VIEWPOINT

Disclosure Is an Essential Component of Ethical Practice
"I Am the Child Abuse Pediatrician"

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Child abuse pediatricians (CAPs) provide expert evaluations for suspected child maltreatment. Recently, there has been increased scrutiny of the work of CAPs in both courtrooms and the popular press.[1] A particular point of reproval is a perceived lack of transparency about how CAPs introduce the work they do. Although some CAPs have published recommendations about how to conduct such introductions, CAP professional societies offer no clear guidance about how to introduce the role of the CAP, and several high-profile cases have alleged a lack of clarity in CAP introduction.[2] Furthermore, the Illinois state legislature has debated a bill that would require CAPs to disclose specific aspects of their role and their relationship with the state's child protective services (CPS) agency.[3] The absence of clear guidelines and ethical standards may impair overall trust in the medical system.

We argue that CAPs have an ethical and professional duty to disclose their role within and outside the medical center and to inform families how their opinion might be used outside of the direct patient care team. We make no claim that failure to introduce the CAP role is a pervasive problem, as many CAPs likely are transparent about their role. Rather, we suggest that professional societies develop clear guidelines for clinician disclosure. This would help to promote the ethical principle of autonomy, which includes a commitment to informed consent and truth telling.[4]

CAPs are a consulting subspecialty service in hospitals, generally asked by the primary team to assess a child for concerns of child maltreatment. They examine the child, interview the parents or guardians, gather information including medical records, and collaborate with other subspecialists such as radiologists and hematologists to assess the likelihood that a child has or has not been maltreated. When the CAP concludes that a child has likely been abused or maltreated, they share this conclusion not only within the care team but also potentially with CPS and or law enforcement, according to state law. CAPs also frequently serve as liaisons between medical clinicians and criminal justice or child protection agencies, including providing court reports or testimony.

Any medical clinician may share medical information about reasonably suspected child maltreatment with CPS pursuant to mandatory reporting statutes. But CAP disclosures beyond the care team often, depending on the jurisdiction, are provided as a matter of memoranda of agreement with those legal authorities, by hospital policy or even state law. Many CAPs are part of "multidisciplinary teams"; within the hospital, this may include other physicians, social workers, or behavioral health specialists. In many cases, these teams also include professionals external to the hospital, such as CPS and law enforcement agency representatives with whom CAPs routinely share patient information. These established information-sharing pathways with legal authorities that investigate and civilly or criminally prosecute suspected child abuse distinguish the practice of child abuse pediatrics from other pediatric specialties. It certainly differentiates CAPs from the perspective of patients and their families. We argue that this difference informs a need for transparency and full disclosure.

Other treating professionals' codes of conduct require disclosure of such relationships. The American Psychological Association, for instance, instructs psychologists to disclose their role when they perform evaluations that will be shared with legal authorities.[5] This disclosure imperative is even stronger when, as is often the case, CAPs are funded by state agencies as part of contracts between hospitals and child protective services agencies. When physicians are employed or paid by a separate entity, the American Medical Association requires disclosure of the "nature of the relationship with the employer or third party."[6] Other professional organizations, including the American Bar Association, similarly require disclosure when there is a potential for a perceived conflict in terms of funding source.[7] The ethical principle of autonomy requires that CAPs disclose these relationships to the families and children they evaluate.

Potential barriers to clarity in CAP introductions include a concern that families might perceive the term *child abuse pediatrician* as an accusation, which might lead to a difficult interaction. Another potential concern is that families' willingness to disclose information might be negatively affected if they know that this information will be shared with CPS. Both worries are, in our opinion, unfounded and cannot justify incomplete disclosure.

Use of the title "child abuse pediatrician" can feel charged and, if not carefully explained, may make parents or guardians feel accused. Creation of and clear communication about institutional guidelines under which CAPs are consulted can diffuse this charge. If a CAP is consulted for all injured children younger than 1 year, for example, the consultation is normalized. CAPs also can be taught and can develop the skill of explaining the importance of such guidelines and the need for their involvement. Regardless, transparency and honesty must outweigh protecting a family's sensibilities, as is the case in other difficult conversations in medicine.

Practically, it is unlikely that the disclosure of the CAP's role would materially alter how parents or guardians might explain an injury. All physicians are mandated reporters and widely understood as such, often limiting parent or guardian disclosure.[8] A parent or

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guardian who would admit to a non-CAP physician that they hurt their child is, in our view, likely to admit the same to a CAP. Furthermore, knowing the CAP's role will enable parents or guardians to make appropriate arrangements, including obtaining legal representation or potentially relevant medical records. Importantly, CAPs frequently diminish initial concern for maltreatment by identifying an accidental or medical explanation for the initially worrisome presentation. CAPs can prevent unnecessary reports to CPS agencies or police or assuage concerns that might have been raised before their involvement. Finally, if a parent or guardian recognizes that they are talking to a subspecialist with expertise in nonaccidental injuries to children, they may be more likely to share relevant information that will help the specialist to identify the mechanism of injury and potentially to identify an alternative, nonabuse explanation.

Perhaps most importantly, ethically, patients and families have a right to know who they are speaking with and the goal of the consultation. When physicians enter a patient room, they are expected to introduce themselves and their role on the care team. Teaching faculty are required to ensure that the role of medical students is not misrepresented or obscured.[9] This ethical imperative respects the patient's right to understand the role of each care team member. Even relatively benign obfuscations of physician expertise have been described as a source of patient distress. Furthermore, while consent forms on admission to the hospital often include treatment by trainees, states have recognized that, in certain vulnerable situations, specific consent is required.[10] Misrepresentation harms trust in the medical system, both among families who interact directly with CAPs and among the broader public exposed to anecdotal misrepresentation in the media. We argue that this misrepresentation holds the potential for particular harm because disengagement with the health care systems may further endanger already vulnerable children in need of protection.

Finally, CAPs should prioritize clarity in their introductions to avoid difficulties when their conclusions lead to legal proceedings. CAPs are likely to be called to testify and will be subject to cross-examination by attorneys for the parents or guardians and child. We are aware of cases in which CAPs failed to accurately disclose their role to parents or guardians, and this failure was used during cross-examination to challenge whether CAPs followed appropriate procedures in reaching their conclusion. Creation of and adherence to clear ethical guidelines could obviate this potential pitfall.

CAPs have an important role in identifying and diagnosing child maltreatment. This role is not secret, nor is it shameful. Reported practices of obscuring the physician's role, even if well intentioned, are unethical and hurt trust in the medical system. We urge hospitals and professional societies to adopt policies that require all physicians and members of the care team to disclose their specific role and, particularly, to ensure that CAPs disclose that their medical assessments may be shared with CPS and law enforcement agencies.

ARTICLE INFORMATION

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