Child Abuse Mandatory Reporting for Physicians

Lawrence R. Ricci, MD, FAAP

Chelsea at age three months visited her pediatrician accompanied by her mother Vickie and father Patrick with a complaint of two days of vomiting and “easy bruising when being held too hard.” Examination revealed two bruises, one on the right side of the mandible and one on the left. The parents thought the injuries were self-inflicted. To the doctor the parents seemed “appropriate.” The pediatrician’s diagnosis was gastroenteritis plus either accidental trauma, inflicted trauma, or bleeding disorder. Treatment was to return if symptoms continue.

Unknown to the pediatrician, Patrick had assumed primary care of Chelsea at age two months when Vickie went back to work. He found Chelsea’s crying stressful. He would often grab Chelsea’s mouth to stop her crying.

A few weeks after this visit, Patrick struck Chelsea across the head with a closed fist. He also shook her. She lost consciousness. He rushed her to the hospital and stated that she had accidentally struck her head on the crib rail. The hospital staff had seen Chelsea a week earlier for an unexplained Acute Life Threatening Event. They did not believe Patrick’s story and immediately called child welfare and the police.

Chelsea sustained a skull fracture, subdural hematoma, parenchymal brain injury, retinal hemorrhages, and a hepatic laceration. She remained an inpatient for two months. Patrick eventually confessed and was sent to prison.

Now ten years old, Chelsea is blind, mentally retarded, and suffering from a seizure disorder. She has sued her former pediatrician for failure to suspect abuse and report as required by law.

What could the pediatrician have done differently?

1. Consider the bruising an indicator of possibly serious abuse.
2. Since child abuse was in the differential diagnosis, consult with a child abuse pediatrician if available and report concern to child welfare.

In 1962 Doctor Henry Kempe, a Colorado pediatrician, along with his colleagues published the landmark paper "The Battered Child Syndrome" in The Journal of the American Medical Association. This paper clearly stated for the first time that many as 15 medical and non-medical providers.

The latest addition to the law, LD 1523, was specifically written because of the death of an infant who not only had a previous broken bone but also had previous unexplained bruises not reported by as many as 15 medical and non-medical providers.

LD 1523 specifically states that a person required to make a report, shall report to the department if a child who is under 6 months of age or otherwise non-ambulatory exhibits evidence of any of the following:

- Fracture of a bone
- Substantial bruising or multiple bruises
- Subdural hematoma
- Burns
- Poisoning
- Injury resulting in substantial bleeding, soft tissue swelling, or impairment of an organ

I would add any bruise in an infant less than six months of age. Many of these injuries are now known as sentinel injuries, injuries that predict further injury if not death.

What should you do when suspecting abuse?

1. Remain nonjudgmental
2. Take a careful history
3. Examine the entire child
4. Document everything and take photos of bruises if possible
5. Consider hospitalization if there is any question about safety
6. Seek consultation. Maine has available round the clock certified Child Abuse Pediatric consultation through the Spurwink Child Abuse Program in Portland, Maine (1-207-879-6160)
7. File a report immediately by calling Child Protective Intake at 1-800-452-1999, available 24 hours a day, 7 days a week including holidays
8. Never forget that if you are going to err, err on the side of child safety

The risk to the physician for not reporting includes a civil fine and of course a potential lawsuit should the child be injured again. Mandated reporters are protected by law from suit for reporting. Of course even worse than a civil fine or lawsuit would be the knowledge that failing to take action contributed to a child’s further injury or even death.
Licensors who have complaints filed against them frequently ask why the Board wastes its time investigating obviously frivolous complaints. While it is important to remember that most complaints are not frivolous to those making them, there is a very simple answer: the law requires the Board to review all complaints. M.R.S.A. 32 §3282-A states, “The board shall investigate a complaint, on its own motion or upon receipt of a written complaint filed with the board, regarding noncompliance with or violation of this chapter or any rules adopted by the board.”

The Board understands that receiving notice of a complaint can be stressful and unsettling. It tries to make the process as simple and efficient as possible; however, if you have questions, please contact the Board office. Although staff cannot give you legal advice, or write your responses for you, they can answer questions about the process, summarized below.

Upon receipt of a complaint the Board has sixty (60) days to notify the licensee of the complaint. The complaint notice, which will arrive as restricted delivery certified mail, will include the complaint, a request for additional information, a Guide to the Complaint Process, and a thirty (30) day due date. It is important that you read the complaint and notice carefully. Try to answer all of the concerns in the complaint and make sure you provide all the requested information. If you cannot complete your response in time, let Board staff know as soon as possible. Staff may grant an extension when necessary.

The response you provide the Board will be shared with the complainant for rebuttal. This is important to remember. Your response should be professional and respectful. Once Board staff has gathered all the information (the complaint, response, rebuttal, records, and any other appropriate material), the Board will review the complaint file at its monthly meeting. The Board tries to review cases within four (4) weeks of receiving your response; however, depending on when your response is received, it may take a little longer.

You are welcome to attend the meeting and listen to the Board discuss the complaint file. While you are welcome to listen, you may not address the Board or interact with individual Board members. If you would like to attend the meeting, please let Board staff know at least two (2) weeks in advance.

Following its review of the file, the Board may dismiss the case, dismiss with a letter of guidance, order further investigation, order an informal conference, or order an adjudicatory hearing. You will be notified in writing of the outcome of the review. If your complaint is dismissed, please keep a copy of the dismissal letter in a safe place. The Board destroys dismissed complaint files and may not be able to provide you a copy of the dismissal letter should you need it in the future.

If the Board orders further investigation it will finish the investigation as quickly as possible, but it may take several months. If the Board orders an informal conference you may wish to consult an attorney. The attorney will not engage the Board during the conference, but could offer you support and advice. If the Board orders an adjudicatory hearing the Board strongly recommends you consult an attorney.

Except for an emergency regarding public safety, the Board cannot take an adverse action at the end of its initial review of a complaint. In order to take an adverse action the Board must hold an adjudicatory hearing or enter into a consent agreement with the licensee.

We are often asked how licensees can avoid getting complaints. Since many of the complaints reviewed by the Board involve some form of poor communication, a good way of lowering the risk of getting a complaint is through good listening, clear explanations, and respect. You may also find helpful information on the Board’s website, www.maine.gov/md which lists all of the adverse actions taken since 1988.
Healer Burnout and Resilience
George K. Dreher, MD

A two part series

“There comes a point, when no matter how hard you beat your mule, he can’t plow no faster.” — Southern saying

We are awash in a sea of change with many new regulations and systems adding complexity to our increasingly huge medical knowledge base. We came into this field because we wanted to be healers and instead find ourselves spending more time on administrative matters than caring for patients, often in tasks requiring far less training than medical school, residency, and perhaps fellowships require. Recent polls indicate the majority of physicians would leave the career of medicine now if they could, and many are moving into associated fields such as insurance or medical management just as the need for more physicians is growing. What are we going to do as a profession and as individuals to counter this trend? This is the first of two articles to consider these problems and look at emerging solutions for the crisis in provider well-being. In this article we will describe some common causes of burnout, and in the next issue of the Newsletter we will consider resiliency with the goal of helping us find ways to re-set ourselves to meet this changing landscape.

We have chosen to become physicians for many reasons including being drawn to the values of thoroughness, commitment, perfectionism, altruism, hard work, caring, and self-criticism. It is all too easy for these to be carried too far into significant compulsiveness, over-commitment/workaholism, denial and inability to admit mistakes, poor self-care and quality of relationships, compassion fatigue, and self-blame. This negative state often is experienced as burnout comprising three major components; emotional exhaustion, depersonalization/cynical attitude, and a sense of low personal accomplishment. These traits can easily negatively impact our well-being, the quality of the care we provide (safety vs. errors), and the quality of caring (empathy vs. detachment) for the patient.

Recent research has found that 45% of U.S. physicians reported at least one of these three key burnout components but even more surprising was the comparison of risk for burnout based on educational history. Compared to high school graduates, the risk for burnout was 20% less for those with a bachelor’s degree, 29% less for those with a master’s and 36% less for those with a PhD, while MDs and DOs were 36% more likely to suffer from burnout symptoms.1 The medical specialties with the highest rate of burnout were Emergency Medicine at 65%, General Internal Medicine at 56%, Neurology at 55%, and Family Medicine at 54%. There are many possible internal and external risk factors for burnout that have varying degrees of impact depending on the individual’s own emotional makeup and life circumstances, though a loss of meaning is often a major factor.2 Other common areas of concern are workload, one’s sense of autonomy/ control, rewards and a sense of mastery, a sense of community, fairness, and the values/meaning one derives from one’s work.3

Research has proven that physician burnout negatively impacts the emotional and physical well-being of the physician and, just as important, negatively impacts the care the patient receives and the patient’s ability to work collaboratively with the physician, thereby promoting improved outcomes.4 Finally, the system employing the physician is negatively impacted financially and in workplace morale, which in turn engenders more of the environmental factors creating burnout.

Yet ways are emerging to counter these trends. Research-based positive outcomes towards re-creating a sense of “joy in practice” will be considered in the upcoming second article.

Disciplinary Actions, 2008

- Fraud 10%
- Lack of Practice 7%
- Incompetence 17%
- MH/SA 52%

15 Mental Health/Substance Abuse Issues
(7 SA only - 8 MH/SA dual diagnosis)
5 Incompetence
4 Unprofessional Conduct
3 Fraud or Deceit in Application
2 Restricted or Denied License due to lack of current practice
29 Total

Disciplinary Actions, 2013

- Fraud 4.3%
- Lack of Practice 4.3%
- Unprofessional 39%
- MH/S 35%

9 Unprofessional Conduct
8 Mental Health/Substance Abuse Issues
3 Incompetence
1 Fraud or Deceit in Application
1 Lack of Practice
1 Surrender while under Investigation
23 Total

George K. Dreher, MD is Chairperson, MMC Medical Staff Provider Health and Resilience Committee, MMC Department of Medical Education, Associate Clinical Professor of Psychiatry, TUFTS/MMC.


www.mainegov/md 3
2014 Meeting Schedule

Meetings are held the second Tuesday of the month convening at 9:00 a.m. Sub-committees (except for PA Advisory Committee) meet prior to the start of the meeting at scheduled times.

**Medical Board Meetings**

- January 14
- February 11
- March 11
- April 8
- May 13
- June 10
- July 8
- August 12
- September 9
- October 14
- November 10
- December 9

**PA Advisory Committee Meetings**

Meetings are held on the following dates at 8:00 am:

- March 4
- June 3
- September 3
- December 2

**Questions? Contact the Board Office at:**

207 287-3601

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Notify the Board of Business and Home Address Changes Immediately

Many people experience problems at renewal time because they have neglected to notify the Board of an address change. To prevent delays, or even loss of license due to lapse, notify the Board immediately of any change in your address.

To verify that the Board has your correct addresses on file, visit: [www.maine.gov/md](http://www.maine.gov/md) and click on "Find a Licensee" at the lower left. If the address is incorrect, simply send a signed note with changes to the Board or submit the new information online at:

[www.maine.gov/online/doclicensing/](http://www.maine.gov/online/doclicensing/)

Confidential Help Available

Confidential professional help for substance abuse is available by calling 207 623-9266.

For more information, visit the MPHP website at [https://www.mainemed.com/member-services/medical-professionals-health-program](https://www.mainemed.com/member-services/medical-professionals-health-program) or send an email to: mphp@mainemed.com

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In memory of Drew Travers, the first Physician Assistant in Maine, who died October 22, 2013 at the age of 68.