

## A Struggle for Certainty — Protecting the Vulnerable

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*Are you sure?* I ask myself.

I stand there listening, watching, as the couple describe their house, its picket fences, their dog, the swing set in the backyard.

*Are you really sure?* The question asserts itself again, in tempo with the ventilator's rhythmic *whoosh*.

*Are we sure we're sure?* Like a siren gaining volume, these piercing words distract me, threatening to derail my focus. I'm here to deliver news that won't be well received. I glance at my patient, an infant lying peacefully in his hospital crib, cherubic features obscured by the tape securing his endotracheal tube. A large subdural hemorrhage was visible on his CT scan, and the radiologist just called with more bad news: healing posterior rib fractures diagnosed on a skeletal survey. Surely there's been a mistake, I tell the radiologist, but my suggestions of overlying artifact or poorly penetrated films can't cast any uncertainty on his diagnosis. The x-rays are nearly identical to images in my textbook labeled "highly suspicious for child abuse" — bulbous bony calluses defiling the otherwise smooth contours of the ribs. Absent a reported history of trauma,

my hope of deeming this constellation of clinical findings accidental is further quashed by the ophthalmologist's description: "multilayered retinal hemorrhages extending out to the periphery, too numerous to count, highly concerning for nonaccidental trauma."

Focus, I tell myself, as I consider the mild-mannered woman sitting before me, her gainfully employed, well-educated husband leaning on the guardrail of his son's hospital bed. I'm finding all this hard to reconcile. The parents of this damaged infant seem so pleasant, even charming, their docile demeanors juxtaposed with multiple injuries without known cause. Detach the facts from the people, I remind myself. I'm here to tell his parents I've called child protective services, and they're under investigation for child abuse.

We had met briefly in the emergency department when the ambulance first brought their son in. His father had found him, a fragile infant only a few months old, seizing in his crib during a nap. When we met, they seemed worried, visibly scared, and I remember looking into the moth-

er's eyes while gathering my history of present illness. I had felt somewhat guilty, probing for details at a time like that, looking for suggestions of a history of nonaccidental trauma. They had moved to this town a few weeks ago, a job transfer prompting them to abruptly pack up their former life several states away and leave family, friends, trusted babysitters behind. Their schedule seemed a blur of per diem shifts and weekend work, with shared child-care responsibilities wedged between, and the mother painstakingly recounted the home remedies for colic she'd tried on the pediatrician's advice. Nothing had seemed to work, she said. I'd briefly mulled over the possible dynamics — crying infant, frustrated caregiver — as the knowledge of the medical findings weighed on me. Looking at them, I'd asked myself, *Is there anything else you can think of?* I'd wished there was. I'd wanted to exhaust all the possibilities.

As a pediatrician who assesses children for possible abuse, I grapple with uncertainty every day. Knowing that a child's safety may be in my hands, I must weigh the objective evidence to determine

whether the signs and symptoms represent the effects of abuse. For me, the question is one of probability, whether mechanistic and historical explanations incongruous with clinical reality exceed my threshold of suspicion for reporting to child protective services. Differentiating between inflicted and accidental injury to a “reasonable degree of medical certainty” — the criminal courts’ lingo — can be complex, at times far from satisfactory to investigators seeking immediacy and omniscience. Even the most unequivocal radiologic and laboratory studies can prove challenging when the knowledge of the gravity of my decisions threatens to sabotage my actions. Though I ultimately defy the temptation to let feelings sway my judgment, I must acknowledge that sometimes I’m tempted. I may feel sadness or anger over the injuries I assess, or frustration with an overburdened protective services system tasked with the near-impossible mission of ensuring the safety and well-being of the most vulnerable.

Then there are subconscious biases that shape all human interaction. *Are you sure?* sounds decibels louder when I find the family likable — when I can imagine myself bumping into them at the local supermarket or in the school parking lot. The more likable they are, the harder it may be to conceive of them being responsible for the child’s injuries. And seeing them as “like me” creates the hardest situation of all.

Most complicating may be the burden of knowing that my assessments could radically change the lives of a child and family forever: thanks in part to my medical impression, a child may

grow up distant from his or her parents, safety taking precedence over biology. Child abuse is never simple, never *not* complicated.

I take solace in knowing I can’t possibly be alone in this confusion. It’s not all up to me, this quagmire of probabilities, imminent risk, and children’s best interests. We work as a team, the medical provider buffered by the independent assessments of social workers, caseworkers, and police who collectively determine the probability of future harm and the necessary steps to safety. The definitions, criteria, and practices we each use to stratify levels of concern and involvement entangle us in a marriage of necessity, with the goal of doing what’s best for children.

Sometimes our relationship works harmoniously, when the gravity of a child’s injuries and the degree of medical certainty prompt swift action, and the child is protected by the provision of safety planning and support for the family and the perpetrator is punished. Sometimes we disagree about the likelihood of future harm, and our discord threatens to taint our impressions of the family’s functionality. There’s a rawness to these investigations — a vulnerability that can affect the caseworkers, social workers, and police officers as they uncover what lies behind the walls of a home where a child may grow up, safely or unsafely, on the basis of their judgment. Yet we must all form our opinions and make judgments, and when we’re wrong there are consequences. Child protection is a complex gamble on successful parenting and happy childhoods.

I often struggle to reconcile the injuries I’ve found with the

tragic knowledge that they were sustained at the hands of a human being, a hand I may have held in consolation or support at the bedside of a battered child. It is challenging to weigh what I know to be true against what I wish were the case. But I can’t allow the sound medical evidence of x-rays revealing “classic” injuries considered “pathognomonic” for child abuse to be trumped by emotion’s rose-colored glasses.

Every case, every family, and every interaction is different. I believe that in this field more than most areas of medicine, we should strive to embody the *tabula rasa*, approaching each encounter free from preconceived notions, stereotypes, and judgments informed by ZIP Code, income level, or skin color. Though we can’t erase the experiences that define us as individuals and shape our reception and expression, our interactions with other people, we can strive to recognize, manage, and understand these influences on our actions and thoughts.

I look back down at my patient, his healing rib fractures, acute brain injury, and retinal hemorrhages revealing a tragic truth about his safety. I am one of society’s sentinels, tasked with identifying children who’ve been injured by those responsible for their care, and I must start the process of protection. I feel a little more clarity as I look back up at his parents, more secure in my medical opinion, and I begin the conversation.

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