

Reforming the Use of Child Abuse Pediatric Teams in Child Protective Cases



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Introduction

The field of child abuse pediatrics is a relatively new phenomenon in medicine, tracing its origins to research conducted in the mid-1960s and early 1970s. In recent years, medical professionals holding certifications in child abuse pediatrics have become increasingly aligned with state child protective services (CPS), advocacy centers, and the judicial system as part of a campaign to diagnose certain injuries and symptoms as indicative of child abuse. While consultation from medical professionals with relevant expertise to more accurately determine if a child has, in fact, been abused can be a beneficial tool for the investigators and courts tasked with preventing and prosecuting child abuse, the alignment of child abuse pediatric teams with CPS investigators and law enforcement raises serious legal and ethical concerns. This paper examines the coordination of child abuse pediatricians with the state child welfare system and the risk that this collaboration can lead to false accusations of child abuse that can, if unquestioned by the courts, forever destroy innocent families.

The Rise of Child Abuse Pediatrics and Alignment with State Authorities

In the mid-1960s, a small team of pediatricians led by Dr. Ray E. Helfer and Dr. C. Henry Kempe began researching the detection, prevention, and treatment of child abuse and neglect ([Lambert](#)). Through the advocacy of Dr. Helfer primarily, teams of doctors, psychiatrists, and social workers were formed to work with abused children and their families. This research and advocacy would eventually lead to the creation of a formal subspecialty in child abuse pediatrics ([The American Board of Pediatrics](#)). It was not until 2006, however, that the American Board of Pediatrics and the American Board of Medical Specialties approved child abuse pediatrics as a formal subspecialty ([Block](#)). The first board certification examination for the subspecialty was held in 2009—three years after approval—by the American Board of Pediatrics ([Schneider](#)).

In the wake of the research conducted by Helfer and Kempe, a British pediatric neurosurgeon, Dr. A. Norman Guthkelch, suggested in a paper published in the *British Medical Journal* that the appearance of blood on the surface of the brains of children who showed no outward signs of physical trauma could be the result of shaking ([Guthkelch 1971](#)). A few years later, in 1974, Dr. John Caffey, a pioneer in the subspecialty of pediatric radiology, published an article examining what he termed “Infantile Whiplash Shaking Syndrome.” Dr. Caffey’s hypothesis drew on case studies that presented “direct and circumstantial evidence” of several markers of nonaccidental injury to a child caused by violent shaking of the infant by a caregiver ([Caffey](#)). The hypotheses proposed by Caffey and Guthkelch would become popularly known as shaken baby syndrome (SBS) and contribute to the organization of modern child abuse pediatrics and the integration of the

Key Points

- The alignment of child abuse pediatric teams with child protective services, law enforcement, and state prosecutors compromises the objectivity of medical examinations of suspected child abuse victims and has led to wrongful convictions of innocent caregivers.
- New medical research along with a string of recent acquittals and conviction reversals raises questions about the reliability of the diagnoses provided by child abuse pediatric teams.
- Texas distributes roughly \$5.5 million each biennium to hospital child abuse pediatric teams who work with DFPS to provide medical consultation, case reviews, and testimony in child abuse cases.
- While there is a proper role for medical professionals to play in child abuse investigations, safeguards should be put into place to ensure objective decision-making and eliminate conflicts of interest among child abuse pediatric teams.

subspecialty with the social service and legal communities. This alignment was furthered with the enactment of the Child Abuse Prevention and Treatment Act (CAPTA) in 1974, which was the first major effort by the federal government to address the problem of child abuse ([National Child Abuse and Neglect Training](#)). Among its provisions, CAPTA provided federal funds to states to enhance the effectiveness of investigations by child protective systems through the creation of multidisciplinary teams that included pediatricians specializing in child abuse ([42 U.S.C.A. §5106a](#)).

Wrongful Convictions Raise Questions

Building on this foundation, the 1980s saw the establishment of children's advocacy centers and a multidisciplinary approach to responding to child abuse and neglect ([Cross et al.](#)). The core focus of this approach was to coordinate the investigative and service activities of the various entities involved in responding to allegations of suspected child abuse, including child abuse pediatricians ([Cross et al.](#)). Eventually, a more or less formalized system for prosecuting suspected cases of child abuse developed out of the coordination facilitated by the multidisciplinary approach ([Gabaeff](#)). It was not until the mid-1980s, as more parents and caregivers were convicted of abuse based on the testimony offered by child abuse pediatricians, that defense attorneys began questioning the veracity of these opinions and sought out medical experts from a diverse cross-section of specialties to counter their testimony ([Gabaeff](#)).

Challenges to the testimony offered by child abuse pediatricians are rooted in research identifying certain preexisting medical conditions that result in heightened fragility or present symptoms that can be mistakenly diagnosed as being caused by intentionally inflicted injury ([Clemetson; Flaherty; Guthkelch 1971](#)). In the years prior to his death in 2016, even Dr. Guthkelch, whose work played a key role in popularizing SBS, began speaking out against what he called the faulty reasoning that was being used to obtain convictions based on the diagnosis ([Cenziper et al.; Guthkelch 2012](#)).

Although comprehensive data on acquittals and exonerations of parents and caregivers accused of abuse based on new medical information does not exist, a number of studies have documented a growing number of cases in which charges were dropped, defendants were found not guilty, or convictions were overturned ([University of California Irvine; Cenziper](#)). For example, a joint study by the *Washington Post* and the Medill Justice Project at Northwestern University found that more than 200 criminal child abuse cases related to SBS alone have unraveled since 2001 based

on new evidence from doctors and scientists researching SBS ([Cenziper](#)).

Responding to the controversy surrounding wrongful convictions based on SBS, the American Academy of Pediatrics (AAP) released a policy statement in 2009 revising their stance on the diagnosis. Foremost among the revisions was a statement recommending that medical professionals no longer use the term “shaken baby syndrome” and instead adopt “abusive head trauma” (AHT) to describe the diagnosis ([Christian, 1410](#)). In justifying this change, the AAP formally recognized that “advances in the understanding of the mechanisms and clinical spectrum of injury associated with abusive head trauma compel us to modify our terminology...” ([Christian, 1409](#)). In addition, the policy statement removed language regarding the presumption of abuse when a patient presents with symptoms indicative of abusive head trauma as well as language stating that these injuries can be used to prove the intent of the caregiver ([Judson](#)). Finally, the AAP recognized accidental injury and “medical diseases that can mimic the presentation of AHT” as other explanations physicians should consider before concluding that injuries to a child were intentionally inflicted ([Christian, 1409-1410](#)).

Continuing advancements in medical science and questions raised by courts and physicians, including those who were instrumental in pioneering the field of child abuse pediatrics, has led to an increasing recognition that child abuse pediatrics is not a “silver bullet” that can conclusively prove allegations of abuse. These developments along with the number of wrongful convictions based on the testimony of child abuse pediatric teams should spur reforms that limit the role the subspecialty plays in investigations. At a minimum, such reforms should be targeted at addressing the alignment of child abuse pediatric teams with CPS, law enforcement, and state prosecutors, which compromises the objectivity of medical abuse investigations and threatens the due process rights of the accused.

Child Abuse Pediatrics in Texas

In Texas, the 81st Legislature created the Medical Child Abuse Resources and Education System (MEDCARES) grant program ([Texas Department of Health and Human Services](#)). MEDCARES provides state funds to hospitals and academic health centers for the establishment and maintenance of programs focused on “the assessment, diagnosis, and treatment of child abuse and neglect” ([SB 2080, 11](#)). Senate Bill 2080 detailed a number of programs that MEDCARES grant funds could be used to support, including “medical case reviews and consultations and testimony regarding those reviews and consultations” ([SB 2080, 12](#)). In its fact sheet on MEDCARES, the Texas Department of

Health and Human Services more directly summarizes the goal of the grant program as providing state funds to child abuse pediatricians to “improve timely and accurate diagnoses, provide treatment, and *give support to investigations*” ([Texas Department of Health and Human Services](#); emphasis added).

Since 2009, the MEDCARES grant program has established a network of 11 participating contractors, each with their own dedicated child abuse pediatric teams ([Texas Department of Health and Human Services](#)). Over the 2017-2018 biennium, MEDCARES distributed more than \$5.5 million among these 11 contractors ([Texas Department of State Health Services 2018, 6](#)). Most of these contractors also participate in a related program administered by the Department of Family and Protective Services (DFPS), known as the Forensic Assessment Center Network (FACN). The goal of FACN is to leverage the medical resources supported by MEDCARES to closely coordinate a group of child abuse pediatricians with DFPS and make them “more readily available to offer their advice and expertise to DFPS caseworkers” ([Texas Department of Family and Protective Services](#)). Today, FACN child abuse pediatricians are available to DFPS caseworkers 24/7 and provided consultation on cases involving more than 31,000 children during FY 2017 ([The Forensic Assessment Center Network](#)).

The active role of child abuse pediatric teams under MEDCARES has largely been embraced by Texas child welfare professionals as an invaluable resource for helping identify abuse and secure convictions. One child welfare professional quoted in a research study on child abuse medical investigations published by the University of Texas and Children’s Advocacy Centers of Texas, Inc., was effusive in her praise of child abuse pediatric teams, saying, “We get reports where it says, ‘This is child abuse.’ They even will go as far as [saying] we recommend this child be removed from the home or from the family” ([CFRI, 27](#)).

This quote, which the publishers of the report deemed important enough to emphasize, is revealing of the symbiotic relationship that exists between the child welfare investigative system and child abuse pediatric teams. Rather than simply providing unbiased medical case reviews and consultations, as intended by MEDCARES, some child abuse pediatricians are taking on an active role in the CPS

investigatory process and seeking to influence the outcome of CPS cases.

Most disturbing, however, is the apparent eagerness of child abuse pediatricians to take on an advocacy role and offer a legal opinion as though it were settled science. Ultimately, whether or not a child was abused is a legal question for the courts to answer. While the opinions of medical professionals can be helpful to the courts in determining the likelihood that a child’s injuries were the result of abuse, medical professionals testifying in court must be careful to not overstep by offering an opinion that is outside their area of expertise. A child abuse pediatrician stating unequivocally that “this is abuse” from his or her clinical perspective, to say nothing of taking the extra leap of recommending the removal of the child, is unfairly prejudicial as it gives a false air of scientific fact to a legal concept. This practice denies accused parents or caregivers, the majority of whom are low-income and poorly educated, their constitutional rights to due process and the presumption of innocence by placing them at the additional disadvantage of having to disprove a legal assertion made by a medical professional, which he or she is not qualified to make.

Texas law requires the Department of Health and Human Services to submit a report to the governor

and Legislature each biennium on MEDCARES grant recipients and activities ([Texas Health and Safety Code Section 1001.155](#)). This report includes data on both inpatient and outpatient examinations of suspected victims of child abuse by MEDCARES grant recipients ([Texas Department of State Health Services 2018, 1](#)). During the 2017–2018 biennium, MEDCARES grant recipients examined a total of 29,695 children through inpatient and outpatient consultations. Of these, 23,970 children were confirmed victims of abuse—a confirmation rate of 80 percent ([Texas Department of State Health Services 2018, 1](#)). For context, during the 2017–2018 biennium more than 63,000 children statewide were confirmed victims of abuse out of a total of nearly 290,000 allegations—a 22 percent confirmation rate ([Texas Department of State Health Services 2018, 5](#)). Confirmation rates were similar for the 2015–2016 biennium ([Texas Department of State Health Services 2016, 11](#)). While children confirmed as victims of abuse by MEDCARES grant recipients represent a subset of the overall victim population, the incredibly

A child abuse pediatrician, offering an opinion that is outside his or her area of expertise, stating unequivocally that “this is abuse” from his or her clinical perspective, denies accused parents or caregivers their constitutional rights to due process and the presumption of innocence.

high substantiation rate among these providers should raise red flags and questions of whether a confirmation bias is at work among child abuse pediatric teams.

Adding to these concerns is the rate at which Texas overturns substantiated allegations of abuse. A report by the *Austin American-Statesman* revealed that the state overturns “more than 1 out of 3 decisions challenged by people who CPS says have abused or neglected a child” (Ball). In 2013, 42 percent of the cases appealed were subsequently overturned (Ball). Considering that only about 3 percent of cases eligible for review are appealed, the possibility exists that the number of wrongful substantiations could be even higher than reported.

Addressing Legal and Ethical Issues

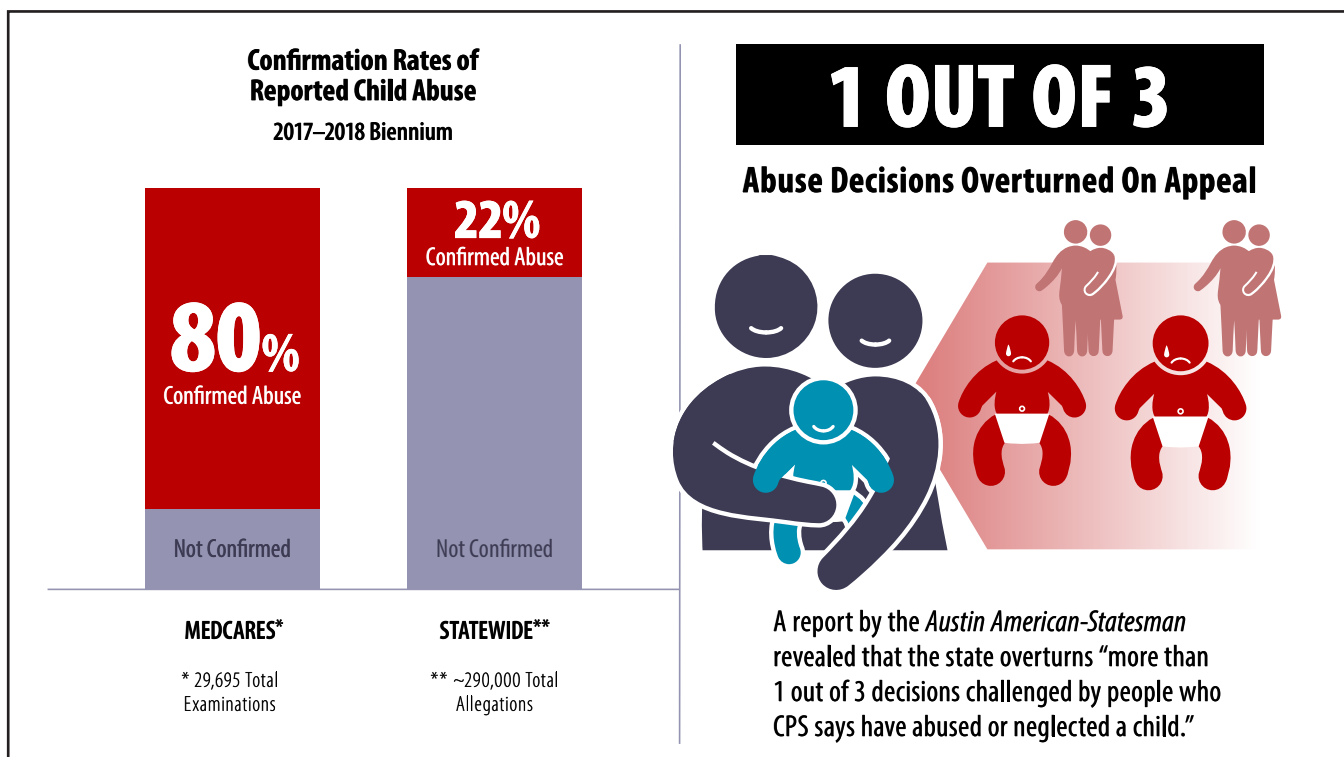
The close, formalized coordination of child abuse pediatricians with CPS investigators, law enforcement, and prosecutors raises serious legal and ethical concerns. In light of the growing number of child abuse cases in which the alleged perpetrator has either been acquitted or had their conviction reversed, states should take steps to address these issues.

Child abuse cases are among the most complex and emotionally charged matters handled by the judicial system. The cost of getting it wrong is incredibly high. No one ever

wants a child to be harmed, especially when one is in a position to have prevented that harm. By the same token, we must recognize the substantial trauma caused by wrongful convictions—both for the child and the family—and work to ensure that innocent families receive the full protection afforded by due process of law.

As noted earlier, one of the biggest temptations facing child abuse pediatricians and, indeed, any medical professional called upon to consult on alleged child abuse cases is the temptation to step outside of their role as a treating physician or neutral interpreter of medical information and assume the mantle of an advocate. Worse still is the tendency for child abuse pediatric teams to assume an investigatory role rightly reserved for law enforcement and CPS. In their extensive examination of medical ethics concerns in child abuse investigations, George Barry and Diane Redleaf present a number of in-depth case studies in which physicians “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” (Barry and Redleaf, 56). While Barry and Redleaf note that there is a proper role for physicians to play when supporting investigations into allegations of child abuse, their research reveals that the initial interrogations of parents and caregivers suspected of abuse are often conducted by hospital child abuse teams (Barry and

Figure 1. MEDCARES grant recipients represent a subset of the overall victim population. The incredibly high substantiation rate among these providers should raise red flags and questions of whether a confirmation bias is at work among child abuse pediatric teams.



[Redleaf, 56–57](#)). This practice, they argue, is a direct violation of the American Medical Association (AMA) Code of Medical Ethics Opinion 2.068, which expressly prohibits physicians from conducting or directly participating in interrogations ([AMA](#); [Barry and Redleaf, 36](#)).

There is good reason for this prohibition. The primary role of the medical professional is to serve as a healer. In its commentary on Opinion 2.068, the AMA notes that a physician's direct participation in an interrogation "undermines the physician's role as healer and thereby erodes trust in the individual physician-interrogator and in the medical profession" ([AMA](#)). Medical professionals assuming an active role in investigating allegations of child abuse carry a significant risk of further eroding this trust by blurring the line between treatment and investigatory activities.

Given that most patients have a limited understanding of medicine and will generally defer to the recommendations of medical professionals for treatment and diagnostic procedures, medical professionals have a duty to provide the patient with enough information to allow the patient to make an informed voluntary decision either accepting or rejecting the proposed evaluation or treatment ([Murray](#)). When the patient is a minor, standard medical ethics dictates that the physician obtain the informed consent of the parent or legal guardian of the minor ([Committee on Bioethics](#)). Texas law explicitly states that parents have the right to consent to the medical care of the child ([Texas Family Code Section 151.001\(a\)\(6\)](#)). The right of parents to consent to the medical care of their child and the requirement that this consent be voluntary and informed impose a duty upon the child abuse pediatrician to ensure that the parent understands that their role is investigatory rather than therapeutic and to disclose when a recommended test or procedure is intended to further the investigation into suspected abuse.

Beyond the conflict between the child abuse pediatrician's investigatory role and the therapeutic role inherent to the medical profession, there is a conflict of interest that arises when the report of abuse is made by the institution that employs the child abuse pediatrician. In many cases, the child abuse pediatrician is the person making the initial report to CPS, further exacerbating this conflict. It is not unreasonable, then, to question the objectivity of the child

abuse pediatrician who either made an initial report of suspected abuse or whose livelihood is dependent upon the institution that made the report. By questioning the objectivity of child abuse pediatricians in these scenarios, we are not suggesting that they are consciously seeking to harm innocent families in order to prove that the initial report of abuse was correct. Rather, we are merely acknowledging the well-documented power of the phenomenon of confirmation bias, which causes an individual to subconsciously seek out or add more weight to evidence that confirms one's initial beliefs. Research is clear that the medical profession is not immune from confirmation bias and that it often arises in the diagnostic context ([Nickerson, 192](#)). Simply holding a hypothesis—for example, that a child's injuries were caused by physical abuse—"can function as a constraint, decreasing the likelihood that one will consider an alternative hypothesis" ([Nickerson, 193](#)).

We are not suggesting that child abuse pediatricians are consciously seeking to harm innocent families in order to prove that an initial report of abuse was correct. We are merely acknowledging the well-documented power of the phenomenon of confirmation bias

When life-altering decisions like separating a child from her family are on the line, it is imperative to put safeguards in place that promote objective decision-making and reduce the risk of harm to innocent families from false accusations. Examples of such safeguards include ending the practice of child abuse pediatric teams engaging in investigatory activities like interrogations that are the responsibility of law enforcement, requiring consult-

ing physicians to screen for certain diseases and conditions that can be mistaken for child abuse, and prohibiting the child abuse pediatric team employed by an institution that makes a report of suspected abuse from playing a role in the investigation of that report.

Conclusion

The alignment of child abuse pediatric teams with CPS, law enforcement, and prosecutors presents a number of ethical and legal issues that place innocent families at risk of harm. While there is a role for medical professionals to play in supporting investigations into suspected child abuse, they must take care to avoid stepping outside their role as objective interpreters of medical data and into the role of advocate. The tendency on the part of child abuse pediatric teams to advocate for particular findings in investigations is not only troubling, it can deny accused parents or caregivers their constitutional right to due process. Child protective policies should also protect innocent families from the

traumatic impact of unjust investigations and removals by taking affirmative steps to mitigate risks posed by the current practice of child abuse pediatrics.

Recommendations

- Eliminate potential conflicts of interests by prohibiting child abuse pediatric teams from consulting or providing expert testimony on suspected cases of abuse reported by the institution that employs the team.
- Adopt regulations consistent with the American Medical Association Code of Medical Ethics Opinion 2.068 prohibiting medical professionals from conducting or directly participating in interrogations related to alleged cases of abuse.
- Require that medical professionals called upon to provide consultation on alleged cases of abuse provide a differential diagnosis for diseases and other conditions that can be mistaken for child abuse or that result in heightened fragility.
- Reform the MEDCARES grant system to promote objectivity in medical abuse consultations and end the alignment of child abuse pediatric teams with CPS, law enforcement, and prosecutors. ★

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