

# **MEDICAL ETHICS CONCERNS IN PHYSICAL CHILD ABUSE INVESTIGATIONS: A CRITICAL PERSPECTIVE**



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## **EXECUTIVE SUMMARY**

The Family Defense Center's mission is to advocate justice for families in the child welfare system. In working on cases for wrongly-accused families who are targeted as a result of Hotline calls to child protective services, the Center handles many cases involving physical findings (typically bone fractures and/or bleeding on the brain or eyes) that are initially believed to give rise to suspicion of child abuse. In most of the Center's cases, these medical findings eventually come to be seen as either the result of an accidental or medical condition or disease; in some cases, the findings that caused child protection investigations are determined not have to have been present at all. While there may have been good reason to consider the possibility that the child was abused in these cases, careful consideration of alternative explanations yields the result that abuse is not a likely explanation, and certainly not a contention that can be proven in a court of law by a preponderance of the available evidence. In the typical Family Defense Center medically complex case, parents are eventually exonerated and children are returned home but only after intervention by the child protection system that lasted weeks, months or even years.

Does this typical fact pattern in Center cases show the child protection and medical assessment system works when child abuse has been alleged based on a medical finding? Or is the system for child abuse investigation, with extensive involvement by the medical profession every step of the way, failing the children and families who are the subjects of Hotline calls?

We submit, in this Paper, that this system of child abuse investigation and medical assessment is failing the children and families. We also submit that the failings are due at least in part to practices that are ethically questionable at best, or plainly unethical at worst. The harm of these practices occurs because, while the child may quickly recover from a toddler fracture, nursemaid's elbow or subdural hematoma that is called in to child protection authorities as suspicious, the trauma families have experienced at the hands of the child protection system does not fade quickly or ever entirely disappear. Moreover, the Center is able to represent only a tiny fraction of the wrongly accused family members in medically complex cases and resources like the Center provides are not available to the vast majority of family members who encounter the child protection and medical care establishment in these cases. Unfortunately, we see little sign that the child protection and medical care establishment are addressing in a meaningful way the harmful impact of erroneous child abuse reports that have resulted from questionable ethical practices that this Paper documents. Indeed, for reasons this Paper documents, we believe that the medical profession has turned a blind eye to the treatment of children and families who are the victims of misplaced child abuse allegations and we are concerned about developments in the handling of medically complex allegations that make these problems worse, not better.

In this Paper, we deal only with cases in which the wrongly-accused parent has been exonerated. As to the exonerated parent, we ask the question "What role did doctors play in the allegation being made in the first place and what were the ethical considerations for these doctors during the cases that eventually ended in an exoneration? Were there ethically required steps that doctors skipped in a rush to reach an ultimately unsustainable conclusion that child abuse was the likeliest explanation for the child's injury? Has the medical care establishment established policies and practices that impede reaching the correct conclusion? Are family members' interests in receiving information and making choices in the best interests of their children compromised by the processes currently in place? And if doctors' medical ethics duties were

violated, what policies and practices should be adopted so that the medical care establishment's involvement in child abuse cases truly does no harm to the children?

Focusing on the medical ethics duties involved in child abuse allegations that come to the attention of doctors, this Paper first presents five illustrative cases that document in detail how the medical profession interacted with the child protection system to disrupt the family life of children who were ultimately determined not to be victims of child abuse after all. These cases all arose in Illinois and are representative cases in the Center's much larger experience in medically-involved child abuse cases.

After the detailed presentation of these cases, the Paper reaches several important conclusions that, we submit, require attention by medical and child protection policy makers as well as individual practitioners in these fields.

To summarize these conclusions:

1. The duty of physicians not to become law enforcement officers or to engage in interrogations is violated by practices under which children are detained at hospitals while medical staff (child abuse pediatricians or social worker under their direction) interrogate parents using police-type tactics that have no place in a medical treatment context (Discussion Section I).
2. After a Hotline call has been made, parents' decision-making as to their children's medical care and their access to their child may be impaired by misplaced assumptions about parental responsibility for suspected child abuse. This impairment deprives children of their rights to have their parents make essential health care decisions on their behalves. (Discussion Sections II and VI). In addition, doctors have an ethical duty to protect the child's familial relationships. If physicians become advocates or willing partners in state child protection actions seeking restricted contact between parents and their children or the removal of a child from her parents, they are acting contrary to medical ethical principles recognizing the importance of "family-centered care" to children. (Discussion Section VI).
3. The development of the child abuse pediatrics subspecialty, which was recognized by the American Board of Pediatrics in 2009, has led to the child abuse pediatrician becoming the lead voice with child protection agencies in their determination of whether they believe child abuse occurred and parental access to children should be restricted. The idea that the child abuse pediatrician's has greater expertise than other subspecialists has been more broadly accepted than is justified, especially if the child abuse pediatrician fails to fully consult with subspecialists in forming her abuse conclusions. (Discussion Section III, VIII).
4. As a result of the development of the child abuse pediatrics specialty, treating physicians and other doctors increasingly are pressed to give deference to opinions of the child abuse pediatrician, and they appear to be succumbing to that pressure in large numbers. This deference leads to economic and other benefits for treating doctors, but reduces the reliance on physicians who have potentially important information that supports the child and family relationship. Deference, to the exclusion of other opinions,

harms the interests of children and families and reduces the quality of information considered by the child protection system in reaching a fair determination of whether child abuse has occurred. (Discussion Section IV).

5. The rights to privacy and confidentiality of medical information are not supposed to be lost as a result of child abuse reporting, though current practices appear to assume a right to share a child's confidential medical information may be shared with state and local authorities and with forensic evaluators without parental consent whenever a child abuse report has been made. This overbroad sharing of information beyond the Hotline call itself is a potentially serious breach of medical ethics (Discussion Section V).
6. Physicians and medical institutions who hold contracts with child protection agencies have a duty to notify parents of children who are being evaluated for child abuse as to these third-party contractual relationships. When parents are not informed of the role of the child abuse pediatrician, or given the informed rights to participate or decline to participate in the child abuse pediatrician's assessment of the Hotline call, including the right to refuse consent to access to records, medical ethics requirements of disclosure and informed consent are violated. (Discussion Section VII).
7. In arriving at medical opinions in connection with legal proceedings, physicians have ethical duties to be honest, objective independent and guided by current scientific thought. These duties encompass recognition of the limits of the physician's expertise, the need to consult with other specialists, a duty to be objective rather than an advocate for a particular outcome, and a duty to maintain a reasonable caseload. The expertise of other disciplines such as orthopedics to the determination of child abuse is discussed at some length. If a child abuse pediatrician strays from his duties to be objective and sets himself up as the superior doctor whose opinion is the sole opinion the child protection system needs to consider, he violates this central canon of medical ethics (Discussion Section VIII).
8. Physicians also have an ethical responsibility to mitigate damage to families. Yet, in no case handled by the Center has this responsibility been met by the medical community; after exoneration, no family has received any offer of assistance or healing by any of the physicians who have caused them injury. This default is the result of the medical profession's failure to acknowledge the harm that wrongful child abuse allegations cause to children and families and to take meaningful steps to remedy that harm. Reconsidering policies and practices that cause the harm to occur would be an important first step in mitigating this damage. (Discussion Section IX and Summary of Conclusions and Recommendations).

This Paper aims to initiate a dialogue with medical care providers, medical institutions, child abuse agencies, and the public about the ethical issues raised in the medical assessment of child abuse reports. To that end, identifying the problems, analyzing the ethical duties and the potential violations of those duties that we have observed, and proposing some possible remedies is a first step toward creating a more just child welfare system. We hope that readers of this Paper will help the children and families and professionals who have contributed to this Paper to achieve this goal.

## **PART I. INTRODUCTION AND BACKGROUND**

### **Overview of the Focus of This Paper**

Beginning in the fall of 2011, the Family Defense Center undertook a major research project to explore the ethical obligations of physicians who become involved in cases of suspected child abuse or neglect. Physicians typically become involved in such cases either as treating physicians or as investigative/forensic medical experts giving reports used in legal proceedings involving child protection issues. This Paper is the result of that research and contains our efforts to present the ethical concerns that have arisen in cases we have handled at the Family Defense Center.

The Paper contains four parts. First, in this Introduction, Part I of the Paper, we explain our focus, our own background of involvement in medically complex cases involving children and families and generally describe the context in which these cases arise. We also provide some background to the child protection system and child abuse reporting that gives rise to some of the ethical concerns this Paper presents. In Part II, we present five Illustrative Cases which provide more detail exemplifying how medically complex child abuse cases arise and present a summary of medical ethics issues posed in each case. In Part III, we present a Discussion of the applicable ethical standards, in nine separate areas of interest, and explain how adherence to these standards in the context of a child abuse investigation could have a salutary effect in mitigating harm to families. The last section, Part IV of this Paper, sets forth our conclusions and enumerates our specific recommendations for improving medical ethical practices that this Paper critiques.

The reasons for undertaking this project, and this Paper that results from the project, follow from the Center's mission to advocate justice for families in the child welfare system. The Center frequently advises and represents parents and other caregivers who are the focus of child abuse calls made to the Illinois Department of Children and Family Services (DCFS) Hotline.<sup>1</sup> Many of the Center's cases bring the medical system into play.

Though our role is to protect the legal rights of families and caregivers who are innocent of wrongdoing as to their children, and though we have been very successful in dramatizing the high rates of error in child protection investigations, including medically-driven abuse cases, we understand and share the concern of the medical profession and the child welfare authorities about the urgent need to prevent and reduce child abuse in our society. It goes without saying that every child deserves to be safe from abuse, and it is, by now, a well-accepted requirement that doctors who come into contact with children they genuinely believe to have been abused have a duty to report this suspected abuse so that it may be fully and fairly investigated. This Paper does not question the right and duty of physicians to make Hotline calls when they reasonably suspect child abuse. Rather, we take such Hotline calls as the starting point for further inquiry into the role of physicians in the child abuse investigations that ensue following the Hotline calls.

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<sup>1</sup> The term "DCFS" is used throughout this report to refer to the Illinois agency that operates the Hotline and conducts non-criminal investigation of child abuse reports; we are aware that different acronyms are used to refer to similar agencies in other states (and sometimes those agencies are county or city based, not statewide agencies as in Illinois).

Once child abuse Hotline calls are made, including calls made by a physician or a hospital staff member, the administrative actions that are taken by DCFS to deprive parents of the right to continue living with and raising their children can be very swift. For most of the parents and families who become Family Defense Center clients, Illinois DCFS has already initiated some administrative action that has severely disrupted the family, such as requiring round-the-clock supervision of parents' interaction with their children or ejecting the parents from the family home altogether, before lawyers are even contacted in order to undertake representation of an accused family member. In these cases, evaluations by a denominated child abuse pediatrician (or fellow or member of the child abuse medical team) often play a decisive role in providing DCFS investigators and their supervisors with impressions and ultimately with evaluative reports that cause grave disruption to the families the Center represents. The Center has, to date, succeeded in exonerating all but a small percentage of the parents and caregivers it represents in these cases, but the damage to parent-child relationships that occurs due to misplaced child abuse allegation is irreparable.

Wrongly accused families experience great trauma due to the actions of the medical institutions from which they have sought help when they end up facing a child abuse allegation in the course of seeking medical care for their child. In many of these cases, the role of the child abuse pediatrician after the Hotline call occurred was never explained to the families. Most parents who have had direct contact with a child abuse pediatrician during the time their child was at the hospital, believed—incorrectly—that the child abuse pediatrician was one of their child's treating physicians. No client of the Family Defense Center has ever received any written explanation of the role of the child abuse pediatrician in reaching a child abuse conclusion. While child abuse pediatricians typically work in consultation with DCFS and police, parents are unaware that child abuse pediatricians are working hand-in-hand with state and local authorities who may have interests adverse to theirs (i.e., an interest in prosecuting them and/or removing their children from them). Only later, typically weeks after the Hotline call, do parents come to learn that their family life hinges on what the report of the child abuse pediatrician says. While they typically are unaware of the significance of the child abuse pediatrician's role while their child is undergoing treatment and the initial Hotline call is being made, family members have often raised questions later on in the process about the child abuse pediatrician's role during investigations and proceedings that ensue, including questions that raise significant ethical concerns.

In light of the questions client family members, staff, colleagues and board members had raised about the ethically proper role of a child abuse pediatrician in both the treatment of a child's injury that is suspected to be due to possible abuse and in the evaluation of that injury, George Barry undertook a detailed review of the medical ethics literature. Through this research, we have sought answers to the question of how a single child abuse pediatrician ethically can: (1) evaluate and report to State investigators and the courts on a Hotline call that her own staff member made; (2) work under a State contract to evaluate for child abuse the patient whose parents sought treatment from her own institution; (3) proceed to access confidential medical records of a child (and sometimes other family members) in order to give an evaluation, without disclosing that contractual relationship to the parents; (4) report to State officials a child abuse conclusion without consulting with specialists in other fields of medicine who were involved in the treatment of the patient and who can and do disagree with the child abuse conclusion; and (5) fail to recognize or take steps to remedy the negative impact on the family that their abuse

opinion has caused even when the parent is not considered to have been, or is not found through legal processes to be a child abuse perpetrator.

After researching medical ethics principles and opinions as documented in this Paper, we believe that there is indeed something ethically problematic with the way the child protection community and the larger medical community, with the newly-adopted child abuse pediatrician specialty, has treated the field of child abuse investigations. The medical ethics issues raised in this Paper should also concern the larger medical and legal communities as well as the community at large given the issues involve the treatment of children and families.

Performing more than one role in a single child abuse investigation necessarily brings up potential ethical conflicts and compromises the objectivity of any professional. These concerns are compounded, moreover, if the child abuse doctor works closely with treating physicians whose care the parent sought for their child where the role of the child abuse doctor promptly becomes adverse to and accusatory toward the parents. Harm to innocent children and their families can result from child abuse specialists whose roles in the process are no longer as treating doctors or neutral scientists, but rather as advocates, working with police and child protection authorities, for the prosecution of family members. Such a role is particularly problematic if parents prove to be innocent of wrongdoing and their children have suffered as the result of an erroneous child abuse diagnosis that could have been prevented.<sup>2</sup> The watchword of the medical profession, “First do no harm,” can be a casualty, along with other medical ethics imperatives, when child abuse doctors play a significant role in the investigation of child abuse cases and that role results, as it far too frequently does, in a false positive finding against an innocent parent or caregiver who may have their children removed as a result of the child abuse specialist’s opinion, may have their career working with children ruined, or may face serious criminal charges.

Of special concern to the Family Defense Center and to lawyers who represent accused persons more generally, is that a referral to a child abuse pediatrician often operates to silence other doctors. This referral to and reliance by the child protection system on the child abuse pediatrician, often to the exclusion of medical specialists and other treating physicians, also elevates the opinions of child abuse pediatricians above those of medical specialists who may have more knowledge of the mechanism or etiologies of the injuries or conditions involved. It also elevates the child abuse pediatrician’s opinion over that of treating physicians and surgeons who may have more information about the child and family than the child abuse doctors possess. These practices, along with special immunities for child abuse reporting and investigation that do not apply to other areas of medicine, makes the child abuse pediatrician effectively an arbiter of the merits of the abuse allegation (at least until a full trial or hearing eventually becomes available to the parents). Indeed, often the child abuse pediatrician is a final decision maker, even when the child abuse doctor’s opinion is misplaced, because child protection authorities frequently rely on the child abuse pediatricians to the exclusion of other medical opinion, which

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<sup>2</sup> See e.g., *In re Yohan K.*, --slip—1-12- (1st Dist. App. Court June 20, 2013) for the account of a two year ordeal of wrongly accused parents who won reversal of abuse findings against them in a vigorously contested and highly complex medical case involving parents who were acknowledged by all parties to be loving and attentive to the children and whose five week old son had numerous unexplained medical conditions. The Family Defense Center’s Melissa L. Staas represented the parents in this case on appeal after having referred them to Ellen Domphe for representation at their lengthy juvenile court trial.

may not even be known or considered. This is how the system frequently works in practice if not by design.

While our review of the medical ethics literature has been conducted by individuals with legal analytical training and experience, consideration of statutes and precedential case law is not our focus in this report. Nor is this Paper meant to be a study of hospital policies and practices in child welfare cases generally, even if some ethically questionable practices at specific hospitals are revealed in the course of the discussion. By the same token, this Paper does not focus on the ways in which child welfare agencies may compound or overcome any problems children and families experience due to actions by doctors that are the focus of this Paper.

In addition to reviewing the medical ethics literature, this Paper brings to bear our own experience in the cases we have handled and the policies and practices of doctors that we have observed in those cases. We make no claim to academic objectivity or neutrality as to the subject discussed in this Paper; both our assessments of the ethical issues at play in these cases and our recommendations for steps that we believe might improve ethical practices are rooted in our backgrounds as advocates as well as researchers. However, we have considered the issues critically, and without straying into legal rather than ethics analysis. This process has led us to a conclusion that there is considerable room for improvement in the way the child abuse specialist and the medical profession as a whole interact with children, parents and the state when there has been a reported suspicion of child abuse and that some of these changes require physicians to take more seriously the medical ethics precepts that they are bound to uphold.

This Paper focuses on the harm done to innocent parents and families, including the injured child, all of whom suffer as a result of erroneous allegations of child abuse. Often, the child's injury that brought the case to the child abuse doctor has fully healed in days or weeks, but the damage to the child's family, as a result of misguided child protection intervention that caused a family separation, lasts a lifetime. Children who have been taken from their parents even for a few hours, let alone days or weeks, may suffer a trauma to their close relationship they had enjoyed prior to the intervention in their families. Parents who are falsely accused of wrongdoing are typically frightened and anxious for both themselves and their child; the accusation alone, even when false, is extraordinarily stigmatizing. Most parents also report considerable fear of another commonplace injury that might necessitate treatment for their child. When the ensuing investigation is not terminated within a day or two, but turn on additional tests and the interpretation of medical information by a person the parents do not know or trust, the parents may lose faith in trusted medical institutions. If the allegations "stick"—even briefly, the costs of legal representation and the battle for exoneration can take on crisis proportions.

The damage to families is not alleviated if and when the parents are vindicated months or years after the child abuse charges were initially leveled against them.

It is sometimes asserted that exoneration at a hearing does not establish that the parent is innocent, and the reader may wonder how the authors may confidently assert that the parents whose cases are discussed here are innocent. We believe that the facts presented here in the Illustrative Cases will speak for themselves, given that not only was each family exonerated by the authorities, but in each case, there was a sound medical explanation for the medical findings that have brought to the child to the attention of those authorities.

Indeed, while we do frequently get asked how we can be confident that our client did not abuse or neglect a child, an unfortunate consequence of any accusation is that no parent, no matter how blameless, can become entirely free from the stigma of having been wrongly accused because parents are not “proven” innocent. The parents who secure exoneration also cannot ever undo the harm they have experienced. Many parents like those in the Illustrative Cases report a day does not go by when they do not think about the fear felt during the time an allegation against them had been pending. Many parents we have represented at the Center report that the pain of being wrongly accused does not go away; they consider the experience “life-changing” and many struggle to shield their children from the harmful effects that a separation, even brief, had on their deepest human bonds. Application of the ethical principles and opinions of the medical profession could have a salutary effect in mitigating all of these harms to families.

The children whose care is at issue in this Paper came to the attention of the medical profession with physical injuries or medical findings for which one conceivable explanation was child abuse. However, in all of the cases addressed in this Paper, there were other equally possible or more likely explanations for the same physical findings, and the parents in these cases were fortunate in gaining access to medical opinion that called an initial child abuse suspicion into question. These types of physical child abuse cases most commonly involve fractures in children who are not verbal, and also very commonly involve intracranial bleeding in young children (manifested in skull fractures, direct brain insults, subdural hematomas and/or retinal hemorrhages). Other injuries such as burns can also present similar ambiguities as to causation. This Paper does not concern the medical ethics of sexual abuse or typical child neglect cases (such as claimed lack of supervision or inadequate shelter). The focus of the cases discussed in this Paper is what the medical explanation for the child’s injury is. Because bones and brain trauma are involved, not only child abuse pediatricians, but emergency room doctors, treating pediatricians, radiologists, orthopedists, neurologists, ophthalmologists and neurosurgeons frequently play a significant or decisive role in the conclusions reached in these cases. These cases may become very controversial and contested, as many involve areas in which there is increasing disagreement within the medical profession itself as to whether certain types of injuries are truly specific for child abuse. Injuries once considered as being specifically indicative of child abuse, such as spiral femur fractures and subdural hematomas, are no longer presumed suspicious per se by practitioners and institutions who previously would have automatically reported such findings to the Hotline. In the wake of medical and legal controversy about these issues, many families are swept into the child abuse system and encounter child abuse pediatricians and other doctors whose opinions on these questions can be sharply opposed—if they are fortunate enough, as the families in the Paper were, to have access to medical expert opinion other than the one the child protection authorities procured.

### **The Family Defense Center’s Background as Advocates for Families Involved in Complex Medical Cases**

In Part II of this Paper, we will present five illustrative cases that all arose in Illinois and were all the subject of Hotline calls to DCFS. While we do not identify the clients, we do have the clients’ permission to use their experiences as our illustrative cases for this Paper. The Family Defense Center represented four of these clients in legal and/or administrative proceedings. The fifth case is one from central Illinois in which we were not the parents’

attorneys at the time the incidents occurred, but we did provide legal advice to the family following the medically-driven erroneous allegation of child abuse.<sup>3</sup>

These five cases are just a sampling of the far larger population of clients who have either been represented by the Center since its founding in 2005 or who, prior to 2005, were represented directly by Diane Redleaf, one of the authors of this Paper. These are all cases in which DCFS was encouraged to proceed based on a conclusion by a doctor that there had been child abuse even though at least another physician, or team of physicians, believed that there had been no such abuse. These are also cases in which treating physicians failed to ask questions or voice reservations or misgivings about a conclusion of child abuse by investigative physicians before the child and parent bore the brunt of an ultimately erroneous conclusion that the child had been abused.

The substantial majority of our clients are severely economically disadvantaged, with 65% of the Center's clients being at or below 150% of the federal poverty line. This mirrors the statistics generally applicable to parents in the child welfare system in the United States. However, a notable fact about the families brought into the child welfare system for physical findings like fractures and subdural hematomas is that these types of cases uniquely cut across all class lines. Parents of higher economic standing as well as families struggling to pay their rent are all potentially subject to an allegation that a fracture or head injury is due to child abuse.

All of the families whose stories are presented in this Paper as illustrative of the ethical issues in physicians' participation in child abuse investigations are two-parent families with strong family and social networks. Furthermore, not only did these families have access to qualified legal counsel but all of these families had the means to access alternative medical opinions besides the ones DCFS procured in their cases. These families had no known history of any violence in their immediate or extended families or criminal offenses or serious mental illness. Except for the child's injury or medical problem, these families almost certainly would not have encountered the child protection system. In each of the illustrative cases, the contention that the child had been abused was vigorously contested, resulting in substantial disagreement between child abuse pediatricians and other medical specialists in areas such as orthopedics and neurosurgery as to the degree of specificity of certain types of injury for child abuse. Given the nature of the injuries involved as ones that could be either caused by abuse or by accidental or medical condition, these cases demonstrate that, when a physical injury to a young child is at issue, *anyone* can be accused of causing the injury or finding that leads to a Hotline call. Thus, the issues raised in this Paper regarding the treatment of these families should be of concern to all families.

Another common feature of the illustrative cases in this Paper that may strike readers as contrary to their preconceptions is that none of these child abuse cases involves a *criminal* child abuse case. While there were preliminary police inquiries in some of these cases, all of the legal actions involving these families were civil or administrative only. Nevertheless, parents often report feeling that they were treated like criminals by the medical professionals with whom they

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<sup>3</sup> In this connection, the Center's direct legal services program operates only in Cook County, Illinois and the collar counties. However, our advocacy has extended to the state-wide child protection system in Illinois (including precedent setting cases we have brought in federal and state appellate courts). Moreover, our consultation activity often includes conferring with parent and family defense attorneys working outside Illinois.

interacted. While the families in these cases lived with severe restrictions, and several lost custody to DCFS for months, the legal system never formally charged any of the parents as criminal offenders.<sup>4</sup> And, most importantly, all of the parents whose cases are discussed here were exonerated of the child abuse charges that child abuse pediatricians had supported in consultation with DCFS and in reports and in testimony against those parents.

The illustrative cases discussed in this Paper have all arisen since 2009, the year in which the medical profession formally and significantly re-organized its approach to child abuse investigations by the creation of the sub-specialty of child abuse pediatrician.

While we are aware of similar practices to those discussed in this Paper at work in other states, where child abuse pediatricians are consulted and relied upon just as heavily as in Illinois, it is possible that some practices described in this report are quite different in other jurisdictions. For example, the head of one child abuse team in another state expressed surprise to learn that isolated subdural hematomas (bleeding in the area between the brain and the membranes that line the skull) in infants were routinely reported as child abuse to Illinois authorities absent other evidence of trauma. Because our in-depth experience is limited to Illinois cases and practices, we urge readers of this Paper to assess whether the ethical concerns raised here apply with equal force in their own communities.

### **The Medical Assessment of Child Abuse in the Context of the Child Protection System and Child Abuse Reporting**

Since 1974, with the passage of the Child Abuse Prevention and Treatment Act (“CAPTA”), child abuse reporting by physicians has been a national mandate. Consistent with CAPTA, Illinois passed the Abused and Neglected Child Reporting Act (“ANCRA”), which mandates that doctors and virtually all other health care professionals report injuries of children to DCFS, if there is “reasonable cause” to believe that the injury is the result of child abuse or neglect. We know from regularly published statistics that the percentage of such reports that are actually confirmed as child abuse after an investigation is quite small, and it would represent very welcome progress if ways could be found to reduce the number of Hotline calls by physicians that turn out to be unfounded, given that every Hotline call that is made carries with it an expenditure of governmental resources, medical staff time and, if a fuller investigation of the Hotline call is undertaken, potential trauma to the family. However, our primary objective in conducting this review and writing this Paper is *not* to discourage doctors or other medical staff from making mandated reports whenever they sincerely conclude that they have such “reasonable cause” to believe a child they are seeing in their professional capacity is abused or neglected by his or her caregiver. Rather, our attention in this Paper is on the ways in which

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<sup>4</sup> What appears to distinguish cases in which an administrative labeling of parents as guilty of child abuse (with some restriction of access to children during the investigation or thereafter) are the only sanctions from cases in which criminal charges are brought are three major factors: (a) the severity of the child’s injury and whether or not the child has made a recovery from the injury; (b) whether there is a clearly identified person who bears primary responsibility for the injury (versus multiple possible alleged perpetrators); and (c) whether there is any prior history of concern as to the accused parent (i.e., history of violence, drug use, paramours vs. married parents, whether there are older children who have no signs of maltreatment). The presence of conflicting medical opinion and the relative weakness of the child abuse pediatrician’s abuse opinion (“more likely than not abuse”) may also be factors weighing against criminal prosecution but these factors do not appear to limit administrative and juvenile court and other non-law enforcement intervention into families.

physicians, in their treatment, investigation, and evaluation roles, deal with an injured child and the child's family, once an investigation of child abuse has been initiated by the making of a Hotline call to child protection authorities.

The concerns this Paper raises do not arise solely, however, from the establishment of the new board certification process for the sub-specialty of child abuse pediatrics in 2009. The 1997 case *Dupuy v. McDonald*, a class action suit which was settled in 2007 (and in which Ms. Redleaf was co-lead counsel prior to her founding the Family Defense Center in 2005), challenged the lack of due process standards in the Illinois child abuse registry system. The class involved 150,000 class members who had been "indicated" (i.e., deemed responsible) for child abuse or neglect. The documents reviewed in that case included those involving hundreds of families who had been accused of physical abuse of the type discussed in this Paper. In the *Dupuy* suit the federal court ultimately found that child abuse reports had been erroneously registered in 74.5% of the cases that came before DCFS administrative law judges after a parent or caregiver had had been "indicated" for child abuse or neglect. The erroneous registrations of these parents and other caregivers as perpetrators of child abuse in turn operated as an employment blacklist for persons who worked with children. Among the defects the federal court adjudicated in declaring the Illinois child protection system to have a "staggering rate of error" was an over-reliance on a single child abuse medical specialist, who supported the conclusion that the child had been abused. The evidence before the federal court in *Dupuy* showed that child welfare authorities relied on child abuse pediatricians and sometimes failed to contact the other doctors who held contrary opinions to theirs. . Unfortunately, such a practice continues, as this Paper shows.

The Center currently secures reversals of administrative determinations of abuse or neglect for between 80% and 90% of its clients. This extremely high reversal rate is in part the result of the fact that child protection authorities have a very low burden of proof to satisfy before labeling a parent or caregiver as guilty of child abuse or neglect. The error rate in other jurisdictions including New York has also been documented as reaching similar staggeringly high levels.

As this very high rate of exoneration shows, as reflected in the Illustrative Cases presented in this Paper, judges who ultimately resolve child abuse court cases can be persuaded to see beyond the superficial conclusion that the child must have been abused because the child abuse pediatrician says so. (*See footnote 4 supra* for an exemplary case in which an appellate carefully sorted through the medical evidence, including neurosurgical, orthopedic and radiological testimony). This effort, however, may require both specialized legal representation and medical specialists to provide second opinions that are simply not available to all innocent parents. Moreover, even when judges make rulings that exonerate parents of wrongdoing, that still leaves families suffering terrible disruption over long periods of time.

The very high rate of error in cases in which the child protection system accuses parents of abuse is not well known to the general public, however. Media presentations of child abuse cases typically involve situations in which the child has clearly been beaten or battered or killed and the suspected abuser has been arrested. These are the factors that make the incident "newsworthy." By contrast, the situations discussed in this Paper generally do not involve a visibly injured, disfigured, or deceased child with a parent or household member under arrest. Doctors' and DCFS investigators' activities in these cases, which occur in conference rooms and

over the phone, involve discussion of whether a particular child's injury that can only be seen on an X-ray or MRI is in fact abuse (and if so, whether the parents were responsible), is not particularly "newsworthy." The result is that the public hears only one type of story from the media about child abuse, and that is not the type of story that is highlighted in this Paper.

In this climate of heightened awareness and legitimate concern about child abuse, child abuse pediatricians have come forward as "advocates for children" and have presented themselves as the leading authorities in detecting when a child has been abused. Their own hospitals, their literature and sometimes the practitioners in this field themselves have extolled their superior abilities to discern whether a child has been abused, often to the exclusion of other deeply knowledgeable physicians and surgeons. State contracts have given child abuse pediatricians broad access to and the opportunity to train child protection investigators, police officers, states' attorneys and judges to rely upon their expertise. Doctors also possess police powers, delegated to them under state law in Illinois and many other states to remove children from their parents in emergencies. These powers, which are not afforded to any other private professional group, further add to the entanglement of child protection pediatricians with the coercive power of state child protection officials. Because they present themselves as child advocates and have direct access to the child protection system authorities, state or local authorities, including police, child protection investigators and prosecutors, rely on them very heavily—as noted, often to the exclusion of other doctors who have relevant information about whether a child's injury was actually caused by abuse. An administratively convenient but simplistic and dangerous perception has developed that child abuse pediatricians are on the side of the angels, fighting against the presumptively "bad" and abusive parent or care provider (a taint that may extend even to the physicians who testify on behalf of the accused parent). In a contest between good and evil framed in this manner, it has been too easy---and too administratively convenient---for commonplace protections of objectivity and scientific consultation to be brushed to the side in the fact finding about whether abuse has actually occurred, and if so, who might be responsible.

\* \* \*

We hope in presenting this Paper we may begin to open a dialogue with members of the medical, legal and allied professions, as well as families affected by the actions of the medical profession in child abuse cases to reduce the pain inflicted on innocent parents and families without impairing the on-going efforts to continue the reduction of child abuse.

## **PART II. ILLUSTRATIVE CASES**

The families whose stories are presented as illustrative cases in this paper have been formally accused of child abuse by DCFS, but then, in all but one instance, fully exonerated at the end of a long ordeal. By “exoneration,” we mean that DCFS itself ultimately decided to “unfound” the abuse allegation or determined that the accused parent was not responsible for the child’s injury or that a juvenile court found there was not a preponderance of the evidence showing abuse. In one of the illustrative cases (“Richard’s”<sup>5</sup>), the parents were cleared of wrongdoing after a lengthy hearing and a “no probable cause” finding by a juvenile court judge. In one case, the juvenile court proceedings were resolved only after the mother “fell on the sword” and accepted a neglect determination against her only (with no findings of abuse); her actions enabled her husband to avoid further delay in lifting the unwarranted cloud on his record as a teacher. This is the only one of the five illustrative cases in which there was any negative finding at the end of the day against any of the parents who had been targets of protracted child abuse allegations. In four of the five cases, juvenile court cases were never brought but DCFS conducted lengthy (several months long) investigations that caused family separations under so-called “safety plans.”<sup>6</sup> In these cases, DCFS itself cleared the parents after a lengthy assessment process or appeal but the child abuse pediatrician had taken action that caused children to be separated from their parents due to a suspicion of child abuse that the child abuse pediatrician had endorsed.

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<sup>5</sup> All five cases presented here involve an actual client of the Family Defense Center, though one of the five (“Justin”) was not represented by Center staff during the investigation itself. To protect all of the involved family members, including the children, from harm that might come from further invasion of their privacy due to the publication of a Paper such as this one, all names of family members have been changed. Confidential case records are maintained at the Family Defense Center in accordance with policies adopted by the agency’s board and in accordance with the Illinois Code of Professional Responsibility. The chronologies and proceedings as well as reported diagnoses involved in these cases are all accurate for the specific case to the best of our ability to document and verify these factual points.

<sup>6</sup> The Center has long advocated for legal protections for families who are subject to safety plans. Safety plans are typically demands that the family must abide by restrictions on their access to their children during a child abuse investigation. Because safety plans are invariably secured through an express threat that the children will be taken into foster care if the parents do not comply with the demand that they either separate from their children or live under restricted (supervised) access to them, the Center does not consider these plans to be “voluntary” even though the sole legal authority for such plans is that they are considered to be a voluntary waiver of the family’s constitutional rights to remain together. Efforts to secure legal redress for safety plan policies and practices have met with setbacks. See *Dupuy v. Samuels*, 462 F. Supp. 2d 859 (N. D. Ill. 2005), *nominally aff’d* at 465 F. 3d 757 (7<sup>th</sup> Cir. 2006), *cert. denied*, 554 U.S. 902 (2008) and, more recently, with some success in limiting the contexts in which DCFS may demand such plans, *Hernandez v. Foster* 657 F.3d 463 (7<sup>th</sup> Cir. 2011).

## Richard's Story<sup>7</sup>

### **The Family**

This case involves a family of five who had recently moved from Chicago to suburban Cook County. The mother, Linda, age 34 at the time of the incident<sup>8</sup> that brought this case to the attention of the child protection system, is a licensed clinical social worker. She had stayed home after her two-year-old twins were born to raise her children. Her husband, Brad, also age 34, is an insurance company executive.

Their newborn baby, Richard, was four weeks old on the day that Brad and Linda discovered his leg was swollen. Linda and Brad didn't know how this injury had occurred or even what it was. Linda and Brad thought Richard might have had a bee sting. Other than the swollen leg, Richard seemed normal, healthy and he was described as a very calm baby. He barely cried even when his leg was manipulated, though it was soon discovered that he had a femur fracture. About a year after the episode, Richard was diagnosed by other physicians, not involved in this matter, as having a condition known as hypotonia (low muscle tone). Hypotonia is associated with a higher-than-normal pain threshold.

Richard has twin siblings, a boy and a girl, who were two years old at the time Richard's fracture was discovered.

### **The Doctors**

Treating doctors:

- The Emergency Room ("ER") Physician. The ER Physician was on duty at the local suburban hospital where Brad took Richard for treatment on the evening of **Day 1**, the day these parents first observed the swelling in Richard's leg. After determining from X-rays that Richard had a femur fracture, the ER Physician either made the Hotline call personally to the Illinois Department of Children and Family Services on the evening of **Day 1** or had a member of his staff make the call. The ER Physician also referred the family to Children's Hospital #1 (CH #1<sup>9</sup>) in Chicago for an immediate transfer in the middle of the night.

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<sup>7</sup> Richard's story was the genesis of this report. George Barry became familiar with the story when he began working at the Center. After he expressed concern about the conduct of the child abuse doctors involved in this case, he expressed interest in researching whether medical ethical standards had been breached. This much fuller report grew out of his research into the medical ethics literature discussed below and analysis of additional case examples.

<sup>8</sup> All ages given in the report were at the time of the start of the incident that brought the case to the attention of child protection authorities.

<sup>9</sup> Hospitals and doctors involved in the Illustrative Cases are denominated as follows: 1. Children's hospitals in Illinois are denominated "CH #1- CH #4. The same hospital is referred to by the same number throughout these examples; 2. Out of state children's hospitals are referred to by location rather than name (*i.e.*, "Ohio Children's Hospital" or "East Coast Children's Hospital"); 3. General Hospitals where children may have been seen for initial or subsequent treatment are referred to as "Gen. Hosp. 1," (etc.); 4. Child abuse pediatricians and child abuse fellows are given common names (e.g., "Jones", "Smith", and "Murphy") and these names are used throughout the report to refer to the same individual. 5. Orthopedists are given names that rhyme with "Doe" (for "O"/orthopedist) in order to easily distinguish them from the child abuse doctors; and 6. Other doctors (pediatricians, radiologists, neurosurgeons) are assigned initials, which may not be the same as their actual names (*i.e.*, Dr. S., Dr. Y.). In order

- Dr. Moe. She was a pediatric orthopedist at CH #1. She treated Richard on **Day 2**. She testified in court on **Day 56** that she could not conclude that Richard had “more likely than not” been abused.
- Dr. Coe. He was the pediatric orthopedist at Children’s Hospital #2 (CH #2) in the Chicago. At Linda and Brad’s request, he examined and treated Richard on **Day 21**. At the time of that examination, Dr. Coe reported to Linda and Brad that it was unlikely that Richard’s femur fracture was due to abuse. On **Day 22**, as DCFS was preparing to take Richard and the two-year-old twins into protective custody, Linda and Brad’s attorney told the assigned DCFS investigator about Dr. Coe’s opinion. Dr. Coe’s written opinion on **DAY 28** was that the probability of Richard’s femur fracture having been caused by abuse was very low and he later testified to that effect in the ensuing juvenile court proceedings.

#### Child abuse doctors:

- Dr. Brown was a Child Abuse Fellow at CH #1, operating under a contract with DCFS to conduct medical investigations of cases of suspected child abuse. A Child Abuse Fellow is a physician trained in pediatrics who is in the process of further training to become a certified specialist in child abuse pediatrics. Dr. Brown had not achieved board certification in pediatrics or in any other specialty, though she had completed a residency in pediatrics. The contract under which Dr. Brown works is actually a subcontract between the Chicago Child Advocacy Center (“CCAC”) and three Chicago area hospitals pursuant to DCFS’ contract with the CCAC to provide such service to DCFS. Under this contract, the child protective services teams at each of the participating hospital prepare so-called “MPEEC” reports for DCFS (MPEEC is an acronym for Multi-disciplinary Pediatric Education and Evaluation Consortium).
- Dr. Brown examined Richard on **Day 2** and concluded that because Linda and Brad did not have an explanation for the femur fracture it was more than likely caused by abuse. Dr. Brown issued her written report to this effect on **Day 22** and testified to this effect in court on **Day 37**.
- The CH #1 child protective services team that participated in this case was comprised of Dr. Brown herself, and her supervisor Dr. Black, who is a Child Abuse Pediatrician, and CH #1 social workers who were on permanent assignment to the hospital’s child protective services team. Eventually, a report was written with input from DCFS (a so-called “MPEEC Report”).

### The Family’s Ordeal

In the middle of the evening on **Day 1**, Brad presented Richard for treatment of a swollen left leg at the emergency room of a hospital in the suburban community in which the family lived. Brad reported that neither he nor Linda had any knowledge of why the leg was swollen. Linda had been out with Richard in public all day on **Day 1**, including at CH #1 in the morning, a friend’s for lunch and a beauty salon from approximately 2:00-4:00 p.m., after which point she went home to make dinner for her family. She had briefly noticed that something seemed odd

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to avoid confusion and to maintain the highest degree of accuracy possible while preserving anonymity, the authors have maintained the same pseudonyms for the same doctors throughout the report.

about Richard's leg when she was at the beauty salon appointment, asking her stylist if the leg looked swollen to the stylist (but the stylist had responded in the negative). When Linda changed Richard's diaper at about 7:00 p.m. after dinner, however, she noticed his leg had swollen up and Richard cried when she changed his diaper. Calling Brad to see the leg, both parents first thought he had some sort of insect bite. New to the suburban area to which they had moved just a few weeks before, they sought a neighbor's advice on where to take Richard for medical attention. The neighbor advised them about the location of the closest hospital in their town and Brad took Richard there right away, leaving Linda home with the twins.

After examining Richard, including x-rays, the ER Physician informed Brad late in the evening as follows: (1) Richard's leg was swollen because he had a femur fracture; (2) there was no orthopedist on duty at the hospital at that hour to treat Richard's femur fracture; (3) he, the emergency room doctor, had determined that DCFS's Hotline would be called, because child abuse is reasonably suspected as a possible explanation whenever a 4-week-old child has a fracture that is unexplained; and (4) in order to treat Richard's femur fracture (immediately) and to assess the possibility of child abuse, Richard had to be transferred to CH #1, which had both orthopedists and a child abuse team and which was located in Chicago, approximately 20 miles away (the same hospital to which Linda had taken Richard that same morning).

Under the stress of the moment Brad and Linda, who had now reached the hospital after having found a neighbor to care for the twins, cooperated fully with this planned transfer. Specifically, under the stress of the moment, they did not ask if it might be possible to proceed with Richard's treatment more conveniently for the family and just as comfortably for Richard by waiting a few hours for an orthopedist to arrive at the hospital the following morning. An ambulance was ordered for Richard, and Linda rode with him in the ambulance to CH #1, while Brad returned to the family home to be with the twins.

On arriving at CH #1 in the early hours of **Day 2**, Linda was interviewed by an investigator employed by DCFS. At the time of this interview, all that was known about Richard's condition was that he had a broken femur. There was still no explanation or definitive opinion expressed by anyone about what had caused the break. Nevertheless, at the conclusion of the interview, this DCFS investigator informed Linda that her parental control and Brad's was being suspended as to all three of their children. Specifically, she was told that DCFS would be taking protective custody of all of her children unless Linda and Brad signed a "safety plan" which would, in effect, install other people to continuously oversee and supervise their parenting. Brad and Linda had no family members in the state, but in the early hours of the morning of **Day 2** they called Brad's parents in Ohio. His mother immediately left for Illinois to help care for the children.

After Linda was advised of the safety plan that DCFS was demanding of the family and the protective custody that DCFS was prepared to take if she and Brad did not agree to the safety plan, Dr. Brown at CH #1 approached Linda for an interview. Under CH# 1's MPEEC agreement with the Chicago Child Advocacy Center which contracts with DCFS, Dr. Jones—the head of the Child Protection Team and Dr. Brown's ultimate supervisor—frequently accept assignments to conduct expert medical investigations for DCFS as to whether the injury or injuries of a particular child under age 3 are the result of abuse or neglect. At CH #1, the only other members of the MPEEC team are hospital social workers, child protection and law enforcement authorities; no other medical disciplines are included on the team.

Dr. Brown did not tell Linda that she worked under a sub-contract with the State of Illinois that was funded by DCFS or that, she reporting her to DCFS, and potentially to police as well, on all of her conversations with Linda and on all of her conclusions about Richard's injury. Indeed, Dr. Brown and her colleagues did not tell Linda that they were not members of the treatment team for Richard or that Linda's decision to speak to them would have no bearing on his medical care at the hospital. Dr. Brown also did not tell Linda that she might eventually testify against Linda and/or Brad in legal proceedings. (This possibility was not a remote one, for Dr. Brown very quickly concluded that the unexplained fracture was likely due to abuse and that conclusion did not change from the moment of first contact Dr. Brown had with the family). Dr. Brown also did not ask Linda for consent to access and review the medical records that had been compiled for Richard at the suburban hospital where he had first been presented for treatment. Linda, who met many doctors and other medical personnel during her overnight stay at CH #1 and at the prior suburban emergency room, was not told whether Dr. Brown would consult with orthopedists at the hospital (as the only treatment Richard needed was orthopedic care) or given any information as to how Dr. Brown would come to any conclusions she might ultimately reach. She was also not informed that Dr. Brown would be continuing to work on a report to DCFS after Richard was discharged. The questioning of Linda, moreover, occurred after she had been up all night attending to Richard and her primary thoughts were concerns as to her son's wellbeing. Feeling she had nothing to hide, she answered all of Dr. Brown's questions to the best of her ability, recounting the events of her day and sharing family history. Dr. Brown later informed DCFS that she believed Linda was "depressed" and this "diagnosis" by a child abuse fellow became the basis for a theory as to why Linda would have abused her son. (Linda had no mental health conditions diagnosed by trained mental health professionals).

Richard was discharged from CH #1 on DAY 2. From **Day 2** to **Day 22**, encouraged by the opinion of Dr. Brown that Richard's injury was more than likely the result of child abuse, DCFS imposed a "safety plan" on Linda and Brad that prohibited them from being alone with, and exercising parental control over, their three children. In order to avoid the children being placed with strangers in foster care, Brad's mother came to Illinois immediately to care for the children and supervise the parents' contact with them.

In the ensuing child abuse investigation, Dr. Brown communicated on several occasions with the DCFS investigators as to her opinion and she provided a written report of that opinion on **Day 22**. Her opinion was that Richard's injury was "more likely than not caused by abuse." She based this opinion on her belief that the parents were "not credible" in saying that they had no knowledge of when or how the fracture had occurred. In turn, her belief about the parents' lack of credibility was based on her opinion that a child with this type of injury necessarily would have cried inconsolably from the time of the injury. She had no information about the character of Brad or Linda from which to determine they were untruthful, however. She did not consider the parents' background, social history, or lack of prior involvement in any law enforcement or child welfare matter in assessing the credibility of their statements that they did not know how Richard's fracture had occurred. Dr. Brown never obtained any other information, other than the single unexplained fracture on Richard's leg, suggesting either parent would harm a child.

Dr. Brown would later testify in juvenile court on **Day 37**, at an ongoing hearing concerning the temporary custody of the three children, that her confidence that Richard would

have “inconsolably cried” at the time his leg was fractured was not based on medical research but based on her experience as a babysitter and “being around children a lot.”

Though Richard’s injury was orthopedic in nature, Dr. Brown did not consult with radiologists or orthopedists in formulating her opinion as to the cause of the fracture and the credibility of the parents in their denial of knowledge as to how the fracture occurred. In fact, Dr. Moe, the pediatric orthopedist at CH #1, who had actually treated Richard and disagreed with Dr. Brown’s opinion that the cause of Richard’s injury could be medically inferred from the mere presence of a fracture. Dr. Moe’s testimony was that a doctor could not tell the cause of a fracture simply from looking at x-rays.

On approximately **Day 15**, Brad and Linda contacted Dr. Coe at CH #2 to obtain orthopedic care for Richard and secure his medical opinion as to the potential causes of Richard’s fracture. On **Day 21**, Dr. Coe reported his conclusions verbally to Brad and Linda that Richard’s fracture was not likely to be due to child abuse but may have resulted from a minimally displaced earlier fracture that had become displaced through minor impact on **Day 1**. It was also the experience of Dr. Coe that parents and sometimes patients themselves do not know when they have fractures and therefore cannot explain how they occurred. Dr. Coe later opined that a variety of actions could have caused a minimally displaced initial fracture that later became a displaced fracture that began to swell. Despite Brad and Linda’s efforts to have DCFS investigators contact Dr. Coe to obtain his opinion before reaching their conclusions or taking action against them. Dr. Moe was also not contacted for her opinion.

On the evening of **Day 22**, immediately after Dr. Brown issued her report, co-signed by Dr. Black, DCFS moved to seize the children from Linda and Brad’s care, coming to their home to take the children from them and from Brad’s mother, who had come to Illinois to provide care under the DCFS-imposed safety plan that had been in effect since **Day 2**. The family did not allow police into the home without a warrant, however.

The next day, **Day 23**, DCFS went to the Cook County State’s Attorney’s Office and secured the filing of petitions in the juvenile court to take temporary custody of Linda and Brad’s children. This action was the direct result of receiving Dr. Brown’s opinion that Richard had more than likely suffered child abuse on **Day 22**. No one (including Dr. Brown and the DCFS investigative team) spoke to either Dr. Coe or Dr. Moe, the orthopedists who had opinions about Richard’s fracture prior to taking this action.

As requested, juvenile court entered a temporary order placing all three of the children in DCFS “temporary custody” pending the further outcome of the hearing. Fortunately, the order the court entered pending further evidentiary review allowed the grandparents to remain in the family home to care for the children. Linda and Brad were required to move out of their family home and could not be alone with their children. This most extreme separation of these parents from their children was enforced until after the judge had heard Dr. Coe’s testimony. Even at that point, the parents were only allowed back into their own home over the objections of the State’s Attorney, guardian ad litem for Richard, and DCFS counsel, each of whom continued to rely on Dr. Brown’s opinion that Richard had been abused.

The case that the State of Illinois filed against Linda and Brad to remove all three children from their custody was ultimately tried before the juvenile court judge as an extended

temporary custody hearing. During the hearing, in addition to other witnesses, including the parents, the judge heard medical testimony from the various doctors who had been involved in the case. Dr. Brown testified to her opinion that Richard's femur fracture was more than likely the result of abuse based on the theory that Richard would have cried inconsolably when his leg was fractured, such that any reasonable parent would have noticed it. Because neither Brad nor Linda reported noticing such a cry, Dr. Brown concluded that child abuse was the likely explanation for the fracture. She further testified that her "inconsolable cry" theory derived from her experience as a babysitter and from "being around children a lot."

Dr. Brown's testimony that the injury could be said to be likely due to child abuse was contradicted by the medical testimony of both Dr. Moe and Dr. Coe, the pediatric orthopedists at CH #1 and CH #2 respectively who had treated Richard. Dr. Coe, in particular, opined that a number of accidental actions could have caused the fracture, and it is possible for a child to have a minor crack in the bone that later becomes displaced upon a minor impact. Neither Dr. Moe nor Dr. Coe endorsed the "inconsolable cry" theory; Dr. Coe pointedly testified that many children and even adults have fractures that go unnoticed.

Ultimately, the juvenile court judge characterized Dr. Coe's testimony that it was unlikely that Richard's femur fracture was due to child abuse as being "convincing." The judge ruled on **Day 72** that there was no probable cause to believe that Richard had been abused and dismissed the petitions that had been filed seeking to make the children wards of the court.

Four days later, on **Day 75**, DCFS put Linda's (but not Brad's) name on the Illinois child abuse register. The entry on the child abuse register would have been maintained for the next twenty years and stopped Linda from working in her career as a social worker when she decided to return to work. , Represented by the Family Defense Center, Linda filed a timely appeal and prevailed in having her name expunged by order of the Director of that Department on **Day 163**, after a separate administrative hearing and additional legal expenses. DCFS continued to rely on Dr. Brown's opinion in labeling Linda a child abuser, despite the "no probable cause" finding by the juvenile court. DCFS's decision to put Linda's name in the child abuse register did not reference the opinions of Drs. Coe and Moe but prominently recites the opinion on Dr. Brown as the basis for its actions.

## **Medical Ethics Problems and Issues**

The above facts suggest several areas in which there are serious medical ethics problems and issues to be considered.

### *The Child Abuse Pediatrician's Interview of Linda*

#### *Was Dr. Brown's interview with Linda a prohibited interrogation?*

In the early morning hours of **Day 2**, Dr. Brown interviewed Linda in order to gather information for her investigation into whether Richard's femur fracture was the result of abuse or neglect. Richard was being held at the hospital while this questioning occurred; Linda was not free to leave with him at any point after he was transferred to CH #1 from the suburban hospital. During her interviews with Dr. Brown and child protection investigators who came to the

hospital and worked together with the hospital's child protection team, Linda was told she could no longer reside with her three children. DCFS issued a threat to her, in the course of or as a result of meeting with child protection team staff, that her children would be taken into foster care if she did not make alternative arrangements for their care. The information that Dr. Brown gleaned from the interview, held after Linda had been awake all night, was that Linda could not explain the femur fracture. This in turn was the primary factor on which Dr. Brown based her conclusion that the femur fracture was more likely than not the result of abuse. Given that Dr. Brown actively participated in both the questioning of Linda while Richard was being held at the hospital, communicated with DCFS as to the next steps in the case, and reported her conclusions from her interview with Linda before Linda left the hospital, it appears that Dr. Brown was involved in the decision not to allow Linda to leave the hospital with her own children or, at a minimum, acquiesced in the decision to separate Linda's children from her.

AMA Code of Medical Ethics Opinion 2.068 – Physician Participation in Interrogation explicitly prohibits physicians from conducting or directly participating in interrogations of detainees. Since Dr. Brown was collaborating with the DCFS and the police in conducting this interview, and since both she and DCFS had the power to summarily take custody of children suspected to be abuse victims, Dr. Brown's interview appears to be similar to the type of interrogation discussed in Opinion 2.068. A more detailed presentation of this ethics opinion is found in Discussion Section I of this article.

*Before conducting her interview of Linda on **Day 2**, did Dr. Brown provide Linda with all of the information to which she was entitled about the specific nature of Dr. Brown's role in the case?*

By failing to disclose to Linda at the time of the interview what her true role was in connection with Richard—as an investigator, not as a treating physician—and what her contractual obligations were to DCFS, it appears that Dr. Brown may have violated AMA Code of Medical Ethics Opinion 10.03—Patient-Physician Relationship in the Context of Work Related and Independent Medical Examinations. A more detailed discussion of this ethics opinion is found in Discussion Section VII of this article.

After conducting her interview in the early morning hours with Linda, Dr. Brown interjected what appeared to be a diagnosis of Linda as “depressed,” even though Dr. Brown is not a mental health professional and had not conducted a formal evaluation of Linda's mental status. This remark by Dr. Brown later led DCFS and the State's Attorney to refer to this observation by Dr. Brown as an explanation for the genesis of Richard's fracture. Linda had reported that members of her family on the distant maternal side had a history of some mental health concern, but Dr. Brown recorded this comment as stating she had a *personal* history of depression, which was untrue. Prior to seeking personal mental health information from Linda, Dr. Brown did not explain that she was a fellow in child abuse pediatrics who was not board certified in any medical specialty, or that her work was being supervised by Dr. Jones. Dr. Black in turn signed off on Dr. Brown's report without meeting with any of the family members and without discussing the case with any treating physicians at CH #1, including Dr. Moe.

Dr. Brown also did not tell Linda that she would be accessing all of Richard's medical records and using information she received from DCFS to determine whether or not Linda or Brad abused their son Richard.

### *The Child Abuse Pediatrician: Consultation with Other Physicians*

Dr. Coe and Dr. Moe were both involved as pediatric orthopedists in Richard's treatment, and each had far more expertise in the analysis of fractures and their causes than Dr. Brown possessed. These doctors had extensive experience with fractures that parents could not explain and had not witnessed. Each of these treating doctors ultimately expressed disagreement with Dr. Brown's opinion that Richard's femur fracture was more likely than not the result of child abuse. Yet, neither of these doctors' opinions was considered by Drs. Brown and Black in their written report to their DCFS colleagues on **Day 22**. Despite having treated Richard's fracture at CH#1, Dr. Brown's hospital, Dr. Moe's opinions were never solicited until the family pressed for her opinion in the ensuing court action. Dr. Brown's written report was the linchpin for all of the dire consequences that followed for this family until **Day 163**. This invites the question whether Dr. Brown's failure to consider contrary opinions of orthopedists violated AMA Code of Medical Ethics Opinion 9.07 – Medical Testimony.

As to Dr. Coe, he examined Richard on **Day 21**. He rendered his opinion that it was unlikely that Richard's femur fracture was the result of child abuse immediately on Day 21 through the family's lawyers to Dr. Brown's DCFS colleagues. There are two possible explanations as to Dr. Brown's and Dr. Black's failure to acknowledge Dr. Coe's opinion or to seek out more information from consulting orthopedists in the face of his opinion, each of which raises ethical issues under Opinion 9.07.

- Did Drs. Brown and Black choose to ignore Dr. Coe's expressly stated contrary opinion, so that they would not have to explain why they may have disagreed with it? If so, it is difficult to see how that would have been compatible with Opinion 9.07. Opinion 9.07 requires doctors to be honest, objective, independent, and guided by "current scientific thought" in providing their opinion on medical matters to the legal system and requires that they be open to reaching an opinion that may differ from the opinion of the party that brought them to the legal contest. Knowing that an orthopedist had rendered an opinion contrary to theirs as to a fracture, shouldn't Drs. Brown and Jones have consulted with at least *one* orthopedist to determine if their own report had a solid orthopedic grounding?
- Or, did Dr. Brown's DCFS colleagues withhold information about Dr. Coe's opinion from Dr. Brown? If that is what happened, then there would be a question whether Dr. Brown may have neglected to inform her DCFS colleagues when she became contractually obligated to them, of what information she considered essential to have in order to be faithful to her own ethical responsibilities.

A more detailed discussion of AMA Code of Medical Ethics Opinion 9.07 – Medical Testimony is found in Discussion Section VIII of this Paper.

#### *Richard's Treating Orthopedist, Dr. M.*

In failing to question the determination of Dr. Brown, her own colleague at CH#1, that Richard's femur fracture was more likely than not the result of child abuse, did Dr. Moe live up to the ideal of providing family-centered care in accordance with the policy of the American Academy of Pediatrics?

Dr. Moe had treated Richard's femur fracture at CH#1 on **Day 2** and not afterward. On **Day 56**, she testified that she could not conclude that it was more likely than not that Richard's femur fracture was the result of abuse. Yet between **Day 2** and **Day 56**, Dr. Brown, her colleague at CH #1, repeatedly provided her opinion that Richard had more than likely been abused and that opinion was the decisive factor in the DCFS pursuing very harsh, life-changing actions disrupting the stability of this family. It is difficult to see how Dr. Moe's "hands off" approach to the investigation, by not raising any concerns with Dr. Brown between **Day 2** and **Day 56**, is consistent with the requirements of AMA Code of Medical Ethics Opinion 10.016 -- Pediatric Decision-Making or with the principle of patient and family-centered care that has been promulgated as policy by the American Academy of Pediatrics.

Interestingly, in her eventual testimony that the bone fracture itself could not be determined to be abuse, Dr. Moe said that she had believed that Dr. Brown and Dr. Black would consider social history factors in making their ultimate assessment and she assumed they had done so. She testified that she had not referred the case to them in order for child abuse pediatricians to provide a detailed assessment of the mechanism of the fracture. Yet, when Dr. Brown testified, she disavowed the importance of social factors and relied solely on the mechanism of the fracture (a matter as to which orthopedists have much more expertise). In other words, both the orthopedist and the child abuse pediatrician made contrary assumptions about the nature of the counterpart's assessment of the fracture as due to child abuse. Had Dr. Moe and Dr. Brown communicated with each other, it is possible that they might have come to a common understanding about the scopes of their respective specialties, so that the entire series of actions in which innocent parents were accused of causing their son's fracture could have been avoided. A more detailed discussion of the requirements related to patient and family-centered care of a pediatric patient is found in Section VI of this Paper.

### **Sean's Story**

#### **The Family**

This case involves another middle class suburban family: Gary, age 29, who is an emergency medical technician; Nancy, age 27, who is a college professor and their three children Felicia, age 4; Misty, age 2; and Sean, age 9 months.

The incident of interest in this Paper involved Sean.

#### **The Doctors**

Several doctors became involved in the treatment of Sean's medical problem and the evaluation of Sean's situation for child abuse or neglect, including the following:

- Dr. F. is a general practice pediatrician.
- Dr. H. is an attending pediatrician at the CH #2 emergency department.
- Dr. Poe is a pediatric orthopedist at CH #2.
- Dr. Williams is a child abuse pediatrician at CH #2.
- Dr. Smith is Dr. Williams' supervisor and is head of the child abuse team at CH #2.
- Dr. Coe is a pediatric orthopedist at CH #2.

The specific roles and actions of each of these doctors will be presented in more detail below.

### **The Family's Ordeal (presented chronologically)**

1. On a Saturday, Sean's parents, Gary and Nancy, took Sean to his regular pediatrician's office for treatment without an appointment. They did this because they observed that he appeared to be guarding his left leg and was not crawling around and pulling himself up stairs as they were accustomed to seeing him do.
2. After x-rays in his office, the on-call pediatrician, Dr. F (not Sean's regular pediatrician), determined that Sean in fact had a left leg fracture. The parents explained that Sean had been in bed with his father two days earlier and had fallen out of bed to the floor but that there had been no sign of injury until Saturday, just before they brought him in to the doctor.
3. Dr. F. did not think it was necessary to hospitalize Sean or to take him to an emergency room or urgent care facility for immediate treatment, but he did refer them to an orthopedist on Monday.
4. Unfortunately, the recommended orthopedist could not treat Sean because it turned out that he did not accept children as patients, so the parents had to return to their pediatrician's office for a second recommendation. The second orthopedist could not make an early appointment to see Sean, so the parents decided simply to take Sean on Monday afternoon, along with his x-rays from Dr. F's. office, for necessary orthopedic treatment to the Emergency Department at CH #2.
5. On reaching the emergency department at CH#2, Sean was first examined by an attending pediatrician, Dr. H. This doctor found him to be normal in all respects, except for the left leg fracture. The parents explained to Dr. H., as they had to Dr. F. on Saturday, that Sean had fallen out of bed on to the floor the previous Thursday evening. Dr. H. confirmed that Sean should be evaluated by a pediatric orthopedist at the hospital. She also included in her treatment plan that the case should be referred for evaluation to a hospital social worker, saying that the fracture was "suspicious for NAT" (non-accidental trauma) without giving any explanation as to why she doubted what the parents had told her about Sean falling out of bed on the previous Thursday or why she thought that fall was not the cause of this injury. She also included in her treatment plan that a skeletal survey should be performed.
6. Shortly after the attending pediatrician's exam, Sean was examined by Dr. Poe. a pediatric orthopedist at the hospital. Dr. Poe. ordered additional x-rays of Sean's left leg and confirmed that Sean had a left leg fracture and that no surgery was required, and he applied (or ordered) a cast for the left leg.
7. Like the attending pediatrician, Dr. Poe's assessment and plan also included a social work consultation and a skeletal survey and indicated:

“If social work/CPS clears and skeletal survey negative, then home. If any concern, admit to Gen Peds for full investigation.”

8. Dr. Poe also specifically included in his plan that there should be follow up for Sean in one week with Dr. Coe, the chief of pediatric orthopedics at CH #2.
9. Ms. G., a social worker, interviewed both parents and they provided her with the same account of Sean’s accidental fall from his father’s bed. Ms. G. reported that the parents were “appropriately concerned and cooperative.” Ms. G. also observed Sean and reported that he was a “well appearing 9 month old infant. . . .” Her conclusion was that “concerns that this injury was inflicted are low. . . .” Nevertheless, Ms. G. referred the matter to Dr. Williams, one of the child abuse pediatricians on the CH #2 child protective services team.
10. Dr. Williams, a child abuse pediatrician, did not examine Sean at this time, but did review records already generated within the hospital by Dr. H. and Ms. G. and also had available the x-rays made at Dr. Poe’s office. Based on the review of records, Dr. Williams concluded that there was a  

“... need for skeletal survey as his age places him in high risk category for fracture due to abuse and there was a delay in care on the part of the parents (compounded by strange recommendations by PCP [primary care pediatrician] office after fracture confirmed on [prior Saturday])” [Parenthetical clarifications added by the authors.]
11. It is not clear whether Dr. Williams’s accusation at this point of “delay in care on the part of the parents” meant that she doubted that parents statements about there being no symptoms between Thursday evening, when the fall occurred, and Saturday, when they took Sean to Dr. F’s office or their reported difficulties in getting an orthopedist to see Sean. In any event, Dr. William’s note communicated a high degree of suspicion and suggests a distrust of the parents’ account.
12. Dr. Williams also specified, however, that if the skeletal survey was negative, then there would be no reason to suspect or report to DCFS that Sean’s injury was the result of abuse. However, if the skeletal survey turned out not to be normal and there *were* other injuries, it was her order that Sean should be admitted to the hospital and that “child welfare involvement would be initiated to exclude possibility of abuse.” In other words, Dr. Williams’ issued an advance directive to make a Hotline call to DCFS if the skeletal survey showed other injuries in addition to the left leg fracture without regard to possible explanations for those injuries and without specifying what sorts of injuries would qualify as suspicious. The mere existence of any injury was thus considered to be sufficient to give rise to suspicion of abuse necessitating a child protection investigation.
13. Nothing in Dr. Williams’ notes suggest that the skeletal survey was going to contribute to the efficacy of any treatment of Sean’s left leg fracture for which his parents had brought him to the hospital for treatment. The only reason for requiring the skeletal survey (which carries with its exposure to additional radiation) was to determine whether

Sean had other fractures that might give rise to even greater suspicion of the parents, though there were no external signs whatsoever that he may have had such other fractures. The parents were never advised that procedures like this skeletal survey were unconnected to the treatment of Sean's left leg, nor were they ever asked for consent to perform such procedures. They were certainly not told that the purpose of the skeletal survey was to cast possible doubt on their explanation for the fracture for which they had sought treatment.

14. On Dr. Williams' order, the skeletal survey was performed on Sean and billed to his parents' account and the results were entered into his hospital records.
15. The skeletal survey revealed a weeks-old healing fracture on Sean's right leg. In accordance with Dr. Williams' advance directive (par. #12), Sean was admitted to CH #2 as an in-patient, though no further treatment was required for either the left leg fracture or the healing right leg fracture. Also in accordance with Dr. Williams' advance directive, the Hotline call was made to DCFS.
16. At the time Sean's parents presented him for treatment at CH #2, that hospital was one of several in Cook County that had child protective service teams headed up by child abuse pediatricians. All of these hospitals with child protective service teams were signatories to a contractual arrangement with the State of Illinois to provide MPEEC reports. Under this agreement, CH #2 and the other signatory hospitals make themselves available to provide medical opinions as to whether particular cases referred by DCFS after Hotline calls had been made did or did not involve child abuse or neglect.
17. On the very same day (Monday) that Sean was admitted to CH #2 and the Hotline call was made as a result of the skeletal survey revealing a healing right leg fracture, Dr. Williams accepted an MPEEC assignment generated by the Chicago Children's Advocacy Center, making her the lead the medical evaluator of whether either or both of the fractures to Sean's left and right legs were due to abuse or neglect. (Under the MPEEC contract that CH #2 holds with the Chicago Children's Advocacy Center, hospitals are assigned to conduct MPEEC evaluations of their own Hotline calls, in what are referred to in the contract as "mandate" cases). Dr. Williams' actions thereafter reflect that she accepted this assignment even though she and her hospital had extensive prior involvement in the case: her hospital had been the Hotline reporter, she had ordered the skeletal survey, and she had already voiced suspicion of the parents' account of the injury for which they sought treatment.
18. As part of the MPEEC investigation, Dr. Williams did a physical examination of Sean. She also ordered a head CT scan. As with the skeletal survey, the head CT scan appears to be entirely a search for additional signs of possible abuse. There is no evidence that the parents were informed that the head CT scan was unrelated to treatment of Sean's leg fractures but was instead designed to build a possible abuse or medical neglect case against them.

19. Dr. Williams wrote her report the next day (Wednesday). The report reflects no abnormal findings on the head CT scan and no other abnormal findings on the physical examination except for the left and right leg fractures. The report does note that Sean is:

“At risk of Vitamin D deficiency (without radiographic evidence of rickets)-eval in progress.”

However, the report does not provide any comment whatsoever on whether this Vitamin D deficiency could possibly have implications for the fracture or the child abuse and neglect issue being investigated.

20. The report obscured the fact that shortly after the parents were made aware of Sean’s healing right leg fracture, Gary told Dr. Williams that Sean had in fact fallen out of his crib in the prior month, just a few weeks before the Thursday fall. He told Dr. Williams that he and Sean’s mother had not thought there was any injury at all as a result of Sean falling out of his crib as they had looked for but observed no symptoms of injury. Even though Gary had conveyed this history to Dr. Williams promptly after everyone became aware of the healing right leg fracture after reviewing the skeletal survey, Dr. Williams continued to describe the healing right leg fracture as “unexplained.” Since Dr. Williams acknowledged later in her report that Sean falling out of his crib the previous month was a “plausible” explanation of the healing right leg fracture, it was clearly inaccurate for her to give the impression that the parents had no explanations as to how this injury may have occurred.

21. Dr. Williams’ report reflected a final conclusion that the fractures were “accidental.” However, she also expressed a “concern” that there had been neglect in that Sean’s healing weeks-old right leg fracture had not been recognized or treated. In the language of the report, this was a “...concern for neglect based on lack of care/awareness for older fracture.” In support of her neglect “concern,” Dr. Williams wrote in her MPEEC report:

“...There is no history of symptoms or seeking care for the right femur fracture despite the fact that (*sic*) is very similar to the left (in location and morphology). I would expect this fracture to have some symptoms of pain or decreased use like the acute [meaning the left leg fracture], but none are given even after inquiry specifically on this matter. [Parenthetical clarification added by author.]

Though Dr. Poe, the pediatric orthopedist, had indicated in his plan for Sean that the patient should follow up with Dr. Coe, also a pediatric orthopedist, Dr. Williams’ MPEEC report does not reflect that she ever discussed her “concern” about child neglect focused on the healing right leg fracture with either Dr. Poe or with Dr. Coe.

22. About two weeks after Sean’s initial admission to CH#2, he was brought back to Dr. Coe for a follow-up examination, as recommended by Dr. Poe.
23. Dr. Williams’ “concern” for “neglect” expressed in her MPEEC report immediately became DCFS’s precise theory of the case going forward. The DCFS acted immediately on that neglect theory by refusing to allow Sean to be discharged from CH #2 until his parents agreed to a safety plan imposed on the family that prohibited them from being

alone with Sean or either of his two older sisters. DCFS further acted on that neglect theory by asserting---initially as to both parents, but later only as to Gary--that the evidence supported an “indicated” finding of child neglect based upon an allegation of harm related to bone fractures. The indicated findings of child neglect against Gary and Nancy was registered in the Illinois State Central Register. While DCFS agreed to expunge the allegations against Nancy, the State Central Register entry against Gary remained in place for the next **eight** months. At that point, Gary’s lawyer was able to persuade an Administrative Law Judge and the Director of DCFS that the allegation of neglect was erroneous. This decision was based on an evidentiary hearing before the Administrative Law Judge at which Dr. F., Dr. Williams and Dr. Coe all were called to testify.

24. Dr. F.’s testimony at the hearing on the central point in controversy was that:

“....it was possible that the parents would not have observed any symptoms with the.... [right leg]...fracture. Infants do not always cry or appear abnormal with slight, small fractures. It was possible that the parents would not realize that the minor had sustained an injury.”

25. Dr. Coe’s testimony at the hearing before the Administrative Law Judge directly contradicted the explanation that Dr. Williams had provided in the MPEEC report for her “concern” that there was neglect in the fact that Sean’s healing right leg fracture had not been recognized or treated. Dr. Coe’s testimony relating to Sean’s weeks-old healing right leg fracture was summarized by the Administrative Law Judge as follows:

“.....it was very common that there would not be any observable symptoms in that type of injury, especially when the child is not walking. [Dr. Coe] explained that when the minor crawls he could mask a slight, fracture injury. He opined that the minor was able to use his left leg, before the August 2011 injury to maintain his mobility. The existing right leg injury may have made the left leg injury less comfortable.”

In determining that Gary was not a perpetrator of child neglect eight months after that accusation had been leveled against him, the Administrative Law Judge specifically said that she found Dr. Coe’s testimony to be “very clear and credible.” During the course of the preparation for the hearing, Dr. Coe attempted to confer with Drs. Williams and Smith (Dr. Williams’ supervisor) about their opinions in this case but they never returned his calls.

## **Medical Ethics Problems and Issues**

At several points in the progression of facts described above, there are medical ethics problems and issues.

### *1. On Ordering the Skeletal Survey*

Sean was a patient who was presented by his parents to CH # 2 for orthopedic treatment of his left leg fracture. That treatment was provided by Dr. Poe. His determination that no surgery was required and that a cast should be applied to the left leg and the actual application of

the cast was the specialized orthopedic treatment that Dr. F. had envisioned on the previous Saturday when he directed that Sean be seen by an orthopedist.

Sean had not come to the attention of CH #2 by order of the DCFS but because of referrals for treatment that the parents sought, Dr. Poe, who had examined Sean and diagnosed the left leg injury had found no need to make a Hotline call to DCFS. Nevertheless, Dr. Williams ordered that Sean be subjected to a skeletal survey that was obviously unnecessary for the treatment of the left leg fracture and for which the parents had not been asked to consent.

Dr. Williams' conduct in this regard is very difficult to reconcile with a physician's duties under AMA Code of Medical Ethics Opinions 10.015-The Patient-Physician Relationship and 10.016-Pediatric Decision Making. A more detailed discussion of these ethics opinions is found in Discussion Section II of this article.

### *2. On Creating an Advance Directive for the DCFS Hotline Call*

As presented in more detail in Discussion Section V of this article, the confidentiality of a patient's medical information and the privacy rights of a patient are core values that are stated many times in various AMA Code of Medical Ethics opinions. However, where abuse is suspected, the ethical prohibition against unauthorized disclosure of a patient's medical information is not absolute. AMA Code of Medical Ethics Opinion 2.02--Physicians' Obligation in Preventing, Identifying, and Treating Violence and Abuse *does* permit the limited disclosure of a patient's medical information when reporting is statutorily mandated with respect to suspected violence and abuse. However, like all of the other doctors who had considered Sean's left leg fracture before her, Dr. Williams did not believe that the fracture was so suspicious that it required a Hotline call under the mandated reporting statute. Nevertheless, her advance directive was that a Hotline call should be made if any other injuries were revealed by the skeletal survey that she ordered without regard to what those other injuries might be and without regard to whether the parents could explain any other injuries. She did not reserve for herself the opportunity to consider the specific nature of any other injury that might appear on the skeletal survey, nor did she reserve for herself the opportunity to consult with appropriate specialists about the implications for abuse or neglect of any other injury that might appear. In fact, Dr. Williams was approving a Hotline call releasing Sean's otherwise confidential medical information if another injury appeared on the skeletal survey, even if the totality of the circumstances would not have satisfied the statutory test for mandated reporting. It is not clear how this can be reconciled with her ethical obligation to respect the privacy and confidentiality of Sean's medical information.

### *3. On Accepting the MPEEC Assignment After Making the Hotline Call*

AMA Code of Medical Ethics Opinion 9.07—Medical Testimony imposes a duty on doctors to be objective and independent in providing their opinion on medical matters to the legal system. Therefore, child abuse pediatricians should only accept an MPEEC assignment to lead a medical investigation of whether there has or has not been child abuse or neglect in a particular case if they can be objective and independent in carrying out that assignment. It is not clear how Dr. Williams could claim to be independent and objective on the question of whether Sean had suffered abuse or neglect, as she was the same physician who had initiated the Hotline call to the DCFS and had already written comments critical of the parents' actions *before* she

received the MPEEC assignment. The ethical requirements for physician independence and objectivity in providing medical opinions to the legal system are presented in more detail in Discussion Section VIII of this Paper.

#### *4. On Failing to Seek Consultation on Orthopedic Issues*

Under AMA Code of Medical Ethics Opinions 9.07—Medical Testimony and 8.04—Consultation, physicians have an ethical responsibility to recognize the limits of their own expertise in medical specialty areas. They have a concomitant responsibility to consult with appropriate medical specialists in arriving at medical opinions. When the Administrative Law Judge hearing occurred eight months after Sean’s treatment at the hospital, Dr. Coe, a physician at the hospital with extensive credentials in pediatric orthopedics, was unequivocal in expressing an opinion that contradicted Dr. Williams’ “concern” for neglect. Had Dr. Williams consulted with Dr. Coe at her own hospital prior to issuing her report, it is reasonable to assume that he may have allayed her “concern” that Sean’s unrecognized and therefore untreated right leg fracture evidenced child neglect. Alternatively, any disagreement between them might have been flagged as requiring further review and reconciliation rather than the suggesting DCFS should simply defer to Dr. Williams’ opinion. Dr. Williams’ failure to consult with Dr. Coe in particular before the issuance of her report is difficult to reconcile with her ethical duties under AMA Code of Medical Ethics Opinions 9.07—Medical Testimony and 8.04—Consultation. The ethical requirements for physicians to seek consultation are presented in more detail in Discussion Section VIII of this Paper.

#### *5. On the Treating Physicians’ Failure to Question the MPEEC Report*

By issuing an MPEEC report that expressed “concern for neglect based on lack of care/awareness for older fracture” Dr. Williams’ prompted DCFS to proceed with its administrative actions against the parents as detailed in par. # 23. The resulting disruption to the entire family on which Sean’s well-being depended was predictable based on Dr. Williams’ report; any MPEEC physician’s consultation is integral to the outcome of a DCFS investigation, as DCFS investigators are trained to rely on the child abuse doctors and they do so. However, the record does not reflect whether Dr. H. or Dr. Poe, both of whom treated Sean at the hospital before MPEEC report was issued had raised any questions whatsoever with Dr. Williams about whether her “concern” was a fair conclusion under the circumstances or whether she had actually discussed her “concern” with either of these other treating doctors. The failure of the treating physicians to participate in any way in the MPEEC investigation and report is difficult to reconcile with their own ethical obligations to protect Sean’s parental and family relationships. Those ethical obligations are presented in more detail in Discussion Section VI of this Paper.

### **Justin’s Story**

#### **The Family**

Justin was born September 3, 2010 to, Melody, age 35, a full-time stay-at-home mother with a master’s degree in non-profit management and, Don, age 41, a clinical psychologist employed by the federal government outside the home.

Justin is Melody and Don's third child. He was 35 days old at the beginning of the episode that caused his family to interact with child abuse doctors and DCFS. Justin has two older brothers, and they were ages 4 and 6 when this episode began. The episode concluded after 97 days, when Justin was 4 ½ months old.

### **The Doctors and An Overview of Justin's Medical Care Up to the Episode**

The neo-natal team of doctors and nurses at CH #4 in Central Illinois provided care for Justin for the first twelve days after his birth during which time he was a patient in the neo-natal unit.

- Justin had a pediatrician, a pediatric neurosurgeon, and a pediatric ophthalmologist, all of whom were involved in his treatment at various times during the first 35 days of his life, while he was a patient at CH #4 and on an out-patient basis after he was discharged from CH #4.
- Justin was treated by physicians in the CH #4 emergency department on the 35<sup>th</sup> day of his life (October 8, 2011) when his parents brought him in because he was vomiting. One of these physicians erroneously concluded that a CT head scan revealed an acute skull fracture. This was **Day 1** of the family's ordeal with the child protection system.
- Dr. Murphy is a Child Abuse Pediatrician and the Medical Director of the Children's Center at CH #4. After interviewing Justin's parents on **Day 1** or **Day 2** (i.e., on October 8 or 9, 2011), she made an erroneous determination that his non-existent skull fracture was "suspicious for non-accidental trauma" and she communicated that determination to DCFS.
- Dr. D is a neuroradiologist at CH #4. He reviewed Justin's CT head scan on October 18 (**Day 11**) and he reported in the medical records that it did not show a skull fracture, but rather a "suture."
- Ohio Children's Hospital. On or about the 55th day of his life (**Day 20**), Justin's parents took him to this prominent out-of-town children's hospital for a second opinion on various medical questions, including whether he actually had a skull fracture. The physicians at this hospital gave an unequivocal opinion in writing on the 66<sup>th</sup> day of Justin's life that he had no skull fracture.

### **The Family's Care for Justin and Their Child Protection Ordeal**

This family's ordeal with a medically-driven false allegation of child abuse was inextricably intertwined with Justin's very fragile health in the first weeks of his life.

1. Justin was so ill at birth with a variety of cardiac and respiratory issues and other critical concerns about electrolyte and protein levels that he spent all but two of the first 20 days of his life in the hospital.
2. The difficulty of resolving Justin's many medical issues is evident from the history of his hospital admissions and discharges. He was first discharged to his home after an initial twelve-day stay in the neo-natal unit following his birth, only to be re-admitted to the hospital after two days. He was then discharged a second time on September 23, but under orders for an intensive regimen of home health care involving intravenous catheterization.

3. Though not a patient in the hospital for the two weeks between September 23 and October 7, Justin's condition was so precarious that his parents felt it necessary that he be seen by one of his doctors or nurses on every single day during this period except one. The doctors who saw him during this period included his pediatrician, a pediatric neurosurgeon and a pediatric ophthalmologist.
4. Because of his unfortunately fragile medical condition, the infant Justin had been under intensive medical monitoring by a variety of pediatric sub-specialists and their nursing staffs from the date of his birth on September 3 through October 7, 2010. That monitoring was minute-to-minute while Justin was in the hospital and daily while he was at home.
5. After Justin's parents brought Justin back to the CH #4 emergency department on October 8, 2010 (**Day 1**) because of vomiting, he was given a CT scan that was misread as showing an acute skull fracture. That interpretation of the CT head scan as showing Justin having an acute skull fracture was later definitively rejected by Ohio Children's Hospital and by other highly qualified physicians. The mark that had been misinterpreted had apparently resulted from Justin not being properly positioned in the equipment used for the CT scan.
6. Because Melody and Don could not explain how Justin may have suffered a skull fracture, a member of Justin's medical treatment team at CH #4 made a Hotline call to DCFS. The decision to make this call was apparently in keeping with the policy of CH #4. As later explained to the local press by a hospital spokesman: *"When a child has an unexplained injury of any sort and is seen in any of our facilities, we are mandated by state law to report the injury to DCFS."*
7. Based on the misdiagnosed skull fracture, Justin's treatment team also referred his case to the Children's Center. The exclusive function of the Children's Center is to deal with cases of suspected child abuse or neglect. In its website, the Children's Center describes its organizational affiliations, its function, and how it collaborates with other agencies in the community having an interest in child abuse as follows: *"The Center is a community service program of the University of Illinois College of Medicine . . . . The [Center] provides direct services to suspected child victims of physical abuse, sexual abuse, and neglect in a child-friendly manner and setting. Medical and social service staff also provide adjunct services to parents, guardians and caretakers. Additionally, they work in collaboration with the many agencies and systems that are involved in a child abuse case. The [Center] is affiliated with [CH4] Medical Center, and is located on the hospital's campus."*
8. Dr. Murphy is the Medical Director of the Children's Center, and in that capacity, she interviewed Melody and Don on **Day 1** or **Day 2** (October 8 or 9, 2010). Naturally, the parents had no explanation to offer as to how Justin may have sustained a skull fracture, given that he had not actually sustained any such fracture.

9. Notwithstanding that Justin had lived in the hospital for eighteen of the first twenty days of his life and had continued to see sub-specialized pediatricians almost daily since his discharge from the hospital two weeks earlier, none of his doctors had reported any injury --- acute skull fracture or anything else -- that was suspicious for abuse. Nevertheless, without consulting with any of those other doctors, Dr. Murphy concluded that Justin had a skull fracture and that it was “*suspicious for non-accidental trauma*” and began to accuse the parents of being child abuse perpetrators. This accusation immediately led to restrictions being imposed on their contact with their children.
10. Based on Dr. Murphy’s conclusion, DCFS imposed a safety plan that commenced immediately on October 8, 2010 and applied to all three of Melody and Don’s children. This safety plan required round-the-clock supervision of Melody’s and Don’s parenting of their children in their home. This plan required the parents to arrange for family and friends to come in from as far away as Pennsylvania and Wisconsin to provide the DCFS-required supervision.
11. Justin was kept in the CH #4 for seven days following his parents taking him to the emergency department out of concern for his vomiting symptoms. He was allowed to go home on October 15 (**Day 7**). However, he was only allowed to go home subject to the safety plan under which the rest of his family had already been living for a week.
12. On October 18 (**Day 11**) Dr. D., a neuro-radiologist at CH4 reviewed Justin’s CT scan, and he concluded that the mark which had initially been labeled as an acute skull fracture was actually an “accessory suture.” He advised the assigned police investigator that it “didn’t look like a fracture at all.”
13. On October 22 (**Day 15**) the safety plan imposed by DCFS was allowed to expire.
14. Shortly after the safety plan expired, Melody and Don took Justin to the Ohio Children’s Hospital for a second opinion. The doctors at that hospital concluded that there was no skull fracture and that Justin’s CT head scan was perfectly normal. Their explanation of the mark that was seen on the CT head scan on October 8 at CH #4 was that it resulted from improper positioning of Justin on the scanning machinery. The final formal written opinion on these points from Ohio Children’s Hospital was issued on or about November 11, 2010 (**Day 35**).
15. On January 12, 2011, about 62 days after the report from Ohio Children’s Hospital (on **Day 97** after their ordeal began), DCFS issued a letter to Melody and Don acknowledging that the abuse allegation was “unfounded.”

## **Medical Ethics Problems and Issues**

Justin’s experience with the medical community based on the misread CT head scan and his family’s subsequent ordeal with the child protection system raises a number of serious medical ethics issues.

### *The Emergency Department Physician*

*Did the emergency department physician violate Justin's rights to privacy and confidentiality of his medical records by making a Hotline call that was the result of a policy of reporting all unexplained injuries?*

People who work regularly in the child abuse field know that children often present with injuries which the parents cannot explain but which turn out to be the result of some unobserved or unremarkable accidental trauma or the result of a previously undiagnosed disease or even, as in this case, a misread x-ray or other test. Yet, the policy of CH #4 was to make a Hotline call to the DCFS whenever there was *"an unexplained injury of any sort."* (Fact No. 6). This across-the-board reporting policy was apparently based on a misunderstanding of the requirements of the Illinois statute, which mandates reporting only when there is a *"reasonable cause to believe"* that the child has been abused or neglected.

Under various opinions in the AMA Code of Medical Ethics relating to a patient's rights to privacy and confidentiality, the CH #4 emergency department physician who treated Justin could make a Hotline call to DCFS only if he had *"reasonable cause to believe"* that abuse had occurred, that is, only if he believed that the statutory standard for a mandated report had been reached. A detailed discussion of AMA ethics opinions that relate to privacy and confidentiality is found in Discussion Section V of this Paper. These opinions do not suggest that a physician would be relieved of his ethical burden to protect a patient's confidentiality and privacy, because the hospital at which he is employed appears to have a lower standard than the statutory requirement for a Hotline call, such as the appearance of *"an unexplained injury of any sort."*

In Justin's case, it appears that the emergency room physician may indeed have been operating under the lower hospital standard for making a Hotline call (*"an unexplained injury of any sort"*), especially since he made the Hotline call without first conferring with the doctors who had been treating Justin. Objectively, there would not have been *"reasonable cause to believe"* based on a single imaging test that a 35 day old infant in very fragile health since birth, who has been under the continuous care of pediatric medical professionals and nurturing parents for his entire life had actually been abused.

### *Justin's Pediatricians*

*In failing to question the determination that Justin had an injury that was suspicious for abuse, did Justin's pediatricians live up to the ethical expectation of providing family-centered care?*

During the first 35 days of Justin's life, there were a number of pediatric physicians, who had been involved in his treatment both inside CH #4 and after he had been discharged from the hospital. These included general practice pediatricians as well as pediatricians with various subspecialties. In view of these physicians' continuous monitoring of Justin's physical condition up to the point at which abuse was first suggested, it seems likely that some or all of them must have had doubts about the plausibility of the abuse allegation.

Whether or not they had doubts, not a single one of the pediatricians on Justin's medical team during the first 35 days of his life raised any questions whatsoever with Dr. Murphy about her conclusion that Justin had a skull fracture and that it was *"suspicious for non-accidental trauma."* These physicians may have assumed that, once another doctor reports child abuse, it is

not their job to take any affirmative steps with respect to that report. Since the resulting disruption to the entire family on which Justin's well-being depended was predictable based on Dr. Murphy's report, one or more of these doctors might have felt justified under the American Academy of Pediatrics (AAP) principle of delivering family-centered care in "pushing back" against Dr. Murphy about her conclusion. The obligation of pediatricians under AAP principles to deliver family-centered care is presented in more detail in Discussion Section VI of this Paper.

### *The Child Abuse Pediatrician: Interviewing Parents*

*Was the Child Abuse Pediatrician's interview of Justin's parents a prohibited interrogation?*

On October 8 or 9, 2010 (**Day 1 or Day 2**), Dr. Murphy interviewed Don and Melody in order to gather information for her investigation into whether Justin's erroneously diagnosed skull fracture was the result of abuse or neglect. (Fact No. 8.) The information that Dr. Murphy gleaned from the interview was that Melody and Don were unable to offer an explanation for the (non-existent) skull fracture. The absence of an explanation for the (non-existent) skull fracture was the circumstance that Dr. Murphy found to be "*suspicious for non-accidental trauma*."

AMA Code of Medical Ethics Opinion 2.068 – Physician Participation in Interrogation explicitly prohibits physicians from conducting or directly participating in interrogations of "detainees." Dr. Murphy was reporting to DCFS as to her conduct of this interview (Fact No. 7 and 8) and DCFS relied on her interviews of the parents. Moreover, since doctors, DCFS and police all have the power to summarily take custody of children suspected of being abuse victims, Dr. Murphy's interview may have crossed the line between questioning for purposes of medical assessment and treatment and the type of "interrogation" that physicians are enjoined against performing under Opinion 2.068. A more detailed presentation of this ethics opinion and the concerns underlying it, including why the "detention" of parents by hospital personnel and DCFS raises concerns similar to those present in the clearly prohibited interrogations of prisoners is found in Discussion Section I of this Paper.

### *The Child Abuse Pediatrician: Consultation with Other Physicians*

*Did the Child Abuse Pediatrician consult with other physicians, as required by the AMA ethics opinions, before opining that Justin had an injury that was "*suspicious for non-accidental trauma*?"*

We previously suggested that Justin's team of several treating pediatricians with different sub-specialties might have done more to raise plausibility concerns after the allegation of abuse was leveled at the parents. The parents had been working with those physicians continuously ever since Justin's birth on a complex set of medical problems, none of which suggested abuse. In the same vein, it would also have been very helpful for Dr. Murphy to test the plausibility of her opinion --- "*suspicious for non-accidental trauma*" --- by reaching out to those pediatricians before communicating that opinion to the DCFS. Had she done so and had the other treating physicians participated in the discussion of whether there was "reasonable suspicion," three months of an extremely traumatic and medically baseless ordeal for the family could have been avoided. However, there is no indication that Dr. Murphy consulted with anyone or that anyone offered a contrary opinion to her before or in the initial period after the Hotline call was made.

A true team approach with other treaters being consulted would be the expectation under medical ethics opinions. The specific ethical problem in this case arises from Dr. Murphy's failure to consult with any neuroradiologist *before* expressing her opinion on October 8 or 9. If such a consultation had occurred with a neuroradiologist, it is obvious that Dr. Murphy's opinion would not have been that there was a skull fracture "*suspicious for non-accidental trauma.*" In turn, there would have been no reason for the DCFS to impose a safety plan on the family.

The physicians at Ohio Children's Hospital were able to determine very quickly from the CT head scan taken at CH #4 that Justin did not have a skull fracture. This reinforces the validity of the question as to whether Dr. Murphy sought out appropriate consultation with other physicians at CH #4 to confirm her reading, which turned out to be erroneous, of that same CT head scan.

As detailed in Discussion Section VIII of this Paper, a physician providing an opinion to the legal system has an obligation to be guided by current scientific thought under AMA Code of Medical Ethics Opinion 9.07—Medical Testimony and an obligation to consult with other physicians where appropriate under AMA Code of Medical Ethics Opinion 8.04—Consultation. While Child Abuse Pediatricians may sometimes find themselves in situations in which they feel pressure to make a hurried decision on whether abuse has occurred in order to prevent a child from being discharged from the hospital to his parents, there are no provisions within Opinions 9.07 or 8.04 relaxing the standards to be observed by Child Abuse Pediatricians in such cases, nor would such relaxation of standards be justified given the serious damage that can result if a Child Abuse Pediatrician communicates an erroneous opinion about abuse to a child welfare agency such as DCFS.

#### *The Child Abuse Pediatrician: Independence and Objectivity*

*Was the Child Abuse Pediatrician in this case in a position to be independent and objective in determining whether Justin was the victim of child abuse given that the hotline call to DCFS had been made from her own hospital?*

CH #4 recognizes that after one of its doctors makes a Hotline call to DCFS under the Illinois mandated reporter statute, it is necessary for an independent investigation to be made as to whether child abuse has actually occurred. In commenting on Justin's story to the local press, a spokesman for the Hospital said:

*"When a child has an unexplained injury of any sort and is seen in any of our facilities, we are mandated by state law to report the injury to DCFS. DCFS then does its own investigation which we (CH #4) have no control over. The investigation is not a medical decision; it is a protocol that has been put in place by the state to protect children." (Quoted from Pekin Times article on March 11, 2011; emphasis added)*

The Children's Center is an affiliate of CH #4. (Fact No. 7). The Children's Center's involvement in formulating an opinion about whether Justin had actually suffered abuse would appear to violate the Hospital's understanding of what its role can be after one of the Hospital's own physicians has made a Hotline call.

As detailed in Discussion Section VIII of this Paper, the same restriction that is recognized in the above statement made by the CH #4 spokesman would also appear to be at least strongly implied by the requirement of AMA Code of Medical Ethics Opinion 9.07—Medical Testimony. Child abuse pediatricians are commonly called to testify at legal proceedings and their opinions are sought with an understanding that, should such testimony be needed in the future, their opinions provided to DCFS may be presented in court. A key requirement of Opinion 9.07 is that physicians must be “objective” and “independent” in providing information to the legal system. Clearly, a child abuse pediatrician working at a hospital from which a Hotline call has been made to the DCFS would not be able to claim the same degree of independence or objectivity in assessing the validity of that Hotline call when conducting a medical investigation of whether child abuse has actually occurred as a child abuse pediatrician working at another hospital.

*Mitigating Harm Done to Justin and His Family  
By Erroneous Child Abuse Allegation*

*Did the physicians who initiated and encouraged the child abuse allegation against Justin’s parents take action to mitigate the harm to Justin and his family by trying to persuade the DCFS to drop its case as soon as it became clear that the allegation was erroneous?*

This family’s ordeal, in contending with the completely erroneous allegation that their sick infant, Justin, had actually been abused, lasted for over three months (97 days), from October 8, 2010 until shortly after January 12, 2011. The safety plan lasted for 14 days, but the allegation was not declared “unfounded” and Melody and Don were not cleared of suspicion for more than two months after the safety plan ended. That ordeal was triggered by an emergency department physician to whom Justin’s parents had taken him for treatment and it was extended by the erroneous opinion of the child abuse pediatrician heading up the hospital’s Children’s Center. The DCFS only started pursuing administrative action against this family, because of the Hotline call on October 8, and it would not likely have persisted in that process but for Dr. Murphy’s opinion within a day or two of the Hotline call that Justin had an injury that was “*suspicious for non-accidental trauma.*” Once started, Don and Melody’s parental relationship to their three children was directly restricted for two weeks and the cloud of suspicion continued to hang over them until January 12, 2011, even though the doctors at CH #4 appear to have recognized their mistake in reading Justin’s CT head scan by October 18—i.e., by the eleventh day of the family’s ordeal. (Fact No. 12)

AMA Code of Medical Ethics Opinion 8.121—Ethical Responsibility to Study and Prevent Error and Harm, more extensively presented in Discussion Section IX of this Paper, defines physicians’ ethical duties to take remedial actions with respect to health care errors and situations in which those errors have caused harm to patients and others. Justin’s case invites the question whether the doctors involved did everything that they could to mitigate the harm caused to Justin and his family by the initial misreading of the CT head scan. It is true that the doctors could not unilaterally have ended DCFS’ unwarranted administrative action against Melody and Don. However, it is also very clear that the administrative action by DCFS against these parents was entirely dependent on the continued acquiescence or pressure of Dr. Murphy. As early as the tenth day of this family’s ordeal, Dr. Murphy could not ethically confirm that Justin had actually suffered an unexplained skull fracture. That being the case, did she take the ethically required steps to mitigate harm to Justin and his family?

## **Amelia's Story**

### **The Family**

Amelia, who was born six week prematurely, was 7 months old when her family encountered the child protection system and child abuse pediatricians. Her mother, Valerie, age 37, is a full-time stay-at-home mother. Valerie's husband and Amelia's father is Jim, age 37, a professional who works outside the home. Amelia is Valerie and Jim's only child.

The intrusion into this family's life by the state child protection system lasted **98 Days**, and much of the narrative account that follows will be stated in terms of that **98 Day** timeline. Amelia was ten and a half months when her family's ordeal ended.

### **The Doctors and the Medical Care Up to the Episode**

- Dr. Y. is a Pediatric Ophthalmologist and was one of Amelia's treating doctors at CH #1 in Chicago. The episode described in this narrative started on **Day 1** when Valerie and Jim took Amelia to Dr. Y for treatment.
- Dr. Jones is a child abuse pediatrician and head of the child protection services team at the same hospital, CH #1, as Dr. Y. Dr. Jones works under the MPEEC subcontract to provide reports to DCFS as to children who are presented for treatment at CH #1.
- Amelia was also examined by an out-of-town team of five doctors working at East Coast Children's Hospital, a major children's hospital. Unlike CH #1's child protective services team, this team included two child abuse pediatricians, a neuroradiologist, a pediatric neurologist, and an experienced general practice pediatrician. In a set of signed written opinions that were dated between **Day 9** and **Day 14**, these five doctors opined definitively that there was no reason appearing from their examination of Amelia and consideration of her medical history to conclude that she had been the victim of child abuse.

### **The Family's Ordeal**

1. In the background of this family's ordeal with a medically-driven false allegation of child abuse was Amelia's very fragile health in the first months of her life. Amelia had been born six weeks prematurely at CH #1 and had been delivered in an emergency caesarean procedure due to fetal distress. After her birth, Amelia had spent almost three weeks in CH #1's neo-natal intensive care unit.
2. At the time of the episode described in this narrative, Amelia, at age seven months, continued to have very significant on-going urological, cardiologic and ophthalmological issues.
3. It was in connection with concerns about Amelia's vision problems that Valerie and Jim took the initiative to seek an opinion from Dr. Y. at CH #1 on **DAY 1**. Dr. Y. ordered an MRI to check for a brain tumor. While the MRI was negative for brain tumor, it did show an old and small subdural hemorrhage. Because of this subdural hemorrhage, Dr.

Y. referred the matter to his colleague at CH #1, Dr. Jones and the child protection services team.

4. Even as he was first telling the parents on **Day 1 that**, after the MRI results became available that they would have to meet with Dr. Jones' child protection team because of his referral, Dr. Y. also reassured them that he was confident that the subdural hemorrhage was *not* the result of child abuse. Dr. Y. would continue to express these reassurances to Valerie and Jim consistently throughout this entire episode.
5. Dr. Jones and the social worker on the child protection services team interviewed Valerie and Jim separately on **Day 2** looking for an explanation for the old subdural hemorrhage. After neither Valerie nor Jim was able to tell Dr. Jones about any trauma that might have caused the subdural hemorrhage, Dr. Jones became accusatory, saying that "Sometimes, people just snap and shake the baby!"
6. At some point on **Day 1** or **Day 2**, a call was made to the DCFS Hotline by one of the doctors involved at CH #1 or by one of the social workers on the hospital's child protection team. It is not known who made the call as this information about the reporter's identity is confidential, but its timing and the circumstances under which the call was made makes it clear that a CH #1 employee initiated the call. As a result, Valerie and Jim each were subjected to two other separate interviews, one by the DCFS investigator and one by a local police officer. Again, nothing came out of those interviews to support a non-accidental (abusive) explanation for the old subdural hemorrhage. As far as Valerie and Jim are aware, after these interviews, the police investigation went no further. However, DCFS kept its investigation open and continued to consult with Dr. Jones on the matter after these interviews and, as discussed below, continued to await Dr. Jones' determination as to whether Amelia had been abused.
7. Although there was no medical need for hospitalization, Amelia was admitted to CH #1 when her parents were first summoned to meet with Dr. Jones on **Day 2**. The doctors admitted Amelia to the hospital in order to perform various medical tests in search of an explanation for the subdural hemorrhage or to find evidence of any other injury unrelated to the subdural hemorrhage. One of the tests which was performed was a skeletal survey for unknown fractures. None of these tests produced either a trauma explanation for the subdural hemorrhage or evidence of any other injury. However, updated measurements of Amelia's skull did re-confirm that there was benign enlargement of her subarachnoid spaces. This finding was important because there is a significant body of opinion expressed in the medical literature that children with this medical condition are susceptible to subdural hemorrhage resulting from minor, commonplace, accidental, and unremarkable head bumps---the type of head bumps of which even vigilant parents might not be aware.
8. The following were Dr. Jones' comments in the medical records on **DAY 4** concerning the results of the medical tests performed at CH #1 under her direction.
  - a. Dr. Jones indicated that none of the findings either confirmed or refuted the possibility of trauma as a cause of subdural hemorrhage.

- b. She made no specific comment about the benign enlargement finding, which was potentially contra-indicative of abuse.
  - c. She acknowledged that Amelia had no other findings suggesting that the baby had suffered trauma.
  - d. She indicated that she would await the outcome of the DCFS and police investigations.
9. At the very same time (**Day 4**) that Dr. Jones was writing this status update on her medical investigation acknowledging that no evidence of child abuse had emerged, Amelia was being released from the hospital. Yet, Dr. Jones' DCFS colleagues involved in the investigation at DCFS would not permit Valerie and Jim to take Amelia home unless they agreed to a so-called safety plan, which is intended to be a short term plan which restricts the parents' access to their child while the investigation continues. Safety plans issue without any court review of the basis for the custodial restrictions they require and families are typically informed that if they fail to agree to the proposed safety plan, their children will be taken from them and placed in foster care. The safety plan that Valerie and Jim signed gave residential custody of Amelia to Valerie's cousin. Valerie and Jim were relegated to the status of visitors, never to be left alone with Amelia. There is no indication from the records that Dr. Jones advised DCFS staff as to any negative impact of such restrictions on the family, and it appears she endorsed the safety plan insofar as her MPEEC team was fully aware of the safety plan that was demanded of Valerie and Jim and did not make any objection to it.
10. Soon after being discharged from CH #1, at Valerie and Jim's initiative and due to family contacts they had on the east coast, Amelia and her medical history and records were brought for evaluation to East Coast Children's Hospital. That hospital had a child protection team of five doctors with various pediatric sub-specialties, including two child abuse pediatricians. In order to comply with requirements of the safety plan, Valerie's cousin had to go along with them on the trip to supervise all of their contact with Amelia.
11. In a set of signed written opinions that were dated between **Day 9** and **Day 14**, these five doctors at East Coast Children's Hospital including the two child abuse pediatricians, opined definitively that there was no reason appearing from their examination of Amelia and her medical history to conclude that she had been the victim of child abuse. Highlights of the opinions included the following points:
- a. Generally, while a small subdural hemorrhage may raise some initial concerns for non-accidental trauma, such a finding is not, in the absence of other injuries or findings, diagnostic of non-accidental trauma.
  - b. A conclusion that Amelia had been abused was unwarranted, because while she had an unexplained subdural hemorrhage, she did not have either a retinal hemorrhage or a neurological dysfunction, and there was no other physical evidence of abuse, such as fractures.
  - c. The old subdural hemorrhage on Amelia's MRI was consistent with her birth and neo-natal history.

12. The definitive opinions of the team of doctors from East Coast Children's Hospital that there was no medical indication that Amelia had suffered child abuse were made immediately available to the DCFS and to Dr. Jones. Those opinions were in the hands of DCFS and Dr. Jones by **Day 16**.
13. Notwithstanding the definitive opinions of the team of doctors from East Coast Children's Hospital that there was no medical indication that Amelia had suffered child abuse, DCFS refused to close its case and continued to insist on its coercive safety plan until it received a final report from Dr. Jones. Dr. Jones was the only doctor whose opinion the DCFS staff affirmatively sought out, due to the pre-existing MPEEC sub-contract between DCFS and CH #1.
14. There is no record (to our knowledge) of Dr. Jones ever expressing any disagreement with the opinions of the team of doctors from East Coast Children's Hospital. There is also no record of Dr. Jones ever issuing a final report. Dr. Jones' coordination with DCFS was clearly circular and self-referential: her **Day 4** note in the medical records indicated that she would await the conclusion of the DCFS investigation, while the DCFS position on **Day 16** was that they could not conclude until they had received Dr. Jones' final report.
15. Repeated exchanges continued to occur after **Day 16** between the parents and DCFS. These exchanges all concerned the questions of when DCFS would end this investigation and, most significantly, when DCFS would stop insisting that the highly intrusive safety plan be observed. Throughout this period DCFS indicated that its investigation would not end until it received a report from Dr. Jones and that if the parents did not continue to agree to the safety plan, Amelia would be taken out of their home, away from Valerie's cousin and into protective custody, e.g. placed with strangers in foster care.
16. Finally, 53 days later, on **Day 79**, DCFS verbally communicated to Valerie and Jim that they intended to close the case as "unfounded" for child abuse, meaning that no credible evidence of child abuse as to Amelia had been found during the investigation. A formal written confirmation of the "unfounded" determination was issued on **Day 98**. As far as Valerie and Jim are aware, DCFS ultimately took this action without ever receiving a report from Dr. Jones.

### **Medical Ethics Problems and Issues**

The above facts suggest several areas in which there are serious medical ethics problems and issues to be considered in connection with the work of Dr. Jones and the work of Dr. Y.

As to Dr. Jones, the problem areas are:

- 1) her accusatory interview of Valerie and Jim;
- 2) her refusal to issue an opinion to DCFS over an extended period of time, especially when the appropriate opinion to be issued was one that was negative for child abuse; and
- 3) her inability to be independent and objective on a matter that had first been reported to DCFS by her own hospital.

As to Dr. Y, the problem areas are:

- 1) his referral of this matter to the hospital's child protection services team even though he expressed a strong opinion that there was no abuse and
- 2) his failure to ask critical questions of Dr. Jones on the handling of this matter as it unfolded and created such great distress for Amelia and her family.

As to both Dr. Y and Dr. Jones, there is also an issue about their failure to mitigate the harm that was done to this family in that they failed to take obvious steps to bring the DCFS investigation to a close and in that way shorten the time that this family was under stress.

Each of these problem areas will be discussed in a separate section below.

#### *Dr. Jones' Interview of the Parents*

*Was Dr. Jones' interview of Amelia's parents while their child was held at the hospital a prohibited interrogation?*

On **Day 2**, Dr. Jones interviewed Jim and Valerie in order to gather information for her investigation into whether Amelia's subdural hemorrhage was the result of abuse or neglect. After questioning that Jim and Valerie felt was extremely hostile in tone, the information that Dr. Jones gleaned from the interview was that Valerie and Jim were unable to offer an explanation for the subdural hemorrhage. The fact that the parents at that interview did not have a traumatic incident to report to Dr. Jones that would, in her mind, have accounted for Amelia's old subdural hemorrhage was apparently a circumstance that Dr. Jones viewed as justifying further investigation, which she never closed.

AMA Code of Medical Ethics Opinion 2.068 – Physician Participation in Interrogation explicitly prohibits physicians from conducting or directly participating in interrogations of detainees. Since Dr. Jones was collaborating with DCFS in conducting this interview, since the child was being held at the hospital at the time of the questioning, and since both she and DCFS have the power to summarily take custody of children suspected to be abuse victims, Dr. Jones' interview appears to be the type of interrogation discussed in Opinion 2.068. A more detailed presentation of this ethics opinion is found in Discussion Section I of this Paper.

#### *Dr. Jones' Refusal to Issue Her Opinion to DCFS*

*What ethical concerns are raised by Dr. Jones' refusal to give DCFS her final opinion so as to expedite closure of the DCFS investigation?*

AMA Code of Medical Ethics Opinion 9.07-Medical Testimony is unequivocal in articulating the duty of doctors to be honest, objective, independent, and guided by "current scientific thought" in providing their opinion on medical matters to the legal system. Though unstated, it is also clearly implicit that in formulating and providing opinions to the legal system, doctors have a duty to be thorough. Discussion Section VIII of this paper includes a detailed consideration of how Opinion 9.07 could apply to child abuse pediatricians performing their role

as medical investigators of suspected child abuse and as liaisons to the state child protection authorities.

In Amelia's case, as far as Valerie and Jim know, Dr. Jones never gave DCFS an affirmative opinion that Amelia had been abused. However, she also apparently declined to advise her colleagues at DCFS that she was ending her investigation because she was unable to conclude that Amelia had been abused. Dr. Jones persisted in this refusal to close the case with her DCFS colleagues even though it was clear by **DAY 4** that tests conducted at her own hospital did not provide evidence of abuse and even though it was clear by **DAY 16** that another highly qualified multidisciplinary team of doctors at the East Coast Children's Hospital had affirmatively concluded that there was no evidence of Amelia having been abused. To the best of Valerie and Jim's knowledge, when the DCFS case against them was finally closed on **DAY 98**, it was the result of DCFS deciding not to wait any longer for Dr. Jones to provide her opinion, an opinion which could only have been negative as to child abuse.

Amelia's case raises a serious question about the ethical obligation of a child abuse pediatrician from whom the state child protection agency (in this case, Illinois DCFS) is awaiting an opinion. If there is no evidence of abuse, can the child abuse pediatrician avoid the ethical burden of Opinion 9.07--Medical Testimony simply by refusing to provide any opinion at all? Such a result would seem to make the guarantees of Opinion 9.07 illusory. Moreover, if a child abuse pediatrician may decide not to render any opinion at all on child abuse in a particular case in which a negative opinion is warranted, this would undermine one of the important claims that has been made about the child abuse pediatrics sub-specialty. Specifically, one of the benefits of the new subspecialty, as discussed in Section VIII of this paper, was supposed to be that parents and families would be spared from long-pending but factually erroneous allegations of child abuse hanging over their heads. This benefit was supposed to result from child abuse pediatricians having the expertise and professionalism to deliver a prompt negative diagnosis as to child abuse when that was warranted.

#### *Dr. Jones' Independence and Objectivity*

As discussed in Section VIII of this paper, a key requirement of Opinion 9.07—Medical Testimony is that physicians must be “objective” and “independent” in providing information to the legal system. Was Dr. Jones in this case in a position to be independent and objective in providing an expert medical investigation and opinion to DCFS under the MPEEC agreement about whether Amelia's subdural hemorrhage was the result of abuse, given that the Hotline call to DCFS had already been made from her own hospital, CH#1? It is difficult to see how a persuasive argument could be made that Dr. Jones would have independence and objectivity in this case. Moreover, since there are several children's hospitals in the same city as CH #1 with fully staffed child protection service teams headed by certified child abuse pediatricians and each party to the MPEEC agreement, Dr. Jones would certainly not have had any need to compromise on independence or objectivity in Amelia's case. Since the Hotline call was made from CH #1, she could simply have requested that the MPEEC assignment be directed to one of the other hospitals.

#### *Dr. Y's Referral of Amelia's Case to CH #1's*

#### *Child Protection Services Team*

If Dr. Y was convinced, as he consistently claimed to be, that Amelia's subdural hemorrhage was not the result of abuse, then was his decision to refer this matter to Dr. Jones' child protection services team ethically sound?

There are several opinions in the AMA Code of Medical Ethics that generally protect a patient's right to privacy and right to confidentiality as to medical records. The injured child, as a patient, has a right to confidentiality and privacy with respect to his medical issues and records and personal information under these opinions. The AMA ethics opinions that impose the obligations on doctors to respect privacy and confidentiality rights do not appear to have a general carve-out for cases of suspected child abuse, only a limited exception to the privacy and confidentiality rules to enable doctors to comply with the requirements of mandated reporting statutes. Moreover, AMA Code of Medical Ethics Opinion 7.025--Records of Physicians: Access by Non-Treating Medical Staff specifically guards a patient's privacy and confidentiality against inappropriate disclosure to non-treating doctors, like Dr. Jones in this case. Yet, Dr. Y. referred Amelia's medical records and history to Dr. Jones without prior permission of Valerie or Jim even though he himself did not believe that she had been abused. This appears to be problematic from an ethical viewpoint for Dr. Y.

The authors of this paper are not in a position to know all of the details of the internal policy of CH #1. However, it is believed that at this particular children's hospital, a policy requires certain injuries in children under the age of one that are not explained to be referred by treating doctors, like Dr. Y., for further assessment by the hospital's child protective services team. There is thus both a presumption of some level of suspicion whenever these unexplained injuries are present (no matter how complex the child's medical issues are) and a deferral of the duty of child abuse reporting away from the treating doctors (who have a duty to report directly to DCFS any reasonable suspicion they have). There is also a concomitant practice of deferring to the assessment of non-treaters in the child abuse unit as to whether to make a Hotline call. Our supposition would be that such an institutional policy would not generally relieve a treating physician of any ethical burden that he might have under the AMA Code of Ethics. In practice, the problem arises especially because after the Hotline call is made, the only doctors that DCFS communicates with as to the results of the call are the MPEEC doctors, not the physicians like Dr. Y., who never thought there was reasonable suspicion in the first place.

#### *Dr. Y's Failure to Critically Question Dr. Jones' Investigation*

Dr. Y. referred Amelia's case to Dr. Jones, even though he was confident that there was no child abuse. Dr. Y was thereafter in a position to observe the resulting ordeal through which this family was living. The question that this raises is whether Dr. Y. should, at some point, have started critically questioning Dr. Jones on how this matter was being handled. There is no indication that Dr. Y. ever made such an effort on behalf of the family.

AMA Code of Medical Ethics Opinion 10.016 -- Pediatric Decision-Making explicitly recognizes the importance of the family relationship to the pediatric patient. The Opinion indicates that physicians should consider what effect their actions could have on those family

relationship, not because the physician has a divided loyalty, but because of the importance of family and parental relationships to the child. In addition, treating physicians, like Dr. Y., have an obligation to provide patient and family-centered care as required by policy statements of the American Academy of Pediatrics, most recently Patient and Family-Centered Care and Pediatrician's Role. A more detailed presentation of these family focused obligations of pediatricians, which would appear to have an application to Dr. Y. in this case, is found in Discussion Section VI of this article.

*Mitigating Harm Done to Amelia and Her Family  
By Erroneous Child Abuse Allegation*

*Did the physicians at Children's Hospital #1 who initiated and encouraged the child abuse allegation against Amelia's parents act as aggressively as possible to persuade DCFS to drop its case as soon as it became clear that the allegation was erroneous?*

AMA Code of Medical Ethics Opinion 8.121–Ethical Responsibility to Study and Prevent Error and Harm establishes the ethical obligation of physicians to take remedial actions with respect to health care errors and situations in which those errors have caused harm to patients and others. This ethics opinion is presented in more detail in Discussion Section IX of this Paper.

It is very difficult to argue that either Dr. Jones, who directed the medical investigation of whether Amelia had been abused, or Dr. Y., who passively observed the medical investigation after referring Amelia's case to the child protection services team, did anything to mitigate the damage done to this family. Had it not been for the family's own resources in being able to obtain additional opinions from East Coast Children's Hospital, it is almost certain that the family's ordeal would have dragged out even longer.

The damage to this family could have been dramatically reduced had Dr. Jones simply accepted the fact that there was no evidence of child abuse and advised DCFS of that fact on **Day 4** after all of all medical tests had been completed at her own hospital. Failing that, she might have dealt forthrightly with the unequivocal "no abuse" opinion of a team of experts from East Coast Children's which reached her on **Day 16**, either accepting it or determining that there was still an avenue for further investigation that created a realistic possibility that evidence of abuse might yet be found.

As the case actually unfolded, Dr. Jones declined to bring her medical investigation to an end at either **Day 4** or at **Day 16**, and she also failed to establish that there was any additional avenue that had to be explored or that warranted being explored before bringing her medical investigation to a conclusion. Instead, she left her medical investigation—and therefore the DCFS case—open, but apparently dormant, doing nothing to advance the medical investigation any further. As a result, the intrusion on Amelia and her family went on for another **82 Days** beyond the receipt of the report from the team at East Coast Hospital until the DCFS determined to "unfound" the child abuse allegation without the benefit of an opinion from Dr. Jones.

Though Dr. Y. did not control or direct the medical investigation, he might have been a force for mitigating the damage to the family. He could have done this by monitoring the progress of the medical investigation—the tests on **DAY 4** and the opinion of the East Coast

Children's Hospital team on **DAY 16**—and pressing Dr. Jones to bring the matter to a timely conclusion.

## **Michael's Story**

### **The Family**

Michael and his twin brother, Brian, had been born one month prematurely, and they were three months old when their family encountered the child protection system. Their mother, Margaret, age 31, worked full-time outside the home at a white collar job. Margaret's husband (Michael and Brian's father) Stan, age 32, had been employed as a public school teacher for seven years at the time of these events. Michael and Brian were the first-born children of Margaret and Stan, and each parent had taken a six-week-long parental leave on the birth of their twin sons. At the time of the episode that brought their family to the attention of DCFS, each parent had been back to work for about six weeks, and the maternal grandparents had assumed day-to-day babysitting responsibility for Michael and Brian in the grandparents' home.

The intrusion into this family's life by the state child protection system lasted **268 DAYS**. Michael and Brian, who had been 3 months old when this family's ordeal began, were a full year old before it concluded. The narrative account that follows will be stated in terms of that **268 DAY** timeline.

### **The Doctors**

This family's ordeal resulted from a disagreement about whether Michael's bone fractures, for which his parents had no explanation, were, or were not, the result of abuse. The opinions of various doctors, some of whom were involved in treating Michael and some of whom merely reviewed medical records in order to provide an opinion on the abuse issue, were at the center of the disagreement.

#### *The Doctors Who Examined and Treated Michael*

None of the doctors who examined and treated Michael thought that his injuries were the result of abuse. These doctors included:

- Dr. E. was one of the pediatricians in the practice group that had been caring for Michael and Brian since their birth. Michael had been seen by other doctors in the practice group four times for routine care. On **Day 1** of the episode recounted in this narrative, the parents brought Michael to the practice group, where he saw Dr. E. for the first time, because the child's left leg appeared swollen. Because of a concern that Michael might have an infection, Dr. E. referred the parents to their local general hospital (Gen. Hosp. #1) emergency department for diagnosis of Michael's left leg injury.

#### Doctors at Gen. Hosp. #1

- Dr. I., Director, Inpatient Pediatrics, was on Michael's treatment team during his stay at the hospital from **Day 1** through **Day 5**. Regarding Michael's multiple fractures that had

appeared in X-rays taken at Gen. Hosp. #1, she was "...not willing to rule as child abuse."

- Dr. Voe, a board certified orthopedic surgeon with extensive training and writing on pediatric issues, saw Michael on referral from Dr. I. on **DAY 14** and again for follow-up on **DAY 49**, and finally for follow up on **DAY 201**. Regarding Michael's multiple fractures, she opined in writing that the femur fractures were more likely accidental than non-accidental and that the rib fractures did not prove abuse.

#### Second Opinion Doctor Who Examined Michael

- Dr. Coe, the pediatric orthopedist at CH #2 in the Chicago area, examined Michael and the medical records on **Day 26** in order to provide his parents with a second opinion, Dr. Coe opined in writing that the femur fractures were more likely accidental than non-accidental and that the rib fractures did not prove abuse. He also indicated that Michael could have been susceptible to fractures as a result of a Vitamin D deficiency.

#### *Those Doctors Who Did Not Examine or Treat Michael*

There were three doctors who were asked to provide an opinion based on a review of the medical records and medical history as to whether Michael's injuries were the result of abuse. Only one of these three doctors gave an opinion that there had likely been abuse.

- Dr. W. is a board certified physician in pediatrics and medical genetics. He opined in writing on **Day 54** that Michael's bone fractures were unlikely to be the result of physical abuse, but were likely to be the result of metabolic bone disease potentially related to Vitamin D deficiency.
- Dr. L. is a radiologist. He made an unequivocal finding of metabolic bone disease and opined specifically in writing on **Day 88** that Michael's fractures were the result of neonatal rickets in a state of early healing.
- Dr. Black is a board certified child abuse pediatrician at CH #1 and provided an MPEEC report to DCFS pursuant to CH #1's subcontract with DCFS through the Children's Advocacy Center. After reviewing Michael's medical records and history and the opinions of all of the doctors listed above, Dr. Black provided her written report about Michael's injuries on **Day 104**. In that written report, she stated her "best medical opinion....that....injuries are the result of physical abuse." (Details are provided in the *Chronology of Medical Proceedings*, below.)

#### **The Family's Ordeal**

From Day 1 forward, this family's ordeal unfolded along two tracks:

1. Administrative and legal proceedings. These proceedings involved challenges by the state to Margaret and Stan's rights to act as parents to their sons Michael and Brian and to live with their sons as a family.
2. Medical proceedings (treatment, examinations, tests, the development of doctors' opinions, and consulting reports). These proceedings involved analysis of Michael's injuries and possible causes of those injuries, including underlying medical conditions.

Some of these medical proceedings were undertaken for treatment of Michael's injuries and others were undertaken in support of the state's position in administrative and legal proceedings seeking to establish that Michael had been abused.

The following is a chronology of the major points first of the administrative and legal proceedings and then of the medical proceedings.

### **Chronology of Administrative and Legal Proceedings**

1. In accordance with Dr. E.'s recommendation, Stan and Margaret took Michael to Gen. Hosp. #1 on **Day 1** for further examination and treatment of the injury to the child's left leg for which the parents had sought treatment from Dr. E. that day. On **Day 3**, a health care worker at Gen. Hosp. #1 made a Hotline call to DCFS reporting that Michael had "a femur fracture and multiple fractures all over his body per the skeletal x-ray. . . ." (Note: while the original Hotline phrase "multiple fractures all over his body" was how Michael's condition was often characterized as this matter was moving forward, that phrase evokes a much more extensive set of fractures than Michael's skeletal survey actually showed.) The Hotline call also mentioned that Michael had a twin brother Brian, and that the grandparents served as babysitters for both boys.
2. From the moment of this Hotline call on, there were severe administrative and legal measures taken against Stan and Margaret that concerned their roles and responsibilities as parents to both of their sons, Michael and Brian. All of these measures were extended to Brian, as well as Michael, even though the Gen. Hosp. #1 examination of Brian on **Day 3** found him to be "in good condition" with a "clear" skeletal survey. The most significant administrative and legal events are enumerated immediately below.
3. Still on **Day 3**, the DCFS investigator informed Gen. Hosp. #1 personnel that DCFS was "putting a hold" on both Michael and Brian and that neither could be released without DCFS approval.
4. On **Day 3** the parents were interviewed by a local police detective, who reported that the parents had no explanation of how Michael's injuries may have occurred, including no "possible accidents or droppings."
5. On **Day 4**, the DCFS investigator requested an MPEEC opinion. The request was made by the DCFS investigator concerning Michael's injuries, because the attending pediatrician, Dr. I., was "not willing to rule as child abuse."
6. On **Day 5**, Michael and Brian were discharged as patients from Gen. Hosp. #1. Michael and Brian were thereafter held at a relative's home forty-five miles away from their own home for the next five months until **Day 159**. This living arrangement for Michael and Brian was established under a DCFS safety plan that later became a protective and then temporary custody foster care arrangement under court order. This was followed by an additional two month period during which continuous and intrusive supervision was imposed on Stan and Margaret's parenting of their sons.

7. On **Day 6**, in support of the temporary custody/foster care arrangement described in the preceding paragraph, the State's Attorney filed with the juvenile court a Petition for Adjudication of Wardship and Temporary Custody of Michael and Brian. This legal action was based upon the State's Attorney's claim that Michael's fractures were the result of non-accidental trauma and that Michael should therefore be adjudicated an "abused minor" and Brian adjudicated a "neglected minor."
8. On **DAY 159**, after having reviewed all of the medical opinions summarized in the section above entitled The Doctors, including the opinion of Dr. Black, the State's Attorney withdrew its claim in the juvenile court that Michael was an "abused minor." At this time, the State's Attorney also agreed to the return of Michael and Brian to the family home, but with Stan and Margaret's parenting being supervised during the week by Stan's father who had moved into their home.

On **Day 160**, which fell at the end of the summer, Stan's contract as a teacher allowed to expire by the school district at which he had worked for two years because his name had been registered as a child abuser in the Illinois State Central Register and the school district could not maintain his position due to its potential liability for employing a person considered to be a child abuser. (Note: in Illinois, names are registered in the Child Abuse Register prior to affording an individual the right to an evidentiary hearing; if there is a pending court case, the right to such a hearing after an individual's name is entered into the State Central Register as an abuse perpetrator is postponed ("stayed") until the court case is concluded. Therefore, Stan had no ability to clear his name from the register while the juvenile court case was pending.)

9. After the withdrawal of the child abuse claim by the State's Attorney in juvenile court, the DCFS instituted administrative action that was ultimately aimed at keeping Stan and Margaret's names on the State Central Register as child abusers for the next twenty years (the relevant time frame under which the registry retains bone fractures due to abuse finding). That child abuse perpetrator registration would have had devastating adverse consequences for Stan's future career prospects as a school teacher. Stan and Margaret were forced to defend themselves against the "perpetrator of abuse" charge in the DCFS administrative action as they had against the comparable claim in the juvenile court. This administrative action by DCFS was not dismissed by the State until **Day 268**.

### *Chronology of Medical Proceedings*

#### Michael's Examination and Treatment by His Regular Pediatrician

##### **(Day 1)**

1. On **Day 1**, Stan and Margaret took Michael to see Dr. E., because the baby's left leg appeared swollen. After examining the child, Dr. E. instructed the parents to take Michael to Gen. Hosp. #1 due to concerns that Michael could have an infection.

#### *Michael's Examination and Treatment at Gen. Hosp. #1*

##### **(Day 1 through Day 5)**

2. Michael was admitted to Gen. Hosp. #1 on **DAY 1** and discharged on **Day 5**. On **Day 1**, Stan and Margaret learned for the first time at Gen. Hosp. #1 that Michael had “calcification” on his left femur.
3. On **Day 3**, Stan and Margaret learned for the first time at Gen. Hosp. #1 that Michael had healing fractures to both of his femurs and old fractures to his ribs on the right lateral side.
4. Dr. I. was Michael’s attending pediatrician during his hospitalization. According to a written comment of the DCFS investigator on **Day 4**, Dr. I. was not willing to rule that Michael’s injuries were due to child abuse. According to a letter on **Day 5** to Dr. E., Dr. I. did refer Michael for follow up two weeks thereafter with the pediatric orthopedist, Dr. Voe.

*Michael’s Examination and Treatment by Pediatric Orthopedists*  
**(DAY 14, DAY 26, DAY 49)**

5. In accordance with Dr. I.’s instructions, Michael was seen by Dr. Voe on **Day 14, Day 49** and **DAY 201**. Dr. Voe’s written report on **Day 49** regarding Michael’s multiple fractures was that the femur fractures were more likely accidental than non-accidental and that rib fractures did not prove abuse.
6. Michael was also seen by Dr. Coe at CH #2 on **Day 26**. After examining Michael and the medical records, Dr. Coe opined in writing that the femur fractures were more likely accidental than non-accidental and that the rib fractures did not prove abuse. He also indicated that Michael could have been susceptible to fractures as a result of a Vitamin D deficiency.

*Review of Michael’s Medical Records and History by Consulting Physicians*  
*Re: Pre-disposing Medical Conditions*  
**(Day 54, Day 88)**

7. On **Day 54**, Dr. W, a physician certified in pediatrics and medical genetics, having reviewed Michael’s medical records and history, opined in writing that Michael’s bone fractures were unlikely to be the result of physical abuse. Instead, he indicated that they were likely to be the result of metabolic bone disease potentially related to a Vitamin D deficiency.
8. On **Day 88**, Dr. L, a radiologist, having reviewed Michael’s skeletal survey at Dr. W.’s request, issued a letter stating his impression that “Michael’s skeleton exhibited unequivocal findings of metabolic bone disease and thus bone fragility.” More specifically, he expressed the belief that Michael was “suffering from neonatal rickets in a state of early healing.”

*Review of Michael’s Medical Records and History by Child Abuse Pediatrician*  
*On MPEEC Assignment*  
**(Day 104)**

9. On **Day 104**, Dr. Black, a Child Abuse Pediatrician at Children's Hospital #1, issued her report under the MPEEC agreement, pursuant to the DCFS referral for such a report on **Day 4**. Concerning Michael's fractures, Dr. Black's report on **Day 104** stated her "best medical opinion . . . that [Michael's] . . . injuries are the result of physical abuse." Dr. Black's report reflected:
- a. That she consulted with a radiologist at her hospital to confirm what specific injuries were shown on the x-rays, but it does not reflect that she consulted with the radiologist as to the possible mechanisms for those fractures.
  - b. That she rejected the written opinions of Dr. Voe, Dr. Coe, Dr. W. and Dr. L., but sought no consultation with other doctors having expertise in orthopedics, pediatric orthopedics, or medical genetics.
  - c. That she relied primarily for her opinion on literature that had been produced between 1990 and 2003 and that suggested degrees by which particular types of fractures were "specific" to child abuse.

### **Medical Ethics Problems and Issues**

Draconian administrative and legal proceedings had been started against these parents immediately after the Hotline call had been made on **Day 3**. This was clearly before any well-considered medical analysis could be applied to the fractures that were reflected on Michael's x-rays. As time passed, with Michael and Brian's family life being totally disrupted by the pending administrative and legal proceedings, a body of medical opinion continued to accumulate in support of the conclusion that Michael's fractures were not the result of abuse. This growing body of medical opinion included the opinion of the attending pediatrician at Gen. Hosp. #1 from which the Hotline call had been made, the opinions of two pediatric orthopedists who treated Michael during the six week span after he left the hospital, and the opinions of two doctors who were asked to review the medical records and history from the viewpoint of their respective specialties—one in medical genetics and the other in radiology.

After all of this medical opinion had accumulated by **Day 88** that abuse was not the likely cause of Michael's fractures, with no dissenting medical opinion, the DCFS and State's Attorney pursuing administrative and legal sanctions against the parents faced the choice of either dropping their cases or failing in adjudication in front of the judges and administrative hearing officers. At this critical point, Dr. Black insinuated herself squarely into this situation in support of DCFS and the State's Attorney by issuing her report on **Day 104**.

What are the ethics problems and issues for Dr. Black in this situation? We believe there are significant ethical questions for Dr. Black around at least two points. First, did she undertake an inappropriate advocacy role and conduct herself as an advocate rather than an independent medical expert? This is discussed below under the caption Advocacy. Second, did she fail in her obligation to consult with appropriate medical specialists? This is discussed below under the caption Consultation.

#### Advocacy

*In the circumstances of this case, was it possible for Dr. Black to conduct her analysis of Michael's medical records and medical history and issue an opinion under the MPEEC*

*agreement without falling into an advocacy mode that would be contrary to AMA Code of Medical Ethics Opinion 9.07--Medical Testimony?*

There was both weight and quality in the collective medical opinion that had already been accumulated that Michael's fractures were not likely the result of abuse. The weight lay in the number of doctors who had issued opinions *against* a conclusion of abuse. The quality lay in the fact that this group of doctors included all the child's treating doctors in the relevant specialty areas plus consulting doctors in allied specialty areas. There was also complete consensus of opinion that Michael's fractures were not likely the result of abuse; no dissenting opinion had been expressed. In these circumstances, we would expect any doctor, like Dr. Black, who is approached for an opinion by legal entities already advocating the position that there had been abuse to be quite cautious about not falling into an un-desirable advocacy mode herself that would pit her against expert medical colleagues.

The Committee on Child Abuse and Neglect of the American Academy of Pediatrics has recognized the importance of "non-advocacy" in its clinical report issued in June 2007 in which it said:

Physicians act primarily as scientists and educators in legal settings rather than as child advocates.

AMA Code of Medical Ethics Opinion 9.07—Medical Testimony clearly expresses the obligation of a physician who chooses to provide expert testimony to be an objective evaluator, not an advocate:

When physicians choose to provide expert testimony, they should.... be committed to evaluating cases objectively and to providing an independent opinion.

In the memorandum of the Council on Ethics and Judicial Affairs in support of Opinion 9.07, under the caption, "HONESTY AND INDEPENDENCE IN THE PROVISION OF MEDICAL TESTIMONY," doctors are admonished against taking on the position of the party that brought them to the legal contest:

Although the testifying physicians' services may have been sought primarily by one party, they testify to educate the court as a whole.

Even more to the point in the case of child abuse pediatricians, who are acting as contracted medical investigators for the State, the Council specifically addresses the ethical obligations on "Testimony of the Non-Treating Physician"

The opinions of non-treating physician experts must remain honest and objective, free from any undue influence.... An independent expert is not affected by the goals of the party for which she was retained, and is not reticent to arrive at an opinion that fails to support the client's legal position.... Avoiding undue influence as an expert once again involves self-examination to ensure that one's testimony is not biased by allegiance to any party in a legal proceeding.

A more detailed discussion of the proscription against advocacy under Opinion 9.07 and how it would apply to child abuse pediatricians taking on medical investigations of suspected child abuse is found in Discussion Section VIII of this Paper.

### Consultation

Dr. Coe and Dr. Voe each have extensive pediatric orthopedic credentials, and each examined Michael as treating physicians. Dr. Coe and Dr. Voe separately opined in written reports that the femur fractures were more likely accidental than non-accidental and that the rib fractures did not prove physical abuse.

Likewise, Dr. W. and Dr. L., who served as consultants, each has specialized medical credentials, the former in medical genetics and the latter in radiology.

By contrast, Dr. Black has no special credentials in orthopedics or in medical genetics or radiology. Moreover, Dr. Black never examined Michael, nor did she participate in the treatment of his injuries. Nevertheless, based on a review of the medical records, including the written opinions of Dr. Coe and Dr. Voe, the treating orthopedists, and Dr. W. and Dr. L., the consulting doctors, and on a review of the investigative file of her counterparts at DCFS, Dr. Black gave her “best medical opinion” that Michael’s injuries were the result of physical abuse. As far as her report reflects, Dr. Black did not seek a consultation with *any* orthopedic specialists concerning the viability of her rejection of specific points in the orthopedic analysis of Dr. Coe or Dr. Voe nor did she seek consultation with other specialists in medical genetics or radiology concerning the viability of her rejection of specific points in the opinions of Dr. W. and Dr. L.

Since child abuse pediatricians do not have the same level of expertise in specialized areas of medicine as doctors who are board certified in those specialty areas, there necessarily are some cases of possible child abuse in which consultation will be required to ensure that an opinion reflects “current scientific thought” as required by Opinion 9.07—Medical Testimony. Moreover, the concept of consultation has its own foundation in the medical profession’s ethics pronouncements, specifically in AMA Code of Medical Ethics Opinion 8.04 – Consultation. In the current child abuse investigation system, we believe that these ethics opinions would at a minimum cause a child abuse pediatrician to consider whether to consult with one or more medical specialists in every case involving fractures or head injuries. In the present case, before Dr. Black rendered her opinion, specialists in pediatric orthopedics, medical genetics and radiology had already rendered their opinions that Michael’s fractures were not likely the result of abuse. In these circumstances, we would have expected Dr. Black to regard consultation with other specialists in those fields to be that much more critical before she would have considered issuing a contradictory opinion about whether Michael’s fractures were abusive.

In addition to AMA ethics opinions, there is also considerable comment in the professional literature of pediatrics, orthopedic surgery, and radiology (including the child abuse pediatrics literature) about how important it is for the child abuse pediatrician to consult with other medical specialists as the child abuse pediatrician is conducting her investigation of a particular case and before making her determination. This literature is also discussed at some length in Discussion Section VIII of this Paper.

Without Dr. Black's written opinion issued on **DAY 104** that Michael's injuries were due to physical abuse, neither DCFS nor the State's Attorney would have been in a position to continue the cases against these parents for abuse. In particular, if Dr. Black had recognized an ethical obligation to seek consultation of physicians with more expertise in pediatric orthopedics than she had, that consultation may have dissuaded her from in effect overruling the opinion of two of Michael's treating doctors who had that orthopedic expertise.

We note that medical ethics and legal ethical principles are quite different with regard to both advocacy and consultation. Doctors are not expected by their governing ethical canons to be champions for "positions" or for the objectives of the party who hired them; doctors are also required to collaborate and consult in reaching scientifically sound solutions. Lawyers, by contrast, *are* expected, by their own governing ethical canons, to champion a client's position within the bounds of the law and lawyers are even ethically *prohibited* from collaborating and consulting to reach an outcome when doing so would be adverse to their client's lawful objectives. But child abuse pediatricians who work extensively with lawyers may stray into a legal advocacy approach without being fully aware that their own ethical canons expressly require them *not* to assume an advocacy position. They also may not appreciate that their obligations as physicians rather than prosecution witnesses or state-contracted consultants requires them to consult with other medical professionals whenever such consultation is necessary to arrive at a scientifically sound opinion.

### **PART III. DISCUSSION OF MEDICAL ETHICAL PRINCIPLES AT ISSUE IN THE ILLUSTRATIVE CASES**

#### ***I. Physicians Have an Ethical Obligation Not to Become Law Enforcement Officers or to Engage in Interrogations***

Many ethical questions emerge from the current approach of the medical profession to cases of suspected child abuse because the role of the physician in these cases begins to overlap and become deeply intertwined with the role of law enforcement. While most physical child abuse cases do involve a child's simultaneous need for treatment as well as assessment of the cause of the child's injuries, the illustrative cases show that many physicians involved in child abuse cases abandon their own traditional roles of treating patients when they participate in child abuse investigations in tandem with state child protection agencies and law enforcement authorities. This is particularly true of child abuse pediatricians for whom the collaboration with state child protection agencies may be formalized by contract, such as the MPEEC agreement in Illinois.

Some activities that are perfectly ethical for law enforcement professionals, i.e., policemen or prosecutors, are incompatible with the ethical obligations of physicians generally or with the ethical obligations of physicians in relation to their patients or family members of their patients. When physicians become directly involved with law enforcement functions in alleged child abuse cases, a number of ethical principles come into play that should guide the physicians in determining their proper role.

Physicians *are* allowed to play certain roles in support of law enforcement, as long as their activities do not in some way ethically compromise an existing patient-physician relationship or otherwise violate a principle of medical ethics. An important example would be the physician serving as a medical examiner to establish the cause of an individual's death by scientific examination of the individual's remains. Physicians, especially pathologists but potentially many other specialists, are uniquely qualified to perform this sort of examination and render opinions on the cause of death (though other forensic specialties may also come into play, such as ballistics, toxicology etc.). On the other hand, physicians are *explicitly prohibited* by the AMA Code of Medical Ethics from being directly or indirectly involved in one of the basic activities of law enforcement that is commonplace for police officers, which is the conduct of interrogations of detainees.

Where a child is held by a hospital ER staff or by nursing staff while his or her parents are being separately questioned about the child's injuries, often behind closed doors and in an accusatory manner, important elements of a detention are present. When the social worker or physician who is doing the questioning promptly reports the parent's statements to the police and child protection agencies, concerns about that detention being coercive are obvious. When the questioning also occurs without any notification of rights, without disclosure that the information is being sought pursuant to a state-funded contract, and with the added possible elements of lack of food and sleep and parental worry about the injured child's condition, the questioning that might appear to the medical community to be benign and well-intentioned is readily perceived by the person being questioned as a coercive interrogation under detention. This makes it entirely

appropriate for the physician to consider the prohibition against interrogation in the determination of his duties to the children and families who are the subjects of the child abuse investigation.

In this regard, persons held “involuntarily” fall within the AMA definition of “detainee.” There have not yet been any ethics opinions specifically discussing how this definition applies in the context of an investigation of possible child abuse or neglect by a child abuse pediatrician. However, the term “interrogation” fits perfectly the experience that parents commonly report after being interviewed about their children’s injuries in the hospital by child abuse pediatricians or social workers. Notwithstanding the hospital setting, some practices used by hospital child protective service teams are very similar to techniques associated with police interrogation of criminal suspects. These common practices include:

- Separating parents from each other and from their children for purposes of lengthy questioning behind closed doors, in a circumstance where the parent does not feel free to leave
- Confronting parents about their explanations;
- Denying that the parents’ explanations could be correct (indeed, sometimes accusing the parent of lying),
- Making veiled or even explicit threats that the parents will lose their children to state custody or not be allowed to retain full custody;
- Keeping parents uninformed about the purposes of the questioning and the fact that anything they say may be used against them by law enforcement and state child protection agencies; and
- Questioning parents when they are already exhausted from a medical ordeal involving an injury to their child.

Indeed, parents who have been called to the attention of a hospital CPS team in these cases often quickly find that they *are* treated as criminal suspects, even if the allegations against them are never seriously considered for actual criminal prosecution. Parents who have reported their experiences in the initial questioning by hospital child protective services teams often refer to the questioning as an “interrogation.” In this regard, these parents point to the highly accusatory tone of the questioning as well as the challenges to their credibility by the doctor or social worker insisting that the explanation the parents offer for an injury “doesn’t fit.”

The questioning at issue here is generally dominated by an effort to obtain a very detailed statement from the parents as to “how the injury occurred.” This includes pressing the parents for information about possible incidents that could account for the injury even when the parents insist that they do not know of any such incidents. It also commonly includes seeking out contradictions between the two parents’ accounts. This questioning is generally less concerned with details about the child’s symptoms, developmental abilities, medical history or course of treatment. In fact, the child abuse “interrogation” almost always occurs *outside* the presence of attending physicians or nursing staff, and the information provided by the parents is rarely even shared with the child’s treating physicians. This underscores the lack of relevance of the

questioning by hospital CPS team members to the ongoing treatment of the child and that the questioning serves a purely forensic purpose. Since the focus of questions is on how the injury occurred (beyond the initial statement by the parent as to whether they have any account at all) and who was present with the child for the prior period in which the injury may have occurred, the authors believe that child abuse doctors or staff under their direction *should not* be engaged in such detailed questioning of parents at all, regardless of whether there is an element of detention of the parent involved in securing answers to the questions.<sup>10</sup> The subjects of these questions are much more appropriately the province of the state child protection agency and law enforcement authorities who have the professional duty to be thorough and critical in their questioning of all genuinely suspected child abusers. Generally, police are quickly called in to interview the parents, though in some cases, they may rely on the questioning conducted by the hospital child protective services team. If child abuse pediatricians were not involved in this form of forensic interrogation, parents would be able to make an informed decision as to whether or not to answer these questions posed by law enforcement authorities. They would no longer be subject to extremely traumatic interrogations at medical facilities that the parents had previously trusted as care providers for their children.<sup>11</sup>

AMA Code of Medical Ethics Opinion 2.068 – Physician Participation in Interrogation, which was issued in 2006, draws a bright line between the function of doctors and the function of law enforcement authorities insofar as interrogation is concerned.<sup>12</sup> Opinion 2.068 has five operative clauses which are discussed immediately below. The overall thrust of these clauses is twofold. First, doctors are themselves prohibited from conducting or directly participating in the actual interrogations of detainees. Second, there are ways in which doctors may support law enforcement personnel in the establishment and conduct of particular interrogations or interrogation programs and in providing medical care to people who are being interrogated.

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<sup>10</sup> Nor should they accept and rely upon verbatim accounts of child protection and police interviews with parents, as the Family Defense Center has repeatedly seen in MPEEC reports. To the extent a medical opinion turns on understands what the parent has reported to authorities, doctors cannot be expected to be fair judges of the accuracy of such account. See note 13 below.

<sup>11</sup> The child abuse pediatricians whom Ms. Redleaf has questioned in depositions in some of the illustrative cases and in other cases not discussed in detail here, have acknowledged that they provide no information about parents' rights during questioning that occurs under their auspices and denied any need for such information. They also acknowledge not informing parents of their contractual relationship with DCFS and law enforcement. The entanglement of child abuse pediatrics with police and child protection practice, all without informing the parent of that close relationship at the time of the child's hospitalization has been seen even more dramatically in several recent cases that are documented in the Illustrative Case. In several Center case, MPEEC reports include whole pages lifted from the DCFS investigation file with slight paraphrasing to mask that source (i.e. "I asked the mother if she left the child" is changed to the "The mother was asked if she left the child") In addition, MPEEC opinions and practices have sometimes included reference to polygraph results as a basis for a conclusion that a parent's account is not credible, even though polygraph results are legally inadmissible and are not reliable as a medical diagnostic technique in any other setting.

Several Illinois child protection pediatricians (Drs. Jones, Thomas and Smith as they are referred to in this Paper) rejected out of hand at the suggestion that Ms. Redleaf made at an annual child maltreatment conference convened by the Chicago Child Advocacy Center that parents should be informed of their rights when being questioned at the hospital by a member of the child protection team after a suspicion had been reported to them. Several members of the audience at the same conference expressed support to Ms. Redleaf for this suggestion.

<sup>12</sup> AMA Code of Medical Ethics Opinion 2.068—Physician Participation in Interrogation was issued in November 2006 based on the report of the Council on Ethical and Judicial Affairs entitled Physician Participation in Interrogation adopted in June 2006. When issued in 2006, Opinion 2.068 was an entirely new opinion, not replacing or amending any prior ethics opinion of AMA on the subject.

However, even these indirect involvements are constrained by specific ethical limitations and obligations on the doctor.

In order to avoid interfering with the doctor's traditional patient treatment role, interrogations are defined in the Opinion as excluding "questioning used by physicians to assess the physical or mental condition of an individual." Therefore, doctors who question parents as to how an injury occurred for the purpose of determining the treatment the child needs would be outside the prohibitions of Opinion 2.068. But ethical concerns arise as to the child abuse pediatricians and their staff social workers who are not members of the child's treatment team and who are operating with the purpose of assisting in a child abuse investigation in order to provide information that will be used by law enforcement and state child protection agencies.

In clauses (2) and (3), Opinion 2.068 unequivocally prohibits physicians from conducting or directly participating in an interrogation—no exception. Those clauses read as follows:

(2) Physicians must neither conduct nor directly participate in an interrogation, because a role as physician-interrogator undermines the physician's role as healer and thereby erodes trust in the individual physician-interrogator and in the medical profession.

(3) Physicians must not monitor interrogations with the intention of intervening in the process, because this constitutes direct participation in interrogation.

The Opinion recognizes that even though such interrogation may be "designed to prevent harm to individuals, the public, or national security," there is no exception to the prohibition against the physician conducting or directly participating in the interrogation. What this means is that, in the context of a child abuse investigation, the child abuse pediatrician would not be permitted to decide that he or his staff member (such as a social worker under his supervision) should conduct the interrogation of the injured child's parent, because that interrogation may prevent harm to the child who is being treated.

In clause (1), Opinion 2.068 permits physicians to fulfill their core professional role—medical diagnosis and treatment of the person who may be sick as a result of the interrogation---but with special safeguards of that person's rights that are necessary in the context of the ongoing interrogation.

(1) Physicians may perform physical and mental assessments of detainees to determine the need for and to provide medical care. When so doing, physicians must disclose to the detainee the extent to which others have access to information included in medical records. Treatment must never be conditional on a patient's participation in an interrogation.

In clauses (4) and (5), Opinion 2.068 in effect permits physicians to assist law enforcement authorities as consultants in the development of non-coercive interrogation strategies. However, the Opinion also requires physicians to report to appropriate authorities any coercive interrogations of which they have reason to be aware. The report must be to as high a level of authority as necessary to trigger an investigation and adjudication of the coercion.

(4) Physicians may participate in developing effective interrogation strategies for general training purposes. These strategies must not threaten or cause physical injury or mental suffering and must be humane and respect the rights of individuals.

(5) When physicians have reason to believe that interrogations are coercive, they must report their observations to appropriate authorities. If authorities are aware of coercive interrogations but have not intervened, physicians are ethically obligated to report the offenses to independent authorities that have the power to investigate or adjudicate such allegations.

As further discussed later in this article (Section VII), the parents in the illustrative cases presented were generally not advised as to who would gain access to the information being provided to the hospital child protective services team members, including that the information could be used by law enforcement and would be provided to state child protection agencies. None of the parents in the illustrative cases was told: (1) that the child abuse pediatrician or social worker worked directly with DCFS and the police (rather than merely filing a Hotline report with state child protection agencies); (2) that they would be sharing all of their notes with these official entities; or (3) that information they were asked for was not for the purpose of treatment; and (4) that the child abuse pediatrician or staff member would not be participating in treatment decisions for their child.<sup>13</sup>

As previously noted, though it is not completely clear, Opinion 2.068 appears to apply only when the person being interrogated is a “detainee.” The Opinion defines the term “detainee” as a “criminal suspect, prisoner of war, or *any other individual who is being held involuntarily.*” The category “other individual . . . being held involuntarily,” however, should include a parent who is not allowed to leave the hospital *with* her child after first having come to the hospital voluntarily to obtain medical care for the child. When the interrogations at issue in this Paper are being conducted, the parent is no longer completely free to leave the hospital with her child. Even when the detention of the child is less explicit, parents who attempt to leave the hospital are typically told they may not do so without first talking with someone from the hospital’s child protective services team. Thereafter, parents who wish to leave the hospital are typically told they must wait for the state child protection agency to clear them to leave with their child. Often, the parents are also first told by a member of the hospital’s CPS team that there will be a “safety plan” (meaning a plan that does not permit them to leave with their child but requires another family member or friend to pick up the child at the hospital pending further investigation by DCFS). All of these steps serve to transform the initially voluntary action of the parent in bringing the child to the hospital for medical care into a coercive situation in which the

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<sup>13</sup> Parents typically report meeting with a half dozen or more doctors in the course of a typical encounter with the ER following a fracture or head injury as to which child abuse is suspected. They also meet a half dozen or more nurses and EMTs and other hospital staff. Parents often are tired and anxious at the time of these encounters, especially concerned about their child and his or her condition and the possible medical treatment their child will require. Therefore, parents are very often and understandably unaware of the specific roles of each the individuals they encounter and if they are told by an ER doctor that they “have to talk to Dr. Thomas or Dr. Black” or the team’s social worker), they almost always comply and assume that they need to do so in order to provide optimal care for their child. These parents are often shocked to learn that these doctors or social workers work hand in hand with law enforcement authorities and child protection. Not one parent represented by the Center reports having been informed of the DCFS contractual relationship these doctors and staff have before or during their meeting with them.

parent is no longer free to leave without first submitting to an interrogation of the sort described here. Thus, it is the authors' view that, where (1) the injured child is held in the control of the child abuse pediatrician, treating physician or other hospital staff; (2) the parent is not free to leave without first speaking to a member of the hospital's child protective services team (regardless of whether the child is otherwise ready for discharge); and (3) the child abuse pediatrician is collaborating with the state child protection agency and law enforcement authorities, the situation is sufficiently "involuntary" to qualify as a "detention" as contemplated by the AMA ethical prohibition.

The position that the interrogation by child abuse pediatricians and social workers is a prohibited interrogation is bolstered, of course, by the fact that many if not most of the parents involved in these cases *do* promptly become criminal suspects (i.e., they are automatically the subjects of open criminal investigations even if no prosecution ensues). In Illinois, Hotline calls in physical abuse cases are automatically referred to law enforcement authorities. This obviously contributes to the highly charged atmosphere in which parents are questioned by child abuse pediatricians and social workers and clearly raises ethical concerns about impermissible interrogations in which physicians should not be participating either directly or indirectly under Opinion 2.068.

Where a child abuse pediatrician or social worker directly under his supervision questions a parent in an accusatory manner as to a child's injury while the child is held at the hospital and is not free to leave with the parent, ethical concerns under clauses (2) and (3) of Opinion 2.068 are ripe. A treating doctor can also be in violation, if he permits his questioning of parents about the circumstances of an injury to stray beyond what is necessary for diagnosis and treatment of the child's injury. Moreover, since clauses (4) and (5) of Opinion 2.068 require that doctors avoid even indirect involvement with coercive interrogations, there would be ethical concerns if child abuse pediatricians were to serve as consultants to law enforcement in designing the interrogation plan for a parent who is being threatened with having his injured child held involuntarily. A salutary effect of the ethical prohibition on interrogations in Opinion 2.068 is that child abuse pediatricians should not permit themselves to be used by the police to circumvent the legal limitations that would apply to a police officer's interrogation of parents who are under suspicion of child abuse.

## ***II. Overview of the Patient-Physician Relationship and the Status of the Parents in Cases of Medical Investigation of Possible Child Abuse***

To analyze many of the ethical questions that arise out of treatment of injured children and the follow-up conduct of medically directed investigations of possible child abuse as described in the illustrative cases presented in this Paper, it is important to determine whether a patient-physician relationship exists between each of the doctors involved and the injured child. Since it seems clear that parents of children receiving treatment for an injury are not themselves "patients," it is also important to consider, beyond the patient-physician relationship, the responsibilities and prerogatives that are contemplated for parents in the AMA Code of Medical Ethics and other authoritative professional literature. The most important and relevant of these is the responsibility of the parent or legal guardian of a young child to decide based on the child's best interests whether to give or withhold informed consent to specific medical procedures. This particular parental responsibility is based on a corresponding ethical duty on physicians, as

clearly detailed in the AMA Code of Medical Ethics, *not* to undertake a medical procedure for a young child without obtaining the voluntary informed consent of the parent or legal guardian.

This Discussion Section II summarizes the ethical principles that are relevant to the questions of patient-physician relationship and informed consent in cases in which there is a medically-directed child abuse investigation. It also points out some of the conflicts that seem to exist between these ethical principles and the current practices of doctors dealing with these cases. More detail can be found in various other sections of the Discussion as noted.

AMA Code of Medical Ethics Opinion 10.016 -- Pediatric Decision-Making consistently treats the child, not the parent or legal guardian, as the patient.<sup>14</sup> That does not mean, however, that the parent or guardian is a stranger or mere bystander to the patient-physician relationship that exists between the injured child described in any of the illustrative cases and his treating doctor(s). It is clear from Opinion 10.016 and the other ethics opinions about the relationship between physician and patient that the parents of children as young as those in the illustrative cases<sup>15</sup> are to be treated as speaking for the child insofar as the child's relationship with the physician is concerned.

Under AMA Code of Medical Ethics Opinion 10.015 – The Patient-Physician Relationship, an injured child would not be in a patient-physician relationship with his treating doctors at all, but for the initial consent of the parents to that relationship.<sup>16</sup> A fact that may seem obvious, but that should be kept in mind throughout the analysis of all of the questions addressed in this Section, is that the patient-physician relationship is initiated by the parent approaching a doctor directly or seeking care at a medical care facility on behalf of the sick or injured child. If the parent does not take that initial, completely voluntary step, a patient-physician relationship is never established.

Under Opinion 10.016, once the patient-physician relationship is established, while the parent is not entitled to absolute control over the treatment of the child's illness or injury, deference to the parent's views about treatment based on the child's best interests is generally required, with the exception being cases in which there is immediate danger to the child that the parent is unable or unwilling to prevent. Even if there is such a danger, however a prompt judicial order after the procedure is undertaken is legally required. Deference to the parents as the persons responsible for directing the course of treatment for a child harmonizes the doctor's ethical standard in determining a pediatric patient's treatment with the applicable legal standards which also command deference to parental decision-making about treatment.

Of course, a doctor who suspects that the parents may have intentionally caused the injury for which the child was brought in to the medical system might not *want* to give deference to the parent's decision-making about treatment. A doctor may believe that deferring to parents suspected of child abuse is not in the best interests of the child, especially if the parent's

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<sup>14</sup> The current version of AMA Code of Medical Ethics Opinion 10.016—Pediatric Decision-Making was issued in June 2011 based on a report of the Council on Ethical and Judicial Affairs entitled Amendment to E-10.016, Pediatric Decision-Making which was adopted in November 2010.

<sup>15</sup> All of the children in the illustrative cases like all of those referred for child abuse investigations to the Illinois MPEEC program are under age three.

<sup>16</sup> AMA Code of Medical Ethics Opinion 10.015—The Patient-Physician Relationship was issued December 2001 based on the report of the Council on Ethical and Judicial Affairs entitled The Patient-Physician Relationship.

treatment decisions happen to be different than his own. In this context, for example, a doctor may view a parent's resistance to diagnostic medical tests as confirmation of abuse rather than a reasonable exercise of parental discretion. However this sort of reaction to parental decision making in the context of an alleged child abuse investigation can be fraught with ethical issues, especially if it leads the doctor to reach unwarranted or premature conclusions about parental guilt or to act to restrict parental decision making rights before any adjudication of parental wrongdoing has occurred. Again, a doctor who is convinced that a parent is thwarting medical treatment in order to hide evidence of the parent's own abusive conduct is free to seek judicial intervention but should not override the parents' decision making authority based on disapproval or disagreement with the decisions or the fact that the parent has been the target of a Hotline call. See discussion at subsection (3) below.

Deference to the parent in medical decision-making for their young children is embodied in the requirement that the physician request informed consent for any medical procedure that he believes is appropriate for the pediatric patient and that the parent is given the opportunity to grant or deny that informed consent. Yet, in many of the cases that are the subject of this Paper, including some of the illustrative cases, physicians have performed medical procedures on the sick or injured child without first obtaining voluntary informed consent of the parent. This failure of informed consent can occur in several ways.

1. In some cases, the parent was never asked to consent.
2. In other cases, the parent was asked to consent, but was not provided with the medical information that would have been necessary to enable her to make an informed decision about whether or not to give that consent.
3. In still other cases, the parent was coerced into "consenting" by threats that she would lose immediate custody of her child by summary administrative action of the state child protection agency.

A common example of a medical procedure being undertaken in the cases that are the subject of this Paper without voluntary informed consent of the parent is a full skeletal survey. It appears that some children's hospitals have a protocol requiring that full skeletal surveys be performed on children under a particular age who have presented for treatment with an "unexplained fracture." In one of the illustrative cases in this Paper, the physicians on the hospital's child protective services team required the full skeletal survey not only for the child who had been presented for treatment of the unexplained fracture, but also for his brother who had no reported medical problems and who was required to be brought into the hospital from home.<sup>17</sup>

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<sup>17</sup> In addition to this particular illustrative case, in at least a half dozen other Family Defense Center cases, repeat skeletal surveys and repeat x-rays of an injury have been demanded by child abuse pediatricians when these tests have no treatment value, and threats of negative consequences have been made by child abuse pediatricians' staff members and DCFS, working together, to parents who refuse to capitulate to the demand for such tests. CT scans have also been demanded without medical justification, with one recent client of the Center being told that the Hotline call would not have been made had their consent to the CT been granted.

We have concluded that the current practices by some child abuse pediatricians and other physicians involved in cases of suspected child abuse constitute performing medical procedures without voluntary informed consent of the parent or legal guardian and that these practices are therefore in conflict with AMA Medical Ethics Opinions. This conclusion is based on five points of analysis that are summarized in captioned subsections immediately below.

*1. Informed consent is a basic policy of medical ethics that was articulated in 2006 at the same time that the traditional concept of therapeutic privilege was repudiated.*

AMA Code of Medical Ethics Opinion 8.08-Informed Consent is the cornerstone of the analysis. Under that opinion, as updated in 2006, informed consent is recognized as a “basic policy” of medical ethics. This recognition of informed consent as a basic policy of medical ethics was a very deliberate decision of the Counsel on Ethical and Judicial Affairs, only pre-dating the establishment of the child abuse pediatrics sub-specialty by about three years.<sup>18</sup>

The 2006 update to Opinion 8.08 was based on the Counsel’s adoption of a more detailed explanatory report “Withholding Information from Patients (Therapeutic Privilege).”<sup>19</sup> This explanatory report first described the traditional idea of medical ethics under which physicians had acted in a paternalistic manner to selectively withhold information from patients, e.g. “therapeutic privilege.” The explanatory report then reaches the unambiguous conclusion that, as an ethical matter, “therapeutic privilege” must be subordinated to “patient autonomy.”

“In recent decades, medical paternalism has given way to the contemporary concepts of patient autonomy and shared decision-making. Today, physicians are called upon to promote patients’ well-being by openly discussing the balance between anticipated benefits of a given intervention and its potential harm. . .

Withholding relevant medical information from patients without their knowledge or consent, in an attempt to minimize potential physical or psychological harms, has been called “therapeutic privilege.” This practice creates a conflict between physicians’ concurrent obligations to act beneficently and to respect patients’ autonomy.”

It is the endorsement of the principle of patient autonomy and the rejection of the concept of therapeutic privilege that forms the foundation for the “basic policy” of informed consent as expressed in Opinion 8.08.

*2. In order for informed consent to occur, relevant medical information must be provided by the physician to the patient or to the person doing the medical decision making for the patient.*

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<sup>18</sup> The fact that informed consent was only recognized as a “basic policy” of medical ethics in 2006 may be surprising to many attorneys, since the concept has been a central feature of the law of most jurisdictions for many years.

<sup>19</sup> “Withholding Information from Patients (Therapeutic Privilege)” CEJA Rep. 2-A-06 (2006)

In addition to declaring that informed consent is a basic policy of medical ethics, Opinion 8.08 also describes in a general way the type and quality of the information that the physician is required to provide to the patient or to the individual responsible for the patient's care to enable an informed consent decision to be made. Specifically, Opinion 8.08 says:

“The physician's obligation is to present the medical facts accurately to the patient or to the individual responsible for the patient's care and to make recommendations for management in accordance with good medical practice. The physician has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice.”

The explanatory report “Withholding Information from Patients (Therapeutic Privilege)” states explicitly that the information provided by the physician as part of the informed consent conversation should include a discussion of “anticipated benefits and “potential harms” of a proposed procedure.

“Today, physicians are called upon to promote patients' well-being by openly discussing the balance between anticipated benefits of a given intervention and its potential harms.”

3. *The basic medical ethics policy of informed consent fully applies to pediatric patients who are too young to make medical decisions for themselves.*

AMA Code of Medical Ethics Opinion 10.016—Pediatric Decision-Making--says in relevant part:

“Medical decision making for pediatric patients should be based on the child's best interest. . . .

Physicians treating pediatric patients generally must obtain informed consent from a parent or legal guardian. . . .”

4. *There are prescribed methods for resolving disagreements between physicians and parents of young children and these do not include physicians ignoring the requirements of informed consent even if they suspect that a parent is covering up child abuse or neglect.*

Opinion 10.016 recognizes that there may be instances in which there is disagreement between a physician and the parent or legal guardian about what is in the child's best interests and that the physician may feel the need to pursue the matter out of concern for the welfare of the pediatric patient. In such a case, Opinion 10.016 states a hierarchy of procedures that should be followed:

“Parents and physicians may disagree about the course of action that best serves the pediatric patient’s interests. . . . When disagreements occur, institutional policies for timely conflict resolution should be followed, including consultation with an ethics committee, pastoral service or other counseling resource. . . . Resolution of disagreements in the courts should be pursued only as a last resort.”

However, what if a physician suspects that refusal to approve a particular medical procedure may result from the parent’s fear that the procedure would implicate her in child abuse or neglect? This question is answered very explicitly in the Report of the AMA Council on Ethical and Judicial Affairs entitled “Pediatric Decision-Making,” which was adopted in November 2007 in support of Opinion 10.016.

“If a physician believes the best interest of the patient is not being considered, or suspects child abuse, the physician should challenge the decision through institutional conflict resolution resources. Involvement of the regulatory or legal system should be a last resort but legal requirements must be respected.”

The clear import of the above statement in the CEJA Report is that *if* a doctor is concerned that a parent is rejecting a medical procedure for the child in order to cover up abuse or neglect, the doctor’s redress is first to an internal conflict resolution system and then in a court of law. The doctor’s redress is *not* to proceed with the recommended diagnostic test or procedure absent consent.

For a child who is too young to make medical decisions for himself, there is only one circumstance which is mentioned in Opinion 10.016 and the supporting CEJA reports, in which a physician would be ethically justified in making a unilateral decision to perform medical procedures without the parent’s informed consent:

“Physicians should treat reversible life-threatening conditions regardless of any persistent disagreement.”<sup>20</sup>

5. *Non-treating doctors, like child abuse pediatricians, are subject to the same ethical requirements as treating doctors, including the requirement of obtaining informed consent from the parent or legal guardian of a pediatric patient.*

As explained in Discussion Section III below, in the cases that are the subject of this Paper, child abuse pediatricians are investigators and liaisons to the legal system, not treating doctors. This does not mean that child abuse pediatricians are free to disregard the ethical rules regarding parental informed consent. AMA Code of Medical Ethics Opinion 8.02-Ethical Guidelines for Physicians in Administrative or Other Non-clinical Roles, which deals specifically with physicians who are not acting as treating doctors, reads in part as follows:

“The ethical obligations of physicians are not suspended when a physician assumes a position that does not directly involve patient care. Rather, these obligations are binding on physicians in non-clinical roles to the extent that they rely on their medical training,

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<sup>20</sup> This exceptional authorization for non-consensual care for children is also mirrored by the state law process for taking protective custody of children in life-threatening circumstances.

experience, or perspective. When physicians make decisions in non-clinical roles, they should strive to protect the health of individuals and communities. (I, VII)”

Mandatory child abuse reporting laws were adopted because physicians were perceived as too inclined to defer to parental prerogatives, too unwilling to take any action which would have the potential of antagonizing a patient’s parent, and therefore not sufficiently open to the possibility that an injured patient had been abused. In each of the illustrative cases in this Paper, the treating doctor, child abuse pediatrician or staff member under his direction decided to make a Hotline report or to refer the child to the child protection team for that purpose. This Hotline report, is supposed to be based on “reasonable cause” to believe that child abuse may have occurred.<sup>21</sup> However, in treating the sick or injured children in these cases, not one of the treating doctors considered it necessary to take legal action to limit the parent’s decision making authority over treatment. None petitioned the court to remove the decision making authority over treatment from the parents. Yet, the child abuse pediatricians in several of these same cases ordered medical procedures such as skeletal surveys for which parents were either not asked to provide informed consent or for which that consent was sought in the intensely coercive atmosphere resulting from the doctor’s and hospital’s threat not to release the child or a subsequent threat that if the parent refused to “agree” to the procedures, the child would be taken into foster care. These actions had the impact of severely limiting the parent’s decision making authority with regard to her child’s care even though the legal as well as the ethical basis for any such limitations may be lacking.

Under AMA Code of Medical Ethics Opinion 10.03—Patient-Physician Relationship in the Context of Work-Related and Independent Medical Examinations, there is a concept of a limited patient-physician relationship.<sup>22</sup> That limited patient-physician relationship exists when a physician is either employed or contracted by a third party to conduct an examination of a person in order to obtain medical information about that person for the third party. Specific ethical rules governing the physician’s conduct toward the person being examined in such a situation clearly have implications for the activities of the child abuse pediatricians described the illustrative cases presented in this article. This subject is discussed at greater length later in Discussion Section VII.

Finally, while parents or other family members of the injured child may not be in a patient-physician relationship with the doctors who are treating the child, the American Academy of Pediatrics has emphasized in its policy statements on family-centered care the special importance of parents and families to the well-being of pediatric patients.<sup>23</sup> This subject is discussed at greater length later in this paper in Discussion Section VI.

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<sup>21</sup> The Illinois Abused and Neglected Child Reporting Act establishes the legal duty on Illinois doctors to make reports when they have “reason to believe” child abuse has occurred. All states have reporting laws, though the specific standard under which they operate may vary. 325 ILCS 5/4.

<sup>22</sup> AMA Code of Medical Ethics Opinion 10.03—Patient-Physician Relationship in the Context of Work-Related and Independent Medical Examinations was issued in December 1999 based on a report of the Council on Ethical and Judicial Affairs entitled Patient-Physician Relationship in the Context of Work-Related and Independent Medical Examinations adopted June 1999.

<sup>23</sup> Patient and Family-Centered Care and the Pediatrician’s Role, Committee on Hospital Care and Institute for Patient and Family-Centered Care, Pediatrics Vol. 129, No. 2, pp. 394-404 (Feb. 1, 2012)

### ***III. Child Abuse Pediatricians as Lead Medical Investigators and Liaisons to the Legal System***

After many years of campaigning by pediatricians with a special interest in child abuse, child abuse pediatricians have now obtained subspecialty board certification and are assuming a leading role in child abuse investigation of many cases that are reported to state child protection agencies by treating physicians as suspicious for child abuse. In Illinois, where the Family Defense Center primarily works, most of the children's hospitals at which the board-certified child abuse pediatricians hold permanent positions are parties to a sub-contract between the Chicago Child Advocacy Center and the state child protection agency (DCFS). Under this contract, they provide expert medical investigation and written opinions for DCFS on the merits of suspected child abuse cases. This Multi-disciplinary Pediatric Education and Evaluation Consortium ("MPEEC") contract provides the funding out of a State of Illinois appropriation for the expert child abuse pediatrician medical review, assessment and opinion for specific cases, including most of the illustrative cases presented in this Paper.

Even in communities where child abuse pediatricians are not on a state or other governmental contract similar to the MPEEC program in Illinois, child abuse pediatricians assume a role as liaisons in cases of suspected child abuse between the medical profession and the civil child protection and legal systems. There has been strong encouragement in the child abuse pediatrics literature<sup>24</sup> for the referral of suspected child abuse cases to a child abuse doctor since well before any doctors were actually certified for the subspecialty of child abuse pediatrics in 2009. The referral of cases to child abuse specialists (informally recognized as such prior to November 2009 and formally certified thereafter) to conduct a medical investigation and to serve as liaison to the state child protection and legal systems can give rise to serious ethical issues of the type discussed throughout this Paper.

#### **Issues That Arise As to the Child Abuse Pediatrician's Role**

Most significantly, the structural issues that the child abuse pediatrics specialty gives rise to include:

- the child abuse pediatrician not seeking out appropriate consultations with other specialists, in particular neurosurgeons and orthopedists;
- the child abuse pediatrician working at the same institution from which the Hotline call, that triggered the investigation, was made and in the same institution in which the child's treatment was provided, which can affect the objectivity of the child abuse pediatrician's opinion;
- the child abuse pediatrician failing to evaluate and weigh the information of colleagues who are treating physicians and who know the parents and family who brought the child in for treatment; and

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<sup>24</sup> The terms "child abuse pediatrics literature" or "literature of child abuse pediatrics" in this Paper refer specifically to articles written for professional journals by physicians who are board-certified child abuse pediatricians. It also includes interviews and comments made for publication by such physicians. A number of these articles were written before the formal establishment of the subspecialty of child abuse pediatrics, where the subject matter discussed was the work of pediatricians who were informally specialized at that time in matters of child abuse.

- the child's treating physicians becoming passive observers, unwilling to question the opinions of the child abuse pediatrician.

### The Vision of the Child Abuse Pediatrician as a Collaborator and Consensus Builder

Before the formal establishment of the sub-specialty in child abuse pediatrics, an article appearing in June 2007 by Dr. Nancy D. Kellogg and the Committee on Child Abuse and Neglect of the American Academy of Pediatrics discussed at some length the advisability of referring cases to "pediatric child abuse consultants" or to "pediatricians with expertise in child abuse" for evaluation as to whether abuse had occurred.<sup>25</sup> Citing literature from the National Association of Children's Hospitals and Related Institutions, the article by Kellogg and the Committee on Child Abuse and Neglect also discussed the operation of the multi-disciplinary team that operated around the pediatrician with child abuse expertise.

Many hospitals and communities have developed child abuse-assessment teams of pediatricians and other professionals who specialize in the assessment of suspected victims of child abuse. Such teams usually have access to additional information from law enforcement and child protective services, such as scene investigation, that may facilitate more thorough injury assessment and diagnosis. Involving such teams early in the process can ensure accurate and comprehensive assessments and information sharing among the medical and nonmedical disciplines involved and can provide for intermediate and long term management of the child and family.<sup>26</sup>

In another article published in 2007, Drs. Jill C. Glick and Kelley Staley described "A Model for a Collaborative and Medically Directed Child Protection Team" at the University of Chicago.<sup>27</sup> The Glick/Staley article describes the role of the child abuse pediatrician within that model in detail.<sup>28</sup> The article makes it clear that the child abuse pediatrician at their institution is the "coordinator" of a team of doctors that is responsible for the "medical component" of the "complex process" by which the determination is made as to whether the child's injury is accidental or inflicted. There is no doubt from the description in the Glick/Staley article that the child abuse pediatrician is, at least from their perspective, the lead medical investigator and liaison to various elements of the legal system. However, there is no suggestion in this article, or in Dr. Kellogg's article, that the referral to a child abuse pediatrician is in furtherance of medical treatment of the child's present injury, unless the term "treatment" is expanded beyond its common usage to include identification and punishment of an offender. In other words, the child abuse pediatrician, as described in these articles, is not a treating doctor but a forensic consultant to someone other than the patient or the parent (i.e., the state or child welfare agency

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<sup>25</sup> Evaluation of Suspected Child Physical Abuse; Kellogg, Nancy D. and the Committee on Child Abuse and Neglect; *Pediatrics*, Vol.119 No. 6, June 1, 2007, pp. 1232-1241. This particular article is referred to internally as a "clinical report from the American Academy of Pediatrics."

<sup>26</sup> Evaluation of Suspected Child Physical Abuse, p. 1234

<sup>27</sup> Inflicted Traumatic Brain Injury: Advances in Evaluation and Collaborative Diagnosis; Glick, Jill C. and Staley, Kelley; *Pediatric Neurosurgery*, 2007, 43:436-441. Dr. Glick is also the director of Child Protective Services, Department of Pediatrics at the University of Chicago Comer Children's Hospital. This article is referred to as an "invited comment" on two other articles that were published in the same volume of *Pediatric Neurosurgery*.

<sup>28</sup> Dr. Glick is credited with being the founder of the Illinois MPEEC program and the functional medical director of the program. She also directs the MPEEC program at one of the three Chicago MPEEC program hospitals.

or the hospital itself). All of the details of the child abuse pediatrician's role relate to determining whether the child's injury is accidental or inflicted, and none of the details relate to determining the course of the child's future medical treatment.<sup>29</sup> An excerpt from the Glick/Staley article makes this clear.

“At our institution, we have developed an interdisciplinary system of evaluation for children with traumatic injury concerning for abuse.

. . . the child abuse physician will review clinical findings and imaging studies. The neurosurgeon and child abuse pediatrician review this information to assess level of concern for abuse or neglect early in assessment. In this way the neurosurgeon and the child abuse pediatrician collaborate in accurately defining the injuries and address consistency between mechanism and injury. The child protective services (CPS) pediatrician contacts the child welfare system and police, and works with social services to inform the parents of the need for investigation.

. . . The CPS team's child abuse pediatrician focuses on collating various data sets for the diagnosis of child abuse including a review of all relevant imaging and surgical findings with the appropriate subspecialists in order to understand the contribution of each to the diagnostic process. A review of the findings is discussed amongst all subspecialists and consensus is the goal. In our model it is not within the purview of the child abuse pediatrician to single-handedly determine if a neurosurgical injury is not consistent with the history, nor does the neurosurgeon make the definitive diagnosis of inflicted head trauma.

After consensus over the medical findings is achieved, the CPS child abuse pediatrician will draft a comprehensive medical consultation that summarizes the finding. . . . This is reviewed with the hospital's medical and social service professionals, all of whom must concur with the findings before it is placed in the medical record. . . . The medical and social workers provide the investigation agencies with a medical consultation, provide the family with the final decision and then the abuse pediatrician remains available to testify in court as to the opinion of the hospital and as a medical child abuse expert.”

Glick and Staley say, in the above excerpt, that “collaboration” and “consensus” among medical specialists is built into the design of the University of Chicago model, with the child abuse pediatrician taking a leadership role, but not a pre-emptive role, in the process. This is noteworthy, because the illustrative cases presented in this paper do not exhibit such collaboration or consensus in practice. Instead, they exhibit “single handed” determinations of abuse being rendered by child abuse pediatricians, including in several of the illustrative cases, child abuse pediatricians working in the MPEEC program.<sup>30</sup> It is also noteworthy, and from our viewpoint very disturbing, that while the model requires that the “comprehensive medical

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<sup>29</sup> The fact that the child abuse pediatrician has a different role than the treating physician is recognized by the American Board of Pediatrics in the content outline for the Child Abuse Pediatrics certification exam. See specifically Section XX. G.

<sup>30</sup> See more on this question in the later section of this article captioned *Discussion. Section VIII. The Child Abuse Pediatrician's Ethical Duty with Respect to Findings of Abuse or Neglect.*

consultation” be reviewed with everyone on the child protection team at the University of Chicago before it is placed in the medical record, there is no requirement that the tentative conclusions be discussed with the treating doctor, so that the treating doctor might have an opportunity to raise questions and concerns about those tentative conclusions that would be relevant to his ethical obligations.<sup>31</sup> While collaboration and consensus are worthy goals, our observation, including in the illustrative cases, is that child abuse pediatricians often do not solicit and often ignore the conflicting opinions of subspecialists as they write the final reports upon which state authorities rely.

#### The Vision of the Child Abuse Pediatrician as Superior to Other Doctors in Determining if Abuse Has Occurred

Another explanation in the pediatric medical literature as to why the referral to child abuse pediatricians for investigation is considered so important is that it is believed that other physicians, including general practice pediatricians, are not necessarily qualified to resolve the question whether or not a child’s injury is due to abuse. Of course, this point creates some tension with the vision of the child abuse pediatrician as a consensus builder who works with other doctors, including, the general practice pediatrician, to come to a sound conclusion that does not elevate the opinion of a child abuse pediatrician above those of other physicians. In an article published in March 2004, the National Association of Children’s Hospitals and Related Institutions headlined its discussion of this point as “Not All Physicians Are Created Equal.”<sup>32</sup> In the same vein, in a 2008 article, as the actual certification of child abuse pediatricians became more imminent, Drs. Emalee Flaherty<sup>33</sup> and Robert Sege described what they perceived as the problem of doctors with inadequate preparation on child abuse issues becoming involved in legal proceedings.

CPS and law enforcement professionals who investigate allegations of abuse often turn to health care providers with little expertise in child abuse pediatrics for their opinion about the cause of a child’s condition. Self-appointed experts with little training and knowledge of child abuse pediatrics may provide expert medical opinion in court. These failures demonstrate the need for all child professionals who make decisions about the disposition of abused children to have access to the expertise of child abuse pediatrics subspecialists.<sup>34</sup>

#### The “Official” Vision of the Role of The Child Abuse Pediatrician

The first group of 184 child abuse pediatricians was certified in November 2009. The description of the function of child abuse pediatricians is set out by the American Board of

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<sup>31</sup> See more on this question in the later section of this article captioned ***Discussion. Section VI. The Treating Doctor’s Duty to Protect the Child’s Family Relationships.***

<sup>32</sup> Children’s Hospitals at the Frontlines Confronting Child Abuse and Neglect: Mandated Medical Expert Review For All Chicago Children. NACHRI Profile Series. National Association of Children’s Hospitals and Related Institutions, March 2004.

<sup>33</sup> Dr. Flaherty is the head of the child protective services team at Lurie Children’s Hospital, one of the three MPEEC subcontracting hospitals in Cook County.

<sup>34</sup> Translating Child Abuse Research Into Action; Flaherty, Emalee G. and Sege, Robert D.; *Pediatrics*, Vol. 122 No. Supplement 1, September 1, 2008, pp. 51-55.

Pediatrics, the organization that certifies each subspecialty in pediatrics. That description reads as follows:

A Pediatrician who specializes in Child Abuse Pediatrics serves as a resource to children, families and communities by accurately diagnosing abuse; consulting with community agencies on child safety; providing expertise in courts of law; treating consequences of abuse and neglect; directing child abuse and neglect prevention programs and participating on multidisciplinary teams investigating and managing child abuse cases.<sup>35</sup>

In an Ethics Forum column posted in American Medical News in June 2010, Dr. Robert W. Block discussed these various roles of the new sub-specialists<sup>36</sup> One set of activities for child abuse pediatricians as described by Dr. Block was clearly in the public health realm—prevention programs, public awareness, professional education.<sup>37</sup> In addition, however, Dr. Block’s column encouraged doctors who suspected that their injured pediatric patients might “possibly” be the victims of child abuse to contact child abuse pediatricians for help and consultation. The nature of the help and consultation that is contemplated by Dr. Block in the AMA Ethics Forum column is that the child abuse pediatrician would investigate the question of whether the child’s injury was due to abuse and assume the liaison role for the particular child’s case between the medical profession and the legal system. Like Drs. Kellogg, Glick, Staley, Flaherty and Sege quoted above, Dr. Block does not anticipate that the child abuse pediatrician will help or consult with the medical treatment of the child’s injury. In this regard, Dr. Block specifically points to the following attributes and professional attainments of child abuse pediatricians as reasons for treating doctors, including general practice pediatricians, to seek help or consultation from the subspecialist child abuse pediatricians. He states that the child abuse pediatricians are:

- “...skilled in diagnosis, intervention, interdisciplinary evaluation and case management.”<sup>38</sup>

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<sup>35</sup> American Board of Medical Specialties website. <http://www.certificationmatters.org/abms-member-boards/pediatrics.aspx>

<sup>36</sup> Child abuse requires specialized treatment, reporting. Block, Robert W., *American Medical News Ethics Forum*, posted June 28, 2010. Dr. Block was the President of the American Academy of Pediatrics for the 2011-2012 term, and he is one of the physicians who had been very active since the early 1990’s in promoting the establishment of the sub-specialty of Child Abuse Pediatrician. In this *Ethics Forum* column, Dr. Block discusses the professional attributes and attainments of Child Abuse Pediatricians, but indicates that these same capabilities would also be found in “some qualified pediatricians who chose not to take the examination but whose experience and expertise are the same as that of the board-certified group.”

<sup>37</sup> The public health dimension of child abuse is discussed in more detail in the later section of this article captioned ***Discussion Section VIII. The Child Abuse Pediatrician’s Ethical Duty with Respect to Making Determinations of Abuse or Neglect***

<sup>38</sup> None of the terms used in this quote from Dr. Block’s AMA Ethics Forum column reveals any involvement whatsoever by the child abuse pediatrician in the treatment of the pediatric patient’s injury. In this context, “diagnosis” means resolution of the question whether child abuse has occurred or not. In this context, “intervention” means the process of dealing with the injured child’s parents or family and law enforcement or civil authorities in order to preclude the possibility of further abuse. While “interdisciplinary evaluation” could refer to the process of consultation with other medical specialists, it alternatively could refer to the process of consultation with law enforcement or child protection agencies about whether or not the injury is the result of child abuse. In the Illustrative Cases discussed in this Paper, the interdisciplinary evaluation involved consultation with law enforcement and child protection agencies as members of the child abuse team that prepares an MPEEC report. In

- “...available to...manage cases as needed....”
- “...carefully trained or have the experience needed to follow cases through sometimes demanding legal processes.”

Clearly, none of the particular professional attributes or attainments or capabilities of child abuse pediatricians are being highlighted because of any expectation that they will contribute to the treatment of the pediatric patient’s injury. Nor are the child abuse pediatricians being presented as the pre-eminent experts in diagnosis within the medical areas most directly involved in the child’s injury. Rather, their attributes are highlighted because, in Dr. Block’s view, they commend the child abuse pediatrician as being uniquely qualified to serve as a coordinator, case manager and liaison between the medical profession and the legal system.

The child abuse pediatrician’s involvement in these cases is clearly not for the purpose of treatment. Therefore, there is a risk in every case of ethical problems arising, if the line is blurred between the treatment and diagnostic role which doctors traditionally perform and this special forensic role which child abuse pediatricians are being asked to perform in cases of suspected child abuse. Of course, this ethical risk is heightened when an institution, such as a children’s hospital, permits itself to be placed in the position of having personnel performing both the traditional treatment and diagnostic role and the forensic role, for example when an emergency room doctor at the hospital makes a Hotline call and a child abuse pediatrician on the staff of the same hospital then accepts an assignment from the state to conduct the resulting medical investigation.

#### ***IV. Economic and Other Benefits to Treating Doctors Resulting From Referring Cases to Child Abuse Pediatricians and From Deferring to the Opinions of Child Abuse Pediatricians***

Treating physicians practicing in communities that are served by child abuse pediatricians must necessarily make professional decisions regarding their interaction with the child abuse pediatrician on each particular case of possible child abuse. Those professional decisions are of two types. First, they must sometimes decide whether to refer a particular case to the child abuse pediatrician. Depending upon the community in which a suspected child abuse case arises, the decision to refer the case to the child abuse pediatrician may rest with the treating physician to whom an injured child was presented, or it may rest, as in Illinois under the MPEEC agreement, with the state child protection agency after the agency has received a Hotline report.<sup>39</sup> Second, they must decide how deferential to be to the opinion of a child abuse pediatrician in any particular case that has been referred—whoever may have made the referral. Are the circumstances of the case such that the treating physician making the referral should be totally passive in accepting the opinion of the child abuse pediatrician, or are the circumstances such that he should ask critical questions testing the strength of the child abuse pediatrician’s process, analysis, and opinion? It is the premise of this Section (IV) of the Paper that in every case of possible child abuse, each of these professional decisions that a treating physician is called upon to make should be guided by ethical principles.

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context, “case management” means the process whereby the medical profession interacts with the legal system in its processing and disposition of the case that is “possibly child abuse.”

<sup>39</sup> See Discussion Section III. We have not surveyed the states to determine how many others have MPEEC type arrangements.

These two professional decisions that must be made in the context of treating a child who may possibly have suffered physical abuse ---whether to refer and how deferential to be ---raise similar but not identical ethical questions. There are certain aspects of the history of how the subspecialty of child abuse pediatrics came into existence and how it has been portrayed in the medical literature that are pertinent to the ethical analysis of both the *referral* question and the *deference* question. This Section IV of the Paper describes the historical background.

An important effect of child abuse pediatricians taking the lead in investigating particular cases of suspected child abuse and in providing liaison to the child protection and legal systems, as described Section III, is that treating physicians, including general practice pediatricians, have become relatively *less* engaged in those cases. In fact, the disengagement of treating physicians, including a child's treating pediatrician, is a common element in the Illustrative Cases presented in this Paper. This "hands off" approach by treating physicians once a Hotline call is made is quite familiar to people like the lawyers at the Family Defense Center. Our staff attorneys at the Family Defense Center frequently review the medical records of children of wrongly accused parents and see many instances in which pediatricians or other treating doctors had important information that child abuse pediatricians should have considered but failed to obtain or failed to take into account. The child abuse pediatricians did not seek out the input of other physicians, including those within their own hospitals, and the other physicians involved with the child generally did not reach out to the child abuse pediatricians to provide information or opinion. The "hands off" approach and deference to child abuse pediatricians by other pediatricians and specialists is troubling but not surprising in view of the extensive child abuse pediatrics literature that explicitly encourages treating physicians to make referrals to child abuse pediatricians and implicitly encourages treating physicians to be deferential to the conclusions of those child abuse pediatricians.<sup>40</sup>

What is very problematic as an ethical consideration for the treating physicians is that this encouragement to become more disengaged and to let the child abuse experts handle the child abuse evaluation is framed primarily in terms of benefits to the treating physicians themselves. The advantage to treating physicians of disengaging from the question of whether their pediatric patient actually has been abused is presented through two important themes in the child abuse pediatrics literature. The first is in the nature of an admonition directed at those treating doctors. The second is in the nature of incentives offered to those same doctors.

#### The Admonition to Defer to the Child Abuse Pediatrician

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<sup>40</sup> The deference to child abuse pediatricians is also reinforced by DCFS training of its own investigators who have been taught that the child abuse pediatrician provides the "gold standard" opinion in any case involving physical child abuse. In a graphic chart prepared by Dr. Jill Glick that has been used in training DCFS investigators (on file at the Family Defense Center), child abuse pediatricians appear at the pinnacle of a flow chart which lists various types of subspecialist underneath it. The same chart states that subspecialists in fields like orthopedics and neurosurgery may not know about child abuse, and general pediatricians may be reluctant to make reports against their patients. In keeping with this training, even though it conflicts with the express directive in DCFS written procedures to defer to orthopedists and radiologists in bone fracture cases, DCFS investigators who have been cross examined in juvenile court decisions have justified their failure to consult with orthopedists or radiologists as consistent with DCFS policy and practice which they understand requires them to "go with our MPEEC doctors" and not solicit the opinion of treating or consulting orthopedists. (Transcript of testimony in Richard's case on file with the Family Defense Center).

There is a frequent admonition in the child abuse pediatrics literature warning that treating doctors to whom injured children are first presented, including general practice pediatricians and family practice physicians, are not as well prepared as the child abuse pediatrician to consider whether child abuse accounts for the child's injuries.<sup>41</sup> The premise is that most doctors, including general practice pediatricians, do not have the same level of competence or familiarity as child abuse pediatricians with medically relevant subjects that would contribute to confirming or negating a child abuse conclusion. This appears to be a calculated effort to put treating doctors on the defensive if they insist on having input into the determination of whether a particular child's injuries are the result of abuse.

A physician who is not a child abuse pediatrician may wonder how child abuse pediatricians can possibly claim a superior ability to draw conclusions as to whether a bone fracture or subdural hematoma is due to child abuse, especially if superiority of child abuse pediatrician's opinion over that of orthopedists, neurosurgeons and radiologists is claimed (as it has been in many Illinois cases on which the Family Defense Center has worked). Because many different areas of medicine come into play in the determination of whether a particular injury is the result of abuse, a child abuse pediatrician cannot credibly claim to be expert in all of them. Certainly child abuse pediatricians do not possess the advanced training in brain and skeletal injuries that neurosurgeons and orthopedists possess. Head injuries, retinal injuries, bone fractures, burns, and "failure to thrive," and sexually transmitted diseases are each medical conditions that involve a different area of medicine. Neurosurgery, ophthalmology, orthopedics, emergency medicine and dermatology, gastroenterology and gynecological specialties all are fields of highly specific knowledge bearing on these injuries or conditions. Specialists in these areas may be expected to have a greater depth of knowledge than the child abuse pediatrician or greater knowledge of the current research in their specific area of medicine. In addition, these specialists treat "normal" populations in which these conditions will occur without suspicion of abuse and therefore they may have a very different set of assumptions about the likelihood of child abuse as a cause for the condition at issue. While the child abuse pediatrician is expected to have *some* knowledge of each of these areas, it is doubtful that the child abuse pediatrician would have *more* expertise than a specialist as to the specific injuries of all these types. Nor will the child abuse pediatrician have experience treating normal non-suspicious injuries of the same type that have been deemed suspicious by virtue of a Hotline call.

The establishment of the child abuse pediatrics sub-specialty was advocated largely based on expertise that the child abuse pediatrician would have in the public health and sociological aspects of child abuse and neglect, rather than on an assertion of enhanced medical or scientific knowledge that other pediatricians or specialist in pediatric areas of medicine (orthopedics, neurosurgery) would not possess.

As reflected in the Illustrative Cases, however, the concerted efforts of child abuse pediatricians to convince their general practice pediatrician colleagues and other medical specialists that they have superior ability to "diagnose" child abuse have often been successful. This has created a mindset for the doctor who is not a child abuse pediatrician that if he, as a

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<sup>41</sup> See comments of Dr. Ann S. Botash, a child abuse pediatrician, quoted in *Health Leaders Media*, November 2009; *see also*: "Translating Child Abuse Research into Action," Flaherty, EG; Sege, RD; Hurley, BS, *Pediatrics* Vol 122, No. 1 (September 1, 2008); and Child abuse: Pediatricians can now be certified to handle cases of abuse and neglect, *Chicago Tribune*, December 4, 2009;

treating doctor, persists in making his own investigation and analysis and deciding for himself that there is no child abuse in a particular matter in which the initial observations may have created a suspicion, he will be outside what others in the medical profession are now loudly proclaiming to be the best practice. This unfortunate pre-emptive effect obviously contributes to the failure of treating doctors in many cases to care for their pediatric patients by asking appropriately pointed questions of the child abuse pediatricians who have determined either that abuse has occurred (the authors' experience), or hypothetically (not the authors' experience) that abuse has not occurred.

### The Incentives for Deference

The incentives for treating physicians to defer to the child abuse pediatricians when there is a suspicion of child abuse with respect to an injury are also described in the child abuse pediatrics literature. These incentives include significant economic and other business benefits as a result of such cases being handled by child abuse pediatricians. The literature suggests that the involvement of a child abuse pediatrician may enable a treating doctor to avoid several uneconomic, professionally difficult, and distasteful aspects of the legal system surrounding suspected child abuse cases. Specifically, various commentators have suggested that deferring to a child abuse pediatrician could benefit the treating doctors---primary care doctors including general practice pediatricians and family practitioners---by protecting their patient relationships, improving the economics of their practices, and reducing the prospects of their being called to testify in child abuse matters.

*Protecting the treating doctor's patient relationships.* The child abuse pediatrics literature suggests that for primary care doctors who have existing and on-going professional relationships with parents, deferring to a child abuse pediatrician can help to minimize or avoid damage to those relationships.<sup>42</sup> In this connection, it has been so routinely articulated in child abuse literature as to become virtually an article of faith that the cause of combating child abuse has suffered because treating doctors are so uncomfortable at the prospect of having to discuss the subject of possible child abuse, especially with parents with whom they have had an on-going relationship.<sup>43</sup> Deferring to child abuse pediatrician has been promoted as a way out of this dilemma for treating doctors.

*Improving the treating doctor's billing.* In a time of increasingly refined coding of medical services for billing purposes, the child abuse pediatrics literature suggests that reliance on a child abuse pediatrician may enable the treating doctor to avoid some of the unbillable or less billable work associated with managing a case of suspected child abuse.<sup>44</sup> On the other hand, the child abuse pediatrician and her team appear to be more insulated from these billing concerns, because of either governmental or charitable foundation funding of their programs.<sup>45</sup> In other words, more money may be available for child abuse assessment when that work is

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<sup>42</sup> "Child abuse requires specialized treatment, reporting," Block, Robert W., *Ethics Forum American Medical News*, June 28, 2010.

<sup>43</sup> "Translating Child Abuse Research Into Action," cited at n. 41 *supra*, pp. 51-55.

<sup>44</sup> "Child abuse requires specialized treatment, reporting,"

Block, Robert W., *Ethics Forum, American Medical News*, June 28, 2010

<sup>45</sup> One example of governmental funding would be the Multidisciplinary Pediatric Education and Evaluation Consortium arrangement in Illinois. One example of charitable foundation funding is Kosair Charities support for University of Louisville, Department of Pediatrics—Forensic Medicine.

performed by a child abuse pediatrician than when the same work is performed by a treating doctor.

Moreover, to the extent that billing is a concern for the child abuse pediatricians themselves, at least one of them has speculated that they may at some time in the future be able to obtain higher billing rates because they will be able to bill as “experts.”<sup>46</sup>

*Cost savings on medical testing.* The child abuse pediatrics literature also expresses the idea that there could be cost savings on medical testing that result when the child abuse diagnosis is placed in the hands of a specialized child abuse pediatrician. On this point, an article co-authored by the Committee on Child Abuse and Neglect of the American Academy of Pediatrics shortly before the formal establishment of the subspecialty said

“Once a suspected victim is identified and further assessment and management is required, using a pediatric child abuse consultant, if available, early in this process may obviate the need for invasive or expensive testing....”

The fallacy in the above quote is two-fold. First of all, in actual practice, child abuse pediatricians have their own “invasive . . . expensive” tests which they sometimes order for no apparent medical reason other than to search for injuries that might evidence child abuse. The most obvious example, as seen in some of the illustrative cases, are skeletal surveys that are systematically required by some institutions (CH #1) whenever a child under a certain age presents with a bone fracture, including even commonplace radius or ulna (wrist) fractures. Secondly, the notion that a parent can safely be accused of child abuse without sometimes extensive medical tests that would support a non-abuse explanation of the child’s injury has been shown to be tragically wrong in some cases. Substituting child abuse pediatricians for medical tests that have the potential to definitively exonerate falsely accused parents is an appalling and dangerous idea.<sup>47</sup>

*Minimizing the burden on the treating doctor to provide testimony in legal proceedings.* Finally, the child abuse pediatrics literature suggests that when a child abuse pediatrician becomes involved, that may relieve the treating doctor of having to carry the burden of any

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<sup>46</sup> See comments of Dr. Ann S. Botash, a child abuse pediatrician, quoted in *Health Leaders Media*, November 2009.

<sup>47</sup> Indeed, all efforts should be made to increase the availability of potentially exculpatory tests and to shorten the time frames under which these test results are available. As reported in the *Denver Post*, April 1, 2012, in the case of Alyssa, i, age 3 months, doctors at the Children’s Hospital Colorado initially concluded in June 2008 that Alyssa’s multiple fractures with no evident bruising could only be explained by abuse. The child was immediately taken from her parents by the Adams County, Colorado child protection services agency and placed in foster care. After two weeks of protesting their innocence and preparing for a legal defense of themselves and their family, the parents died in despair at the husband’s own hand. That despair had apparently been heightened by their being told that the genetic testing for an alternative disease based explanation of Alyssa’s fractures would not be concluded until October---three to four months in the future. Within days after the parents’ deaths, however, genetic testing was concluded and established that Alyssa actually suffered from spinal muscular atrophy. Spinal muscular atrophy explained not only Alyssa’s fractures that had precipitated the erroneous child abuse allegation, but also other observations that had been made by Alyssa’s parents and her pediatrician concerning delayed physical development in the month before the fractures were observed. Spinal muscular atrophy is a rare, but not astronomically rare, disorder, effecting 1 in 10,000 children.

testimony that may be called for in subsequent legal proceedings.<sup>48</sup> As one general practice pediatrician has candidly written about this advantage:

“Like most pediatricians, I am intimidated by the idea of testifying in court. But all of these specialists have answered questions from lawyers on many occasions; the witness box is a basic part of the landscape of the new specialty.”<sup>49</sup>

The suggestion that treating doctors could be completely relieved of the burden of testifying is illusory. In highly contested child abuse cases in which the families have resources to bring all available expert testimony to bear on the outcome of a legal proceeding, attorneys representing parents accused of child abuse are not precluded from calling as witnesses *any* doctors who were involved in the diagnosis and treatment of the injured child. Nevertheless, even the idea of simply being able to shift some of the burden of providing medical testimony in a contested child abuse case is likely to be a powerful, but ethically dubious, incentive for many treating doctors to defer to child abuse pediatricians to render the relevant opinions in child abuse cases.

### Summary

The child abuse pediatric literature has openly suggested to treating doctors, including general practice pediatricians and primary care physicians, that there are several economic and business advantages which they would enjoy as a result of deferring to child abuse pediatricians:

- Protecting existing patient relationships;
- Avoiding unbillable or low billable work by sending it to a group of doctors whose economics do not depend on that billing; and
- Avoiding the witness stand in legal proceedings.

The perception, as well as the fact, that there are tangible economic and business benefits for a general practice pediatrician or primary care practitioner who adopts a strategy of routinely relying on a child abuse pediatrician is precisely the ethical reason why those treating doctors should *not* adopt such a business strategy. Instead, at a minimum, ethical standards would seem to require that individual consideration be given in each case to the specific negative effect of the referral on the patient’s confidentiality and privacy rights and on the patient’s parental and family relationships as discussed in other sections of this Paper. The fact that it may be good business for general practice pediatricians and primary care physicians to defer to the opinions of child abuse pediatricians should heighten sensitivity to the potential ethical problems of doing so.

### ***V. The Treating Physician’s Ethical Obligation to Protect Patients’ Rights to Privacy and Confidentiality of Medical Information***

Under the AMA Code of Medical Ethics, the injured child, as a patient, has a right to confidentiality and privacy with respect to his medical issues, records and personal information. The AMA ethics opinions that impose obligations on doctors to respect privacy and confidentiality rights do not have a general carve-out for patients who are injured children. In

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<sup>48</sup> Inflicted Traumatic Brain Injury: Advances in Evaluation and Collaborative Diagnosis, Glick, Jill C. and Staley, Kelley, *Pediatric Neurosurgery* 2007, 43:436-441.

<sup>49</sup> The Marks of Childhood or the Marks of Abuse. Perry Klass, M.D., *The New York Times*, May 11, 2009.

some cases of suspected child abuse, however, the treating physician's ethical duties to protect their patients' confidentiality rights may be compromised in two respects.

First, the injured child's confidentiality and privacy rights are violated if, in the course of child abuse reporting, a treating physician voluntarily communicates to the state child protection agency medical information beyond the minimum required by the state's mandatory reporting statute without the specific consent of the parent to do so. The fact that there may be provisions in the state or federal statutes that protect the treating physician from legal liability for communicating more than the minimum required does not relieve the treating physician of the burden of adhering to this ethical limitation on disclosure. Yet physicians or nurses or other persons under physician supervision frequently discuss a patient's history with DCFS and other doctors under the mistaken assumption that a Hotline report and a call or other request from DCFS or a child abuse pediatrician justifies disclosure of any and all patient information.

Second, giving child abuse pediatricians liberal access to patient records without specific consent of the child's parent or allowing disclosures of a child's medical information from one physician to another creates the potential for significant ethical violations for any physician involved in the transfer. Moreover, if parents are told they must cooperate with a child abuse investigation by giving consent to release of confidential medical records under threat that if they fail to do so they will lose custody of their child, any resulting consent to the disclosure of medical records that would otherwise be confidential is hardly informed, knowing and voluntary.

The confidentiality and privacy rights of patients are core values that are stated, not once, but many times in the AMA Code of Medical Ethics. One of the nine foundational Principles of Medical Ethics is specifically focused on the patient's privacy and the confidentiality of the patient's medical information. It reads in its entirety as follows:

IV. A physician shall respect the rights of patients, colleagues and other health care professionals, and shall safeguard patient confidences and privacy within the constraints of law.

In turn, Principle IV forms the basis for one of the six fundamental elements of the patient-physician relationship delineated in AMA Code of Medical Ethics Opinion 10.01---Fundamental Elements of the Patient-Physician Relationship.<sup>50</sup> This is the right to confidentiality, as expressed in the excerpt below.

The patient has the right to confidentiality. The physician should not reveal confidential communications or information without the consent of the patient, unless provided for by law or by the need to protect the welfare of the individual or the public interest.

The right to confidentiality in the patient-physician relationship is not abrogated as a fundamental right of the patient where there is a mandated report of possible child abuse or neglect, because of "the need to protect the welfare of the individual. . . ." Any suggestion to the contrary is negated by the way in which Opinion 5.05---Confidentiality and Opinion 2.02---

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<sup>50</sup> AMA Code of Medical Ethics Opinion 10.01 -- Fundamental Elements of the Patient-Physician Relationship was issued in June 1992 based on the report of the Council on Ethical and Judicial Affairs with the same title that was adopted in June 1990.

Physicians' Obligations in Preventing, Identifying, and Treating Violence and Abuse were specifically revised in 2006 and 2008 respectively to address mandated reporting. Each of these opinions states that if there is in fact a mandated report, it has to be limited in its content to the minimum information required. In other words, the vitality of the underlying confidentiality rights of the patient in a mandated reporting situation has been re-affirmed in Opinion 2.02 and Opinion 5.05.

AMA Code of Medical Ethics Opinion 5.05 -- Confidentiality states the general rule that a patient's information disclosed to the doctor is confidential.<sup>51</sup> AMA Code of Medical Ethics Opinion 5.059 – Privacy in the Context of Health Care establishes that the scope of the information that a physician is ethically precluded from divulging is not limited to a narrowly defined category of technical medical information, but also generally includes “information which is concealed from others outside of the patient-physician relationship.”<sup>52</sup> Opinion 5.05 recognizes an exception to the general rule of confidentiality for situations in which disclosure to civil authorities is required by law. However, it states unequivocally that in such situations mandated reporters should provide “the minimum amount of information required.” The “minimum . . . information required” clause was written into Opinion 5.05 as part of the 2007 revision of Opinion 5.05. In other words, this represents an affirmative statement by the Council on Ethical and Judicial Affairs in 2007 that the “mandated reporter” exception to the general rule of confidentiality was to be given its narrowest possible scope.

To the very same effect is AMA Code of Medical Ethics Opinion 2.02 – Physicians' Obligations in Preventing, Identifying, and Treating Violence and Abuse, which reads in part as follows:

(b) When a jurisdiction mandates reporting suspicion of violence and abuse, physicians should comply. However, physicians should only disclose minimal information in order to safeguard patients' privacy. Moreover, if available evidence suggests that mandatory reporting requirements are not in the best interests of patients, physicians should advocate for changes in such laws.<sup>53</sup>

There is only one reasonable unified interpretation of Opinion 10.01, Opinion 5.05, and Opinion 2.02 with respect to mandated reports of possible child abuse or neglect. The medical profession has a fundamental ethical value of respect for a patient's privacy and for the confidentiality of a patient's medical information. Mandated reporting in cases of possible child abuse or neglect is an exception imposed by the law on the medical profession, and as an ethical matter, the profession has chosen to express acquiescence to mandated reporting in its ethics opinions. However, physicians who have decided that they must make a mandated report in a

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<sup>51</sup> AMA Code of Medical Ethics Opinion 5.05---Confidentiality was most recently updated in June 2007 based on the report of the Council on Ethical and Judicial Affairs entitled Opinion E-5.05, 'Confidentiality,' Amendment adopted November 2006.

<sup>52</sup> AMA Code of Medical Ethics Opinion 5.059---Privacy in the Context of Health Care was issued in June 2002 based on the report of the Council on Ethical by the same title adopted December 2001.

<sup>53</sup> AMA Code of Medical Ethics Opinion 2.02 – Physicians' Obligations in Preventing, Identifying, and Treating Violence and Abuse was issued in June 2008 based on the report of the Council on Ethical and Judicial Affairs adopted November 2007 entitled Physicians' Obligations in Preventing, Identifying and Treating Violence and Abuse.

particular case are bound by the ethical obligation to limit the content of the mandated report to the minimum necessary to comply with the letter of the reporting law.

To the authors' knowledge, none of the parents in the illustrative cases signed specific consents to release the child's medical records to DCFS or to any person working on a contract with DCFS during their encounters with hospital child protective services team members. Nevertheless, in each of these cases, the child abuse pediatricians were given broad access to the child's medical records even though Illinois' child abuse reporting statute does not require any disclosures between doctors and does require only very limited disclosures to the DCFS. Specifically, the Illinois statute, like those in other states, requires the following information in the mandated report:

- The name and address of the child and his parents or other persons having custody;
- The child's age;
- "the nature of the child's condition, including any evidence of previous injuries or disabilities...."
- "any other information that the person filing the report believes might be helpful in establishing the cause of such abuse or neglect and the identity of the person believed to have caused such abuse or neglect."<sup>54</sup>

In the illustrative cases described in this Paper, the mandated Hotline report was made by a physician or other hospital personnel as required by the child abuse reporting statute. The person making the mandated report (or the person ordering that the mandated report be made) had determined that he or she had "reasonable cause to believe" that the injured child was abused or neglected.<sup>55</sup> This invocation of state investigative powers by making the Hotline report did not constitute a determination that any abuse whatsoever had occurred, as consistently emphasized by DCFS and the child abuse pediatrics literature. Therefore, while the Illinois child abuse reporting statute invites doctors to provide additional information that "might be helpful," doctors who do so risk running afoul of the ethical directive to make the minimum disclosure allowed. The minimum disclosure required by the mandatory reporting statute would in effect appear to be the maximum disclosure allowed by the AMA ethics opinions absent parental consent to further disclosures. Under this analysis, the doctor's Hotline report should include the child's essential identifying information and a description of the injury that brought the child into his or her care, and nothing else.

State statutes explicitly relieve doctors making mandated reports of legal concerns about violating the doctor-patient privilege unless the Hotline call is made in bad faith.<sup>56</sup> Along the same lines, regulations under the federal HIPAA statute also consider such mandatory reports to be protected disclosures.<sup>57</sup> However, these statutory and regulatory immunities should not be

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<sup>54</sup> ANCRA, 325 ILCS 5/7.

<sup>55</sup> ANCRA 325 ILCS 5/4.

<sup>56</sup> ANCRA, 325 ILCS 5/4.

<sup>57</sup> Child Abuse, Confidentiality, and the Health Insurance Portability and Accountability Act, Committee on Child Abuse and Neglect; *Pediatrics*, Vol. 125 No. 1 pp. 197-201, January 2010. This article purports to provide pediatricians with information about their **legal** obligations and boundaries for disclosing information without parental consent under HIPAA specifically and generally under state law in cases of suspected child abuse. Since the article is styled as a "policy statement" of the American Academy of Pediatrics, it is stunning that it does not make a single reference to the medical profession's ethical standards regarding patient privacy and the

understood as negating the ethical requirements imposed on these doctors to protect confidentiality and privacy of their patients. The distinction between legal requirements and ethical standards of the medical profession is explicitly recognized in AMA Code of Medical Ethics Opinion 1.02 – The Relation of Law and Ethics.<sup>58</sup> The fact that a physician may be able to defend himself against legal action for breach of confidentiality by invoking statutory or regulatory provisions like those mentioned above does not relieve him of his ethical burden.

In each of the illustrative cases presented in this Paper, it was the parent, acting as the surrogate for her child under Opinion 10.015---The Patient Physician Relationship, who had consented initially to the establishment of the patient-physician relationship with the treating doctor. These parents did not forfeit any of their prerogatives under Opinion 10.015 by virtue of a Hotline call having been made naming their children as potential child abuse victims. These parents continued to have the responsibility for making treatment decisions for their children under Opinion 10.016---Pediatric Decision-Making. Therefore, if disclosures were going to be made in furtherance of the child abuse investigations, it is evident that it was these parents whose consent to those disclosures should have been requested. Though each of the parents in the illustrative cases was ultimately exonerated of child abuse allegations, none of them would have voluntarily waived their child's confidentiality and privacy rights and consented to having the matter referred to a child abuse pediatrician had they been fairly informed of the jeopardy this would soon put them in or the impact this disclosure was likely to have on their fundamental family rights.

For a treating doctor to send the child's medical records to a child abuse pediatrician for review is not the same as sending those medical records to another medical specialist, such as an orthopedic surgeon or neurosurgeon, since the review by the child abuse pediatrician is solely for investigative or forensic evaluation, not treatment, purposes. If it were the police seeking the medical records of a child who was a possible abuse victim, rather than a child abuse pediatrician, few physicians would simply hand over the records without requiring a subpoena or other court order. AMA Code of Medical Ethics Opinion 7.025 – Records of Physicians: Access by Non-Treating Medical Staff recognizes that a non-treating doctor, for example a child abuse pediatrician, has no more right to a patient's confidential and private information than any other stranger to the patient-physician relationship. Opinion 7.025, which was adopted in 1999, summarizes this principle as follows:

Only physicians or other health care professionals who are involved in managing the patient, including providing consultative, therapeutic, or diagnostic services, may access the patient's confidential medical information. All others must obtain explicit consent to access the information.<sup>59</sup>

In conclusion, there is an ethical requirement that the parent's voluntary consent be obtained before a child abuse pediatrician, state child protection agency or law enforcement

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confidentiality of medical records and how pediatricians to whom the article is directed should reconcile those ethical obligations with decisions that they have to make about how much of their patients' privacy and medical information should be voluntarily and routinely disclosed.

<sup>58</sup> AMA Code of Medical Ethics Opinion 1.02—The Relation of Law and Ethics was issued prior to April 1977 and was updated in June 1994.

<sup>59</sup> AMA Code of Medical Ethics Opinion 7.025 – Records of Physicians: Access by Non-Treating Medical Staff.

authority is provided with more than the minimum information from the child's medical record that is required by the state's mandated reporting law. The fact that there is a suspicion of possible child abuse does not justify physicians either ignoring the requirement that parents consent to disclosure or coercing such consent from parents.

## ***VI. The Treating Doctor's Duty to Protect the Child's Parental and Family Relationships***

The ethics opinions of the American Medical Association and the policy statements of the American Academy of Pediatrics both recognize that the family relationship is critical to the health and well-being of the pediatric patient.

AMA Code of Medical Ethics Opinion 10.016 -- Pediatric Decision-Making explicitly recognizes the importance of family relationships to the pediatric patient. The Opinion indicates that physicians should consider what effect their actions could have on those family relationships, not because the physician has a divided loyalty, but because of the importance of family relationships to the child. In fact, the Opinion was revised in 2011 specifically to deal with ethical issues arising in the treatment of an HIV-infected child whose illness has implications for the parent-child and extended family relationships.

Likewise, the American Academy of Pediatrics has overseen the on-going development of the concept of "family-centered care." This concept, re-styled in 2012 as "patient and family-centered care," appears in policy statements in its official professional journal dating back to 2003.<sup>60</sup> As with Opinion 10.016, the theme of the AAP policy statements on family-centered care of pediatric patients is not about compromising the child's well-being in the interests of parents or other family members. Rather, the policy statements recognize that the family relationship is critically important to the child-patient herself and that the pediatric treatment plan should be designed to strengthen that relationship. Quoting from the most recent policy statement,

Patient- and family-centered care is an innovative approach to the planning, delivery, and evaluation of health care that is grounded in a mutually beneficial partnership among patients, families, and providers that recognizes the importance of the family in the patient's life. . . . Health care professionals who practice patient- and family-centered care recognize the vital role that families play in ensuring the health and well-being of children and family members of all ages. These practitioners acknowledge that emotional, social, and developmental support is integral components of health care. They respect each child and family's innate strengths and cultural values and view the health care experience as an opportunity to build on these strengths and support families in their caregiving and decision-making roles. Patient- and family-centered approaches lead to better health outcomes and wiser allocation of resources as well as to greater

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<sup>60</sup> In 2003, the American Academy of Pediatrics issued a policy statement on this subject: Family-Centered Care and the Pediatrician's Role; Committee on Hospital Care; *Pediatrics* Vol. 112 (3), pp. 691-695, (Sept. 1, 2003). That policy statement was revised in 2012 by a new policy statement: Patient and Family-Centered Care and the Pediatrician's Role, Committee on Hospital Care and Institute for Patient and Family-Centered Care, *Pediatrics* Vol. 129, No. 2, pp. 394-404 (Feb. 1, 2012).

patient and family satisfaction. . . . Patient- and family-centered care in pediatrics is based on the understanding that the family is the child's primary source of strength and support and that the child's and family's perspectives and information are important in clinical decision-making. . . ."<sup>61</sup>

The American Academy of Pediatrics policy statements discuss what family-centered care might mean for pediatricians in certain clinical situations. However, they are silent as to what family-centered care requires from either a treating doctor or a child abuse pediatrician in the case of an injured child who has been identified as a possible child abuse victim. The AAP policy statements do not say how a pediatrician treating such a child can be "family-centered" while exposing the child's parental and family relationships to the risk of severe damage of the sort that befell our ultimately-exonerated clients whose cases are presented in this Paper.

We believe that treating physicians should consider steps that could be taken at three different points to protect the child's family relationships and limit the damage that a Hotline call, investigation and child abuse evaluations can cause to those family relationships.

First, before making a Hotline call related to a child's injury, the treating physician should be rigorous in deciding whether there actually is "reasonable cause" to believe that child abuse may have occurred. Nothing in this Paper is meant to suggest that a physician should not make a Hotline call when he has "reasonable cause" or whatever the requisite standard might be under his own state's mandatory reporting statute. However, a relatively small percentage of Hotline calls to state child protection agencies are finally determined to be child abuse,<sup>62</sup> including calls from doctors. Not only are the substantial majority of Hotline calls deemed to be "unfounded" upon investigation, but there has been a documented 75% rate of error in those indicated findings that are reviewed on appeal (the Center's own rate of exonerating its clients approaches 90%). It is therefore very likely that some treating doctors are calling in suspicions that are unfounded and that child abuse doctors are sometimes concluding that child abuse occurred where it did not or where the evidence available did not substantiate the initial suspicion. There are even situations, as in Amelia's case, in which the doctor who referred the case to the child protection team with the understanding that the Hotline call would result, expressed the belief that the injury was not suspicious for abuse but made the referral anyway "Better safe than sorry" reporting may be safe for doctors, but it is not the legal standard and it is *not* safer for families. Any treating doctor or medical care provider who consistently makes reports and triggers investigations that prove to be unfounded, like the vast majority of the Center's other medically-contested cases, may be falling short in his duty to protect his patients' parental and family relationships.

Second, once the treating doctor concludes that a Hotline call should be made, the patient confidentiality and privacy protections of the medical ethics rules do impose limits on the content of what is reported and the manner in which the report is conveyed. As explained earlier (Discussion, Section V of this Paper), the AMA ethics opinions state that the mandatory report should include only the minimum amount of medical information required by the law. If the

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<sup>61</sup> Patient and Family-Centered Care and the Pediatrician's Role at pp. 394-395

<sup>62</sup> As reported by the U.S. Department of Health and Human Services, Administration on Children, Youth, and Families, Children's Bureau, in 2009, there were 763,000 substantiated cases of "child maltreatment" based on approximately 3.3 million reports to child protective service agencies.

Hotline call has to be made because there truly is “reasonable cause” to believe that child abuse may have occurred, the treating physician should understand that he only has ethical license to provide the minimum information required by the statute. If the treating physician has no reason to believe that the parent or parents presenting the injured child had any role in the suspected abuse, then he should make that point clearly to the person taking the Hotline call in order to avoid compounding the potential damage to families.

Third, as stated in Discussion Section IV of this Paper, a doctor who makes or directs or supervises staff in the making of a Hotline call should not thereafter passively defer to another specialist with respect to the outcome of any ensuing investigation. In those states that have arrangements like the Illinois Multidisciplinary Pediatric Education and Evaluation Consortium described in Discussion Section III, a Hotline call will often result in a child abuse pediatrician being assigned at the request of the state or local child protection agency to conduct a medical investigation of whether the child’s injury is the result of abuse. If the child abuse pediatrician does make a determination that, notwithstanding the parent’s insistence to the contrary, the child’s injury was the result of abuse, the treating doctor should at a minimum carefully review and formulate appropriate questions about that determination. If the evidence in support of the child abuse pediatrician’s determination is not persuasive, the treating doctor should make that point both to the child abuse pediatrician and to the investigators; he should also express his willingness to oppose that determination. It would not be consistent with the duty to protect the injured child’s parental and family relationships for a treating doctor to permit an unpersuasive determination of child abuse by a child abuse pediatrician to go unopposed. Sadly, too few physicians are willing to speak out when they disagree with an opinion by a person who bears the title “child abuse pediatrician.” For the families involved, however, their lives, livelihoods and children’s futures all rest on the medical profession “getting it right.” These families have to be able to rely on treating physicians speaking up to the state child protection agency, if they have doubts about the opinion of the child abuse pediatrician.

## ***VII. The Child Abuse Pediatrician’s Disclosures in Interactions with the Family***

Child abuse pediatricians themselves have acknowledged that their conclusions about whether or not abuse has occurred can often be dependent on what they hear about the circumstances of the child’s injury rather than just on what they see in examining the child. As one child abuse pediatrician has explained this:

"There's an expectation that we can just look at an exam or an X-ray and tell you if a child has been abused. . . . That's not true.<sup>63</sup> A child can have a broken leg for many reasons. It's all in the history of the injury: did the story the parents tell make sense? Did

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<sup>63</sup> The Child Abuse Pediatrician who is quoted in the text is Dr. Jill Glick. The quoted excerpt makes it clear that child abuse pediatricians rely heavily on what they hear about how an injury occurred. We, at the Family Defense Center and other lawyers who represent wrongly accused parents do not have any such “expectation” as Dr. Glick refers to in her first sentence of the quote. The quote is taken from an article presented by the National Association of Children’s Hospitals and Related Institutions (NACHRI) in March 2004 as part of the NACHRI Profile Series. The article is entitled “Children’s Hospitals at the Frontlines Confronting Child Abuse and Neglect: Mandated Medical Expert Review for All Chicago Children.”

the story the day-care provider tell make sense? Is there corroborating evidence to support the histories provided?"<sup>64</sup>

In addition, at least one clinical report of the American Academy of Pediatrics underscores the need for precision in documenting exactly how the parent describes the "mechanism of injury or injuries" by "using quotes whenever possible. . . ."<sup>65</sup>

If the interview with the parents is so important in enabling the child abuse pediatrician to fulfill his or her investigative role, what are the ethical standards that the child abuse pediatrician should observe in his interaction with the parents? Also, what disclosures as to the purpose of the meeting and the questions should the child abuse pediatrician make?

### Child Abuse Pediatrician's Duty to Disclose His Role

Even well-educated parents (including parents who are lawyers themselves) have reported to the Center that they did not realize that the only role of the child abuse pediatrician they met with at the children's hospital<sup>66</sup> was an investigative role. They also did not realize that the child abuse pediatrician would be reporting his findings to DCFS and law enforcement authorities. This information was not communicated to the parents orally or in writing. It is unclear how many parents would have consented to the interviews had they understood the purpose as potentially adverse to their own family's interests.

When a parent brings her child to an emergency room or clinic for treatment, she meets a number of doctors, nurses, social workers, and receptionists each of whom has questions. Most parents naturally assume that the function of these medical personnel and their questions is to treat the child's injury. Because parents are usually in a heightened state of emotional concern about their children at the time they are first introduced to the child abuse pediatrician, then tend not to inquire too deeply about the purpose of the hospital CPS team members' questions. Parents generally desire to cooperate in getting through whatever processes the hospital has established in order to get the child treated so they can all return home. Prior interactions that parents may have had with medical institutions generally reinforce their pre-disposition to trust the doctors in these hospital settings. Especially in these circumstances of a parent's heightened vulnerability, the child abuse pediatrician has an ethical duty to make specific disclosures about

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<sup>64</sup> To the extent that reliance on parent interviews is the hallmark of the child abuse pediatrician's craft, however, it is remarkable that heavy reliance on double and triple hearsay accounts as to what the parent told police or child protection investigator is broadly allowed as the basis for determining what account the parent gave. In this respect, child abuse pediatricians appear not to be practicing medicine but acting as credibility judges without the benefit of standard rules of evidence that protect individuals from undue reliance on improper, attenuated or unduly prejudicial information. Efforts to insure that parents' statements are video or audiotaped (with informed consent to such procedures) would help to insure that child abuse pediatricians do not rely upon misrepresentations of parents' statements in reaching their conclusion.

<sup>65</sup> Evaluation of Suspected Child Physical Abuse, Kellogg, Nancy D. and Committee on Child Abuse and Neglect, Pediatrics, Vol. 119 No. 6, pp. 1232-1241.

<sup>66</sup> For information about the identification of certain hospitals as "children's hospitals," the reader is referred to the publications of the National Association of Children's Hospitals and Related Institutions, sometimes identified by the acronym NACHRI. Child abuse pediatricians, of which there continue to be a very limited number around the country, are generally associated with children's hospitals and with child protective service (CPS) teams within those hospitals. The children's hospitals themselves are generally located in major cities or in university hospital settings.

his investigative role before he or the staff under his direction begin interviewing the family concerning the child's injury. Without these disclosures, parents report feeling very surprised and deeply betrayed when they learn that this particular doctor works on contract with the child protection agency, and not as part of the treatment team for their injured child. The parents involved in the Illustrative Cases were not generally aware that the information they were providing to the child abuse pediatrician or hospital CPS team would be used against them later to mount a child abuse case, because none of them believed the child abuse-related inquiries applied to them *as suspects* at least until they had answered many questions that they naively assumed were being asked in order to help their child.

A reasonable set of disclosures by a child abuse pediatrician before he begins questioning parents in these situations would include the following points:

1. That the child abuse pediatrician or the hospital CPS team social worker is in an investigative role and is not a member of the child's team of treating doctors,
2. That the child abuse pediatrician's role is to reach a conclusion about whether there has been child abuse or neglect and that the parents are among the persons who are currently suspected of being child abuse perpetrators,
3. If applicable, that the child abuse pediatrician operates under a contract to provide forensic opinions to the state child protection agency and is paid at least in part by the state or by a non-profit child protection organization,<sup>67</sup>
4. That the child abuse pediatrician will communicate her conclusion to the state child protection agency and potentially to police and prosecutors as well and that she may or may not communicate her conclusion to the doctors who are treating the child,
5. That in order to reach a conclusion about whether she thinks there has been child abuse or neglect, the child abuse pediatrician or other staff member of the hospital CPS team has to interview the parents and possibly others and examine the child and review records of the child for which she needs the parent's consent,<sup>68</sup> and
6. *That the parent has a right to refuse the interview and to decline to give consent to the examination and record review and any refusal will not affect the care and treatment the child receives at the hospital.* The child abuse pediatrician can state the consequences of

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<sup>67</sup> Illinois and Kentucky are illustrative. In Illinois, there is state funding through the Multidisciplinary Pediatric Evaluation and Examination Commission agreement. In Kentucky, the Pediatric Forensic Medicine team at the University of Louisville was created with a grant from Kosair Charities in 2007 and has been funded in later years with on-going grants from that same non-profit organization. Both of Kentucky's certified Child Abuse Pediatricians are members of this group.

<sup>68</sup> The medical profession's ethical rules concerning a patient's right to privacy and confidentiality of medical records cannot be pre-empted by permissive regulations of a state administrative agency that provide legal cover for physicians to share private patient information and to disclose medical records. AMA Code of Medical Ethics Opinion 7.025-Records of Physicians: Access by Non-Treating Medical Staff explicitly requires that patients consent to non-treating doctors being given access to their medical records. Therefore, any suggestion that child abuse pediatricians may routinely receive such records of injured children without parental consent, because child protection agency rules purport to permit such disclosures must be rejected.

such refusal in a non-threatening manner—*i.e.* that a full and complete assessment may not be possible without the parent’s participation and consent, but the child abuse pediatrician should not threaten a negative outcome if the parent refuses, nor should the child abuse pediatrician promise any favorable outcome contingent on cooperation with the interview.

The duty to make disclosures of this type is found in AMA Code of Medical Ethics Opinion 10.03--Patient-Physician Relationship in the Context of Work-Related and Independent Medical Examinations.<sup>69</sup> That opinion deals with physicians who are “Industry Employed Physicians (IEPs)” or “Independent Medical Examiners (IME’s).” These are physicians who are employed or contracted by a third party business, employer or insurance company to conduct medical examinations on specific individuals who have been identified for such examination by that third party.

The purpose of these medical examinations is to permit the IEP or IME to report directly to the third party organization by which he is employed or with which he is contracted. Under Opinion 10.03, the IEP or IME is said to have a limited patient-physician relationship with the person being examined, and the IEP or IME is directed to disclose to the person being examined his role and responsibility to the third party before the medical examination occurs. As a practical matter, of course, this prior disclosure creates an opportunity for the person being examined to decline the medical examination and accept whatever consequences may follow. For example, an applicant for life insurance can decline to take the medical examination prescribed by the insurance company and risk the insurance company refusing to issue the policy. A job applicant can decline to take the medical examination prescribed by the prospective employer and risk not being offered the job.

When it is a child who would be the subject of a medical examination by an IEP or IME giving rise to a limited patient-physician relationship, Opinion 10.03 does not explicitly address the question of who should receive the prior disclosures from the IEP or IME. However, it is obvious—owing to a lack of any reasonable alternative—that those prior disclosures under Opinion 10.03 should be made to the parent. This is because it is the parent who has the power to consent as surrogate to the establishment of the patient-physician relationship under Opinion 10.015—The Patient-Physician Relationship and because it is the parent who has the power to provide informed consent to treatment under Opinion 10.016—Pediatric Decision Making.<sup>70</sup>

A child abuse pediatrician, as an IME, should provide the disclosures to parents of injured children as required under Opinion 10.03 before starting any medical examination of the child or interviews with the parent. Those disclosures enable the parent to decide whether to consent on behalf of the child to the limited patient-physician relationship that is described in Opinion 10.03. These disclosures may cause some parents to be guarded in responding to questions posed by the child abuse pediatrician or his staff. Other parents may decline to be

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<sup>69</sup>AMA Code of Medical Ethics Opinion 10.03--Patient-Physician Relationship in the Context of Work-Related and Independent Medical Examinations was issued in December 1999. It was based on a report with that same title to the Council on Ethical and Judicial Affairs of the American Medical Association, which had been adopted in June 1999.

<sup>70</sup> The application of AMA Code of Medical Ethics Opinion 10.015—The Patient-Physician Relationship and AMA Code of Medical Ethics Opinion 10.016—Pediatric Decision Making is discussed more fully in Discussion Section II.

interviewed altogether. Still others may insist upon some safeguards around any interview, such as preparation of transcripts or video recording or the presence of a monitor (or possibly legal counsel) who can make an accurate record of what is actually asked and answered.<sup>71</sup> However, the possibility that a well-informed parent, given the disclosures suggested above might respond in any of these ways cannot be an ethical reason for the child abuse pediatrician's failure to make the disclosures required by Opinion 10.03. On the contrary, it is clear that the reason why the disclosures are prescribed by Opinion 10.03 for IEPs and IMEs is to give the person who is going to be the subject of the medical examination the opportunity to decline. Child abuse pediatricians who do their evaluations at the behest of state child protection agencies and conduct their medical examinations, including interviews with the parents that are so integral to their analysis, *without* making the prior disclosures would appear to be in violation of Opinion 10.03.

### ***VIII. The Child Abuse Pediatrician's Ethical Duty with Respect to Making Determinations of Abuse or Neglect***

AMA Code of Medical Ethics Opinion 9.07-Medical Testimony<sup>72</sup> is unequivocal in articulating the duty of doctors to be honest, objective, independent, and guided by "current scientific thought" in providing their opinions on medical matters to the legal system. Though unstated, it is also clearly implicit that in formulating and providing opinions to the legal system, doctors have a duty to be thorough. There have been no revisions of Opinion 9.07 or the supporting memorandum of the Council on Ethical and Judicial Affairs since the establishment of the child abuse pediatrics subspecialty. So what does Opinion 9.07 and the CEJA supporting memorandum require of a child abuse pediatrician in formulating opinions on cases like the Illustrative Cases presented in this Paper? In our view, a child abuse pediatrician should consider the following five inter-related areas with respect to each case referred to him or her in order to comply with the ethical standards as expressed in Opinion 9.07 and other opinions.

1. Scope and Limits of Expertise. The child abuse pediatrician should have a firm understanding of the scope and limits of his or her own expertise in considering a particular case of possible child abuse and in formulating an opinion.
2. Consultation. In many of the cases of possible child abuse that are referred for evaluation, the child abuse pediatrician should recognize the need for consultation with other medical specialists in formulating an opinion if their own child protective services teams do not include experts in the medical areas the child's injury involves

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<sup>71</sup> The value of documenting *exactly* what the parent says about how the injury occurred, including using quotes whenever possible, has been articulated by at least one child abuse pediatrician and the Committee on Child Abuse and Neglect. Evaluation of Suspected Child Physical Abuse, Kellogg, Nancy D. and Committee on Child Abuse and Neglect, Pediatrics, Vol. 119 No. 6, pp. 1232-1241. If selected quotes from what the parent says are deemed important for an investigating child abuse pediatrician, then a more comprehensive transcript or recording of the entire interview would seem to be a safeguard to which the parent would be reasonably entitled and as to which the medical investigation team would have no logical objection.

<sup>72</sup> AMA Code of Medical Ethics Opinion 9.07—Medical Testimony was issued December 2004 based on the Report to the Council on Ethical and Judicial Affairs entitled Medical Testimony which was adopted in June 2004. While Opinion 9.07 speaks in terms of "testimony," we believe that it is fairly applicable to the entire investigative process of Child Abuse Pediatricians in cases of possible child abuse in that the process ultimately culminates in testimony in a certain percentage of those cases.

3. The Public Health Role. The child abuse pediatrician should recognize that he is responsible for pursuing public health solutions to the problem of child abuse as well as taking the lead in medical investigations and serving as liaison to the legal system in some cases of possible child abuse. However, this role can be compromised if the child abuse pediatrician is seen as too closely allied with the prosecutors, police, or state agencies seeking to take children away from their parents. This public health role can also be compromised if the child abuse pediatrician disparages the role of other physicians in preventing, identifying and treating child abuse.
4. Objectivity, Independence, Openness to the Possibility of a Negative Opinion and Non-Advocacy. The child abuse pediatrician must be objective and independent in her evaluation of any particular case of possible child abuse and disinterested in what the conclusion might be. She must be guided by “current scientific thought” and open to the possibility of opining that there was no child abuse in any particular case that is referred to her, and she must be dedicated to exploring that possibility thoroughly. In other words, quickly reaching a conclusion that a child has been abused based on judgments of the credibility of the parent (including the parents’ lack of an explanation for an injury the child abuse pediatrician thinks the parent should have observed or been aware of more quickly) is ethically unsatisfactory for any doctor, but especially for the child abuse pediatrician. The child abuse pediatrician might generally be an “advocate” in the public health arena for developing awareness and education about child abuse and programs to combat child abuse. However, she should not be an “advocate” for a particular injured child in the sense that she is pre-disposed to reaching a conclusion that the child’s injury is the result of abuse rather than accident or disease. Nor should the child abuse pediatrician ever reach a decision that a child was abused based on statistical probabilities that injuries of the sort she is observing are more commonly believed to be due to abuse than to other causes. Limiting consideration of alternative causes of children’s injuries to such conditions as osteogenesis imperfecta does not comport with the open mindedness a child abuse pediatrician should maintain throughout the investigation and assessment of a case.
5. Case Load Capacity. The child abuse pediatrician should have a realistic appreciation of how much of his own time will be required to make an objective, thorough, completely independent, and disinterested evaluation of any particular case of possible child abuse. As a consequence, the child abuse pediatrician should recognize that there are limits on the number of such referrals that he can fairly take on at any given time, if his objective is to complete investigations and reports in a timely manner and thereby lift the cloud of suspicion for child abuse as promptly as possible from innocent parents and families.

We will elaborate on each of these areas, in order below.

### 1. Scope and Limits of Expertise

Each child abuse pediatrician has an ethical duty under Opinion 9.07 to assess the limits of his own expertise as it relates to the analysis required in a particular case of possible child abuse.

Opinion 9.07 recites in part:

“In various legal and administrative proceedings, medical evidence is critical. As citizens and as professionals with specialized knowledge and experience, physicians have an obligation to assist in the administration of justice.

When physicians choose to provide expert testimony, they should have recent substantive experience or knowledge in the area in which they testify....All physicians must accurately represent their qualifications...”<sup>73</sup>

Opinion 9.07 provides no specific guidance as to the scope of expertise of any particular medical specialty. However, the dual ethical directives that doctors have “recent substantive experience or knowledge in the area in which they testify” and that they “accurately represent their qualifications” would certainly appear to preclude a child abuse pediatrician from representing that his knowledge of the causes of fractures or head injuries, for example, is superior to that of orthopedists and neurosurgeons. Yet, in the rush to establish their expertise, child abuse pediatricians in the MPEEC program have trained DCFS investigators to consider their opinions as to bone fractures and head injuries to be of greater validity than those of subspecialists. Given the inherently judgment-laden nature of any child abuse diagnosis, and the fact that child abuse determinations are not an exact science, this effort to set themselves up as superior in knowledge about injuries that might be due to abuse can be very misleading and confusing to the public and to other consumers of child abuse medical opinions.

The official materials of the American Board of Pediatrics and the literature and commentary of the child abuse pediatricians themselves are all somewhat vague as to the boundaries of the new subspecialty’s expertise. One mass media organization recently characterized child abuse pediatricians as doctors who are “certified as experts in determining whether a broken bone or a bruise is accidental or intentional.”<sup>74</sup> Unfortunately, this overly broad pitch for the expertise of the child abuse pediatrician undoubtedly has left the impression with the reading public that child abuse pediatricians can bring to bear all aspects of medical expertise required to reach a conclusion on cases of possible child abuse. It also certainly has left the erroneous impression that child abuse pediatricians have omniscience on the subject of child abuse that pre-empts any independent role for other medical specialists or child protection professionals. Because of administrative convenience, such exaggerated claims of superior expertise by child abuse pediatricians in determining whether an injury was accidental or inflicted continues to gain acceptance among state child protection agencies who are acting to deprive parents of custody of their children or who are otherwise grossly interfering with family life.<sup>75</sup> Moreover, judges who ultimately resolve these matters can be persuaded to see beyond

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<sup>73</sup> AMA Code of Medical Ethics Opinion 9.07-Medical Testimony.

<sup>74</sup> Child Abuse Pediatricians Recommend Basic Parenting Classes to Reduce Maltreatment and Neglect; Rochman, Bonnie; *Time Magazine* (electronic edition); April 4, 2012.

<sup>75</sup> It is sometimes confusing as to what exactly the child abuse pediatrician is claiming to have an expertise in diagnosing, because in numerous juvenile court cases and DCFS expungement appeals the Family Defense Center has handed, child abuse pediatricians have disavowed claims that, by giving an opinion that a child is abused, they

the superficial conclusion that the child must have been abused because the child abuse pediatrician says so, but this effort may require both specialized legal representation and the services of medical specialists that are simply not available to all innocent parents.

The child abuse pediatrics literature tends to break down the expertise of the child abuse pediatrician into four areas of knowledge and professional judgment. These are:

- a. expertise in the sociological and demographic aspects and data of child abuse,<sup>76</sup>
- b. expertise in the available data regarding correlation between particular types of injury and child abuse,
- c. expertise in judging the plausibility of a parent's explanation of an injured child's condition,<sup>77</sup> and
- d. expertise in functioning as the liaison to the civil authorities and legal system.<sup>78</sup>

None of these four areas would amount to a claim of such deep expertise in a medical specialty area as to obviate the need in particular cases for specialists in that area, such as orthopedic surgeons, neurosurgeons, and radiologists. Indeed, because child abuse cuts across so many areas of medicine and also requires the liaison function to be fulfilled, it seems doubtful that any child abuse pediatrician could be truly "expert" in every area of medicine involved in child abuse cases.

Consistent with the identified areas of expertise, child abuse pediatricians are expected to be knowledgeable in all four areas (a)-(d) above. The American Board of Pediatrics' content outline for the certification examination in child abuse pediatrics is consistent with these subject areas. That content outline, however, also recognizes the continued role of specialists such as neurosurgeons, radiologists, and orthopedists in the evaluation of cases of possible child abuse. Certainly, there is nothing in the content outline to suggest that the expertise of child abuse

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are thereby giving an opinion that some identified person *intended* to cause harm to the child. Several child abuse pediatricians have clearly limited their opinions to stating that the child was "abused" but they have no opinion as to what any person who "abused" the child may have intended when the injury occurred. Yet to call an injury non-accidental requires that *some* level of what lawyers would call "mens rea" (state of mind) or intent was present in an agent who caused the injury. To a lawyer, the words used by child abuse pediatricians in describing an action as "abuse" can seem to be illogical and contrary to the legal definition of the question at issue. Thus, in several Family Defense Center cases, *any* deliberate action of a parent, whether or not with intent to harm, has been labeled by child abuse pediatricians as an "inflicted" injury. An innocent grabbing of a child or an action by an unknown person is often labeled incorrectly as an "inflicted" injury and synonymous with "non-accidental trauma" and synonymous with "abuse" by child abuse pediatricians.

<sup>76</sup> The Pediatrician's Role in Child Maltreatment Prevention; Emalee G. Flaherty, John Stirling Jr., The Committee on Child Abuse and Neglect of the American Academy of Pediatrics; *Pediatrics* Vol. 126 No. 4, October 2010, pp. 833-841.

<sup>77</sup> Translating Child Abuse Research Into Action; Flaherty, Emalee G. and Sege, Robert D.; *Pediatrics*, Vol. 122 No. 1, September 1, 2008, pp. 51-58. Evaluation of Suspected Child Physical Abuse; Kellogg, Nancy D. and the Committee on Child Abuse and Neglect, *Pediatrics*, Vol 119 No. 6, June 1, 2007, pp. 1232-1241. See also: Children's Hospitals at the Frontlines Confronting Child Abuse and Neglect: Mandated Medical Expert Review for All Chicago Children, a report of the National Association of Children's Hospitals and Related Institutions issued in March 2004.

<sup>78</sup> Child abuse requires specialized treatment, reporting; Robert W. Block; *American Medical News Ethics Forum*, posted June 28, 2010.

pediatricians is so deep in any medical specialty as to pre-empt the role that such a specialist might play in a particular child abuse investigation.<sup>79</sup> Yet, current practice is that child abuse pediatricians and their staffs routinely advise investigators for the DCFS in Illinois that they are the doctors to whom the investigators should listen and whose opinions have the most weight, even in the face of administrative rules and regulations that call for a more balanced consideration by child protection investigators of all of the specialized medical opinion.<sup>80</sup>

## 2. Consultation

Since child abuse pediatricians cannot all have the same level of expertise in specialized areas of medicine as doctors who are certified in those areas, there necessarily are some cases of possible child abuse in which consultation will be required to ensure that an opinion reflects “current scientific thought.”<sup>81</sup> The concept of consultation has its own foundation in the medical profession’s ethics pronouncements, specifically in AMA Code of Medical Ethics Opinion 8.04 – Consultation.<sup>82</sup> In the current child abuse investigation system, we believe that it is ethically required of the child abuse pediatrician to consider in every case referred to him whether he should consult with one or more medical specialists.

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<sup>79</sup> The content outline of the American Board of Pediatrics for the certification examination in Child Abuse Pediatrics is available to the public. Strong inferences cannot be drawn from the outline, since it simply enumerates topical areas subject to examination, not the content of the knowledge. However, the various items in the outline are traceable to a degree to the four areas of expertise mentioned in the text as being claimed in child abuse pediatrics literature. The outline as revised in 2010 had a 5% allocation for “epidemiology and social/cultural context of child abuse,” a 7% allocation for “core knowledge in scholarly activities,” and a 6% allocation for “societal response.” It also had a 10% allocation for “abusive head trauma, a 10% allocation for “cutaneous,” an 8% allocation for “musculoskeletal injuries,” a 2% allocation for “visceral injury,” a 2% allocation for “ear, nose, throat, neck, mouth and face injuries,” a 2% allocation for ophthalmologic findings and eye injuries” and four additional categories that receive in aggregate a 25% allocation and that appear to be specifically related to matters of sexual abuse.

<sup>80</sup> For example, DCFS Procedures at Procedure 300-Appendix B (2) (head injuries) and 9 (bone fractures) call for investigators to obtain an opinion from the doctor with the most specialization in the affected area and lists, as to bone fractures, radiologists and orthopedists. Despite this specificity in the rule in Richard’s case for example, DCFS investigative staff consistently testified that they relied on the opinion of a non-board certified child abuse fellow and did not consider it necessary to obtain the opinions of any of the treating orthopedists. Moreover, the child abuse fellow herself did not obtain or consider the opinions of the treating radiologists and orthopedist. She nevertheless represented herself as an expert in the “mechanism” of fractures. When asked about how she knew that Richard would cry inconsolably, she cited her extensive experience being around children and no medical studies. As it turned out, Richard had hypotonia, a condition consistent with a high tolerance to pain, which was never considered as a possible explanation for why his fracture had not been noticed earlier. The treating orthopedists did not believe the injuries were best explained by child abuse, because the fracture by itself did not provide enough information as to the circumstances in which the break occurred. They were not consulted, however, prior to the issuance of either the child abuse pediatrician report or the indicated finding of child abuse against Richard’s parents. See Richard’s Story in the Illustrative Cases.

<sup>81</sup> The requirement that physicians’ opinions reflect “current scientific thought” is stated explicitly in AMA Code of Medical Ethics Opinion 9.07-Medical Testimony. Some of the information the child abuse pediatric curriculum may lag behind advances in specialty fields. See *In re Yohan K.*, 1-12-3472 (corrected opinion June 20, 2013), n. 4 *supra*, for examples of failure to consider potentially relevant tests and medical conditions that child abuse pediatrician ignored because of lack of familiarity with research.

<sup>82</sup> AMA Code of Medical Ethics Opinion 8.04--Consultation was issued prior to 1977 and updated in June 1992 and June 1996. Under the opinion, there is a duty of consultation that would apply in the context of a patient-physician relationship. There is no reason to believe that it would not similarly apply in the case of limited patient-physician relationship between an injured child and a Child Abuse Pediatrician, if the Child Abuse Pediatrician desires to reach a conclusion on whether child abuse has occurred and recognizes the limits on his own expertise.

The importance of the child abuse pediatrician seeking consultation from other medical specialists is at least implied in the content outline of the certification examination issued by the American Board of Pediatrics<sup>83</sup> and is endorsed in the child abuse pediatrics literature. In this regard, a 2007 article by Drs. Glick and Staley of the University of Chicago emphasizes the need for consensus among the doctors on the child protection team in reaching a conclusion about whether the child's injury was inflicted or accidental.<sup>84</sup> In the case of a brain injury, which is the focus of the article, that consensus would include the neurosurgeon. Whether the child's injury was inflicted or accidental remains, in Dr. Glick's view, most definitely a conclusion reached by the child protection team, but not the unilateral conclusion of the child abuse pediatrician as leader of the team.

This idea is expressed quite clearly in the Abstract of the article:

The neurosurgeon is a key member of the child protection team and relies on the team to obtain necessary historical information to address consistency of the mechanism with the sustained injuries and has an integral role in determining the team's final opinion.

It is elaborated upon in the later description of the model for a collaborative and medically directed child protection team at Dr. Glick's hospital

The CPS team's child abuse pediatrician focuses on collating various data sets for the diagnosis of child abuse including a review of all relevant imaging and surgical findings with the appropriate subspecialists in order to understand the contribution of each to the diagnostic process. A review of the findings is discussed amongst all subspecialists and consensus is the goal. In our model it is not within the purview of the child abuse pediatricians to single-handedly determine if a neurosurgical injury is not consistent with the history, nor does the neurosurgeon make the definitive diagnosis of inflicted head trauma.

After consensus over the medical findings is achieved, the CPS child abuse pediatrician will draft a comprehensive medical consultation that summarizes the findings.

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<sup>83</sup> The American Board of Pediatrics; Content Outline for the Certification Examination in Child Abuse Pediatrics; Section XIX G.

<sup>84</sup> Inflicted Traumatic Brain Injury: Advances in Evaluation and Collaborative Diagnosis; Jill C. Glick, Kelley Staley; *Pediatric Neurosurgery*, 2007, 43:436-441. Dr. Glick is a certified child abuse pediatrician associated with Child Protective Services, Department of Pediatrics at The University of Chicago. This article is an "invited comment" on two other articles that were published in the same volume of *Pediatric Neurosurgery*. It is noted that, while Dr. Glick's 2007 article describes a child protective services team on which the neurosurgeon is a member, another doctor writing about this system in 2010 states that neurosurgeons, orthopedists, and urologists are rarely full-time members of the teams, but instead that the child protective services team will call upon the specialist as a consultant. At other Illinois hospitals with which the authors are familiar, these specialists are rarely consulted during the course of the preparation of MPEEC and other child abuse evaluation reports and no one but police and child protection investigators are considered members of the "child protection team." Doctors at CH #1 routinely have answered deposition questions about "consultation" by pointing to reports they have read in the child's medical charge and rarely mention in-person discussion of a questionable case as to abusive vs. accidental cause of a child's injuries. Indeed, in Richard's case and in several earlier and current cases the Center has handled, considerable disagreement amongst doctors at CH #1 has come to light in Center cases as to the conclusions the child abuse pediatricians have reached but that disagreement is not reflected in CH #1 MPEEC report.

The literature of certain other groups of medical specialists, namely orthopedic surgeons and radiologists, since the formal establishment of child abuse pediatrics is also very instructive on the ethical obligation of child abuse pediatricians to seek consultation. As described below, it demonstrates the continued interest of the orthopedic surgeons and radiologists, even after the emergence of child abuse pediatrics, in the development of what could be characterized as “current scientific thought” about children’s injuries that may or may not be the result of abuse.

At intervals during 2010, within months after the announcement that the first group of child abuse pediatricians had been certified nationwide, six different articles were published online in *Clinical Orthopedics and Related Research*<sup>85</sup> related to the problem of differentiating accidental or disease based orthopedic injuries in children from orthopedic injuries that are the result of child abuse. The authors of these articles were teams of eminent orthopedic surgeons and radiologists from children’s hospitals around the country.<sup>86</sup> These six articles illustrate how very intricate and detailed the “current scientific thought” can be behind the question of whether a particular child’s orthopedic injury is the result of accident, disease, or abuse. In January 2011, these six articles, along with other historical material, and an editorial comment were presented together as a Symposium in *Clinical Orthopedics and Related Research* under the title Nonaccidental Trauma in Children. While not saying a word about the newly established subspecialty of child abuse pediatrics, the editorial comment does cogently describe the continued involvement of orthopedic surgeons in evaluating “this condition” (meaning possible child abuse).

Heightened awareness of this condition provides confounding patterns including an increasing group of parents who find themselves suspected of child abuse with subsequent careful analysis that provides a ready explanation for their child’s injury. Such circumstances produce extreme frustration, both to the conscientious reporting physician as well as to the distressed family. The possibility of conditions such as occult osteogenesis imperfect, “temporary brittle bone disease” (as described by Patterson) as well as rare orthopedic disorders such as congenital pseudarthrosis of the tibia add to this complexity. The orthopedic surgeon should not underestimate the value of his experience and wisdom in providing wise interpretive counsel to the child abuse evaluation team. The wisdom of Solomon is required to make the right call in every patient. It is hoped that this symposium will help in these judgments.<sup>87</sup>

Each of the six articles in the Symposium demonstrates the long evolution of the body of scientific thought around orthopedic injuries in cases of possible child abuse by including a systematic review of the existing medical literature, some of the reviews dating back to the earliest and best known scholarship in the field from the mid-1940s.<sup>88</sup> These literature reviews

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<sup>85</sup> This is a peer-reviewed publication of the Association of Bone and Joint Surgeons.

<sup>86</sup> There are seventeen different authors listed in various combinations on the six articles. All seventeen of the authors are from children’s hospitals in major cities of the United States or Canada or from children’s hospitals that are university affiliated. The affiliations noted for fifteen of the seventeen authors suggest that they are orthopedic surgeons. The other two are radiologists.

<sup>87</sup> Nonaccidental Trauma in Children: Editorial Comment; Harish S. Hosalkar, Dennis R. Wenger; *Clinical Orthopaedics and Related Research*, January 2011, pp. 751-752.

<sup>88</sup> Multiple Fractures in the Long Bones of Infants Suffering from Chronic Subdural Hematoma; Caffey, John; *AJR Am J Roentgenol*. 1946; 56:163-173. This is a classic article by Dr. Caffey about his observation of femur fractures

are annotated into the reference notes for each of the articles. As a result, taken together, the six articles provide a comprehensive view of evolving scientific thought, over the 65 year period prior to the establishment of the sub-specialty of child abuse pediatrics, as to how doctors might determine whether a child with orthopedic injuries has been the victim of abuse.

Individually, each article addresses an aspect of the larger problem of differentiating between orthopedic injuries that result from child abuse and those that do not. The range of subjects discussed and the strategies that the various teams of authors are exploring for dealing with the child abuse investigation problem can be seen in the titles of the articles enumerated below and the brief synopsis of each.

- a. Femur Fractures in the Pediatric Population: Abuse or Accidental Trauma?<sup>89</sup> Based on a retrospective review of femur fracture cases reported in the literature, this article proposes a predictive model for probability of child abuse based on three risk factors.
- b. The Radiographic Approach to Child Abuse.<sup>90</sup> In large part, this article is an extension of the published work of Dr. P. Kleinman fourteen years earlier in classifying fractures as being of high, moderate or low specificity for child abuse. It also includes a discussion of diseases that cause the bones to be more prone to fracture and that therefore can be “mimics of abuse.”
- c. The Epidemiology of Nonaccidental Trauma in Children.<sup>91</sup> This article concludes that, because of the lack of true epidemiological studies, there is not much basis for confidence that we have a very accurate idea about the incidence of fracture resulting from non-accidental trauma.
- d. Unexplained Fractures: Child Abuse or Bone Disease? A Systematic Review.<sup>92</sup> This article discusses in some detail the possibility that bone fractures can result from disease as well as trauma—either accidental or non-accidental. While several diseases are mentioned, the focus of the discussion is about potential confusion in diagnosis between child abuse and osteogenesis imperfecta.
- e. Child Abuse: The Role of the Orthopaedic Surgeon in Nonaccidental Trauma.<sup>93</sup> This is an overview summary article discussing several ideas that are dealt with in greater depth in the other articles. These include incidence of child abuse, orthopedic manifestations of

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in children with subdural hematoma. Among the very well-known and very early pieces that are also cited is The Battered Child Syndrome, Kempe, CH, *JAMA* 1962, 181: 17-24.

<sup>89</sup> Baldwin K, Pandya NK, Wolfgruber H, Drummond DS, Hosalkar HS. Femur fractures in the pediatric population: abuse or accidental trauma. *Clin Orthop Relat Res.* 2011; 469(3): 798-804. doi: 10.1007/s11999-010-1339-z.

<sup>90</sup> Dwek JR. The radiographic approach to child abuse. *Clin Orthop Relat Res.* 2011; 469(3): 776-789. doi: 10.1007/s11999-010-1414-5.

<sup>91</sup> Mulpuri K, Slobogean BL, Tredwell SJ. The epidemiology of nonaccidental trauma in children. *Clin Orthop Relat Res.* 2011; 469(3): 759-767. doi: 10.1007/s11999-010-1565-4.

<sup>92</sup> Pandya NR, Baldwin K, Kamath AF, Wenger DR, Hosalkar HS. Unexplained fractures: child abuse or bone disease? A systematic review. *Clin. Orthop Relat Res.* 2011; 469(3): 805-812. doi: 10.1007/s11999-010-1578-z.

<sup>93</sup> Sink EL, Hyman JE, Matheny T, Georgopoulos G, Kleinman P. Child abuse: the role of the orthopaedic surgeon in nonaccidental trauma. *Clin Orthop Relat Res.* 2011; 469(3): 790-797. doi: 10.1007/s11999-010-1610-3.

child abuse, orthopedic management of the patient, and a recommended approach for the orthopedic surgeon to deal with the legal aspects.

- f. Child Abuse and the Legal System.<sup>94</sup> The author of this article acknowledges that his experience with these matters has been in the role of a witness for family members, particularly parents. The article points out weaknesses in the child abuse literature, explicitly questions whether a child abuse pediatrician knows more about what produces childhood fractures than an orthopedic surgeon, and discusses the dangers to which children can be exposed while in state custody.

None of the articles individually or the package of Symposium articles taken together arrives at a statistically compelling correlation between child abuse and some tightly defined set of medical observations. Instead, these articles demonstrate that the medical investigation of child abuse continues to involve diseases that are “mimics” of child abuse and injuries that have varying degrees of specificity to child abuse. While no simple answers emerge from the six Symposium articles that particular injuries are always indicative of child abuse, there are a number of themes that do recur throughout the articles. Four of these themes are described below:

- i. The Inherent Ambiguity as to the Cause of Orthopedic Injury

In most cases of bone fracture in a child, unless there is a candid acknowledgement of abuse, there are going to be alternative possible explanations that have to be considered. One of these is going to be “non-accidental trauma” (an alternative commonly used expression for child abuse in some of these articles and in the title to the Symposium). The others include accidental trauma<sup>95</sup> (impact) or disease that makes bone fractures possible without any noticeable trauma (impact). The point of these articles and the Symposium in which they appeared is to update the learning about how orthopedists and radiologists can in some cases distinguish injuries caused by child abuse from those caused by accident or disease and in other cases how they can assess the probability that a particular injury was due to child abuse.<sup>96</sup>

- ii. The Particular Expertise of Orthopedic Surgeons

Some of the articles say explicitly, and the others imply, that orthopedic surgeons have particular expertise in determining whether bone fractures are or are not the result of child abuse.<sup>97</sup> There are situations in which an orthopedic surgeon would be critical to that

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<sup>94</sup> Sullivan CM. Child abuse and the legal system. Clin Orthop Relat Res. 2011; 469(3): 768-775. doi: 10.1007/s11999-010-1564-5.

<sup>95</sup> The frequently used word “trauma” itself causes confusion for child protection investigators, lawyers and judges who use the word in a different sense than doctors typically mean it to convey. Doctors may say that they believe an injury was caused by “trauma” when then mean any type of impact. Lawyers and child protection investigators may read the term to mean a more pejorative connotation than doctors intend.

<sup>96</sup> The objectives of the Symposium are stated in Hosalkar HS, Wenger DR. Nonaccidental trauma in children--editorial comment. Clin Orthop Relat Res. 2011; 469(3): 751-752. doi: 10.1007/s11999-010-1680-2.

<sup>97</sup> Sullivan CM. Child abuse and the legal system. Clin Orthop Relat Res. 2011; 469(3): 768-775. doi: 10.1007/s11999-010-1564-5.

determination<sup>98</sup> and in which the orthopedic surgeon would have the unique training and experience necessary in determining the “mechanism” of the injury.<sup>99</sup>

### iii. Working with CPS and “Multi-disciplinary teams”

Some of the articles acknowledge the value of orthopedic surgeons working with child protective services and with “multi-disciplinary teams” of professionals in determining whether children presenting with bone fractures have been the victims of child abuse or neglect.<sup>100</sup> However, there is no general endorsement of the quality and efficacy of the existing “multi-disciplinary teams.” In fact, Dr. Christopher Sullivan, author of one of the invited articles in the Symposium, criticizes the structure of the “multi-disciplinary” team as currently constituted, pointing out that medical specialists are not regular members of the “multi-disciplinary teams.”<sup>101</sup>

### iv. Balancing Risks

Some of the articles recognize that there are serious risks resulting from errors *in either direction* in determining whether a child’s orthopedic injury is caused by abuse or accident or disease.<sup>102</sup> There is a high morbidity and mortality risk to the injured child, if he has been the victim of abuse, but the conclusion is erroneously reached that he was not abused. On the other hand, these articles also acknowledge that there is a high risk to the injured child’s parents and family and to the child’s parental and family relationships, if an erroneous diagnosis of child abuse is made (i.e. a false positive) by the orthopedic surgeon or by the child abuse doctor.

We have included this somewhat detailed discussion of the Symposium from *Clinical Orthopedic and Related Research*, because of what it suggests about how doctors outside of the child abuse pediatrics subspecialty perceive the need for child abuse pediatricians to obtain consultation. The timing of the publication of the Symposium immediately after the certification of the first group of child abuse pediatricians may not have been entirely coincidental. We believe the Symposium represents a very strong affirmative statement by eminent orthopedic surgeons and radiologists that they should continue to have a vital and undiminished role in the determination of whether particular orthopedic injuries in children are the result of abuse, even though there is now a group of pediatricians certified as child abuse pediatricians.

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<sup>98</sup> Sink EL, Hyman JE, Matheny T, Georgopoulos G, Kleinman P. Child abuse: the role of the orthopaedic surgeon in nonaccidental trauma. Clin Orthop Relat Res. 2011; 469(3): 790-797. doi: 10.1007/s11999-010-1610-3.

<sup>99</sup> Sullivan CM. Child abuse and the legal system. Clin Orthop Relat Res. 2011; 469(3): 768-775. doi: 10.1007/s11999-010-1564-5.

<sup>100</sup> Sink EL, Hyman JE, Matheny T, Georgopoulos G, Kleinman P. Child abuse: the role of the orthopaedic surgeon in nonaccidental trauma. Clin Orthop Relat Res. 2011; 469(3): 790-797. doi: 10.1007/s11999-010-1610-3.

Hosalkar HS, Wenger DR. Nonaccidental trauma in children--editorial comment. Clin Orthop Relat Res. 2011; 469(3): 751-752. doi: 10.1007/s11999-010-1680-2; Sullivan CM. Child abuse and the legal system. Clin Orthop Relat Res. 2011; 469(3): 768-775. doi: 10.1007/s11999-010-1564-5 (though Sullivan points out that medical specialists are not regular members of the “multi-disciplinary teams.”)

<sup>101</sup> Sullivan CM. Child abuse and the legal system. Clin Orthop Relat Res. 2011; 469(3): 768-775. doi: 10.1007/s11999-010-1564-5. Coincidentally, Dr. Sullivan is the Chair of Pediatric Orthopedics at the University of Chicago Comer Children’s Hospital, the same institution at which Dr. Jill Glick is the lead child abuse pediatrician.

<sup>102</sup> Pandya NR, Baldwin K, Kamath AF, Wenger DR, Hosalkar HS. Unexplained fractures: child abuse or bone disease? A systematic review. Clin Orthop Relat Res. 2011; 469(3): 805-812. doi: 10.1007/s11999-010-1578-z. Hosalkar HS, Wenger DR. Nonaccidental trauma in children--editorial comment. Clin Orthop Relat Res. 2011; 469(3): 751-752. doi: 10.1007/s11999-010-1680-2; Sullivan CM. Child abuse and the legal system. Clin Orthop Relat Res. 2011; 469(3): 768-775. doi: 10.1007/s11999-010-1564-5.

We believe that in order to provide an opinion in a case of possible child abuse that is guided by “current scientific thought” as required by AMA Code of Medical Ethics Opinion 9.07 – Medical Testimony, the child abuse pediatrician would necessarily have to consider whether one or more medical specialists should be consulted and if so, must consider seriously the opinions and conclusions of the consultants. Moreover, once such a medical specialist is consulted, we believe as an ethical matter that the child abuse pediatrician must give due consideration to the opinion of that specialist on the question of whether a child’s injury is due to accident, disease, or abuse. That child abuse pediatricians will seek such consultation appears to be contemplated by the American Board of Pediatrics, endorsed in the child abuse pediatrics literature, and strongly encouraged by the literature of some of those other medical specialists. Yet, in practice, in most of the cases that are the subject of this Paper, child abuse pediatricians have been very reluctant to consult with other medical specialists and did so only minimally. This leaves the family with the expense of seeking out the necessary opinions of specialists after the child abuse pediatrician has mislabeled the injury as being due to child abuse, sometimes because of a mistake as basic as the misreading of x-rays or other imaging tests (*see, e.g., Justin’s Story*). By failing to consult with specialists to insure a higher degree of accuracy, many erroneous conclusions have been reached that the parents involved had been abusive to their children. Those erroneous conclusions of abuse have in turn caused significant damage to the children’s parental and family relationships.

### 3. The Public Health Role

Child abuse pediatrics is a subspecialty that was established to pursue public health solutions as well as to provide doctors who can take a leading role as medical investigators and liaisons to the legal system in cases of possible child abuse. The natural orientation of child abuse pediatrics to public health solutions is reflected in the fact that a significant number of the doctors who have been certified as child abuse pediatricians around the country also have formal training in the public health area, as evidenced by degrees such as a masters of public health (MPH).

AMA Code of Medical Ethics Opinion 2.02 – Physicians’ Obligations in Preventing, Identifying, and Treating Violence and Abuse addresses violence and abuse as a public health problem, in addition to recognizing that it is an element of the condition that physicians encounter in treating specific patients.<sup>103</sup> The public health solutions discussed in Opinion 2.02 include measures aimed at establishing prevention programs, promoting awareness of and education about the problem of violence and abuse among the public and within the medical profession, and fostering community outreach.<sup>104</sup>

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<sup>103</sup> AMA Code of Medical Ethics Opinion 2.02---Physicians’ Obligations in Preventing, identifying, and Treating Violence and Abuse was issued in June 2008 based on a report of the Council on Ethical and Judicial Affairs entitled Physicians’ Obligations in Preventing, identifying, and Treating Violence and Abuse which was adopted in November 2007.

<sup>104</sup> See specifically subsections (2) (b), (c) and (d) of AMA Code of Medical Ethics Opinion 2.02 – Physicians’ Obligations in Preventing, Identifying, and Treating Violence and Abuse.

The medical literature over the last 50 years has also consistently described the child abuse issue in public health terms.<sup>105</sup> Therefore, it is not surprising that when literature began to emerge about child abuse pediatrics, a major aspect of the role that was described for the doctors certified to this new sub-specialty concerned classic public health objectives – prevention, public education and awareness, and medical profession education and awareness. This was in keeping with the fact, also noted in the literature, that there are very few child abuse pediatricians in relation to the number of alleged child abuse victims around the country.<sup>106</sup>

The expectation that the practice of child abuse pediatrics will be extensively engaged in public health solutions, as well as medical investigations and liaison to the legal system, is also very clear in the official description of the child abuse pediatrician's functions and activities issued by the American Board of Pediatrics which describes these doctors duties as including serving as a "resource to children, families and communities"; "consulting with community agencies on child safety;" and "directing child abuse and neglect prevention programs".<sup>107</sup>

The Illustrative Cases discussed in this Paper involve child abuse pediatricians operating in their role as lead medical investigators and liaisons to the legal system. We have also presented a brief discussion about the child abuse pediatricians' public health role without offering any comment about their performance in that role. The reason for this discussion is that the public health function of child abuse pediatricians is an important part of the context in which the miscarriages of justice that are the subject of this Paper are occurring. First, since the public health function is often couched in terms of advocacy, we suspect that some child abuse pediatricians may perceive themselves mistakenly as advocates for children, even as they are performing their lead medical investigator and legal liaison roles. Second, the public health leadership role of child abuse pediatricians does provide these physicians with the appearance of added authority and eminence and makes their determinations seem even more unassailable. The unfortunate result of this is that other doctors and other medical professionals caring for children are that much less likely to look for and challenge mistakes that the child abuse pediatricians make in their role as lead medical evaluators of child abuse allegations. Third, to the extent child abuse pediatricians are seen as being closely allied with police and prosecutors in efforts to separate children from parents who are ultimately exonerated of abuse allegations, this may diminish the ability of child abuse pediatricians to perform their public health role by reaching into communities most severely affected to gain the trust of families and community organizations.

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<sup>105</sup> Child Abuse Pediatrics: New Specialty, Renewed Mission; Angelo P. Giardino, Nancy Hanson, Karen Seaver Hill, John M. Leventhal; *Pediatrics*, 2011. Evaluation of Suspected Child Physical Abuse; Kellogg, Nancy D. and the Committee on Child Abuse and Neglect; *Pediatrics* Vol. 119 No. 6, June 2007, pp. 1232-1241. A Better Start: Child Maltreatment Prevention as a Public Health Priority; Francie Zimmerman, MSW; James A. Mercy, PhD; *Zero to Three*, May 2010; Child Maltreatment 2011; U.S. Department of Health & Human Services, Administration for Children, Youth and Families, Children's Bureau (22nd Annual Report); The Battered-Child Syndrome; Kempe CH, Silverman FN, Steele BF, Droegemueller, W, Silver HK.. *JAMA*. 1962; 181:17-24.

<sup>106</sup> Child Abuse Pediatrics: New Specialty, Renewed Mission; Angelo P. Giardino, Nancy Hanson, Karen Seaver Hill, John M. Leventhal; *Pediatrics*, 2011.

<sup>107</sup> American Board of Medical Specialties website. <http://www.certificationmatters.org/abms-member-boards/pediatrics.aspx>

#### 4. Objectivity, Independence, Openness to the Possibility of a Negative Opinion and Non-Advocacy

The legal system often has to depend on doctors to provide expert input on factual issues that are elements of the determination of whether a particular child has been the victim of abuse or neglect as defined in the law. The medical profession has formally decided that the preferred approach to delivering an opinion on these issues to the legal system is going to be through child abuse pediatricians—hopefully after all necessary and appropriate consultations with other medical specialists. Having assigned this role to the child abuse pediatricians, it would have been preferable for the medical profession to avoid referring to these doctors as “advocates” or “advocates for children.” In delivering testimony to the legal system on factual issues related to the legal determination of child abuse, child abuse pediatricians cannot be “advocates” or “advocates for children.” The Committee on Child Abuse and Neglect of the American Academy of Pediatrics recognized the importance of such “non-advocacy” in its clinical report issued in June 2007 in which it said: “Physicians act primarily as scientists and educators in legal settings rather than as child advocates.”<sup>108</sup>

There may be a solid ethical foundation for applying the concepts of “advocacy” or “being an advocate” or “being an advocate for children” to a child abuse pediatrician who is involved in pursuing public health solutions to the problem of child abuse. Advocacy is affirmatively encouraged in the Principles of the Ethical Practice of Public Health:

Public health should advocate and work for the empowerment of disenfranchised community members, aiming to ensure that the basic resources and conditions necessary for health are accessible to all.<sup>109</sup>

This explains why, notwithstanding the confusion that the language of advocacy can cause, that language would actually fit well when used by child abuse pediatricians and their institutions with respect to the public health role. The challenge for child abuse pediatricians is to recognize that even though “advocacy” is encouraged in pursuit of public health solutions, it is *prohibited* by Opinion 9.07 in cases of possible child abuse that have been referred for medical investigation and liaison to the legal system. Difficult though it may be, child abuse pediatricians must recognize that while they are appropriately “advocates” in pursuing public health solutions for the at-risk population of children in their communities, that “advocacy” cannot extend to seeking protective intervention for the individual child whose case is referred for medical investigation and liaison to the legal system. Such a protective mindset would amount to a bias that violates the requirements for objectivity and independence of AMA Code of Medical Ethics Opinion 9.07-Medical Testimony.

Opinion 9.07 clearly expresses the obligation of a physician who chooses to provide expert testimony to be an objective evaluator, not an advocate:

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<sup>108</sup> Evaluation of Suspected Child Physical Abuse; Kellogg, Nancy D. and the Committee on Child Abuse and Neglect; *Pediatrics* Vol. 119 No. 6, June 2007, pp. 1232-1241

<sup>109</sup> This is Principle 4 of the Principles of the Ethical Practice of Public Health, Version 2.2. This code of ethics is comprised of twelve principles and was issued in 2002 by the Public Health Leadership Society under a cooperative agreement with the Centers for Disease Control and Prevention.

When physicians choose to provide expert testimony, they should be . . . committed to evaluating cases objectively and to providing an independent opinion. . . .”

In the memorandum of the Council on Ethics and Judicial Affairs in support of Opinion 9.07, under the caption, “Honesty and Independent In the Provision of Medical Testimony,”<sup>110</sup> doctors are admonished against taking on the position of the party that brought them to the legal contest: “Although the testifying physicians’ services may have been sought primarily by one party, they testify to educate the court as a whole.”

Even more specifically to the case of child abuse pediatricians, the Council addresses the ethical obligations on “Testimony of the Non-Treating Physician”:

The opinions of non-treating physician experts must remain honest and objective, free from any undue influence.... An independent expert is not affected by the goals of the party for which she was retained, and is not reticent to arrive at an opinion that fails to support the client’s legal position... Avoiding undue influence as an expert once again involves self-examination to ensure that one’s testimony is not biased by allegiance to any party in a legal proceeding.

In many of the Illustrative Cases in this Paper, the child abuse pediatrician crossed the line between objectivity and advocacy when they actively supported restrictions on the family’s contact with their child (and allowed their facilities to be used for implementation of such restrictions) and when they asserted that they, rather than another doctor, held the primary opinion to which deference was required. We understand that child abuse pediatricians have an instinct to protect the individual child, especially if they have made up their minds that the child was abused by someone. However, advocacy for limitations on parental rights and failure to acknowledge explicitly when there is no evidence that the parent was a perpetrator puts child abuse pediatricians squarely into a prosecution “camp” in many cases in which more objectivity would further the purpose of getting to the truth while protecting children and families. Indeed, being too ready to ally with the prosecution or DCFS; dismissing or ignoring the opinions of medical colleagues who offer alternative hypotheses to an abuse conclusion, or adopting a jaded or cynical view of parents who have been deemed to be suspects in child abuse cases, may account for many of the erroneous determinations made in the cases of wrongly accused parents. Even those child abuse pediatricians who wish to appear neutral may become so strongly allied with prosecutors, police, and DCFS that being viewed as a neutral forensic expert may effectively be impossible.

The irony is that this prosecutorial alliance with the child abuse pediatrician, as has occurred in Illinois, is exactly the *opposite* of the effect that introduction of child abuse pediatricians were supposed to bring about in these matters. A consistent claim made in the child abuse literature was that one of the benefits of the new subspecialty was going to be that parents and families would be *spared* from long-pending but factually erroneous allegations of child abuse hanging over their heads.<sup>111</sup> While this benefit may in fact occur in some cases and in other jurisdictions

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<sup>110</sup>Medical Testimony, CEJA Report 12-A-04 (2004)

<sup>111</sup>Interview on February 17, 2010 by Tulsa World with Dr. Robert Block, the leading proponent of child abuse pediatrics and the 2011-12 President of American Academy of Pediatrics.

where a different culture is present, or where the relationships between child abuse pediatricians and law enforcement or child protection officials are less well established, there remain a staggeringly high number of false positive child abuse allegations with which child abuse pediatricians have been involved in Illinois. The Family Defense Center, for example, exonerates nearly 90% of the parents it represents in hearings before the DCFS administrative law judges, including many cases in which child abuse pediatricians have written opinions stating abuse was “more likely than not.” Even if a substantial percentage of cases are eventually deemed to be unfounded by child abuse pediatricians, that does not diminish the harm that occurs in the false positive cases they deem to be child abuse. It is unclear if the net benefits of weeding out false allegations of child abuse have in fact been achieved through the adoption of the child abuse pediatrics specialty or if there is a true increase in clearing the wrongfully accused more quickly than if no such specialty existed. Obviously, if a child abuse pediatrician approaches cases that are referred for medical investigation in the role of a “child’s advocate,” and the that advocacy proceeds from the assumption that the child has been the victim of abuse before the evidence of such abuse has been fully gathered and weighed and alternative hypotheses considered, the potential benefit of a prompt and accurate negative diagnosis may become illusory.

### 5. Case Load Capacity

Some of the child abuse pediatrics literature candidly acknowledges that there is a significant imbalance between the small number of child abuse pediatricians and the huge number of cases around the country that are reported to state child protection agencies as possible child abuse.<sup>112</sup> Yet, surprisingly, the literature does not suggest any additional criteria that might serve to limit child abuse pediatrician involvement to cases in which their specialized expertise would be most helpful, such as cases with complex social histories, cases with a high degree of legal complexity or cases involving somewhat less medical complexity than some of the physical abuse allegation cases involve. On the contrary, much of the child abuse literature seems to be encouraging treating physicians to refer all of their cases of possible child abuse to child abuse pediatricians,<sup>113</sup> limited only by considerations of geography.

Unfortunately, the cases of our clients described in this Paper demonstrate that it is all too common for child abuse pediatricians to make a positive diagnosis of child abuse in situations in which that diagnosis is not factually sustainable in later legal proceedings. This invites the question whether the aspirational goal of referring all cases of possible child abuse really gives the small number of available child abuse pediatricians the time needed to adequately consider the specific facts of each case that is referred, to consult as much as they should with other doctors who have substantive expertise in the divergent areas of medicine that may be implicated in each child’s case.

At the same time as child abuse pediatricians have erred by failing to consider all the medical evidence in cases they review, there is a genuine need for child abuse pediatricians to be *more* involved in many cases in which abuse is far more apparent and the children are suffering

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<sup>112</sup> Child Abuse Pediatrics: New Specialty, Renewed Mission; Angelo P. Giardino, Nancy Hanson, Karen Seaver Hill, John M. Leventhal; *Pediatrics*, 2011.

<sup>113</sup> Child abuse requires specialized treatment, reporting; Robert W. Block; *American Medical News Ethics Forum*, posted June 28, 2010.

ongoing injuries as a result. Cases involving a single incident or episode in which physical abuse, accident, or disease could be explanations seem to be the least appropriate cases in which to have child abuse pediatricians on the front lines. Children who have been beaten repeatedly, starved, or sexually abused can benefit a great deal from having a skilled child abuse pediatrician assigned to evaluate their overall medical and psychological condition. Such children would benefit from medical treatment recommendations for the court and service providers. Moreover, because child abuse pediatricians are not distributed uniformly throughout the country, it is necessary to accept the fact that not every community will be equally well served by child abuse pediatricians.<sup>114</sup> Of course, this does not mean child abuse pediatricians can take shortcuts in communities in which they have too many cases. Each individual child abuse pediatrician maintains the obligation under Opinion 9.07 to continually monitor his own workload to ensure that he is not taking responsibility at any given time for more of these cases than he can reasonably handle well.

Continuing down the path of referring complex medical cases to child abuse pediatricians who give abuse opinions contrary to those of orthopedists and neurosurgeons in highly contested cases is an increasingly problematic practice.. Clearly the interests of children require the medical profession to engage in more consultation, and less conflict, as well as more scientifically based consideration of the possible explanations for children's injuries.

## ***IX. The Ethical Responsibility to Mitigate Damage to Families***

The child abuse pediatrics literature encourages treating doctors with access to child abuse pediatricians to refer virtually all cases of possible child abuse to those child abuse pediatricians. This makes it inevitable that there will continue to be cases, like the Illustrative Cases described in detail in Part II of this Paper, in which the child abuse pediatrician reaches a hurried, and often unilateral, positive diagnosis of child abuse only to have that positive diagnosis later found to be factually erroneous. These are cases in which the later recognition that no abuse had actually occurred is based on the compelling weight of medical opinion of physicians or teams of physicians, or an assessment of facts not known by the child abuse pediatrician at the time she rendered her opinion that abuse was the best explanation for a child's injury. Unfortunately, in many of the cases in which the child abuse conclusion is later found to be erroneous, the state child protection agency and sometimes the police and criminal or civil courts have already taken severe action against the parents.

Cases started by the state child protection agency because of a factually erroneous determination of abuse by the child abuse pediatrician require at least a period of weeks and more often a period of months to resolve in favor of the wrongly accused person. A period in which an accused parent awaits exoneration will inevitably be a period of tremendous emotional pain for the entire family. During this period, safety plans or temporary custody arrangements are imposed by the state child protection agency and parents who work with children may be at serious risk of losing their livelihood. These arrangements, lasting weeks or months, deprive the sick or injured child and his brothers and sisters of the continuing nurturing care of their parents,

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<sup>114</sup> For example, in 2009, five child abuse pediatricians in the original nation-wide class of 184 were located in Tulsa, Oklahoma, a high per-capita proportion.

in favor of care by some more distant relative if not a complete stranger. When a child abuse pediatrician advises a state child protection agency to take action against a parent for abuse, and it is later determined on the strength of compelling medical opinion that no abuse had occurred, we believe that the AMA Code of Medical Ethics Opinion 8.121—Ethical Responsibility to Study and Prevent Error and Harm requires that the mistake be acknowledged and that measures be taken to mitigate the damage done to the family. Yet very little effort has been made by the child abuse pediatric profession to acknowledge its own mistakes, analyze why they occurred, or take steps to mitigate the harm their own actions may have caused to the affected children and families.

Most of these cases will attract very little publicity because families who are subject to erroneous child abuse reports rather wish *not* to discuss publicly the humiliating ordeal they have experienced. Most parents who have been vindicated by the legal system have been traumatized by the experience of the accusation, even if their children were not removed from them and even if no legal proceedings ensued. Once exonerated, they understandably just want to move on with their lives. Occasionally, however, one of these cases will receive much more attention in the media, sometimes because of the horrific way in which the case ends.<sup>115</sup> From time to time, one of the cases will become the occasion for an affirmative lawsuit seeking a recovery for the damage resulting from the actions the child abuse pediatrician caused the child protection authorities to take. These cases shine a spotlight on policies and practices of dubious legality that may have been applied to dozens if not hundreds of other parents who have not filed suit.<sup>116</sup> Erroneous child abuse opinions that lead to restrictions on family life, legal action, loss of custody, and blacklisting of parents who work with children due to the placement of their names in child abuse registers can inflict severe emotional damage on the injured child, his parents and his extended family from which families have great difficulty fully recovering. While the amount of damage actually inflicted on the parents, family and the relationship can be a function of how much time elapses between the erroneous diagnosis of abuse by the Child Abuse Pediatrician and the later exoneration, severe adverse consequences have been reported in situations in which the erroneous diagnosis was only of record for a relatively short period of time.<sup>117</sup>

Even quickly exonerated parents who have been wrongly accused of abuse find their trust in the medical profession and hospitals can be shattered, and some have reported permanent harm to their family life even after a relatively short separation. Legal and medical expenses cause a severe strain on all but the wealthiest families, with some investigations causing severe financial strain, including bankruptcy and potential ruin of careers, even when the accused is

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<sup>115</sup> See note 47 regarding case of Alyssa.

<sup>116</sup> One such case brought by the Family Defense Center is *Hernandez v. Foster*, cited in note 8, in which a child with a broken arm which his parents said must have occurred when he climbed out of his crib and fell for the first time was subjected to a Hotline call by a doctor who misrecorded information about the child's ability to walk and climb. The doctors in *Hernandez* were not sued but the state child protection authorities who seized the child and then held him under a safety plan were successfully sued in a case that sets clear standards prohibiting detention of children and imposition of safety plans under coercive conditions.

<sup>117</sup> The importance of how long a time period family is placed under stress by the system of medically directed child abuse investigation is illustrated by the case described in footnote 47 above. Alyssa's parents apparently had been advised that they did not have any power to obtain necessary genetic testing of their child on an emergency basis. As a result, they were led to believe that the excruciating emotional trauma of the separation from their injured child under a cloud of suspicion for child abuse was going to last for three months or more. When the results of the genetic testing became available shortly after their deaths, it conclusively exonerated them of child abuse.

eventually exonerated, as the *Dupuy* court found). Even if the family is able to regain its stability, families invariably report difficulties the children experience after having been removed from the family home. Sadly, many families do not regain that level of stability, especially if there are stressful financial obligations as a result of an expensive legal battle or a career impact of a false child abuse finding.

An obvious way for innocent parents, like those whose cases are described in this Paper to bring an end to the ordeal inflicted on their families by a child abuse pediatrician's erroneous conclusion of abuse is to obtain a second opinion from other qualified expert doctors as quickly as possible.<sup>118</sup> While there are certified child abuse pediatricians who have made themselves available for engagement as expert witnesses, it is unfortunate, but true that most innocent parents who are simply trying to restore their families in an emergency would not have the financial resources necessary to obtain second-opinion medical expert assistance any more than they have the financial resources necessary to obtain market-rate legal assistance. The injustice in this situation is exacerbated by the fact that the child abuse pediatrician whose erroneous determination created the problem will very often have been funded by the state or by a non-profit organization.<sup>119</sup>

Reviewing our cases at the Center, including the Illustrative Cases presented in this Paper, it is incontrovertible that child abuse pediatricians have made errors in the past in concluding that child abuse had occurred in particular cases. We doubt that there are many doctors who think that child abuse pediatrician conclusions on the abuse issue are going to be 100% accurate in the future. Whether acknowledged or not, the current program for medically directed investigation of cases of possible child abuse, even if modified over time in ways that we have suggested, involves a conscious choice to accept a certain number of "false positives" on the child abuse diagnosis to the detriment of parents and families in order to achieve the maximum effect in protecting the children. This is not a choice that we would ever endorse, for the goal of any fair evaluative and adjudicative system is to limit error in both directions to the maximum extent possible. However, we must assume for present purposes that the medical profession will adhere to the decision to accept false positives in its investigations of possible child abuse, and that does create its own ethical challenge for the medical profession.

While some number of false positive child abuse findings is inevitable, the lack of recognition of the need to mitigate the harm of such findings is very troubling. At the present time there is nothing in the child abuse pediatric literature concerning the physician's obligation (or collectively, the obligation of the medical profession) to repair the damage inflicted on parents or other family members who have been psychologically and emotionally injured by an

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<sup>118</sup> This was one of the defensive measures taken by the parents described in Justin's case. Because these parents had the financial resources, they were able to obtain a second opinion from physicians at an out-of-town children's hospital. That second opinion was unequivocal that their son did not have a skull fracture, thus undermining the basis for a diagnosis by a child abuse pediatrician at their local children's hospital that child abuse had occurred. Most of the families described in this Paper were able to find second opinions due to their connections to the Center, which has worked with some of the leading orthopedists and neurosurgeons in the Chicago area. But persons with less access to legal counsel may often find themselves without recourse to contest an erroneous child abuse pediatrician opinion. In such cases, the desperation and sense of despair an innocent wrongly accused parent feels can be overwhelming.

<sup>119</sup> The United States Supreme Court described the imbalance of resources between the parent and the state in any child abuse prosecution in its landmark decision *Santosky v. Kramer*, 455 U.S. 745 (1982).

erroneous false positive diagnosis of child abuse. Whatever else might be done to improve the system discussed in this paper and to restore some needed balance for parents and families, it is obvious that there should be an ethical obligation on the medical profession to make available, without pre-condition, gold-standard mental health services to parents and families that are shown to be victims of erroneous child abuse diagnoses, regardless of how long or short a period the false allegation may have persisted.

AMA Code of Medical Ethics Opinion 8.121—Ethical Responsibility to Study and Prevent Error and Harm discusses physicians' ethical duties to take remedial actions with respect to health care errors and situations in which those errors have caused harm to patients and others.<sup>120</sup> One of the remedial actions that is prescribed is "to provide for continuity of care to patients who may have been harmed during the course of their health care."<sup>121</sup> If parents and other family members and the injured child himself suffer emotional trauma as a result of having to endure a period of disruption to the parental and family relationships, any psychiatric care or other mental health services that might be necessary would certainly seem to fall within this "continuity of care" concept.

The first step in mitigating the harm resulting from an erroneous determination of abuse made by child abuse pediatricians, including the damage done to families in the name of protecting children is to recognize that the problem is real. The extent of the harm should then be studied in the way other medical evaluations that have proven erroneous have been studied. Steps within the profession that acknowledge imperfections and remedy them should be adopted continuously. If it is inevitable that children and families will be damaged by mistaken medical judgments, moreover, then treatment for the families should be designed to mitigate the harm. In none of the cases discussed in this report has the family been offered any therapeutic assistance after the accusation was acknowledged to be inaccurate. The family was simply left to move on, on its own. Most of the families, except those who have no genuine choice of health care providers due to the limitations of their locations, have moved on, but they have not returned to the hospital at which their ordeal occurred. Trust in the medical community that turned against them to make a false accusation that went to the heart of what they hold most dear—their children—has been hard to repair. It is primarily for this reason that we hope the concerns in this paper will be discussed and seriously considered and remedial steps taken. It is important that children and families are able to have trust in their doctors. However, the experience of being subjected to a poorly conducted and incomplete medical investigation of child abuse following a Hotline call is an experience that has shattered and is continuing to shatter that trust for too many American families.

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<sup>120</sup> AMA Code of Medical Ethics Opinion 8.121—Ethical Responsibility to Study and Prevent Error and Harm was issued in December 2003 based on the report to the Council on Ethical and Judicial Affairs entitled Ethical Responsibility to Study and Prevent Error and Harm in the Provision of Health Care which was adopted in June 2003.

<sup>121</sup> The quoted language is from subsection (4) of Opinion 8.121.

## **PART IV: SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS**

### **REGARDING ETHICS AND PRACTICE STANDARDS**

Throughout this Paper, we have suggested ways in which we believe practices that hurt innocent families could be improved and practice made to conform to medical ethics precepts. This is a summary and elaboration of the key recommendations

#### **1. TREATMENT OF PARENTS.**

The Code of Medical Ethics suggests that the doctor-patient relationship extends to the child, not the parents.<sup>122</sup> However, the Code also indicates that parents have a distinct role as surrogates who agree on a child's behalf to the doctor-patient relationship and as preferred decision makers with respect to the course of the child's treatment.<sup>123</sup> When parents are the subject of a Hotline call, the parent's rights as a decision maker should not be limited by doctors. In practice, however, parents are treated as suspects and their role as decision makers can be compromised by the Hotline call alone. This can be subtle or it can be overt, as when a child abuse pediatrician tells an investigator that she supports the need for a safety plan restricting the parents' contact with their child.

We recommend that child abuse pediatricians begin a dialogue with parents who have been wrongly accused of child abuse and their legal representatives as well as with doctors who have presented testimony in their favor. Only by first hearing and then acknowledging the extent to which their own practices can negatively impact innocent families can child abuse pediatric practices change in the direction of improving the fairness of the entire child abuse evaluation process.

We recommend that child abuse pediatricians explicitly adopt a policy of respect for the rights of parents to decline to participate in any investigation of them as a suspect in a child abuse matter. A "bill of rights" for parents who are subject to child abuse investigations should include the right to information about the status of the investigation, their own status as subjects of the investigation, their rights to counsel in the course of any interview, and their genuine right to refuse to be questioned without that refusal being held against them or used as the occasion for a Hotline call or accusation of lack of "cooperation."

The Code of Medical Ethics deals with situations in which doctors, acting as employees or contractors of third parties, are called upon to examine people outside the traditional patient-physician relationship,<sup>124</sup> and these are the ethical standards that should apply to a child abuse pediatrician in her interaction with a parent on a case that has been referred to her for investigation. Current practices of inadequate notice to parents as to the limitations of the doctor-patient relationships should be corrected. If child abuse pediatricians proceed with questioning of a parent, they should fully inform parents about their role in the ensuing law enforcement and child protection investigation including any contracts they have to perform evaluations for third parties. Parents should not be misled into thinking that they are being asked

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<sup>122</sup> Code of Medical Ethics Opinion 10.016 – Pediatric Decision-Making

<sup>123</sup> Code of Medical Ethics Opinion 10.015 – The Patient-Physician Relationship; Code of Medical Ethics Opinion 10.016 – Pediatric Decision-Making

<sup>124</sup> Code of Medical Ethics Opinion 10.03 – Patient-Physician Relationship in the Context of Work-Related and Independent Medical Examinations

questions by and providing information to the doctor to aid in the treatment of their sick or injured child when in fact they are being asked questions solely to assist a government-funded investigation into whether their denial of child abuse is credible. Accordingly, child abuse pediatricians and their teams should identify themselves as such to the parent before the interview begins and explain that they have an investigative and not a treatment role. They should explain that the information gleaned from the interview and the child abuse pediatrician's conclusions will be communicated to the police and included in a report given to child protective services investigators pursuant to a state contract or other understanding. They should also explain that the treatment of the sick or injured child does not depend in any way on participating in the interview. If the parent chooses not to participate in such an interview or asks to delay the interview until someone else can be present, that decision should be respected.

## **2. THE IMPORTANCE OF THE EDUCATION/PUBLIC HEALTH FUNCTION OF CHILD ABUSE PEDIATRICIAN; INSURING BALANCE WITH THAT FUNCTION, NOT LAW ENFORCEMENT.**

The Code of Medical Ethics appears generally to have recognized violence and abuse as public health issues.<sup>125</sup> The medical literature specifically discusses child abuse as a public health problem and describes the major role of the child abuse pediatrician as involving activities that promote public health through programs aimed at child abuse prevention.<sup>126</sup> This function can be lost as child abuse pediatricians become increasingly allied with prosecutors, police and child protection agencies. The child abuse pediatricians should keep in mind that while advocacy for children and for awareness of child abuse as a social problem is part of their public health mission, that does not mean that they should advocate in every doubtful case for a conclusion that a particular child has suffered child abuse and they should not set themselves up as judges of parents.

## **3. NO CHILD ABUSE PEDIATRICIAN SHOULD PARTICIPATE IN THE INTERROGATION OF A PARENT WHOSE CHILD IS BEING HELD INVOLUNTARILY AT THE HOSPITAL OR IN OTHER CIRCUMSTANCES THAT MAKE THE PARENT'S PARTICIPATION LESS THAN INFORMED**

As to particular cases referred to them by treating doctors, the literature describes Child Abuse Pediatricians as serving in an investigative role in relation to the injured child, not as a treating physician.<sup>127</sup> In performing their investigations, Child Abuse Pediatricians should, however, keep in mind the stricture in the Code of Medical Ethics against physicians conducting or directly participating in any interrogation.<sup>128</sup> It appears there has been little guidance to child abuse doctors about factors that make their questioning of parents as to child abuse particularly

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<sup>125</sup> Code of Medical Ethics Opinion 2.02 – Physicians Obligations in Preventing, Identifying, and Treating Violence and Abuse

<sup>126</sup> The Pediatrician's Role in Child Maltreatment Prevention; Flaherty, EG; Stirling, J; The Committee on Child Abuse and Neglect; *Pediatrics* Vol. 126, No. 4, pp 833-841 (October 1, 2010); Child Abuse Pediatrics: New Specialty, Renewed Mission; Angelo P. Giardino, Nancy Hanson, Karen Seaver Hill, John M. Leventhal; *Pediatrics*, 2011

<sup>127</sup> Child abuse requires specialized treatment, reporting, *American Medical News Ethics Forum* (2010); Inflicted Traumatic Brain Injury: Advances in Evaluation and Collaborative Diagnosis, Glick, Jill C., *Pediatric Neurosurgery* 2007; 43:436-441.

<sup>128</sup> See Code of Medical Ethics 2.068 – Physician Participation in Interrogation

ethically troubling. These factors including the presence of police and state child protection agency investigators in proximity, the separation of the parents for purposes of questioning, the child abuse pediatrician's assumption of an adversarial posture during the questioning by contesting the parent's account where there is no basis for doing so, the physical condition and emotional state at the time of the questioning, and the parent's lack of awareness as to the investigative (not treatment) function of the doctor who is asking questions and what their rights might be in this setting. Where the questioning of the parent occurs when the child is being held by other medical personnel and is not free to leave, the questioning is even more fraught with coercive qualities that raise a serious ethical concern.

As physicians, the child abuse pediatrician should take steps to ensure that their own activities are not too closely allied with police and prosecutors whose investigative activities may be highly coercive. Techniques that are acceptable for law enforcement and child protective authorities may not be appropriate for physicians to engage in. Child abuse pediatricians could benefit from greater awareness of and sensitivity to the vulnerabilities of parents who have come to the hospital seeking answers about their children's medical condition. Child abuse pediatricians who capitalize on these vulnerabilities to create an unduly coercive environment for family member likely are doing a disservice not only to the children and families they service, but to the interests of science and medicine, just as coercive interrogation techniques by law enforcement authorities can backfire when employed against a wrongly accused individual.

#### **4. TREATING PHYSICIANS MUST STAY INVOLVED IN THE EVALUATION OF THE CHILD ABUSE ALLEGATION.**

The literature suggests that one of the motivations for establishing child abuse pediatrics as a sub-specialty was for the benefit of other doctors who are involved in the treatment of the injured child. The child abuse pediatrician enables these other doctors to avoid aspects of the legal system surrounding suspected child abuse and neglect cases that they may find to be unpleasant or uneconomic or professionally difficult.<sup>129</sup> However, whatever the reasons other doctors may not wish to get involved with a child abuse case, treating physicians ethically cannot refrain from providing opinion that is relevant to the conclusion. And if their opinions are discounted by child abuse doctors, they have a duty to their patient to speak up.

#### **5. EVEN IF CHILD ABUSE IS REPORTED, PHYSICIANS HAVE A DUTY TO PROTECT THE CHILD'S AND FAMILY'S CONFIDENTIALITY AND PRIVACY.**

Notwithstanding that they may have significant legal protection in making a child abuse Hotline call on a particular case to DCFS, treating doctors should consider the limitations imposed under the Code of Medical Ethics on the scope and detail of the information reported.<sup>130</sup> Some medical literature does advise treating doctors to refer cases of suspected child abuse to child abuse pediatricians for investigation. However, a treating doctor would appear to be violating his obligation under the Code of Medical Ethics to protect the patient's confidentiality and privacy, if he were to make such a referral and consult with a child abuse pediatrician about his patient without obtaining a prior waiver of confidentiality and privacy from the parent after the parent

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<sup>129</sup> Child abuse requires specialized treatment, reporting, *American Medical News Ethics Forum* (2010)

<sup>130</sup> Code of Medical Ethics Opinion 5.05 -- Confidentiality

had been informed about the purpose of the referral.<sup>131</sup> There would be similar ethical concerns if a treating doctor were to provide information, without prior waiver of confidentiality and privacy from the parent, to a Child Abuse Pediatrician to whom a case had been referred by DCFS. The abrogation of patient confidentiality by reporting laws is not extend as far as occurs in practice. In addition, some reporting laws create conflicts with ethical duties of physicians, giving rise to a need for advocacy by physicians for tighter confidentiality protections in reporting laws themselves.

Moreover, it is unclear both legally and ethically that a Hotline call abrogates the confidentiality and privacy of the child patient as fully as current practice appears to assume. In other words, the child's records and his sibling's records as well should not be freely shared among treating doctors, child abuse doctors and authorities, as current practice appears to condone, absent express consent by the parent. Parental consent is too freely assumed to be unnecessary as a pre-condition to disclosure of records made prior to or separately from the Hotline call itself. The need for voluntary consent is sometimes even ignored in the course of demanding intrusive additional lab tests and x-rays which are pressed upon parents under threats of taking their children into foster care. The doctor who is treating the injured child should consider the confidentiality and privacy rights of the patient in determining the scope of the information reported to DCFS. In addition, if the doctor who is treating the injured child believes that a referral to a child abuse pediatrician is appropriate or that it is appropriate to provide information to a child abuse pediatrician who has become involved at the request of DCFS, a waiver of confidentiality and privacy should be sought from the injured child's parent as the exception to privacy protections for reports of suspected child abuse does not extend to liberally sharing all medical records and history of the child with non-treaters whom the parent has not sought out for the child. Furthermore, the child abuse assessment report as to any child should be considered to be part of the child's medical file, not the property of the State or law enforcement authorities.<sup>132</sup>

## **6. SEEKING A CONSENSUS BEFORE CONCLUDING THAT THE INJURY RESULTS FROM CHILD ABUSE.**

Child abuse pediatricians should freely collaborate with colleagues in appropriate areas of medical specialty --- neurosurgeons and orthopedic surgeons and radiologists in particular --- in arriving at a determination as to whether or not a particular child's injuries were the result of accident or child abuse or underlying disease. In accordance with the literature, a determination that there has been child abuse should only be based on a consensus among the doctors representing the relevant specialty practices. And it is a much better practice to include specialists in related areas of medicine as members of the child protection medical team than to rely on child abuse pediatricians to seek them out for opinion on an ad hoc basis.

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<sup>131</sup> Code of Medical Ethics Opinion 7.025 – Records of Physicians: Access by Non-Treating Medical Staff; Code of Medical Ethics Opinion 5.059 – Privacy in the Context of Health Care

<sup>132</sup> In several recent Center cases that are more recent than the Illustrative Cases in this report, the parents have been completely stymied for several months in their efforts to obtain copies of the MPEEC reports that DCFS relied upon. These reports are not provided to them in their children's medical files and sometimes are not included in the DCFS files they wait for after an indicated or unfounded decision has been made. Clearly, there is no room for "secret" evidence and secret medical opinion that is being used to impair family life and individuals' rights when they work with children.

There is a strong theme in the literature regarding child abuse pediatricians that they are expected to be collaborative with other substantive medical specialists, or even more strongly that they are to find consensus with those other relevant medical specialists, in reaching opinions that there has been child abuse or neglect in a particular case.<sup>133</sup> This concept of collaboration and consensus for non-treating doctors, like child abuse pediatricians, is akin to the idea that is explicit in the Code of Medical Ethics that treating doctors should obtain consultation “when medically indicated in the care of the patient or when requested by the patient or the patient’s representative.”<sup>134</sup>

Consultation does not mean merely reading a radiological report or ordering lab tests. Seeking out another opinion requires that opinions should not be limited to information to understand the medical conditions on their face (such as what condition an x-ray shows) but should also include consideration of alternative possible causes of injuries. These opinions and experiences of other medical specialists should be discussed openly in order to achieve the goal of consensus among doctors when possible and to clarify the issues that require further assessment. The child abuse pediatric specialty was adopted, among other things to provide *increased* coordination of the input by various medical specialists into child abuse evaluations. Disregarding the opinions of other medical specialists defeats this important purpose for the creation of the new sub-specialty.

Full membership of subspecialists in the hospital child abuse team could go a long way to improving the quality and consistency of medical opinion reached by child abuse pediatricians and bringing new scientific developments in areas related to the child’s injury to bear in the assessment of each child’s case. We believe that teams that include specialists like orthopedists, neurosurgeons, and radiologists as full partners in reaching the child abuse conclusion may be less prone to reaching ultimately unsustainable conclusions.

Unfortunately, the model of collaborative practice has strayed from what is contemplated by medical ethics opinions and has become, in some hospitals a model of cooperation with prosecutorial bodies and child protection authorities to the exclusion of medical professionals whose information would benefit the child and a wrongly accused parent.

## **7. THE CHILD ABUSE PEDIATRICIAN AND OTHER PHYSICIANS SHOULD INSURE THAT THE CHILD’S FAMILY TIES ARE SUPPORTED REGARDLESS OF THE HOTLINE CALL.**

There is an extensive literature to support the idea that the doctor treating the pediatric patient should take into account the importance of the patient’s family relationships in providing those services.<sup>135</sup> This literature forms the basis for defining ethical and practice standards for treating doctors who have referred a patient to a child abuse pediatrician or who have had a patient referred to a child abuse pediatrician by the DCFS. To the extent conclusions reached by child abuse doctors are based on negative assessments of parents’ credibility (including assumptions that the parent should have observed an incident that accounts for an injury and

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<sup>133</sup> Inflicted Traumatic Brain Injury: Advances in Evaluation and Collaborative Diagnosis, Glick, Jill C., *Pediatric Neurosurgery* 2007; 43:436-441

<sup>134</sup> Code of Medical Ethics Opinion 8.04 -- Consultation

<sup>135</sup> See: Patient and Family-Centered Care and the Pediatrician’s Role, *Pediatrics* Vol. 129, No. 2, pp394-404 (2012)

failure to do so is “suspicious”) and not medical science, the basis for these conclusions should be specified. Moreover, particular caution should be exercised in expressing any opinion that the parent’s account is not credible, as that can be a legal conclusion, as opposed to a medical judgment.

#### **8. CHILD ABUSE PEDIATRICIANS SHOULD BE NON-PARTISAN RATHER THAN CHILD ADVOCATES ALLIED WITH THE PROSECUTION OF THE PARENTS.**

The Code of Medical Ethics opinion that is applicable to a doctor formulating an opinion in connection with legal proceedings cautions against doctors taking on the role of advocate for any medical conclusion. Instead, the doctor’s medical opinion is to be based on “current scientific thought” that has “gained acceptance among peers in the relevant field.”<sup>136</sup> Given the frequency of disagreement between child abuse pediatricians and many orthopedists and neurosurgeons as to such issues as whether spiral fractures are indicative of abuse and whether a constellation of findings are diagnostic of shaken baby syndrome/abusive head trauma, the advocacy role undertaken by child abuse pediatricians in proselytizing for pro-child abuse conclusions and restrictions on families’ interactions with their children is particularly inappropriate. Furthermore, efforts to seek a superior standing as “the” prevailing opinion on the question of whether child abuse has occurred and working to silence other physicians who give medical testimony on behalf of accused persons runs contrary to medical ethical norms.

#### **9. IN THE SPIRIT OF “FIRST DO NO HARM,” THE MEDICAL PROFESSION SHOULD RECOGNIZE WHEN ITS PRACTICES CAUSE HARM AND SHOULD WORK TO MITIGATE THAT HARM WHENEVER POSSIBLE.**

The medical profession has an obligation to get the child abuse conclusion right as often as is medically possible, and to recognize the harm it can cause to children and families if it gets that conclusion wrong or causes others in the system (such as DCFS investigators) to reach the wrong conclusion based on their medical evaluations. Recognizing that there will always be some cases of mistaken accusations against innocent parents and family members, the child abuse pediatric profession needs to do a better job of evaluating its own errors and correcting them and assisting in the treatment and care of families who have been the victims of false reports. Families who have been wrongly accused suffer acutely and alleviating this suffering is part of the obligation of ethical physicians who participate in the system of care that may have traumatized a family in the name of trying to protect a child from abuse that never occurred.

Tellingly, there is currently no effective system in place for child abuse pediatricians to assess their own errors and take corrective action to help the family heal. Child abuse pediatricians have been largely silent as voices on behalf of the wrongly accused, when they should be at the *forefront* of efforts to insure that their own evaluations do no harm to the children and families they serve. Hospital administrations bear responsibility too for insuring that the child abuse pediatricians in their employ consistently make medically sound evaluations of the cases before them and that they make treatment available to the families who may have been traumatized by a false accusation. Recognizing that the child abuse pediatricians are not omniscient, treatment and support for families who have been victims of the trauma of a false accusation should become readily available. Sadly, however, not one child abuse pediatrician

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<sup>136</sup> Code of Medical Ethics Opinion 9.07 – Medical Testimony.

who has worked on any of the dozens of cases handled in the Center involving exoneration of a wrongly accused caregiver has acknowledged she was wrong.