Disparities in Child Maltreatment Reporting
by Suzanne B. Haney MD, MS, Editorial Board Member, Pediatrics

In this month's Pediatrics, Drs. Palusci and Botash offer a sobering insight into the disparities that exist in child maltreatment reporting (10.1542/peds.2020-049625). Throughout the past few decades, research into child maltreatment has continually supported the concept that we, as humans, are susceptible to judgment errors in diagnosing and reporting abuse. We both fail to recognize abuse in intact white families and have an increased suspicion of abuse in underrepresented minorities.

I have seen this far too often when I am consulted on cases of possible child abuse; the resident calls me, gives me the very concerning history of an unexplained fracture in a 3-month-old with no history of trauma, and then proceeds to tell me that "the family is nice" and therefore the fracture must have another explanation. While this is an overt example of bias, it serves to explain how easy it is to make judgments about patients and families based on skin color, socioeconomic status, or intellect.

Systems I and II thinking is described in the book "Blind Spot" by Daniel Kahneman and applied to child maltreatment by Skellern. System I thinking is fast, automatic, pattern-based thinking. This is an evolutionary process that allowed us to rapidly decide between safety and danger and to reduce the energy and brain power needed for everyday processes like driving to work or "gut" decisions. However, type I thinking can lead to bias and stereotyping. Type II thought processes are more time consuming, but generally more accurate and involve more detailed, analytical thinking. One way of reducing the errors in system I thinking is through cognitive forcing-processes to ensure that type II thinking is followed for important and vital decisions. A surgical time out is an example of cognitive forcing to prevent wrong-site surgeries and other medical mishaps.

Palusci and Botash provide a framework for mitigating type I bias in our diagnosis and treatment of children with suspected abuse:

- Provide education to providers and other medical professionals on child maltreatment and bias.
- Use standard tools, protocols and pathways in both suspecting and diagnosing abuse to minimize the impact of bias and type I thinking. For example, my institution has a pathway which requires involvement of the hospital child protection team for all fractures in children less than 12 months of age.
- Maximize the use and effectiveness of multidisciplinary teams to recognize bias in cases of suspected abuse. Should all reports of abuse be reviewed by a multidisciplinary team?
- Ensure that we, as pediatric professionals, understand and reflect on our own biases and...
expectations. Are we minimizing abuse because the family is "nice" as they reflect attributes that our society considers "good"?

Responding to racism and bias begins by looking at our own actions and practices and continually assessing the impact of our decisions on the health and wellbeing of our patients. Given the risks of either over- or under-reporting abuse, we need to be cognizant of the factors which contribute to our decision-making so that we minimize the chances that bias influences the care of our patients.

References:


- [Child Maltreatment and Mortality in Young Adults](#)
- [Child Maltreatment and Adult Living Standards at 50 Years](#)
- [Clinical Considerations Related to the Behavioral Manifestations of Child Maltreatment](#)
- [Facebook](#)
- [Instagram](#)