family? Why don't we lift families out of poverty instead of punishing them disproportionately for raising their children the best they can with the resources they have available?

These sorts of questions challenge my understanding of the role of a physician in society. I want to be creating possibilities for my patients, not taking them away. I want to be proactively collaborating with their families, not exasperatedly throwing up my hands, excusing my harmful action or inaction by saying, "I did what I was required to do." When it comes to protecting children, I do not believe the fields of social work and medicine are inherently limited to the status quo. Yet it is hard to be creative when we do not see successful alternatives to what is in front of us. It is especially hard when we face big problems with small tools based on paperwork and entrenched social values that are not inclusive of the variety of human experiences in our communities, especially the experiences of the families who are likeliest to be reported to CPS for child mistreatment.

To the father I witnessed lashing out angrily at the physician: I am sorry you felt so helpless about your sick child. You and your family, like all of us, deserve the best of health and happiness. You should not have yelled, but I understand that you were afraid you did not have what you needed to take care of your daughter. What will it take to get you what you need?

## References

1. Child Welfare Information Gateway. *Child Maltreatment 2019*: summary of key findings. Children's Bureau, US Department of Health and Human Services; 2021. Accessed October 13, 2022.  
<https://www.childwelfare.gov/pubpdfs/canstats.pdf>
2. Child welfare and alcohol and drug use statistics. National Center on Substance Abuse and Child Welfare. Accessed June 22, 2021.  
<https://ncsacw.samhsa.gov/research/child-welfare-and-treatment-statistics.aspx>
3. Putnam-Hornstein E, Needell B, King B, Johnson-Motoyama M. Racial and ethnic disparities: a population-based examination of risk factors for involvement with child protective services. *Child Abuse Negl.* 2013;37(1):33-46.
4. Maguire-Jack K, Font SA, Dillard R. Child protective services decision-making: the role of children's race and county factors. *Am J Orthopsychiatry.* 2020;90(1):48-62.
5. Disproportionality and race equity in child welfare. National Conference of State Legislatures. January 26, 2021. Accessed October 12, 2022.  
<https://www.ncsl.org/research/human-services/disproportionality-and-race-equity-in-child-welfare.aspx>
6. Rivaux SL, James J, Wittenstrom K, et al. The intersection of race, poverty and risk: understanding the decision to provide services to clients and to remove children. *Child Welfare.* 2008;87(2):151-168.
7. Children's Bureau. *Child Maltreatment 2019*. US Department of Health and Human Services; 2021. Accessed September 1, 2022.  
<https://www.acf.hhs.gov/sites/default/files/documents/cb/cm2019.pdf>
8. Berger LM, Cancian M, Han E, Noyes J, Rios-Salas V. Children's academic achievement and foster care. *Pediatrics.* 2015;135(1):e109-e116.
9. Fong K. Concealment and constraint: child protective services fears and poor mothers' institutional engagement. *Soc Forces.* 2019;97(4):1785-1810.
10. Substance exposed newborns reporting and notifications. Louisiana Department of Children and Family Services. Accessed June 22, 2021.  
<http://www.dcfslouisiana.gov/page/481>
11. LA Child Code Art 603. Louisiana State Legislature. Accessed June 22, 2021.  
<https://www.legis.la.gov/Legis/Law.aspx?d=73195>
12. Thomas MMC, Waldfogel J. What kind of "poverty" predicts CPS contact: income, material hardship, and differences among racialized groups. *Child Youth Serv Rev.* 2022;136:106400.
13. Dickerson KL, Lavoie J, Quas JA. Do laypersons conflate poverty and neglect? *Law Hum Behav.* 2020;44(4):311-326.
14. Fong K. Neighborhood inequality in the prevalence of reported and substantiated child maltreatment. *Child Abuse Negl.* 2019;90:13-21.

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