CUNY York College

Overview of The Ethical Concerns Regarding Mandatory Reporting of Child Abuse

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07/14/2023

Child abuse and maltreatment presents as one of the unfortunate realities that many healthcare providers may come across in their careers. There is a complex ethical dilemma regarding when to report these suspected cases. Healthcare providers must steer the delicate balance between preserving confidentiality of these patients and families, and safeguarding the well-being of vulnerable children. There are several different forms of child abuse, with one of the simplest forms being defined as “The neglect of a child including physical, sexual or emotional abuse” (ChiaChiLiu, 2019). In states like New York, registered PAs are recognized as medical professionals that have the duty to be mandatory reporters of child abuse or maltreatment based on rational observations, professional training, and general suspicion. The general guidelines of reporting child abuse in New York state follows a few standard steps. Once there is a suspicion of abuse, PAs do not need to notify parents/legal guardians and will need to contact 311 or NYS Central Register of Child Abuse and Maltreatment (SCR) to make the report.

It is important to note that a PA reporting child abuse in a clinical setting is not a definitive accusation, but instead is a means to ensure the wellbeing and safety of that patient (NYC Children, 2023). After the provider that is reporting in good faith does so, investigations and interventions are carried out by the appropriate authorities. These are the individuals who determine whether abuse or maltreatment has occurred and take the necessary actions to protect the child. The ethical dilemma presented to PAs as mandatory child abuse reporters lies in the balancing of their duty to protect the child's wellbeing, beneficence, with considerations of confidentiality and possible strain placed on the relationship with the child and their family, namely respecting autonomy and confidentiality. We will further discuss the various types of child abuse, examples and how to improve on reporting abuse in this paper. Above all, it is important for PAs to navigate this dilemma ethically and follow the guidelines set in place to ensure the best interests of the child are upheld, while maintaining the professional responsibilities that PAs are tied to upholding.

As mentioned, child abuse reporting is critical to the safety and wellbeing of adolescent patients. Amongst 676,000 children in the US who experienced maltreatment, about 75% experienced neglect, 18% experienced physical abuse, and 8% experienced sexual abuse (USPSTF, 2018). Amongst this same population, around 14% of children experienced multiple forms of maltreatment and more than 1,700 of these children died as a result of their abuse (USPSTF, 2018). One of the most obvious benefits to reporting child abuse is simply removing the child from a situation where they are at risk for physical harm. As previously mentioned, children have lost their lives to child abuse; in very extreme cases, we risk losing the patient when careful attention is not paid to such a critical matter. Ethically, we are bound to our principle of beneficence, and we must always do right by the patient. A pro of mandatory reporting is that we can remove the patient from a possible dangerous situation. Another major advantage of mandatory reporting is that it provides the opportunity to prevent the long term negative emotional side effects of abuse for this vulnerable population. With mandatory reporting, providers can make positive steps towards protecting a child from the often life-long trauma of abuse from caregivers. Often, providers have the chance to serve as the voice for the child who does not know when or how to speak up about their abuse, or does not even know their abuse is occurring. Childhood abuse can negatively impact both adolescent development and have sustained impacts through adulthood (USPSTF, 2018). Both child abuse and neglect are considered forms of complex trauma. They are associated with negative psychological outcomes such as depression, substance abuse, chronic pain, and long-term disability (USPSTF, 2018).

While both of those points must be considered, it is important to note that there are also negative aspects of reporting abuse. One of the most prominent, due to its domino effect, is how a false report might affect family function and dynamics (USPSTF, 2018). If a family is falsely accused of child abuse or neglect, the child in question would likely be removed from the family. This can cause emotional distress for both the child and the family, the stigma associated with false allegations can have

a lasting effect on both personal and professional lives. Having the child be separated from their family due to an incorrect reporting can cause long term psychological trauma (USPSTF, 2018). Additionally, a false report can create a negative stigma around the family, damaging reputations and relationships of the family involved, whether that is amongst the family or between the family and the outside world (USPSTF, 2018). These allegations would likely follow them throughout their life, emotionally or otherwise. Consequently, though the pros for accurately reporting abuse is clear, we must also consider the negative effects a false report could have on the lives of those involved. Though false reports are relatively rare, the potential harmful effects cannot be undermined.

Though it's been emphasized at length that providers have both legal and ethical obligations about reporting suspected child abuse, sometimes it's not as easy as it might seem on paper. Socioeconomic statuses of families and their children play into how much reporting actually happens. Clinical bias, unfortunately, plays a big role in reporting of suspected maltreatment of children. As research suggests, there has been over-reporting of families with low socioeconomic or minority status, with underreporting of families of higher socioeconomic status and Caucasian families (Letson et al., 2023).

The CDC cites a combination of individual, relational, community, and societal factors that contribute to the risk of child abuse and neglect. This includes caregiver traits such as mental health issues, limited education, young age, substance use or abuse, and low income (Letson et al., 2023). However, clinicians must interpret social risk factors and apply them in practice in ways that do not perpetuate bias. Unfortunately, racial inequality does significantly impact the medical field, clearly illustrated by the fact that Black children are more likely than White children to be reported as victims of child abuse.

Providers ultimately need to make a decision regarding whether mandated reporting is necessary and whether a medical assessment should be conducted to identify any additional injuries (Letson et al., 2023). Despite the availability of evidence-based clinical guidelines for identifying child maltreatment, several studies have revealed that clinicians display biases when evaluating symptoms. For example, research has indicated that abusive head trauma is more frequently overlooked in young White infants compared to minority infants, as well as in infants from "intact" families compared to families where the parents are not living together. Furthermore, underrepresented minority children are more likely than White children to undergo a skeletal survey and be reported for suspected abuse, and children without private insurance are also more likely than those with private insurance to undergo such evaluations and be reported (Letson et al., 2023).

Both under-reporting and falsely reporting child abuse can have significant detrimental effects. Dissecting a case example, regarding the issue of medical child abuse (MCA), will help illustrate the possible negative effects of reporting falsely. MCA is considered to be a broad, unique form of child abuse. This can be understood as subjecting a child to treatment of an illness that is unnecessary and may cause harm to the child. There are many variants of MCA including Munchausen by Proxy, when a caregiver synthesizes the child's illness for sympathy, and even something called anorexia by proxy, when a caregiver imposes their eating disorders onto the child (Yates & Bass, 2017). This is a very complex issue because the intention of the caregiver does not determine whether MCA is present or not. This means that even if it seems that the caregiver is acting with what they think is the patient's best interest in mind, it does not remove the concern of abuse. In the review article *The perpetrators of medical child abuse (Munchausen Syndrome by Proxy) – A systematic review of 796 cases*, the authors bring a quote which compares it to physical abuse by saying that "a mother might violently physically assault her infant because she is fed up with the child crying, she is intoxicated or drugged, or she earnestly thinks that is the way to get the infant to behave and start eating, but it is still called physical child abuse"

(Yates & Bass, 2017). Once MCA is suspected, the people who are typically considered reliable sources can no longer be trusted. The idea being implied is that once MCA is a concern clinicians must follow through with working it up, no matter what the parent says. This is because, regarding MCA clinicians must "be aware that perpetrators may induce illness in children," and will say whatever it takes to convince medical professionals (Yates & Bass, 2017).

The consequences of such an approach can yield to be very worrisome to the core function of the healthcare system and family dynamics in the US. These consequences can easily be illustrated in the case of Maya Kowalski. In the Netflix documentary, *Take Care of Maya*, the devastating story of the Kowalski family is displayed. As a young child Maya developed excruciating pain all over her body and her mother, an RN, found a doctor who specialized in such issues and who diagnosed her with complex regional pain syndrome (CRPS). CRPS is usually triggered by an injury to a limb, however the pain lasts much longer and is much more severe than the initial injury warrants. Slight touch can trigger extreme pain in individuals with CRPS and quality of life is greatly diminished (Complex Regional Pain Syndrome, n.d.). It is most beneficial to begin treatment consisting of pain relief, spinal cord block and psychotherapy early on. In Maya's case it took a while for the diagnosis to be made and all conventional treatments did not work, resulting in the doctor turning towards ketamine treatment which was reserved for severe cases. Being that this disease can have flares, although the initial ketamine treatment greatly helped Maya, she eventually had a flare up which brought her back into the hospital. Upon intake, Dr. Sally Smith suspected MCA being that the mother, Beata, was persistent in requesting ketamine, a typically "strong" drug, for her daughter. Additionally, Beata fit the profile of a typical MCA perpetrator as suggested by Yates and Bass. As they say, "Almost all perpetrators of MCA in the reviewed cases were women and the mother of the victim…A healthcare-related occupation was mentioned in nearly half of the cases" (Yates & Bass, 2017). Beata, Maya's young mother was also an RN and therefore along with her persistent nature, in her advocating for her child, Dr. Smith was concerned for MCA and

sounded the alarms. Once the situation was set in motion it all went downhill. The whole healthcare team, social workers and judicial system sided with the conclusion of Dr. Smith. The parents were banned from seeing Maya leaving Maya in physical pain along with emotional pain. As Maya herself describes the situation, “One day I was in the ICU and my mom kissed me on the forehead and was like ‘I love you. I’ll see you tomorrow.’ I never saw her again. I was medically kidnapped” (Roosevelt, 2023). The grief that Beata felt because she could not protect her daughter, from what was medically diagnosed and backed by a competent doctor, led her to killing herself leaving her family without a mother and a wife.

This case clearly brings up many issues with the way the medical field dealt with what they considered MCA. Dr. Smith was mandated to report what she found to be child abuse as that is the required role of clinicians. Similarly, as expected, once suspected of MCA Beata was no longer viewed as reliable, as suggested should be done in the above study, and thus everyone began to side with Dr. Smith. In this case, along with many others, Dr. Smith was sorely wrong in her concerns and much of the pain experienced by so many people could have been prevented with some slight adjustments in how the issue was dealt. First, when the original doctor wrote his letter in compliance with what Beata was saying, other doctors could have spoken with him and listened to what he had to say in order to make a more informed decision of whether he, or Dr. Smith was correct. Additionally, even if this was the right move to be made in part of the medical team, the court system and social workers could have been more understanding of the pain of both mother and daughter, and allowed Beata to give her daughter a hug. Ultimately, the fact that she could not see her daughter and give her a hug to console her is what killed Beata. This case affirms that reporting child abuse is a great responsibility that poses valid ethical concerns and should therefore require proper training and thought, therefore reform is suggested.

As discussed, child maltreatment is an important public health problem which has presented an increase in deaths per day due to child abuse and neglect from 1998 to 2021 (Statista Research

Department, 2023). US states mandate by law that physicians must report suspected child maltreatment, however it is clear that health care providers experience multiple barriers to reporting which could lead to missed cases or over-reporting. When looking into how we can ensure that reporting of child abuse and negligence are efficient moving forward, we would like to use a national survey study to understand the relationship between knowledge and confidence of child maltreatment recognition and reporting (Mandadi et al., 2021). The study demonstrated that knowledge in child maltreatment recognition and reporting was significantly correlated with confidence in reporting and recognition with a $p<0.001$ (Mandadi et al., 2021). In layman's terms, clinicians who had higher knowledge in this topic felt more confident which would lead to more correct reports with better outcomes. There was also a significant relationship between knowledge and confidence in respondents from states with training in child maltreatment recognition and reporting requirements as a condition of licensure and re-licensure with a $p<0.01$ (Mandadi et al., 2021). This suggests that having this training has a positive effect on clinician knowledge and confidence. Although reporting suspected child maltreatment is mandatory by law, not all states require a child maltreatment rotation. The study concluded that physicians who have had child maltreatment training have high confidence and knowledge with the management of child maltreatment and thus could improve child maltreatment recognition and reporting. For these reasons, we recommend an inclusion of mandated child maltreatment training in residency/fellowships and mandated training for medical licensure in all states as it could improve child maltreatment recognitions, reporting, and could also limit unnecessary reportings. We come to this recommendation after reviewing the results of the mentioned cross-sectional survey study of physicians in Pediatric Emergency Medicine.

As previously mentioned, PAs are also known mandatory reporters when it comes to child abuse. We believe mandatory reporting should come with checks and balances in order to ensure that there is proper and just reporting. As we've illustrated, mandatory reporting is a delicate matter and raises complex ethical concerns. When considering how this relates to the PA profession, we recommend

expanding the previously mentioned child maltreatment rotation/program to the current PA curriculum during ER and/or Peds rotations, as well as in any applicable class in the didactic year. In doing so, we allow new PAs to confidently apply the tools learned, to efficiently and correctly report child abuse/negligence while also limiting negative impacts from over-reporting. PAs play a critical role in bridging the gaps in our current healthcare system. We believe this aspect of the PA profession and practice allows us to treat the patient in a holistic sense and includes a more comprehensive approach. This delivery of conscientious care is crucial, due to the complexity of this sensitive dilemma. With proper utilization of training resources, we can optimize the roles of PAs as clinicians and mandatory reporters to limit future cases like Maya's.

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