Child abuse continues to be a problem that affects many children. In 2002, about 1.8 million children in the United States were reported to the child protective services (CPS) divisions of state human services divisions because of suspected abuse or neglect. In those cases, CPS determined that almost half of these children had been maltreated. About 20% of these children were victims of physical abuse, and between 1,000 and 2,000 children died because of their maltreatment.
Young children are particularly vulnerable to abuse. An analysis of 2002 vital statistics showed that child abuse or homicide was the fourth leading cause of death for children ages 1 to 4. About 90% of child abuse deaths occur in this young age group.

Child abuse may go unrecognized. Ewigman found child maltreatment was drastically underreported and underrecognized as a cause of child fatality. He performed a population-based study of all children younger than 5 who had died and found that only 47.9% of children with documented abuse histories were identified as abused on their death certificates.

About 60% of the deaths caused by child abuse are preventable. Children may suffer further abuse when child abuse is not recognized or reported. According to one study of children diagnosed with abusive head trauma, physicians had treated 31% of the children previously for signs and symptoms caused by their abuse but the diagnosis of abuse had been missed. Of those children whose head injuries had not been identified, 28% were re-injured before the cause of injury was determined, and 9% of those children died.

**PHYSICIAN DECISION MAKING CONCERNING CHILD ABUSE**

Warner and Hansen developed a multistep model that shows the factors affecting physician identification and reporting of suspected physical abuse. This model divides the decision process into four stages: assessment and evaluation, identification, reporting, and validation. The authors discuss the barriers that can occur at each stage of the process and that may prevent the identification and reporting of maltreatment. Although the authors have researched the existing data and provided good support for their model, this model has not yet been tested in a prospective study.

In this article, we combine the first two stages of the Warner-Hansen model and discuss the factors associated with physician recognition of child abuse. We then group the second two stages and describe barriers to physician reporting, including how validation of prior reports affects reporting.

**BARRIERS TO PHYSICIAN RECOGNITION OF CHILD ABUSE**

Several barriers may impede physician recognition of child abuse. Physicians simply may not be familiar with the typical physical syndromes associated with abuse, or they may have other psychological and subconscious biases that interfere with recognition of abuse.

**Lack of Knowledge and Training**

Physicians may not have the knowledge and skills to assess maltreatment adequately or to manage cases of suspected maltreatment. Although it is not always easy to determine that a particular injury is caused by abuse, many physicians have little training regarding child abuse, which limits their ability to recognize even the most obvious cases of child abuse. In our Chicago area study, 29% of the participants said they had received no continuing education about child abuse in the previous 5 years. The same study showed physicians who had some education about child abuse post-residency were much more likely to report all suspected abuse to CPS than those practitioners who had none.

Continuing education about child abuse is even more important today because the body of knowledge about child maltreatment is expanding rapidly. Research has contributed considerable new knowledge that can help practitioners differentiate intentional injuries from unintentional injuries.

A good patient history is key to determining whether a child has been maltreated. When physicians fail to elicit complete and thorough histories, they
may draw conclusions extrapolated from their own experience. We have observed that physicians often fail to ask caretakers for sufficient information to determine the cause of an injury. Several reviews of hospital emergency department and inpatient records show physicians failed to document information about how the injury occurred, where the injury occurred, the presence of any witnesses to the injury, the history of previous injuries, and a complete physical examination. In the cases reviewed, some physicians may have asked the appropriate questions and completed an appropriate evaluation, but their information-gathering effort could not be assessed because the information was not documented in the medical record.

**Psychological Barriers**

It can be difficult for physicians and others to comprehend that a parent or caretaker would intentionally harm a child. Physicians sometimes think they can recognize and judge who is capable of abusing a child. For example, the physician may deny that a family may have abused a child because they appear caring and concerned. The idea that parents who are compliant and friendly in other aspects could harm a child causes dissonance for the physician. Sharing similar characteristics with a family, especially socioeconomic class, makes it even more difficult for the physician to label the caretaker as a "child abuser."*

Familiarity with the family may make the recognition of maltreatment even more difficult. Physicians have described how knowing a family well may interfere with their ability to recognize that a child has been maltreated. Other psychological factors also may prevent physicians from identifying and reporting maltreatment. Sanders discussed the discomfort that physicians feel when dealing with the parents of maltreated children. He suggests treating a maltreated child can stir up the physician's own ambivalent feelings about parenting. Sanders claims most parents have some negative and hostile feelings about their children, in addition to the positive feelings. These ambivalent feelings cause some physicians to avoid the family, while other physicians become angry and accusatory towards the maltreated child's family. Pollak and Levy described how anxiety caused by countertransference of fear, guilt, shame, and sympathy may prevent a physician from reporting suspected maltreatment.

**Family Racial and Socioeconomic Factors**

Several studies suggest race may influence the recognition of suspected maltreatment. Carole Jenny found physicians were more likely to miss abusive head trauma as a cause of a child’s symptoms when the families were white and intact. In an analysis of data from the first National Incidence of Prevalence Study of Child Abuse and Neglect (NIS), the authors found that hospitals were more likely to identify child abuse when the child was black and from a lower socioeconomic group. Racial differences in the evaluation of children with injuries that might have been related to abuse were noted in a Philadelphia study. Injured black children were up to seven times more likely to have the diagnosis of abuse considered compared with white children.

**BARRIERS TO PHYSICIAN REPORTING OF SUSPECTED ABUSE**

Even when physicians do suspect that a child has been maltreated, and even though all states mandate that physicians report suspected maltreatment, physicians do not report all suspected cases of physical abuse. In a survey of Chicago area pediatricians, 8% of the participating physicians admitted that, during
the previous year, they had not reported children they suspected had been physically abused.\textsuperscript{9} In another study, 30\% of pediatricians randomly selected from 15 states said they had failed to report suspected child abuse at some time in their career.\textsuperscript{22} The percentage of physicians who had not reported suspected maltreatment was probably higher in this study because the study asked about career, and not recent, experience.

When Australian pediatricians and general practitioners were surveyed in a similar study, 43\% of the physicians said they had not reported cases of suspected abuse or neglect at some time in their whole career.\textsuperscript{23} These results may have differed from the other two studies because the study included general practitioners in addition to pediatricians and included both abuse and neglect reports.

Several factors can contribute to a physician not reporting suspected abuse.

**Type of Maltreatment**

Saulsbury\textsuperscript{24} surveyed Virginia physicians and found that most physicians reported suspected physical abuse (91\%), but fewer physicians reported suspected physical neglect (58\%), emotional abuse (45\%), or medical neglect (43\%). In a survey of Alabama pediatricians and family practitioners, these physicians reported 89\% of cases of suspected child physical abuse and 94\% of suspected child sexual abuse.\textsuperscript{25} Arizona physicians also were more likely to agree that some forms of maltreatment should be reported to CPS and other forms may not need to be reported.\textsuperscript{26} Most physicians agreed that drug use during pregnancy should be reported to CPS. In another study, respondents indicated that they were much more likely to report sexual abuse than either physical abuse or neglect.\textsuperscript{27}

There may also be a threshold effect based on what physicians find to be acceptable parenting practices, such as the use of physical discipline. Morris et al. found that physicians who were more tolerant of physical discipline were less likely to suspect that a particular injury was caused by abuse.\textsuperscript{28}

**Physician Specialty**

Physicians’ areas of specialty may affect their decision to report certain types of maltreatment. In one study, general practitioners expressed a more cautious attitude about reporting than the pediatricians.\textsuperscript{23} However, pediatricians were less likely to agree that failure to thrive needed to be reported to CPS when compared with family practitioners or emergency physicians.\textsuperscript{26}

**Family Racial and Socioeconomic Factors**

Although racial and socioeconomic factors appear to have some influence on reporting, an analysis of NIS-1 data did not find black children were overreported to CPS.\textsuperscript{29} In fact, the analysis found white children were more likely to be reported to CPS if they were from a lower socioeconomic class, known by law enforcement, known by a medical agency, or female. According to a latter analysis, physicians reported 55\% of white children they suspected were maltreated but only 50\% of black children they suspected were maltreated. There also were racial differences in reporting depending on the type of maltreatment. White children who were emotionally maltreated were less likely to be reported, while white children who had been physically abused or sexually abused were more likely to be reported to CPS.\textsuperscript{30}

Although Hampton et al.\textsuperscript{18} suggested child maltreatment is more likely to be identified and reported if the family is poor, Drake and Zuravin\textsuperscript{31} determined that families with poor socioeconomic status were not over-represented as reported to CPS for suspected physical abuse, nor was CPS more likely to substantiate that physical abuse had oc-
curred in poor families compared with families from higher socioeconomic groups. They reviewed CPS-based data and non-CPS-based data to determine if there was a disparity in identifying, reporting, or CPS substantiation based on socioeconomic standing. The data was less clear regarding sexual abuse and neglect. A separate analysis of the first and second years of the NIS data did not show that the family’s income influenced reporting.\textsuperscript{30}

**Lack of Knowledge and Training**

Education about child abuse recognition not only affects physician identification, but also affects physician reporting behavior. King\textsuperscript{32} studied the effects of education on the lifetime reporting practices of physicians and other mandated reporters and found mandated reporters with more than 10 hours of training reported a significantly larger percentage of children whom they suspected had been abused than did those with fewer than 10 hours of training.

**PHYSICIAN REASONS FOR NOT REPORTING SUSPECTED MALTREATMENT**

Many practitioners say they do not report suspected maltreatment because they do not want to hurt their relationship with the family.\textsuperscript{9,24} In some cases, they believe that they can work with the family without outside intervention and that they can manage the maltreatment better than CPS.\textsuperscript{9,23,24} One option these practitioners may choose is to refer the family to a social worker for intervention or to a mental health professional for counseling.\textsuperscript{9,22}

Some physicians do not report if they believe a child would be harmed by the report.\textsuperscript{32,24} Physicians express a concern that if they report a case to CPS that is unfounded, they will lose the family as patients, and the family then will not receive the needed medical and social service follow-up.\textsuperscript{28} Physicians also express concern that a report will otherwise interrupt the child’s treatment or cause a child not to return for essential care.\textsuperscript{22,34}

**Previous Experience with CPS**

Many physicians mistrust CPS because of negative experiences. Only a minority of physicians report they were kept informed about the status of an investigation.\textsuperscript{9,35} Other studies also have shown that this lack of CPS investigator feedback affects physician attitude and becomes a barrier to physician reporting.\textsuperscript{32,36}

The Pediatric Practice Research Group (PPRG) study showed a majority of physicians believed children they had reported to CPS had not benefited from CPS intervention.\textsuperscript{9} Arizona physicians said that they were unsure that a report to CPS would lead to an improvement in the child’s welfare.\textsuperscript{26} Many physicians express a concern that nothing will happen as a result of their report to CPS.\textsuperscript{24} Almost half of the physicians in the PPRG study (49\%) indicated that their last experience with CPS made them less willing to report in the future.\textsuperscript{9}

Because primary care physicians may see a small number of maltreated children, physicians may not be able to place a negative experience in the context of a range of experiences and responses by CPS. Any experience identifying or reporting suspected maltreatment may take on additional significance and distort their future actions. Some physicians describe a sentinel experience that continues to affect their decision making.\textsuperscript{8} Sometimes this sentinel experience has caused them to change an office routine (eg, now the physician completely undresses every child). For other physicians, an inadequate response from CPS has caused them to question the value of reporting to CPS. These physicians describe feeling exposed when CPS did not follow up on their concerns.
Although CPS response appears to affect physician reporting, factors other than the physician’s previous experience with CPS may play a greater role in the physician’s decision to report. In one study, a professional’s belief that a report to CPS would benefit a child or family had less effect on the professional’s decision to report than the severity of the maltreatment and the legal mandate to report.27 Other studies have also shown that the severity of the abuse affects physician reporting.22,27 Some physicians say they do not report if the abuse or neglect is not serious. Other physicians indicate that they did not report if they thought that the “situation had resolved itself.”22

Misunderstanding of CPS Role

Many physicians misunderstand both the child abuse reporting laws and the role of CPS. State laws are purposely vague. Most state laws mandate that physicians report to CPS if they have reason to believe or reasonable cause to suspect that a child has been abused. According to one study, some physicians misinterpret these laws to mean that they are obligated to report abuse allegations made by someone else, even if they have no reason to suspect abuse.37

The legal system is designed to ensure that professionals in contact with children will report suspicion of abuse. The role of the state CPS is to investigate and determine whether or not the child was, in fact, abused. However, the most common reason given for not reporting was that physicians were reluctant to report before they were absolutely certain of the diagnosis.22,24 Many of the general practitioners in an Australian study indicated that reports should only be made if one is quite certain of abuse.23

Fwigman opines that child maltreatment is underreported because there is no universal definition of child maltreatment. He points out that the concept of child maltreatment is defined by social and political advocacy and that the definition fluctuates.4 Most state laws mandate that physicians report to child protective services if they “have reasonable cause to suspect,” but reasonable cause is not defined.

On the other hand, physicians report that the legal mandate to report makes it easier for them to inform a family that they are reporting suspected maltreatment.6 Zellman found that the legal mandate to report most strongly correlated with the physician’s decision to report suspected maltreatment.27

Many physicians expect that if they report suspected maltreatment to CPS that CPS will automatically remove that child from the home and place the child in foster care. In fact, most CPS agencies provide extensive family support, and are appropriately reluctant to remove children from their parents. Further research may better elucidate whether these expectations of dire consequences may cause the physician not to report their suspicions to CPS.

Other Barriers to Reporting

Office-based practitioners describe a need for other resources to assist them in making decisions about whether a child was maltreated, how to evaluate the child to make that determination, and whether they should report to CPS. They explain that immediate access to child abuse experts would assist them in determining their level of suspicion that a child was abused and how they could best keep this child safe while CPS investigates.8 Many physicians lack access to mental health and other community resources that could assist them in making decisions.

Physicians also describe system problems that sometimes impede the recognition of maltreatment. Following through on suspected child maltreatment takes precious office time and interrupts office flow. Physicians explain that a suspicion of maltreatment requires ex-
tra time to elicit a careful history, extra
time to explain to the family the need to
report to CPS, and extra time to notify
CPS.8,14 Offices may not contain all of
the imaging equipment and other diag-
nostic capabilities needed for physicians
to determine their level of suspicion of
maltreatment. Physicians are then faced
with the dilemma of how to ensure the
child’s safety while they collect the in-
formation they need to determine the
cause of the child’s condition.

Healthcare plans can serve as an
impediment to a quality child abuse medical
assessment. Physicians have described
how certain health care plans have pre-
vented them from obtaining diagnostic
studies or consultation from the insti-
tutions that would provide the quality eval-
uation needed to assist them in determin-
ing whether a child had been maltreated.8

Physicians also are concerned that, if
they report suspected maltreatment, they
will have to testify in court. Physicians
fear testifying in court for a variety of
reasons. Most physicians are not trained
in the court system and have little or no
experience providing testimony. The
court is an adversarial system, where the
physician’s knowledge, skills, and treat-
ment choices may be questioned. Physi-
cians may be concerned about the time
involved in providing this testimony.15,24
In one study, 15% of the physicians listed
“spending time in court or other legal
proceedings” as one of the adverse con-
sequences they had suffered as a result of
reporting suspected abuse to CPS.9 Dur-
ing the previous year, 12 of 13 physicians
said that they had spent a median of 5
hours (range: 1 to 22 hours) preparing to
testify and providing testimony in court
about children they had reported to CPS.

The need to testify can be costly for
the physician, since physicians may be
given little notice or choice about the
date or time to testify and frequently are
not reimbursed for their time away from
their practice. Despite child abuse report-
ing laws that grant physicians immunity
for reporting suspected maltreatment,
physicians have been sued for malprac-
tice because of their reports to CPS.38

When deciding whether or not to
report suspected maltreatment, physi-
cians often consider the potential costs
of reporting while determining both risk
and benefit to the patient.8,32 Mandated
reporters who suspect that more harm
than good will come from a report are
less likely to report suspected maltreat-
ment.32 Some physicians may deem the
personal “cost” of reporting as outweigh-
ing the benefit of reporting, because of
the increased time needed to evaluate
the patient, arrange for the child’s safety,
and make a report to CPS.7,22

SUMMARY

Physicians systematically underiden-
tify and underreport cases of child abuse.
These medical errors may result in con-
tinued abuse, leading to potentially se-
vere consequences. We have reviewed a
number of studies that attempt to explain
the reasons for these errors. The findings
of these various studies suggest several
priorities for improving the identification
and reporting of child maltreatment:

Improve continuing education about
child maltreatment. Continuing educa-
tion should focus not only on the iden-
tification of maltreatment but also on
management and outcomes. This edu-
cation should include an explanation
of the role of CPS investigator and the
physician’s role in an investigation. The
education should provide physicians
with a better understanding of the over-
all outcome for children reported to CPS
to help physicians gain perspective on
the small number of maltreated children
they may care for in their practice. This
education should emphasize that the ma-
jority of maltreated children will benefit
from CPS involvement.

New York is the only state that man-
dates all physicians, as well as certain
other professionals, take a 2-hour course
called Identification and Reporting of
Child Abuse and Maltreatment prior to
licensing.39 Cited studies in this article
suggest that such a mandate might be
expected to improve identification and
reporting, thereby encouraging other
states to adopt similar regulations.

Give physicians the opportunity
to debrief with a trained professional after
detecting and reporting child abuse. The
concept of child abuse and the gravity of
the decision to report can be troubling to
the reporter. The debriefing could include
discussions of uncomfortable feelings
physicians may experience related to
their own countertransference reactions.

Provide resources to assist physicians
in making the difficult determination of
suspected maltreatment. The role of ac-
cessible telephone consultation should
be evaluated, along with formalized col-
laborations with local Emergency De-
partments with pediatric expertise.

Improve the relationship between
CPS and medical providers. For ex-
ample, CPS workers should systematically
inform the reporting physician about the
progress of their investigation and the
outcome for the child and family. Several
past reports have made specific sugges-
tions to improve the working relation-
ship. Warner and Hanson recommended
that positive outcomes be programmed
into the reporting process.7 They sug-
gested that CPS have special phone lines
staffed by well-trained employees for
mandated reporters to call.

Finkelhor and Zellman34 proposed
a more radical change to improve the
working relationship between CPS and
mandated reporters. They suggested
that certain professionals, with demon-
strated expertise in the recognition and
treatment of child abuse and registered
as such, should have “flexible reporting
options.” Options include the ability to
defer reporting, if there are no immedi-
ate threats to a child, or to make a report
in confidence and defer the investigation until necessary. Finkelhor and Zellman emphasized that this model would improve physician-reporting compliance and enhance the role of CPS while reducing the work burden for CPS.

Improve interaction with the legal system. Child abuse pediatric experts who have courtroom experience could provide education and support to physicians who have little preexisting experience with the legal system. Reimbursement for time spent supporting legal proceedings should be equitable and may reduce physician concerns about lost patient revenue.

Retrospective studies and vignette analyses provide much information about some of the barriers to child maltreatment reporting and describe many of the reasons why physicians do not identify and report all child maltreatment. Future prospective examinations of physician decision-making may further explain the physician's decision-making process and the barriers he or she faces when identifying and reporting child abuse.

REFERENCES