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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

How Should Race and Resource Context Influence How Neglect Is Considered by Clinicians?

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Abstract

Separation of children from their parents is one possible traumatizing consequence of a mandated report, which is not to be taken lightly. This commentary on a case considers how racism and poverty should influence clinicians' construal of their duties as mandatory reporters of abuse and offers recommendations about how to respond in similarly difficult cases.

Case

AB, age 1 year, is accompanied to a visit with pediatrician, Dr K. AB's grandmother apologizes for missing prior scheduled appointments and explains that she and her daughter both work many hours beyond full-time. Dr K asks about AB's caregiver when they're at work. AB's grandmother pauses and explains that neighbors "check in on" AB during the day. Dr K, recording AB's below-normal weight, certainly feels there's enough evidence to suspect that AB is neglected, although AB's lack of regular adult supervision and insufficient caloric intake are due to poverty, not to insufficient parental impulse or love.

Dr K hesitates, therefore, to "suspect" neglect. Dr K learned that one result of a recent mandatory report to the state's child welfare agency led to a 3-year-old patient's removal from a home in which the parents live in poverty. When that child returned to Dr K for an annual visit, the child was in a third foster care home, could not sustain eye contact with Dr K, would not engage in any kind of play Dr K tried to initiate, and was still underweight.

Dr K worries, "Neglect is obvious, so, yes, I suspect it. This means I'm mandated by federal law to report this to the state. But, ethically, that hasn't helped some of my patients before and might do more harm than good for AB." Dr K doesn't speak with anyone else and wonders what to do.

Commentary

Federal law requires that all 50 states have procedures for mandatory reporting by certain individuals when they suspect child abuse and neglect.[1] This case illustrates a common dilemma in child welfare for mandatory reporters and caregivers who seek help

for children with profound vulnerabilities. Dr K clearly recognizes what constitutes neglect from a medical perspective (ie, the child is underweight and alone for a good portion of the day). However, after asking the grandmother one question about childcare arrangements, Dr K did not ask additional questions to better understand what was happening in the life of the family or to evaluate what the improper weight may be due to—for example, the child's having a medical condition or not being fed properly or regularly, or something else. We do not know whether differences of language or culture or racial dynamics affected the ability of the grandmother and Dr K to communicate effectively and truly understand one another. Regardless, Dr K is justified in being concerned by the mere fact of a 1-year-old child being left alone for long periods of time. Whether Dr K took the extra step of considering the cause of AB's neglect—specifically, whether it is attributable to intentionally inadequate caretaking or perhaps to financial hardship, lack of access to childcare, unstable housing, or food insecurity—is not stated in the case. In short, Dr K was left with many unknowns about what could be contributing to his concerns about the health and well-being of the child, but he seems worried that help is needed.

For mandatory reporters, especially medical doctors who are trained to examine the totality of a patient's well-being, the dilemma is whether to make a diagnosis of neglect or child maltreatment generally and report the family to a child abuse hotline or to dig deeper into the circumstances of the family's life to learn more about the root causes of the warning signs. A deeper dive might result in recognizing the problem as poverty or hardship and lead to efforts to connect the family to concrete support as opposed to labeling the problem as child maltreatment.

The next section outlines the grounds for this assertion and places Dr K's dilemma within the larger context of a system that is doing harm. We then explain ethical concerns stemming from definitions of neglect and mandatory reporting. Finally, we discuss distinguishing between hardship and neglect and describe an ethical approach to child welfare.

Report or Look Closer?

As Dr K recognizes, the dilemma of whether to report or to probe for signs of abuse or neglect is heightened by the limitations of the likely responses from child protective services (CPS). Dr K remembers a specific case with a similar fact pattern in which CPS involvement did not lead to positive outcomes for the child. In fact, the overall health and well-being of that child may now be worse as a result of the call to the hotline and placement in 3 foster homes. The child that Dr K recalls now has great instability in life and is separated from family, which is affecting the child's development and has interfered with healthy bonding, not to mention that the child remains underweight. This information adds to the ethical challenge that he faces in reporting what he suspects is neglect and risking further harm or taking an alternative approach.

In the case, the physician reveals his ambivalence about the child's circumstances, noting on the one hand that the child's being underweight and left alone "are due to poverty" and, on the other, that "neglect is obvious." Is it obvious? While hardship can be harmful, is hardship that causes harm de facto child maltreatment? We assert it is not and that a closer look is warranted. Is it critical to connect families struggling with hardship to supportive and concrete services? Absolutely. Is a call to a child abuse hotline necessary in this case or even what would be helpful? Could other supportive or protective steps be taken in lieu of a hotline call? Does Dr K feel this is truly the most

appropriate or only way to address the situation? Or is it that, as a mandatory reporter, Dr K feels compelled to report to avoid culpability? Too often, we believe it is the latter.

The case raises several difficult ethical questions for clinicians.

- Do clinicians have the necessary information to reasonably suspect neglect and report it as such?
- Could mandatory reporting impair clinicians' ability to do what they feel is in the best interest of their patients' overall health and well-being?
- Does harm caused by reporting constitute a violation of clinicians' oath?
- Is a decision to make a report in any way influenced by race or social standing or any other factors in the family's situation other than the child's condition?

These questions result from, reflect, and contribute to an approach to child welfare in the United States that places many parties in ethical conflict. For mandatory reporters, such as Dr K, ethical conflict centers on legal reporting requirements vs gathering more information about possible causes of signs of abuse or neglect. For the family itself, the conflict is whether to seek medical attention for the child and risk being reported.[2]

Ethical Concerns

The need for ethical clarity in child welfare is demonstrated by persistent racial disparities in outcomes—such as children of color being "more likely to experience multiple placements, less likely to be reunited with their birth families, more likely to experience group care, less likely to establish a permanent placement and more likely to experience poor social, behavioral and educational outcomes" than White children[3]—and it is clear in the words used by those who have experienced the system to describe it.[4] Recognition of the harm that the child welfare system causes is reflected in the case, which describes the negative impacts on a child reported for neglect (ie, withdrawn and underweight) and the child's subsequent treatment by the system designed to protect the child (ie, 3 foster home placements). The origins and evolution of the child welfare system are well documented[5] and deserve to be discussed at greater length, but 3 key flaws are noteworthy: (1) the system is reactive rather than proactive and causes trauma; (2) it offers few alternatives to separating families; and (3) it disproportionately intrudes in the lives of families with low income and families of color.[6,7,8] These flaws are highlighted in the following discussion of ethical concerns.

Mandatory reporting. Mandatory reporting[1] has been recognized as a structure of oppression, especially for Black and Indigenous populations.[9] Mandated reporters may fear that they will be sued for not reporting suspected child abuse, as some states allow such tort claims.[10] This fear of liability places tremendous pressure on mandated reporters and may increase the chances that a report is made when it is not necessary. For example, reporters may make a call for neglect for what they recognize as poverty-driven circumstances. Insofar as they are aware of mandatory reporting requirements, families experiencing vulnerability may be disincentivized to seek help.[11] In such instances, family integrity hangs in the balance, and trauma to children often follows.

Neglect. Neglect is the most common reason children are separated from their families and placed in foster care.[12] The term *neglect* is not defined in federal child welfare statute, except in the broadest terms.[13] Rather, it is left to the states to define, resulting in inconsistent definitions across the nation. What may be considered neglect that rises to the level of maltreatment in one state may not be neglect at all in another.[14] Unlike

criminal law, in which offenses are categorized by count and require a mental state as an element of a crime, no such requirements exist in child protection law definitions.[15]

Ambiguity in legal definitions of neglect increases the likelihood that decisions to report will be made subjectively.[15] In the case, what constitutes neglect is front and center (ie, Dr K says on the one hand that the problems "are due to poverty" and on the other that "neglect is obvious"). Potential criminal liability or loss of professional licensure for not reporting can increase stress for mandatory reporters, as they seek to avoid underreporting due to fear of legal liability and to avoid overreporting out of an abundance of caution. Should medical professionals, especially pediatricians, be trusted to make sound professional judgments without facing potential criminal liability? We suggest the answer to both questions is yes.

Harm. In the case, Dr K has concerns about 2 harms to the child that arise at 2 levels: the harm of the child's being underweight and home alone at times if the child remains in the family and the harm of the child's experiencing instability and disruption as a result of separating the family. Both harms require contemplation and weighing both the short- and long-term consequences. On the one hand, we know that very young children are especially vulnerable to factors that impede their healthy development, including the lack of consistent care and attention to their physical and emotional needs.[16] On the other, we also know that very young children are particularly sensitive to disruption in their attachments to and bonds with their parents and that changing caretakers and making frequent moves can impair them for life, physically and psychologically.[16,17]

The ethical dilemma of having to choose one form of harm over another should have no place in a system intended to protect children. Nonetheless, the child welfare system's primary response to a report of child abuse and neglect, when the report is substantiated, is to investigate a family and separate the child from that family. Separation causes trauma to children and their parents, even when it is necessary.[17,18] Accordingly, there is growing concern about harms that traditional child welfare approaches and vague definitions of neglect cause children.[19] For example, the child welfare system continues to surveil and police poor families and families of color, exposing them to increased reporting and the harm of separation, even when poverty, not neglect, is the main concern.[20] Decades of poor outcomes for children and youth in the child welfare system, including more than 20 000 young people exiting care annually[21] without the permanency of a family and the supports and connections needed for their well-being, provide additional evidence of the system's harmful results.[22,23,24,25]

How to Respond

Dr K must work within the system of which he is a part and in accordance with the laws that govern his professional behavior, which include reporting obligations when he has good reason to suspect that a child is being neglected. While it is not his job to determine if neglect has occurred, it should be his job to understand enough of the facts to warrant a report and risk the further harm that reporting can bring. Dr K has an opportunity to engage with the child's parent and grandparent to explore age-appropriate childcare arrangements and proper nutrition. He has an opportunity to ask for more frequent appointments and possibly link the family with a home visiting nurse.

Through activities such as these, Dr K would have an opportunity to ascertain whether it is indeed the family's poverty that is responsible for the child's being underweight and

left alone or whether the caretakers are intentionally neglectful. In either case, help will be needed, but the additional information and insight could help Dr K determine where that help should come from and what form it should take. Nevertheless, the nature of the dilemma will not change until child welfare changes how it responds to both poverty and neglect. We assert that, in the face of the known harms and dangerous effects of common child welfare practices, the continuation of those practices—and the vast funding of those practices—constitute a lack of systemic ethics and will continue to put reporters, such as Dr K, squarely in ethical dilemmas.

As a field, we allow preventable harm to occur with little and sometimes no consideration of transforming the system that causes the harm. In fact, we require harm to occur before most interventions, services, or supports are made available, and then we exacerbate harm to children and their parents by causing additional trauma in our responses, which include unnecessary family separation—often without reasonable efforts to keep family members safely together.[26]

What Should Child Welfare Practice Look Like?

An ethical approach to child welfare in the United States requires explicit acknowledgement and ownership of the harms that have been caused and a corresponding duty to stop causing harm and to dismantle harm-causing structures and approaches.[7] The child welfare system can and should be reconceived and restructured, at minimum, to do no harm. Ideally, like whole health and wellness approaches to medicine, child welfare could become a framework for a preventative approach and, when needed, be restorative and healing. This framework would clearly distinguish hardship from child maltreatment and contain safeguards to prevent the confusion of the two.[27] It would incentivize efforts to understand child and family needs and provide critical services and supports as opposed to clinicians' fear of criminal liability making intervention the default. This type of approach would allow a medical professional like Dr K to stay focused on what the child needs to be healthy and what can be done to help the parent or caretaker better ensure the child's needs are met. Dr K would—and should—retain the ability to call child protection services in any instance when abuse is suspected or the child is in immediate danger, but this option should be fully at the discretion of the pediatrician based on their professional judgment.

Overall, an ethical approach requires investments in historically disadvantaged communities and in robust networks of familial support (ie, primary prevention).[28] Such an approach should be designed and driven by families and communities. Partnerships with community members enable trust that is essential for families to make stigma-free and threat-free requests for help, admitting their vulnerabilities along with their openness to help and support without fearing the loss of their children. With appropriate community investment, could the family of the child in the case find support for reliable childcare? For proper nutrition? For transportation to medical appointments? Resoundingly, yes.

In the absence of immediate danger or harm, an ethical approach demands alternatives to separating families that do not threaten the integrity of family relationships and unity. There is growing research demonstrating that community-based, universally available family supports diminish the need for formal intervention by CPS.[29] Place-based approaches that provide an array of services and concrete supports within the communities where families live and work are showing promise.[30] These approaches are consistent with research demonstrating the positive impact of providing material

supports to families to prevent the greater harm of not attending to those needs.[31,32] Family resource centers are one example of a form of community support that is nonthreatening and nonstigmatizing. Compassionate community responses that recognize and can meet cultural and familial needs—including basic human and material needs—before a physician or other mandatory reporter faces a dilemma of whether to report or call for help can make a difference.[33] They can also serve as an alternative to a referral by a physician who sees need or feels concern but does not suspect maltreatment.

It is time for an overarching systemic commitment to nonmaleficence in child welfare and a corresponding duty to invest in families and communities to help them thrive as a first step to repairing historic and ongoing harm. Failure to make such commitments affirmatively and to redesign child welfare accordingly represents a profound moral and ethical shortcoming and abnegation of justice for families. However, reform will not replace the need for state intervention in instances of severe physical, sexual, and emotional abuse or intentional neglect. It would, however, dramatically reduce the trauma that occurs when families are subjected to state intervention when other, less intrusive measures could alleviate stress and risk, help to keep children safe, and preserve the integrity of families and children's relational health.

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