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PERSONAL NARRATIVE

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

Arielle Schecter, 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 from 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.¹ *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.²

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).³ Black children are more likely to be removed from their homes after CPS investigations and less likely to be legally reunited with their families.^{4,5} 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.^{3,6} 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.⁷ Nationally, it takes an average of 33 days before supportive services are even initiated for a CPS-involved family.⁷ Evidence suggests that CPS-involved children have

worse outcomes than their uninvolved peers on academic and mental health measures.^{7,8} 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.⁹ 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.⁹

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.⁸ 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"?^{10,11} 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,^{9,10,12,13,14} 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.dcf.louisiana.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.

Arielle Schecter, MD is a family medicine intern at the University of California, San Diego. Before attending medical school at the University of Rochester, she worked for 8 years in Louisiana's nonprofit sector.

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