1-1-2022

The Real Cause Of The Broken Rib: Developments In Pediatricians' Approach To Child Abuse; 1960 - 2020

Sofia Charania

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The Real Cause of the Broken Rib: Developments in Pediatricians' Approach to Child Abuse; 1960 - 2020

A Thesis Submitted to the Yale University School of Medicine In Partial Fulfillment of the Requirements for the Degree of Doctor of Medicine

by

Sofia Charania
May 2022
Abstract

The Real Cause of the Broken Rib: Developments in Pediatricians' Approach to Child Abuse; 1960 – 2020. Sofia Charania and Naomi Rogers. Department of History of Medicine, Yale University, School of Medicine, New Haven, CT.

In 1962, C. Henry Kempe published his landmark work, *The Battered Child Syndrome*, and set into motion a new discourse on child abuse within the American pediatrics community. This paper discusses the tension pediatricians felt between longstanding assumptions of parental virtue and the implications of the emerging conversation on child abuse started by Kempe. It also discusses the resistance shown by some pediatricians to accepting the reality of abuse and the slow process by which that resistance was overcome, aided by factors such as pediatricians’ involvement in adoption procedures. As pediatricians began confronting and understanding child abuse more deeply, their views of the ‘family’ and who they served became more nuanced and complicated. Their engagement in the conversation on child abuse therefore also influenced their thinking about related issues such as family privacy, corporal punishment, and children’s rights. This paper is based on an analysis of primary literature published in the journal *Pediatrics* between 1962 and the late 1970s, the historical period in which child abuse was explicitly named, defined, and discussed for the first time in the medical literature. Contemporary pediatricians continue to grapple with questions about children’s rights, shared decision-making, and the importance of minors’ consent. The COVID-19 pandemic has also brought the topic of child abuse to the forefront of pediatricians’ consciousness, as rates of abuse and neglect are suspected to be high given the stressors brought on by the pandemic and the interruption to in-person school attendance. Today, child abuse is an established part of the pediatric lexicon and pediatricians face the challenge of championing children’s rights while constrained by the limited resources health care has to address child abuse and neglect.
Acknowledgements

Throughout my work on this thesis, I have received a great deal of support. I would first like to thank my supervisor, Professor Naomi Rogers. Her guidance was instrumental in the formation of my research questions, depth of my analysis, and contextual framework for this project. The thoughtful feedback she provided was incredibly helpful not only for writing this thesis, but for instructing me on how to think about the intersection of medicine and society. Dr. Rogers’ patience and consistent willingness to share her unique perspective is what allowed this project to come to life.

I would also like to thank the Yale School of Medicine for the supportive and collaborative atmosphere it has fostered. I was met with much enthusiasm and support when I expressed that I was interested in pursuing a humanities-based thesis. Yale has allowed me to explore all my interests fully, and for that I will always be grateful. I am also grateful to the Section of History of Medicine for supporting students such as myself in contemplating broad questions about medicine and society.

Third, I would thank the Yale library staff, especially Melissa Grafe, who have made themselves available throughout the entire pandemic, and who have answered dozens of questions at all hours of the day. The library staff were incredibly helpful in ensuring that I was able to access the American Academy of Pediatrics (AAP) electronic resources. On that note, I am also grateful to the AAP for not only making new knowledge widely available to physicians and scientists, but also for digitizing thousands of journal articles dating back to the 1950s. The primary literature for this project was sourced through the AAP electronic archives, which were incredibly helpful and allowed for remote work through the pandemic.

Finally, I would also like to thank my family for their unending support throughout my time in medical school. I would not be here without their love and good counsel. I cannot imagine having survived medical school without the positivity and upliftment of my husband, parents, and in-laws.
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Introduction & Statement of Purpose

In 1962, pediatrician C. Henry Kempe and his colleagues published a landmark article titled “The Battered Child Syndrome” in the *Journal of the American Medical Association* (JAMA) and set into motion a nation-wide discussion on child abuse among pediatricians.¹ In the article, Kempe proposed a clinical syndrome described as “young children who have received serious physical abuse, generally from a parent or foster parent.”² The syndrome was identified by a combination of physical exam findings and elements of the story given by the caretaker. Kempe’s work built on existing research by radiologists, pediatricians, and psychiatrists, but was unique in that it integrated their findings into a single cohesive syndrome that would become recognized by pediatricians as a medical diagnosis.

“The Battered Child Syndrome” serves as an entry point into this thesis’s deliberation on how American pediatricians’ views have shifted over time. Because society’s notions of appropriate parenting, proper treatment of children, and children’s role within the family are dynamic, pediatricians’ views on these subjects are also constantly changing. This thesis seeks to document the slow change in pediatricians’ views in the decades following Kempe’s publication, from 1960 to 1979.

Despite the fact that child abuse has been discussed openly by pediatricians for nearly 60 years, it remains one of the most challenging issues for pediatricians today. First, the problem is not a lucrative one for hospitals to solve, for along with pediatricians, it requires the involvement of social workers, government agencies, and the court system. Second, pediatricians’ biases, clinical experiences, and personal backgrounds influence their ability to identify abuse and

² See footnote 1. 17
determine how it ought to be handled. Unlike many other medical diagnoses that can be identified by specific tests, child abuse is difficult to diagnose, emotionally challenging to confront, and often swept under the rug. Thus, reflecting on the evolution of the pediatric profession’s understanding of abuse, neglect, and adjacent topics can help physicians place themselves within a broader historical context as we continue to navigate these issues within the field of pediatrics today. Additionally, this study may help modern pediatricians focused on advocacy work and political activism to understand how boundaries within the field have shifted over time.

Previous scholars at the intersection of history and medicine have discussed the complexity of treating child abuse. Scholars approaching the topic from a clinical perspective have pointed to physicians’ willingness to accept abuse as a diagnosis and the developmental characteristics of abused children.\(^3\) Historian Stephanie Coontz has pointed to the challenges of family life in the 1960s and 1970s such as the high poverty rates, parental substance use, and domestic violence, including child abuse.\(^4\) Law professor John E.B. Myers discussed the role that physicians played in a societal awakening about child abuse in the period immediately after Kempe’s article.\(^5\) Historian of medicine and physician Mical Raz has discussed positive and negative consequences of expanded mandatory reporting laws in the late 1960s and early 1970s.

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\(^3\) Silver, Larry B., Christina C. Dublin, and Reginald S. Lourie. “Child Abuse Syndrome: The ‘Gray Areas’ in Establishing a Diagnosis.” *Pediatrics* 44, no. 4 (October 1, 1969): 595. Silver et al argued that physicians sometimes found it difficult to accept the reality of child abuse. and Elmer, Elizabeth, and Grace S. Gregg. “Developmental Characteristics of Abused Children.” *Pediatrics* 40, no. 4 (October 1, 1967): 596. Elmer and Gregg studied developmental characteristics of a group of abused children when admitted to the Children’s Hospital of Pittsburgh due to abuse and then again several years later.


and the high rates of removal of children from their biological homes as a result of these reporting laws.\textsuperscript{6}

This thesis will highlight how American pediatricians’ attitudes on child abuse children’s rights relative to the family have shifted in response to “The Battered Child Syndrome.” The process by which pediatricians first accepted the reality of child abuse and then began changing their views on children’s rights was turbulent and slow, as it required pediatricians to abandon long held commitments to the family unit and ideas about parental morality. However, this thesis argues that Kempe’s work was instrumental in precipitating that profession-wide shift in views. It also aims to shed light on how pediatricians saw the scope of their role expand as their views on child abuse evolved.

For this thesis, literature by historians on topics such as children’s rights, child abuse, and the American family were consulted to build the contextual framework of America in the 1960s and 1970s. In conjunction, an extensive literature search was conducted in \textit{American Academy of Pediatrics} journals from the years 1960 to 1979 and 2010 to 2020. Particular attention was paid to all articles focused on child abuse, neglect, and children’s rights, as well as any adjacent topics such as parental attitudes towards children, children’s attachment to caregivers, accidents, mental health challenges in caregivers, etc. In reading and analyzing these articles, attention given to assumptions made about children and parents, the implications of writers’ assumptions and questions, and whether abuse and neglect were mentioned or left out of such conversations.

This thesis is structured into eight sections. The first three sections provide context and explore the ways pediatricians wrote abuse and children’s rights in *Pediatrics* in the 1960s, prior to and immediately after Kempe’s publication. The next three sections discuss these topics in the 1970s, after Kempe’s work had been around for several years. The seventh section focuses contemporary pediatricians and their approach towards children’s rights and child abuse. The eighth section focuses on the COVID-19 pandemic and the effect it has had on pediatricians’ understanding of children’s rights, ethical dilemmas presented by the pandemic, and how we might champion children’s rights with these ethical challenges in mind.
Discussion

BACKGROUND & CONTEXT ON THE 1960s

Henry Kempe & Others

C. Henry Kempe’s article, “The Battered Child Syndrome,” was released in the prestigious *JAMA* in 1962 and became a turning point within the pediatric profession. Prior to this article, Kempe had established the first national Child Protection Team and had published several other works such as “Problem of Parental Criminal Neglect and Severe Physical Abuse of Children” in the *Journal of Diseases of Children*. However, “The Battered Child Syndrome” was unique in its effect on the pediatric profession.

In the 1962 article, Kempe proposed a clinical syndrome of “young children who have received serious physical abuse, generally from a parent or foster parent.” The syndrome was comprised of physical exam findings and elements of the history or “story” given by the caretaker. Kempe suggested that this syndrome occurred most often in children younger than three years of age and often included a discrepancy between the history provided by the caregiver and the physical exam findings. Kempe stated that exam findings may have included evidence of soft tissue and skeletal trauma, overall poor health, and signs of neglect, as well as specific features such as fractures in different stages of healing and subdural hematoma.

“The Battered Child Syndrome” built on research by radiologists, pediatricians, and psychiatrists of the time, and the way that Kempe integrated their findings was part of what made his work so influential. Kempe and his colleagues surveyed hospitals and district attorneys nationwide to collect data on the incidence of the clinical syndrome being studied and what legal

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7 See footnote 1. 17–24.
9 See footnote 7. 17
10 See footnote 1. 17-24.
action was pursued after the medical diagnosis was made. The evidence collected indicated that among 71 hospitals participating in this study, 302 cases of the clinical syndrome existed, with legal action taken in one-third of cases. District attorneys reported knowledge of 447 cases in a similar time period. Kempe referred to these data in his study to demonstrate how rampant the issue of child abuse was.

Kempe also used work published by several pediatricians and social workers to explain the ‘battered child syndrome’. Several radiologists had written about bone injuries between the 1930s and 1960s, which Kempe cited as evidence. Kempe also cited several studies that focused on subdural hematoma and skeletal lesions between 1946 and 1959. John Caffey’s work, “Multiple Fractures in Long Bones of Infants Suffering from Chronic Subdural Hematoma,” in particular, contributed to the identification of abuse after he recognized that several children with subdural hematoma also presented with long bone fractures. Kempe drew upon these radiologists’ work as evidence for his identification of a broader clinical syndrome. Their findings allowed Kempe to claim that the bone lesions found in children, in conjunction with other aspects of the medical history, were indicative of violence toward children. Kempe also referenced articles authored by social workers about children who presented to the hospital with a constellation of symptoms that fit in with his ‘battered child syndrome’.

Although Kempe’s work spurred conversation, he was not the first person to recognize child abuse. As Katherine Bain, the Deputy Chief of the Children’s Bureau, noted, the volume of papers on abused children had increased from one or two papers per year to about 15 between

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11 See footnote 1. 17.
1961 and 1962.\textsuperscript{14} “Abused Young Children Seen in Hospitals,” one of the earliest influential works published on abuse, was written by Elizabeth Elmer, a social worker, in 1960 and was cited by Kempe and several others who wrote about abuse.\textsuperscript{15} Elmer stated that children “are hospitalized every year through the ignorance, gross negligence, or deliberate abuse of the parents or other responsible adults.”\textsuperscript{16} She cited the cases of six infant patients at Children’s Hospital of Pittsburgh who were hospitalized due to suspected abuse. The purpose of her paper was to point out the issue of abuse as a blind spot in the social work profession. She argued that society as a whole found the idea of abused children repugnant and preferred not to think about it, and that this was “the chief reason that so little systematic study has been devoted to abused children and their families.”\textsuperscript{17} However, despite criticizing the lack of attention given to the issue of child abuse, Elmer described the issue as applying to relatively few children, stating “a small number of infants and children” were affected and describing the issue as “a rare hospital phenomenon.”\textsuperscript{18} Why Elmer felt the need to emphasize that the issue of abuse was so rare was curious, given that her paper sought to bring attention to the matter rather than to downplay its importance. “A Project To Rescue Children from Inflicted Injuries,” published in 1962 by Helen Boardman in \textit{Social Work} (and also cited by Kempe and several others) referenced social work literature that recounted numbers of abused children, some of whom were released back to their parents’ custody and subsequently died of additional injuries.\textsuperscript{19} Boardman listed in shocking detail examples of abuse which the Children's Hospital of Los Angeles had treated in 1960.

A 3 1/2 year old boy, who had multiple bruises, was admitted critically ill. Although he had minimal injury to the anus, four inches above the anus was a round hold through the rectal

\textsuperscript{16} See footnote 15. 98.
\textsuperscript{17} See footnote 15. 98.
\textsuperscript{18} See footnote 15. 98.
wall, the musculature, and perforations of the bladder. The doctors were convinced an object had been gently inserted and then strong force applied. The mother had left him in the care of his newly acquired stepfather, whom she had known for a year and who was on parole as a narcotics user.\textsuperscript{20}

Boardman discussed adults’ tendencies to give reports that did not account for injuries, claim ignorance as to how the injuries occurred, blame others, and attempt to protect other adults involved in the case.\textsuperscript{21} All of this pointed to the challenges in identifying and diagnosing child abuse, which was perhaps why Boardman highlighted just how horrific abuse could be in such detail. She also discussed new reporting procedures that had been implemented by the hospital in 1959 after officers, a presiding judge, and hospital staff shared their insights on abuse. The new reporting procedures included involving social workers in evaluating the family and making decisions on reporting. The new implementations were shown to be effective at a similar meeting one year later (at the time of publication).\textsuperscript{22}

**Response to Kempe’s work**

Kempe’s 1962 article became seen as a symbolic turning point within the pediatric profession itself. His work labeled abuse as a clinical syndrome in a way that had not been done before, and this aided in the identification and diagnosis of abuse. Characterizing the constellation of symptoms as a ‘syndrome’ led to increased recognition and diagnosis by pediatricians. Many writers have described the 1960s as a period when child abuse was brought under the purview of pediatricians. For instance, Stephen Pfohl, a sociologist at Ohio State University, stated that Kempe’s article was a turning point in the profession’s willingness to

\textsuperscript{20} See footnote 19. 44.
\textsuperscript{21} See footnote 19. 45.
\textsuperscript{22} See footnote 19. 49.
label abused children and led to the profession viewing abuse as a sort of ‘illness.’ Peter Conrad and Joseph Schneider in *Deviance and Medicalization* also described the 1960s as the period in which child abuse became clearly defined as a medical problem as a result of Kempe’s work.

A *JAMA* editorial in the July 1962 edition - the same edition that included Kempe’s landmark article - encouraged physicians to consider the diagnosis of abuse wherever the child’s medical history included repeated injury, echoing Kempe’s recommendation. Annie Kempe’s *A Good Knight For Children: C. Henry Kempe’s Quest to Protect the Abused Child* mentioned the challenges Kempe faced in writing and speaking about this controversial topic. She wrote about hearing death threats aimed at her father, but claimed that he always seemed unfazed, perhaps because he was accustomed to receiving harsh criticism for his work. However, it seems that no physicians published work explicitly disagreeing with Kempe or stating that child abuse was not happening.

Vincent Fontana, a director at two New York Hospitals and head of the Mayor’s Task Force on Child Abuse and Neglect for New York City, in his 1963 article “The Maltreatment Syndrome in Children” did not explicitly disagree with Kempe’s work, but rather argued that many children did not appear “battered.” He stated that obvious physical trauma was not always present, and that neglect, malnutrition, or a number of other factors could contribute to the ‘unrecognized trauma’ Kempe mentioned. He proposed the term “maltreatment syndrome” to capture the syndrome more fully and encompass signs such as emotional and nutritional

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deprivation. Although the term “maltreatment” began appearing more frequently as the topic of child abuse received more attention through the 1960s and following decades, the term “maltreatment syndrome” did not appear in the literature frequently as a medical diagnosis.

Several journals later published articles on abuse by other researchers, who referenced Kempe, Fontana, Boardman, and Elmer. Additionally, symposiums and conferences were held in which abuse and neglect were discussed. For instance, “Unsuspected Trauma with Multiple Skeletal Injuries During Infancy and Childhood” was a paper discussing skeletal injuries in children thought to be due to trauma, presented in a symposium on “The Battered Child” at the Academy of Pediatrics in Chicago in October 1961. The June 1963 edition of *Pediatrics* included a review of *Protecting the Battered Child*, a pamphlet which had been presented at the meeting at the Annual Forum of the National Conference of Social Welfare in 1962. The American Academy of Pediatrics established a Committee on the Infant and Pre-School Child, which produced the report *Maltreatment of Children - The Physically Abused Child* in 1966. The report proposed recommendation for legislation on mandatory reporting.

Frederic Silverman noted that between 1946 and 1961, about three articles on child abuse were published in the medical literature per year. After Kempe coined the term “battered child syndrome” in his 1962 article, the annual number of publications on child abuse rose to about 30 per year during the 1960s and over 50 per year in the 1970s. The PubMed database also shows a similar increase in discussion on child abuse. Between 1962 and 1969, Kempe’s article is cited

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28 McHenry, Thomas, Bertram R. Girdany, and Elizabeth Elmer. “Unsuspected Trauma with Multiple Skeletal Injuries During Infancy and Childhood.” *Pediatrics* 31, No. 6 (June 1, 1963): 903.
29 “Protecting the Battered Child.” *Pediatrics* 31, no. 6 (June 1, 1963): 902.
30 “Committee on Infant and Pre-School Child: Maltreatment of Children.” *Pediatrics* 37, no. 2 (February 1, 1966): 377–382.
three times, but between 1970 and 1979 it is referenced 16 times in the database and the number of references increases each decade.

Cultural Context in 1960s America

Prior to Kempe’s landmark article in 1962, some actions had been taken by hospitals and governmental agencies with the aim of protecting children. During the beginning of the century, several laws and governmental legislations reflected increasing public interest in children’s welfare. The 1909 White House Conference on Children led to the formation of the “Mother’s Aid” Movement and the American Association for the Study and Prevention of Infant Mortality. During the 1950s, California enacted legislation that required hospitals to report injuries inflicted on children that violated penal law. Various steps were taken across the country to support the welfare of children, but by the time Kempe’s article was published, a concerted national effort to identify and correct abuse had not begun.

In the years following his work, however, public concern and media coverage of child abuse grew rapidly. In 1963, the Children’s Bureau published model legislation for individual states to adopt as they developed legal requirements for reporting child maltreatment. John Reinhart, a pediatrician, and Elizabeth Elmer stated in 1964 that “public opinion concerning child abuse, once a tiny trickle, has swollen to a sizeable torrent” and cited the model legislation as a result. Between 1963 and 1967, every state in the US passed mandatory child abuse reporting legislation. Additionally, media sources during the 1960s began discussing child

33 Cal. Pen. Code 11110, 11161.5. 11160, 11161, 11162 These sections discuss reporting of child abuse cases.
abuse in detail. Katherine Bain in her 1963 commentary “The Physically Abused Child” in *Pediatrics* stated that the volume of articles in academic journals and popular magazines on the topic of child abuse had increased over the last several years.\(^{37}\)

Pfohl highlighted specific popular publications in the early 1960s that brought the topic to light including “Cry rises from beaten babies” in a 1963 copy of *Life*, “The shocking price of parental anger” in a 1964 *Good Housekeeping*, and “Terror struck children” in a 1964 *New Republic.*\(^{23}\) As well as reporting on the issue, often with dramatic headlines, Mical Raz argued in *Abusive Policies: How the American Child Welfare System Lost Its Way* that the popular press typically portrayed child abusers as mentally ill.\(^{38}\)

**Public Attitudes Regarding Abuse**

Despite the positive reaction to Kempe’s work, many people during the 1960s accepted physical force against children. William Goode, in his 1971 article “Force and Violence in the Family” noted that adults used force and threat to socialize children.\(^{39}\) He stated that “no very sharp eye is needed to know that American parents typically use force on their children from the earliest ages on.”\(^{40}\) In the 1970 book *Violence against Children; Physical Child Abuse in the United States*, David Gil stated that “culturally determined permissive attitudes toward the use of physical force in child-rearing seem to constitute the common core of all physical abuse of children in American society.”\(^{41}\) It is curious that popular media sources often described abusers

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\(^{37}\) See footnote 14. 895.

\(^{38}\) See footnote 6. Loc 203 of 4756


\(^{40}\) See footnote 39. 627.

as mentally ill, as if trying to make sense of the phenomenon of child abuse, when surveys indicated that the use of physical force in child rearing was common at the time.

It seems that a fine line existed between what constituted a normal use of physical force in child rearing and what constituted ‘abuse.’ However, even ‘abuse’ was still not considered a major societal problem in the beginning of the 1960s, and many Americans showed tolerance for abuse and sympathy for abusers. A nationwide study conducted by National Opinion Research Center (NORC) of the University of Chicago in 1965 evaluated public opinion about the topic of child abuse.42 The survey results showed that over 80% of adults in the US were aware of the general issue of child abuse. Only 13.7% of respondents stated that they would talk with a child’s family if they learned the child had been abused, but 70% would be willing to talk with the police or a local welfare agency. These numbers indicated a reluctance for direct confrontation, but a general acknowledgement that the state and other agencies had a role in protecting children. 66% of respondents thought that perpetrators of abuse should be supervised and treated rather than punished.43

**Physician Attitudes Regarding Abuse**

Physician attitudes toward child abuse in 1960s shifted through the decade. Prior to Kempe’s work, child abuse was considered a social problem, not a medical problem and was often ignored.44 Several writers have also discussed the barriers that prevented pediatricians to identify “abuse” as a syndrome before Kempe’s work in 1962. For instance, many emergency

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44 See footnote 36.
room physicians seemed to be unaware of the possibility of abuse as a diagnosis or were psychologically unwilling to believe in it. Among those who did believe in the possibility of abuse, many were hesitant because of the suspected nature of abuse and were hesitant to report families and get involved in legal proceedings.

Additionally, prior to Kempe’s 1962 article, physicians seemed reluctant to explicitly blame parents for the injuries of abused children. For instance, Caffey’s “Multiple Fractures in the Long Bones of Infants Suffering from Chronic Subdural Hematoma” published in 1946 did not offer an explanation for the physical exam findings noting that subdural hematoma was often accompanied by fractures of long bones. Pfohl outlined how several other radiologists’ hypotheses for what they saw on x-rays changed over the 1950s, becoming somewhat less vague as the decade progressed. For instance, Barmeyer and Anderson suggested the x-ray findings might be due to childhood accidents in 1951. Silverman proposed “parental carelessness” as the reason in 1953. Wooley and Evans blamed “indifference, immaturity and irresponsibility of parents” in 1955. Bakwin proposed “parental conduct” as the reason for the findings in 1956. Although all of these radiologists left their proposed causes vague, it did seem as though they were inching closer to explicitly identifying intentional abuse as the cause of the pattern of subdural hematoma and long bone injuries in children. By 1959, Donald Miller’s article “Fractures Among Children I. Parental assault as a causative agent” actually identified “parental assault” as a common cause of fractures in children.

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45 Some emergency room physicians did not believe in the possibility of abuse as a diagnosis. See footnotes 7 and 14. Some were aware of the concept of abuse but were psychologically unwilling to believe it. See footnotes 1 and 8.
46 Other emergency room physicians were concerned about becoming involved in legal proceedings. See footnotes 6 and 14.
47 See footnote 13.
48 Pfohl cited these studies in “Discovery of Child Abuse.” See footnote 23. 315.
When physicians did acknowledge the role of parents in the injuries of abused children, they often portrayed the parents as victims as well. Through the 1960s, even as more physicians began diagnosing abuse, abusive parents were typified as patients who needed help. Serapio Zalba’s 1966 article “The Abused Child 1. A Survey of the Problem” discussed the preferability of keeping children within the home whenever possible. He stated that parents needed treatment themselves and discussed some of the challenges for social workers in treating such families. He did not discuss what punishment or legal ramifications ought to exist for such perpetrators of abuse.\textsuperscript{50} Several articles in \textit{Pediatrics} also took this stance, as well as Kempe’s 1962 article itself.

\textbf{Legal Changes & Physician Responses}

In 1963, the Children’s Bureau proposed model legislation on reporting physically abused children. The Bureau recommended reporting by physicians or institutions on any case where there was reasonable cause to suspect abuse, suggested procedures for reporting, provided immunity from liability for the reporting physician, established that physician-patient privilege nor husband-wife privilege could be a ground for excluding evidence, and that anyone not reporting a suspected case of a battered child would be guilty of a misdemeanor. Several states adopted this model legislation during the 1960s.\textsuperscript{51}

The response to the 1963 Children’s Bureau model legislation varied among physicians. Reinhart and Elmer, who had written about abuse, responded to the model legislation in a 1964 \textit{JAMA} editorial.\textsuperscript{52} They stated that the model law’s language would resolve physicians’ hesitation

\textsuperscript{52} See footnote 35.
about reporting suspected abuse that had not been ‘proven’ requiring reporting when there was
“reasonable cause to suspect” abuse.\textsuperscript{53} The law also resolved issues of physician-patient privacy,
they argued, as it would place the child’s right to safety above the rights of the patient to
protected communication. Further, they stated the law removed the “risk of time-consuming,
expensive litigation which might result” after reporting.\textsuperscript{54} They also lauded the fact that the law
specified and standardized the procedures for reporting, which they argued would reduce biases
in reporting data. However, they warned that one hole in the law was that it focused on one child
and failed to discuss dangers to other children in the household. Further, the legislation (and
specifically the possibility of criminal prosecution) might lead abusive parents to bring their
injured children to the doctor less frequently, thereby increasing the risk to the children. Children
could be at increased risk if the parent’s anger at being reported was released on the child.
Finally, they stated the legislation might cause hardship to parents who were reported in cases of
accidents rather than abuse.\textsuperscript{55}

support for the proposed legislation as well. He argued that abused children were unable to
protect themselves by recounting their stories and that physicians ought to cooperate with other
organizations to protect children.\textsuperscript{56} The American Academy of Pediatrics Committee on the
Infant and Preschool Child in 1966 supported mandatory reporting by physicians in cases of
suspected abuse. Their recommendations for legislation were that physicians should be required
to report immediately to the agency with responsibility of investigating child abuse, and that

\textsuperscript{53} See footnote 52. 359.
\textsuperscript{54} See footnote 52. 359.
\textsuperscript{55} See footnote 52. 359.
such an agency should have ample resources to take action to protect children and keep a registry of such cases.\textsuperscript{57}

A 1963 \textit{New England Journal of Medicine} editorial “More on the Battered Child” discussed the Children’s Bureau conference which had recommended that individual states pass laws to make reporting by physicians mandatory.\textsuperscript{58} The journal opposed the recommendation because in most states, it would mean reporting to police agencies, which they speculated would remove any chance of therapy for the family. The editorial stated “Until society can find an adequate substitute for a child's natural family (and it is clear that some present foster-family arrangements leave much to be desired, with frequent moves and poor identification of the child with the foster parents) it would seem wise to seek other ways of management of this problem.”\textsuperscript{59} This indicated that not all physicians supported the proposed legal change, nor did they all see mandatory reporting laws as progress in the right direction.

A 1964 \textit{JAMA} Office of the General Counsel editorial titled “Battered Child Legislation” discussed the Bureau’s recommendation that states enact mandatory reporting laws and took a similarly less favorable view.\textsuperscript{60} The editorial posed the question “is compulsory reporting the answer?” The editorial stated that abuse could be identified by several other professionals such as teachers and social workers before reaching the physician. “To compel reporting by the physician alone may single him out unwisely,” the editorial claimed.\textsuperscript{61} Like Reinhart and Elmer, the editorial warned that parents might avoid seeking medical care for abused children because of the risk posed to themselves if reported and stated that the legislation should have provided

\textsuperscript{57} See footnote 30.
\textsuperscript{59} See footnote 58. 1437.
\textsuperscript{61} See footnote 60. 386.
protection for the abused child’s siblings. Finally, the editorial argued that no evidence existed that mandatory reporting alone would “eradicate undesirable social conduct.” Katherine Bain stated in her 1963 editorial response that requiring doctors or hospitals to report cases of abuse would not end or reduce rates of abuse, as it focused on reacting to the problem rather than preventing it, and because it would not rehabilitate the parents.

A 1967 article titled “Child Abuse Laws- Are They Enough?” by Silver, a child psychiatrist, discussed the outcome of the model legislation implemented in 1963. Physicians in DC were questioned about battered child syndrome, their awareness of community procedures available, and their attitudes about reporting. The results suggested that a high percentage of physicians were unaware of the battered child syndrome and about community procedures. One in five physicians reported rarely or never considering child abuse when seeing an injured child. Over one half of the physicians did not know the correct procedure to follow in their community. Further, almost one in four physicians stated that they would not report a case of suspected battered child syndrome with the concern that evidence would not stand up in a court proceeding. Silver et al concluded that that child abuse laws alone would not be sufficient to protect children until communications between medical professionals and government and community agencies were improved.

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62 See footnote 60, 386.
63 See footnote 14.
ANALYSIS OF PEDIATRICIANS’ VIEWS ON ABUSE IN *PEDIATRICS: 1960s*

Henry Kempe’s work in 1962, alongside the works of several other researchers during the decade, provided pediatricians with new vocabulary such as “battered child” for describing childhood trauma. These key works prompted the beginning of a gradual shift away from more euphemistic terms which obscured or implied the lack of a direct cause. Researchers who wrote about the topic after Kempe were able to expand the discussion on child abuse to include new physical exam and findings and psychological effects. Many researchers also medicalized the discussion around the abusers themselves. However, the discourse on abuse was still very limited by the end of the decade. As Katherine Bain, Deputy Chief of the Children’s Bureau, observed in 1963, the number of articles written about abuse had increased sharply in recent years, but most members of the public were still reluctant to discuss abuse.\(^6^5\)

**Beginnings of a Discussion**

Members of the American Academy of Pediatrics (AAP) first discussed child abuse explicitly during the 1960s. Several works in *Pediatrics* were published about the specific topic of abuse, including six articles, two commentaries, two book reviews, and five letters to the editor. Many additional works were also published on topics related to abuse such as trauma, childhood accidents, failure to thrive, and poisonings. The discourse on child abuse slowly expanded throughout the decade, especially once states began enforcing mandatory reporting laws.

One way that pediatricians began discussing child abuse in a more holistic sense was the discussion of non-physical findings in cases of abuse. In September 1966, Edward Isaacson, a

\(^{65}\) See footnote 14. 895.
pediatrician in Illinois, wrote to the editor of *Pediatrics* in support of the recent legal changes that allowed for prosecution of physically abusive parents. However, he lamented the fact that pediatricians could not take action in the case where a child was emotionally battered due to “the deprivation of parental care, love, guidance, or the stimulation…[for] adequate emotional development.” Isaacson argued that millions of dollars were spent every year on psychiatric care and the treatment of mental and emotional diseases, almost all of which had “their onset in childhood by one or many forms of emotional battering.” Thus, he argued that pediatricians must try to “detect the stress and tension” at home that could lead these diseases. Isaacson concluded his letter by saying “Let us now enter the second phase of the syndrome. Let us “tune in” on the emotional battering to which the child is a subject.” Isaacson’s call for the pediatric community to extend their attention to emotional and psychological effects of deprivation of love and stimulation showed that individual pediatricians were expanding the understanding of the “battered child” and incorporating findings that were not purely physical into the discussion.

**Medicalization of Abusers**

Many of the physicians discussing child abuse in *Pediatrics* during the 1960s used language that medicalized the act of abusing children. For instance, in “The Physically Abused Child,” Bain argued “many of the parents are themselves so psychologically damaged that they are beyond the reach of our present therapeutic measures.” The implication that the abusers were psychologically ill and that the abusers themselves needed therapeutic intervention is one example of medicalization of abuse in the early literature on child abuse. Further, Bain explicitly

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67 See footnote 66.523.
68 See footnote 66. 523.
69 See footnote 14. 897.
stated that “the physician has a primary responsibility for diagnosis” regarding child abuse.\textsuperscript{70} Using the term “diagnosis” implies identification of disease or process with a biochemical basis rather than a social ill. Some of the suggestions outlined in the 1966 recommendation by the AAP Committee on Infant and Preschool Child included crisis management programs and community therapists.\textsuperscript{71} These recommendations reinforced medicine’s role in managing abuse by calling for healthcare workers to provide services in the community.

Evaluating the medicalized language used to describe abusers during the 1960s is challenging, as our understanding of topics such as “medicalization” and “overdiagnosis” have changed significantly since then. Medicalization involves interpreting aspects of reality “in medical terms and treating them as medical problems rather than social, political, or existential ones.”\textsuperscript{72} However, holistic definitions of health, such as the World Health Organization’s “a state of complete physical, mental, and social well-being” imply that every aspect of life could be seen as a health problem. Thus, it is unclear whether the language of medicalization applied to abusers reflected a natural widening of the boundaries of medicine or whether it was a conscious attempt to bring abusers under the purview of the medical system. Further, it is unclear whether physicians truly felt that medicine as an institution could offer the most effective solutions to abuse or whether physicians wanted to keep families together and abusers away from law enforcement. The result of medicalization of abusers was two-fold. First, parents seemed less blameworthy if child abuse could be viewed as a symptom of mental illness. Physicians were hesitant to point the finger at parents (which will be discussed in the following section), so it may

\textsuperscript{70} See footnote 14. 897.
\textsuperscript{71} See footnote 30.
seem reasonable that medicalization was used to reduce cognitive dissonance among physicians identifying abuse. Second, the medicalization of abusers contributed to the idea that abuse could cross class and racial lines. Whether this trend was more harmful or helpful remained undefined by the end of the decade.

Limitations to the Discourse

Discourse about public opinion

Several specific individuals led the discussion on child abuse during the 1960s. In the 1960s Pediatrics literature, some of these individuals stated or implied that American society at the time was unwilling to explicitly address abuse. For instance, Bain stated in her 1963 article “The Physically Abused Child” that the volume of publications on abuse increased during the 1960s, but “this isn’t the sort of thing the American family wants to read about at breakfast.”

Bain was a leader in the field of children’s welfare and in the discussion on abuse. As the sole woman in her 1925 medical school class, she went on to become one of the few prominent female pediatricians of her time and she eventually joined the Children’s Bureau, where she influenced research in child development. She published several works that were effective in spreading awareness about childhood poisonings among physicians and among the general public during the 1950s. Bain was a recognized expert and key actor in the field of children’s welfare, and her statement that Americans were averse to thinking about child abuse in Pediatrics the year after Kempe’s landmark paper likely affected the trajectory of the discussion on abuse among the scientific community. Several articles outside of the AAP literature at the

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73 See footnote 14, 895.
time also expressed the viewpoint that American families disliked thinking about abuse, Kempe’s works among them. These claims - always based on the researchers’ anecdotal experiences rather than data- legitimized the idea that public opinion would be a challenge rather than an asset in handling the issue of child maltreatment. Further, these arguments may have contributed to an anchoring bias among physicians during the 1960s who were reading literature on child abuse for the first time and developing their vocabulary and conceptual frameworks for identifying and understanding the issue.

By the end of the decade, several writers continued to point out the public’s reluctance to discuss abuse, indicating that little had changed in the way of public opinion. Perhaps the strongest example of this was the 1969 article “Child Abuse Syndrome: The “Gray Areas” in Establishing a Diagnosis,” which argued that some physicians found it difficult to accept “the reality of willful child abuse.” The article also reported five situations in which physicians considered cases of childhood injury to fall within a “gray area” and thus hesitated to report. One example of such a situation was “subjective interference,” which referred to subjective issues that prevented reporting. This included cases such as physicians who rarely or never considered the possibility of child abuse, those who stated they would not report a case even given sufficient evidence of abuse because of implications to the family or to their practice, and those who felt that reporting was unhelpful. By 1969, the topic of child abuse had been discussed in the academic literature for several years, so the idea that some physicians were unwilling to accept the reality of abuse may have been indicative of two possibilities. The first is that many physicians at the end of the 1960s were unaware of the discourse on child abuse taking place within the pediatric community. The second is that many pediatricians were aware of the

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75 See footnote 3, 595.
76 See footnote 75.
discourse and the data on child abuse but preferred not to involve themselves in their patients’
domestic conflicts or change their practice. As Edward Isaacson stated in his letter to the editor
in 1966, “many of the pediatricians whom I have come to know go out of their way to avoid
‘becoming involved’ with the family structure and the emotional development of their
patients.”77 As such, they may have denied the existence of child abuse to resolve any cognitive
dissonance about the matter.

Failure to discuss direct causes of trauma

Pediatrics in the 1960s included several articles focused on abuse and neglect after
Kempe’s 1962 article was published in Journal of the American Medical Association. However,
many articles on topics that we now associate with neglect and abuse failed to explicitly discuss
those matters even after 1962. For instance, the 1960 article “Some Approaches to Research in
Childhood Accidents,” in which Dr. George Wheatley and Dr. Stephen Richardson discussed
existing research on childhood injuries as well as new directions for research in the future did not
define “accidents” or explicitly mention the role of neglect or abuse in pediatric patients
presenting with “accidents.”78 As the article was published prior to Kempe’s landmark article in
1962, it is unsurprising that the term “battered child” is not used. However, the term “abuse” or
any mention of intentionally inflicted violence also did not appear in the article. In discussing
future areas for research, however, the article asked whether childhood accidents were
“associated with certain patterns of socialization – for example, certain forms of discipline, the
rate and manner in which parents foster independence in their children…?”79 Wheatley and

77 See footnote 66. 523.
78 Wheatley, George M., and Stephen A. Richardson. “Public Health: Some Approaches to Research in Childhood
79 See footnote 78. 345.
Richardson proposed an example situation in which “a quarrel between the parents [was] followed shortly by harsh and unjustified punishment of the child.” Thus, any reference to intentionally inflicted violence toward children was couched in the terms “discipline” and “punishment,” which likely did not seem violent. Beyond this, Wheatley and Richardson did not elaborate further or explicitly mention intentionally inflicted violence on children or the role of inadequate adult supervision in childhood injuries. Additionally, they acknowledged that African American children were more likely to become injured or killed by burns than White children and that boys were more susceptible to injury than girls, but did not elaborate on the mechanisms through which this could take place or suggest this topic as an area for further study. Finally, the article discussed a study conducted by Dr. Fuller on childhood injuries in which the characteristics of children such as courage and emotional excitability were evaluated in relation to the likelihood of injuries. However, Wheatley and Richardson did not discuss the characteristics of caregivers or others in the household in relation to childhood injuries. In the section on the role of pediatricians, recommendations were not provided on evaluating for signs of violence.

Overall, several of the writers during this decade associated factors such as young parental age, unplanned pregnancy, and stresses such as a child’s behavioral problems, marital tension, or vague factors such as problems within the family atmosphere with negative outcomes for children such as accidents and poisonings. However, no specific links or steps were proposed as to why these factors would lead to the negative outcomes. The researchers implied that parents might be overwhelmed or frustrated but did not state why or how that could lead to children’s injuries. For instance, the 1967 review article “Sudden and Unexpected Death in Infancy: A

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80 See footnote 78. 345.
81 See footnote 78. 345.
Review of the World Literature” by Dr. Marie Valdes-Dapena stated that many mothers of affected children were younger and/or had more children when compared to mothers of unaffected children.\textsuperscript{82} The review also stated that cases of unexpected death were higher among lower socioeconomic groups. However, the article did not elaborate on the mechanisms through which lower maternal age, increased number of children, poverty might lead to this outcome, thus leaving abuse and neglect out of the conversation. Finally, specific cases of recurrences of unexpected infant death within individual families were mentioned. In one case, six of eight children died unexpectedly. In a second case, a wealthy mother lost three unrelated adopted infants to unexpected death. We now know that the syndrome of sudden unexpected infant death (SIDS) is not a familial illness, but the actions of the parents in the first case were not questioned. In the second case, the infants were not biologically related, but Dr. Valdes-Dapena also did not discuss the actions of the adoptive mother or parents in the recurrent infant deaths.\textsuperscript{82}

In terms of psychological issues we now associate with neglect and abuse, the 1961 article “School Phobia in Older Children and Adolescents: Diagnostic Implications and Prognosis” discussed 20 cases of children with school phobia and investigated their medical histories for somatic complaints, anxiety and depression, and pathologic maternal attitudes. However, the study failed to consider a history of neglect and/or abuse as potential factors leading to the phobia.\textsuperscript{83} We see an avoidance of explicitly discussing the topics of neglect and abuse in other situations where discussion may have been warranted during the 1960s as well. Very few articles during this decade were actually centered around abuse (17 titles out of over 1,000+ in total) and most articles did not explicitly discuss neglect and abuse as potential causes


\textsuperscript{83} Milman, Doris H. “School Phobia In Older Children and Adolescents: Diagnostic Implications and Prognosis.” \textit{Pediatrics} 28, no. 3 (September 1, 1961): 462.
of injury, trauma, poisonings, or other negative health outcomes. However, many of the factors that were concluded as being correlated with the negative health outcomes in question were adjacent to the topics of neglect and abuse. Factors such as a higher number of children, mother working outside the home, and lower average age of parents logically seem like they could lead to less time spent with children and higher risk of neglect. Factors such as unwanted pregnancy and disappointment with the child could have been associated with parental stress and frustration, leading to a higher risk of physical or emotional abuse.

Whether researchers were making a conscious decision not to discuss abuse is unclear. Specific articles on abuse were published in *Pediatrics* after Kempe’s 1962 article. However, several articles published after that year still failed to explicitly mention abuse, perhaps reflecting pediatricians’ continued hesitation to blame parents outright, even after the syndrome of abuse had become medicalized. It does not seem as though physicians had a motive not to discuss poor parenting, but concepts such as parental privilege to punish were not questioned or challenged. The lack of addressing of abuse and neglect in several articles begs a question of whether these topics were still not at the forefront of physicians’ minds by the end of the 1960s or whether some physicians still lacked the language and vocabulary to describe child maltreatment despite the new discourse on the topic.

**Failure to acknowledge the role of SES & Race**

AAP literature during the 1960s emphasized the idea that abuse crossed socioeconomic and racial/cultural lines. Child abuse was portrayed as something that could affect any American household. For instance, in 1966, the suggestions made by the Committee on Infant and Preschool Child included “day care services that could liaison with community abuse
management centers” and programs that would relieve overwhelmed parents by providing childcare, but the recommendations’ did not specifically focus on poverty alleviation or specify that childcare ought to be subsidized for all families. The committee did not acknowledge that the suggestions offered were the very things that lower income families were unable to afford, and that those families may be at greater risk for abuse incidents.

The 1968 article “Child Abuse: Early Case Findings in the Emergency Department” by Joan Holter and Stanford Friedman built on the work of individuals such as Vincent Fontana and Elizabeth Elmer who believed that many maltreated children were treated in the ED setting for alleged accidents. Holter and Friedman surveyed 156 cases of children who presented for treatment of accidental injuries. Nurses made judgements about the nature of children’s injuries, placing each case into the category of “accident,” “repeated accident,” “suspected abuse,” or “accident with neglect,” and the cases were evaluated based on several factors. Holter and Friedman concluded that many of the families in the “suspected abuse” group revealed acute and chronic stressful situations such as financial difficulties and unemployment. Holter and Friedman recommended that emergency departments keep an adequate and multi-disciplined professional staff, encouraged the greater utilization of staff such as pediatric social workers and public health nurses in providing more comprehensive care, and even recommended that public health nurses should routinely visit the homes of “high risk” children. However, they did not emphasize the importance of poverty alleviation programs or offer any suggestions for reducing the stressful situations that seemed to be associated with higher likelihood of abuse.

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84 See footnote 30, 381.
Later, in 1969, David Gil discussed data from a nationwide survey conducted by the Department of Health, Education, and Welfare. The study revealed that a majority of families reported for abuse were of a lower socioeconomic status and that ethnic minority groups were over-represented in the study group. Gil acknowledged this result and stated that “life in poverty generates many additional stressful experiences which...are likely to become precipitating factors of child abuse.” However, he also prefaced the findings of the study by emphasizing that incidents from middle- and upper-class families may have been under-reported to a greater extent than from lower class families. Although Gil’s concluding remarks acknowledged the importance of poverty elimination as a route toward reducing the incidence of abuse, it is important to note that his assertion that abuse went under-reported among the middle and upper class was not supported by data, nor did he cite literature that proved his claim. 

Beyond socioeconomic status, race was also not discussed in the 1960s AAP literature as a factor that modulated the risk of abuse. A 1967 article by Elmer and Grigg evaluated the developmental characteristics of a group of 20 children five years after they presented to the Children’s Hospital of Pittsburgh with multiple skeletal injuries resulting from abuse. The children were assessed by pediatric, psychiatric, audiometric, and psychological evaluations; Rorschach Test; school reports of the children’s classroom behaviors; and questionnaires administered to mothers. In addition to studying a limited pool of twenty children/families, the article stated that several high socioeconomic status families declined to participate in the study, implying that the remaining pool of study candidates was skewed toward lower socioeconomic status. Elmer and Grigg concluded based on the twenty cases they studied that prolonged neglect more frequently accompanied the abuse of White children. Although fewer than ten African

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American families were evaluated in the survey, the authors drew conclusions that implied that African American children were less likely to suffer from abuse. These findings supported the aspect of the discourse that stated that abuse crossed racial boundaries.

Elmer and Gregg’s 1969 article “Infant Injuries: Accident or Abuse?” studied 113 children who were either accidentally injured or abused in detail. Their data indicated that the families came from all social classes and were White as well as African American. Thus, their work contributed to the narrative that abuse crosses class and race lines and that any family could struggle with abuse. However, they also reported that “a major factor in all instances was the reaction of the caretaker to family stress” and that “economic and personal stress were common and probably had existed for some time.” Their work did not acknowledge the contradiction in their findings given the fact that minority races faced increased economic and personal stress, which would then be associated with higher rates of abuse.

Even when data showed that children from lower socioeconomic status families or minority races were more likely to experience abuse or neglect, researchers often implied with what they stated or failed to state that abuse should not be viewed as an issue of poverty or of certain races. The discussion around abuse did not center on poverty alleviation or on reducing stresses, but instead on how medical care could best accommodate at risk families. The discourse of pediatricians showed a general tendency to obscure the role of race and socioeconomic status in child abuse. Whether this was a deliberate attempt to secure funding from policy makers by portraying abused children as potentially White and/or middle- or upper-class is unclear.

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89 See footnote 88. 438.
Overall, the discourse about abuse truly began explicitly during the 1960s, and pediatricians were able to discuss willfully inflicted childhood injuries more explicitly than before. Some pediatricians also began to recognize that the effects of abuse extended beyond what Kempe had originally stated. However, pediatricians were still not well equipped to discuss socioeconomic status and race as it related to abuse by the end of the decade.
ANALYSIS OF PEDIATRICIANS’ VIEWS ON CHILDREN’S RIGHTS IN *PEDIATRICS*: 1960s

Debates by pediatricians on children’s rights during the 1960s led to an increased sense of responsibility that adults felt towards improving children’s welfare. Pediatricians began seeing themselves as responsible for a widening set of topics that could affect children’s health outcomes, including television advertisements into their purview. Additionally, adoption and the institutions surrounding it served as a catalyst for pediatricians to think about children’s rights in a new context and furthered these debates. Children’s rights were viewed as competing value clashing with the idea of family privacy, and pediatricians began giving consideration and importance to the former over the latter during this decade.

Despite the progress made in the discussion of children’s rights, there were still limitations to the discourse. First, pediatricians did not yet use explicit language of ‘children’s rights’ in their discussion of abuse or corporal punishment and did not cite human rights as a reason for why abuse was wrong. Secondly, race and the was largely left out of any discussion on rights. It seemed as though the default or standard child that pediatricians envisioned themselves responsible for was White and middle-class.

Progress for Children’s Rights

During the 1960s, American pediatricians as well as policymakers agreed that ensuring the general welfare of children was an important societal goal. As Leona Baumgartner, the Commissioner of Health for New York City, stated in the 1962 article “Fifty Years of Work for Children,” Congress’s concern for children began increasing after the establishment of the Children’s Bureau in 1912 and continued into the present day. In fact, some pediatricians

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implied that ensuring the welfare of children, at least as measured by statistics such infant mortality rates, was considered to be a marker of American success and pride in the eyes of other countries. For instance, in “The Unmet Needs of Children” William Stewart, the Surgeon General, lamented America’s infant mortality rates relative to Sweden and Britain, stating that “for a nation that prides itself on its dedication to the human individual, these national figures are hard to tolerate.”

There was also an assumption that working towards children’s welfare would benefit all of society. Baumgartner stated in 1962 that “results with the young pay off socially, even if they do not vote,” as an argument to encourage the Children’s Bureau to take action.

In addition to meeting the immediate needs of children, however, the parameters pediatricians assigned to societal responsibility toward children began increasing. For instance, in 1963, Samuel Wishik, a physician-scholar in the field of public health, argued that cigarette advertising companies glamorized smoking and cited evidence that children were more likely to start smoking early if family members did so. He argued that responsible adults should help reduce the number of children who began smoking by expressing to them explicitly that smoking was unwise. He also argued that “tobacco advertising should operate within ethical limits concerning the appeals that are made to young people.” This reflected the notion that pediatricians viewed adults as morally responsible for the effects on children’s health caused by the secondary effects of their behaviors such as smoking.

Second, the role that pediatricians played in the process of adoption led to their increased scrutiny of the responsibility they had toward child patients and the rights children were granted.

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92 See footnote 90. 526.
94 See footnote 93. 537.
within healthcare. Adoption brought to light the fact that children and adults – in this case prospective parents – could have competing interests. Donald Smith addressed this in “Pediatric Consultation in Adoption Practice,” stating that the pediatric consultant to an adoption agency was “primarily responsible to and for the child, and secondarily to the agency.”95 Additionally, adoption posed an ethical dilemma for pediatricians, given that the medical evaluation of a child could affect their chance of placement with an adoptive family. As Smith stated, the ratio of adoptive parents to adoptable children was declining, implying increased difficulty for placement. He also mentioned that the idea of what constituted an ‘adoptable’ child was increasing, but that certain diseases and disabilities still reduced likelihood of placement with a family.96 Morris Green and Carolyn Godfrey also expressed interest in the dilemma of pediatricians’ role prior to adoptive placement and conducted a study to identify whether the health care planning for 40 children prior to placement was adequate and where it should have been improved to prevent problems post-placement.97 Overall, adoption forced pediatricians to compare their perceived responsibility towards ordinary pediatric patients with their perceived responsibility toward orphaned patients. Smith stated as much in 1968, writing that “the pediatrician must distinguish those responsibilities to the agency from his more traditional role with children and families in private practice.”98 Being involved in the adoption process led pediatricians to critically analyze a specific situation in which the best interests of children and adults could differ. The difference in biological status relative to the parent figure forced pediatricians to look more closely at children’s rights in general.

95 Smith, Donald C. “Pediatric Consultation in Adoption Practice.” Pediatrics 41, no. 2 (February 1, 1968: 520.
96 See footnote 95. 521.
98 See footnote 95. 520.
Third, pediatricians during the 1960s viewed family privacy – or more specifically, the privacy of the adults in a family – as a competing value with children’s rights. Pediatricians in this decade began articulating that children had a right to adequate care even if that conflicted with family privacy. For instance, Deisher and O’Leary implied that greater visibility of children in society prior to entering school would be beneficial, lamenting that “it is unfortunate that five or six years of a child’s life must pass before anyone becomes aware” of behavioral difficulties, which only became evident on school entry.\textsuperscript{99} Later in the decade, Joan Holter, a social worker and Stanford Friedman, an emerging leader in behavioral pediatrics, recommended that a “public health nurse should routinely be sent into the home of the children in the ‘high risk’ group” to help prevent accidents in troubled families.\textsuperscript{100}

Limits to the Discourse

One limitation to the discourse on children’s rights during the 1960s was the lack of explicit acknowledgement of children’s rights, both as a concept in general and as a reason why child abuse was wrong or why government intervention was necessary. Child abuse was regarded as reprehensible and morally wrong, but the discussion was not framed in terms of children’s right to not be harmed. Well-cited articles on abuse in \textit{Pediatrics} made no mention of children’s rights. Further, pediatricians in the 1960s accepted the idea of parental privilege to punish, and corporal punishment was never discussed as a violation of children’s rights or as morally wrong. For instance, in 1963, a group from the New York Medical College studied child rearing practices in a low socioeconomic status group and discussed the use of corporal

\textsuperscript{100} See footnote 85. 137.
punishment as a common practice. Most mothers in the study described themselves as “easy-going” in interviews, despite using corporal punishment. The investigators in the study stated that “even though most mothers used corporal punishment to enforce obedience, the absence of strong strictures in relation to time of getting up, meal-times, bottle drinking, and use of eating implements, made us agree that most mothers were ‘easy-going’ in these areas.” This reflected the idea that corporal punishment was regarded as a practice that could exist within appropriate parenting. In “Child Abuse Syndrome: The ‘Gray Areas’ in Establishing a Diagnosis,” investigators explored reasons why physicians found it difficult to establish or rule out the diagnosis of child abuse. 19% of cases were explained by physicians giving parents the benefit of the doubt that they meant to use only ordinary force in punishment. 6% of cases were explained by physicians being unable to draw a line between parental privilege to punish and abuse.

A second limitation to the discourse on children’s rights revolved around the lack of discussion of the intersection on race and rights. Although race was mentioned occasionally, there was an implicit assumption that pediatricians, when speaking about the theoretical “child,” were imagining a White middle-class child, which led to non-White children being left out of the emerging narrative on children’s rights. Even when non-White children were discussed, concrete actions or solutions were not proposed or encouraged. For instance, Harry Elam discussed specific historical and social factors contributing to negative health outcomes associated with being Black in “Malignant Cultural Deprivation – Its Evolution.” He discussed with great detail the lasting psychological effects and oppression experienced by Black Americans.

102 See footnote 101, 301.
103 See footnote 3, 594–600
descended from slaves. Although he made a vague encouragement to pediatricians to find ways to overcome the physical and emotional challenges faced by Black children, he did not provide specific or concrete actions that should be taken. 105 His article would have been an opportunity to argue that Black children had a claim or a right to specific accommodations or interventions because of the centuries of institutionalized violence that led to the “deprivation syndrome” he described, but he did not do so. Overall, the needs of Non-White children were discussed as an after-thought in the emerging discussion on children’s rights.

105 See footnote 104. 325.
BACKGROUND & CONTEXT ON THE 1970s

Public Opinion on abuse

During the 1970s, more Americans were aware of the issue of child abuse and may have sensed that abuse and neglect were on the rise. Several states showed an increase in reported cases. For instance, Massachusetts showed a dramatic increase in the statewide number of cases reported from 1967 to 1979. However, McDonald and Reece argue that the new reporting laws may have contributed to the increase rather than a true rise in incidence of abuse. Richard Gelles, in his 1976 article “Demythologizing Child Abuse” argued that the myth of rising child abuse could be attributed to the fact that abuse got little public attention and media coverage prior to the 1960s. Additionally, abusers continued to be portrayed as mentally ill in the media, similar to the decade prior. For instance, the Saturday Evening Post published the sensational headline “Parents Who Beat Children: A Tragic Increase in Cases of Child Abuse Is Prompting a Hunt for Ways to Detect Sick Adults Who Commit Such Crimes” in 1972.

At the same time, Erin Pizzey’s Scream Quietly or the Neighbours Will Hear was published in 1970 and reflected the ongoing women’s movement. As feminism brought light to the issue of ‘battered wives,’ this also brought attention to the topic of child abuse. Philosopher Ian Hacking in “The Making and Molding of Child Abuse” had suggested that the physical abuse of women and children began to be viewed as two results caused by patriarchal domination. However, Americans’ awareness of the issue did not prevent abuse

109 Pizzey, E. Scream Quietly or the Neighbours Will Hear. Harmondsworth: Penguin Publisher, 1974.
from occurring, given the high rates of reported abuse. Additionally, over 80% of American families were estimated to use physical punishment at some point during childhood even by the early 1970s.\textsuperscript{111}

Discussions in academic literature

Within academic literature, articles on abuse continued to be produced in increasing numbers throughout the 1970s. In addition to journal articles, the number of symposiums and committees on abuse continued to increase. For instance, the 1973 edition of the \textit{New England Journal of Medicine} published a 40-page supplement to the April issue, which was titled “The Proceedings of a Symposium on Child Abuse” and was sponsored by the Medical Society of the County of New York.\textsuperscript{112} The interdisciplinary journal \textit{Child Abuse and Neglect} was later established in 1976.\textsuperscript{113} However, two major disagreements about abuse and abusers arose in the 1970s. The first centered around the role of socioeconomic status and whether or not abuse was primarily an issue of the poor. The second was a question about whether abusers should be considered and treated as mentally ill.

On whether abuse was an issue of the poor, Vincent Fontanta, who had written about abuse extensively, in a 1973 letter to the editor of the \textit{New England Journal of Medicine} wrote that since the 1960s, “it has been established that child maltreatment is neither rare nor does it occur only in ghettos.” He stated “among the middle and upper classes child abuse and neglect

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occurs secretly behind closed doors and shuttered windows.”¹¹⁴ David Gil, a sociologist, argued that violence against children is deeply rooted in child rearing, implying that it could occur at all socioeconomic levels.¹¹⁵ Leroy Pelton, a social worker and professor, argued that the poor were publicly scrutinized more than the wealthy and that the poor were more likely to be known to social agencies and law enforcement while these agencies had less access to wealthy homes and families.¹¹⁶ A 1974 commentary in *Pediatrics* argued that “abuse and neglect do occur in middle- and upper-class families; they should not be viewed as completely a function of educationally, occupationally or socially disadvantaged parents.”¹¹⁷ Historian Mical Raz has shown that Parents Anonymous, an advocacy group for parents with the goal of preventing abuse, also played a role in the child abuse narrative, portraying abuse as something that crossed class lines. Jolly K, one of the founders, testified alongside other members of Parents Anonymous in front of Congress that abuse affected families from all walks of life, not only the poor.¹¹⁸

On the other hand, several researchers have found that abuse was more likely to occur among lower socioeconomic classes, especially among those known to public agencies. Richard Gelles suggested that abuse was more common among the poor and that social stresses such as unemployment may contribute to abuse.¹¹⁹ David Gil’s 1971 article “Violence Against Children” discussed his 1967 study which found that nearly 60% of the families involved in abuse incidents had been on welfare during or prior to the study year and 37.2% had been receiving public

assistance at the time of the incident. 48.4% of reported families had incomes below $5000 in 1967 but only 25.3% of families had such low incomes in 1967. The majority of parents also did not graduate from high school.\textsuperscript{120} Gil also emphasized that the living conditions of poverty generated stressful experiences that could precipitate child abuse.\textsuperscript{121}

The American Humane Association (AHA) also collected data which showed that for the year 1975, 53.25% of reported families had yearly income under $5000 which, again, was disproportionately low.\textsuperscript{122} Leontine Young’s study in 1964 examined case records of 300 families in rural and urban areas known to local welfare agencies because of child abuse or neglect reports, and found that in 71% of families, the primary wage earner was an unskilled laborer.\textsuperscript{123} Even Fontana, who argued that abuse occurred at all socioeconomic levels, stated in his 1973 letter to the editor that abuse is “inextricably linked with unbearable stress, with impossible living conditions, with material or spiritual poverty, alcoholism, assaults, robberies, murders and the other ills,” most of which seem likely to disproportionately affect the poor.\textsuperscript{124}

Leroy Pelton acknowledged this disagreement among professionals studying abuse in “Child Abuse and Neglect: The Myth of Classlessness” and staunchly opposed the idea that abuse and poverty were separate issues.\textsuperscript{125} He described the idea of classlessness as a myth, for “problems of child abuse and neglect are broadly distributed throughout society, suggesting that their frequency and severity are unrelated to socioeconomic class.”\textsuperscript{126}

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\footnote{120}{See footnote 115. 640.}
\footnote{121}{See footnote 115. 645.}
\footnote{124}{See footnote 114.}
\footnote{125}{See footnote 116.}
\footnote{126}{See footnote 116. 608.}
\end{footnotes}
argument that poor families were more available to public scrutiny and more accessible for social and law enforcement agencies. However, he argued that “we have no grounds for proclaiming that if middle-class and upper-class households were more open to public scrutiny, we would find proportionately as many abuse and neglect cases among them. Undiscovered evidence is no evidence at all.”

He also argued that abuse and neglect were related to degrees of poverty, and that environmental problems of poor households made neglect much more dangerous than it would be in middle-class homes. Giovannoni and Billingsley found in their 1970 study that the highest incidence of neglect occurred in families living in the most extreme poverty, thus bolstering Pelton’s claim.

Pelton also argued that presenting a picture of abuse as distinct from or transcending social class was harmful because it would affect funding decisions. He also argued that the myth allowed the issue to be portrayed as broader than it really was. “Ultimately, by encouraging the view that abuse and neglect are widespread throughout society, the myth presumably aids in prying loose additional federal funds for dealing with these problems.” He warned that legislators would earmark money for finding the unreported cases of neglect and abuse among the middle and upper classes rather than allocating the funding for poverty-oriented services. He also argued that maintaining the myth of classlessness allowed medical professionals to view child abuse and neglect as “psychodynamic problems, in the context of a medical model of “disease,” “treatment,” and “cure,” rather than predominantly sociological and poverty-related problems.”

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127 See footnote 116. 610, 614.
128 See footnote 116. 614.
130 See footnote 116. 614.
131 See footnote 116. 613.
132 See footnote 116. 613.
On the issue of abusers’ psychological health, Gelles argued that the most persistent myth around abuse was that “someone who physically beats or injures a child is somehow mentally disturbed or ill.” Gelles opposed this idea, stating that research on the matter had not provided any supporting evidence. He mentioned the cultural approval of violence in child rearing as evidence against the idea that most abusers were ill. Fontana’s 1973 letter to the editor that stated abuse did not occur only among the poor also stated it did not occur only among the mentally ill. Thomas Szasz, a psychiatrist, spoke out against Kempe and Helfer’s insistence in their 1968 book *The Battered Child* that abusing parents want help, since none of the parents in the book had actually requested help. On the other hand, Gelles argued that the myth of the abuser as ‘sick’ placed blame onto the parents rather than on society which had upheld “pro-physical force norms for parenting.” He believed that abusing caretakers should be viewed as a victim instead, as they had been deprived of the opportunity to meet their children’s basic needs.

**Legal Changes & Physician Responses**

In 1974, President Richard Nixon signed the Child Abuse Prevention and Treatment Act (CAPTA) into law, which provided states with funding to prevent, investigate, and prosecute cases of abuse and neglect. In 1974, Federal Office of Child Development gave a grant to the

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133 See footnote 107. 138.
134 See footnote 107. 138.
135 See footnote 114. 1044.
137 See footnote 107. 139.
Institute of Judicial Administration, a nonprofit research center, to revise the 1963 model legislation. The model legislation was subsequently amended in 1975 with penalties for nonreporting. Ultimately, Secretary Mathews decided not to require states to adopt model legislation as a condition for federal funding, but CAPTA still set the federal standards for reporting requirements.\(^{139}\) The response to CAPTA varied among professionals involved with abuse. Head Start pioneer Jule Sugarman recommended against penalties for failure to report, due to concern that penalties for nonreporting would lead to an atmosphere of fear and could lead to fear-motivated overreporting.\(^{140}\) In response to the legal changes of the 1970s, Albert Solnit, child psychiatrist and director of the Yale University Child Study Center, commended legislative actions that helped develop “an orderly way of reporting child abuse” and the ability to plan for services but decried the “legislative impulsivity” that led to chaos.\(^{141}\) He echoed Sugarman’s concern that overreporting led to fewer services being stretched out for more families.\(^{142}\) Civil rights attorney Richard Steven Levine pointed out that a majority of case workers in the late 60s and early 70s were white middle-class women without children, most of whom did not hold degrees in social work. Many investigations hinged on caseworkers’ personal judgements of families who were often from different cultural and socioeconomic backgrounds.\(^{143}\) This implied that enforcing CAPTA would apply middle class white standards to a diverse set of families. A commentary in *Pediatrics* in October 1974 on CAPTA complained that reliable data about the magnitude of the problem was lacking.\(^{144}\)

\(^{139}\) See footnote 6. Loc 1307 of 4756.  
\(^{140}\) See footnote 6. Loc 1528 of 4756.  
\(^{141}\) See footnote 6. Loc 1480 of 4756.  
\(^{144}\) See footnote 117. 393.
Throughout the decade, the number of reports increased substantially, but these reports did not affect families uniformly. Between 1977 and 1978, 19% of all reports were made on African American families, who made up just 11% of the national population. Similarly, 8% of reports were made on Hispanic individuals, who made up 5% of the national population. During the decade, an increasing number of children were removed from their homes and placed in either foster homes, institutions, or moved from placement to placement. The exact number of children in foster care during the 1970s is unclear. However, between 1962 and 1977 the rate of children in foster care increased significantly. Additionally, foster care had served white children earlier in the century but by the mid 1960s, children of color represented a disproportionately high amount of foster care cases. In 1977, about a quarter of children in out-of-home placement (foster care or institutions) were African American, though they constituted under 11% of American children in total. David Fanshel, Goldstein, Freud, and Solnit’s work focused on children’s psychological need for stability, and many of them argued that long-term placement in foster care was psychologically damaging. Solnit, for instance, argued that family privacy was “essential in creating the intimacy necessary for family integrity” and was frequently “coercively invaded” following false reports “based on life-style differences and on prejudice against minorities, single-parent families, and low-income families.”

In 1977, the Supreme Court ruled on the **Ingraham v Wright** case of two students who had been beaten with a paddle in school. The Court ruled that school spankings, no matter how harsh, did not violate the constitution’s ban on cruel and unusual punishment. David Gil

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147 See footnote 6. loc 1481 of 4756.
criticized this decision, stating that it encouraged child abuse.\textsuperscript{148} Rodger Bybee, a Professor of Education, also pointed out the contradiction between the government’s effort to protect children with mandated reporting laws and the result of the 1977 court case.\textsuperscript{149} This court decision was not discussed by pediatricians or physicians in any major journal, however.

\textsuperscript{148} See footnote 41.
By the 1970s, in line with the developments within legislation, the AAP articles acknowledged both the existence of child abuse and that it was more common than pediatricians had previously thought. The 1974 Committee on Infant and Preschool Child Task Force went as far as to state that abuse was at the point of public outrage. During this decade, the discussion on child abuse and neglect entered around several key issues. The first issue was the boundaries of what pediatricians ought to look for when considering child abuse. This discussion included a delineation between neglect and abuse and involved mixed opinions on the scope of child maltreatment at the time. The second issue was the role of race and socioeconomic status on the likelihood of abuse. The final issue was conflicting messaging on the role of parents and how harshly they should be scrutinized in cases of abuse, as well as the most effective next steps once abuse was identified by pediatricians.

Progress in the Discourse on Abuse

A Push to Expand Boundaries of Concern

During the 1960s, several researchers had written about the myriad signs and symptoms of abuse, and writers during the 1970s accepted the idea that child abuse presented in many different ways. Vincent Fontana was a key champion of the idea that pediatricians should be alert towards several subtle factors that could indicate maltreatment during the 1970s. Fontana, a director at two New York Hospitals and Chairman of the Mayor’s Task Force on Child Abuse and Neglect for New York City, had published The Maltreated Child: The Maltreatment Syndrome in Children in 1964, and worked to expand the boundaries of what pediatricians ought

\footnote{See footnote 117. 393.}
to have been concerned about when evaluating a child’s wellbeing during the 1970s. In his 1973 article, “The Diagnosis of the Maltreatment Syndrome in Children” Fontana reiterated the claim from his book that Kempe’s term “battered child syndrome” excluded cases where children lacked evidence of trauma but showed inconspicuous but concerning signs such as emotional and nutritional deprivation.\textsuperscript{151} The article also mentioned factors in the parent-child relationship that could be indicative of abuse, such as a parent’s lack of interest in the child’s activities or an aggressive attitude when approached about problems concerning the child’s health. A few years later, Fontana also published “A Multidisciplinary Approach to the Treatment of Child Abuse,” which brought attention to the American Humane Association’s estimation that in addition to the 30,000 - 40,000 cases of battered children, there were also 100,000 cases of sexual abuse and 200,000 - 300,000 cases of psychological abuse annually.\textsuperscript{152} Additionally, shaking infants became recognized as a dangerous practice that led to subdural hematoma during the decade, adding to the understanding of abuse.\textsuperscript{153} Overall, the literature pushed the boundaries of what constituted maltreatment, and by the end of the decade, pediatricians reading \textit{Pediatrics} should have been aware that abuse extended beyond bruises or fractures.

**Neglect as a Specific Form of Maltreatment**

In addition to the work done to expand the boundaries of child maltreatment, neglect began to be discussed as a unique form of maltreatment, distinct from abuse, during the 1970s. The beginnings of the distinction between abuse, or maltreatment, and neglect are evident as

certain articles focused on neglect specifically and others discussed neglect in a new way in relation to abuse. However, there were still limitations to this distinction during the 1970s.

A 1973 article “The Law and the Abused and Neglected Child” by Jacob Isaacs LL.B., Chairman of the Committee on Juvenile Law and Procedures, was helpful in illustrating differences between neglect and abuse through a discussion on reporting laws and the implications for physicians. For instance, Isaacs stated that cases involving deprivation of food, shelter, or other forms of guardianship were handled under the statutory definition of neglect rather than abuse.154

One limitation to the distinction between abuse and neglect was evident in “The Working Mother and Child Neglect on the Navajo Reservation,” published in 1973 by Robert Kane, a family medicine physician associated with the Indian Hospital in Shiprock, New Mexico. The article was one of the earliest works investigating neglect specifically. The study, which compared a group of neglected children with a control group, showed that the average family size in the neglect group was smaller than that of the control group.155 However, a study conducted by Simons et al found a higher percentage of abuse in larger families, and this study was discussed as a source of conflicting evidence, thus equating neglect (investigated in this study by Kane et al) with abuse (investigated in the Simons et al study).156

The 1974 article “Child Abuse: A Five Year Follow-up of Early Case Findings in the Emergency Department” investigated the outcomes of children who were admitted to the emergency department and were designated as a case of “suspected abuse,” “gross neglect,” or

“accident.” Friedman, a physician in the Departments of Pediatrics and Psychiatry at the University of Rochester School of Medicine, suggested that the lack of a significant difference in outcomes between children in the three groups may reflect that childhood injuries could be “viewed as occurring on an accident child abuse continuum.”\textsuperscript{157} A 1977 study “Pediatric Social Illness: Toward an Etiologic Classification” by Eli Newberger et al. discussed the impact of family stress on the occurrence of neglect, abuse, failure to thrive, accidents, and poisonings, and pointed out a key factor in which of those diagnoses would be made. Newberger et al stated “whether or not a child’s injuries are characterized as having been “abusively” or “neglectfully” obtained depended on the clinician’s ability -or willingness- to attribute the cause of the symptoms to the child’s parents.”\textsuperscript{158} Both of these articles reflected the idea that abuse and neglect could exist alongside accidents on a continuum or spectrum with one another.

Mixed Opinions on Scope of the Problem

Although pediatricians during the 1970s seem to have accepted the existence of child abuse and its negative long and short term implications, there were disagreements on the scope of the issue. These disagreements spanned the question of whether abuse was on the rise or not, as well as whether the problem existed in isolated incidents or whether it was a larger cultural problem.

Fontana, in his 1973 article “The Diagnosis of the Maltreatment Syndrome in Children” and in the 1971 edition of his book, stated that maltreatment of children was increasing.\textsuperscript{151} The 1974 article “Battered Child Syndrome: Review of 130 Patients With Controls” reviewed


medical and social records of 130 battered children admitted to San Francisco General Hospital between 1965 and 1971, and found a steadily rising number of admissions for abuse during the time period, supporting Fontana’s argument.159 Elizabeth Elmer cited two studies with similar findings in “A Follow-up Study of Traumatized Children.”160

In a 1973 review of Fontana’s book, The Maltreated Child: The Maltreatment Syndrome in Children Eli Newberger, argued that Fontana’s claims about the scope of the problem were too extreme, stating that he “exhorts the reader on nearly every page.”161 To a similar effect, Gil stated in a 1972 letter to the editor that “society’s abuse of children is far worse than abuse by individuals - i.e. hunger, inadequate pediatric care, poverty, corporal punishment in schools and institutions and that these are far worse than child abuse by individuals.”162

David Gil’s work was the first contribution to the discussion on societal violence against children that would take place in the 1970s. Several writers discussed the normalized forms of abuse towards children in the Pediatrics literature. For instance, in a 1973 article, “A Practical Approach to the Protection of the Abused Child and Rehabilitation of the Abusing Parent,” Henry Kempe stated that “the impulse for battering children is universal” when discussing how challenging parenting was.163

However, there was an effort to create some distance from violence towards children and portray those practices as historical. Culturally acceptable violence against children was

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discussed in the past tense, rather than as a presently occurring injustice. For instance, the 1972 article “Resistance to Dealing with Parents of Battered Children” by Wyman Sanders of the Department of Psychiatry and Pediatrics at UCLA School of Medicine stated “children have been beaten, abused, killed, and “sacrificed” since ancient times...in fact, for years children have even been rocked to sleep with nursery rhymes describing the phenomenon.”

Humpty Dumpty, The Old Woman who Lived in a Shoe, and Rock-a-Bye Baby were included as examples of such nursery rhymes. Additionally, two articles in the April 1973 journal discussed infanticide as a historical practice. Theo Solomon, the former Director of Research for the Mayor’s Task Force on Child Abuse and Neglect in New York City, wrote in his 1973 article “History and Demography of Child Abuse” about the practice of infanticide, which he stated was responsible for more child deaths than any other cause except the bubonic plague. Solomon wrote about the practice in several cultures and stated that infanticide occurred until the early 1800s. He did not discuss the existence of the practice in the present-day, though we know that the practice continues to occur today in India, China, and several other countries. Finally, prescriptive language advising parents or pediatricians to bring about changes in parenting were not present in any of the articles discussing socially acceptable forms of violence towards children.

Race & SES

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166 See footnote 165. 773.
The 1970s also saw more discussion about the impact of race and socioeconomic status on abuse. Articles during this decade seemed to judge non-White parents more harshly than their White counterparts. For instance, in a 1973 article, Navajo mothers who worked outside the home were studied and compared to those who did not work outside the home to evaluate for likelihood of neglect. By 1973, a similar study had not published in *Pediatrics* about White mothers, who constituted a much higher proportion of working mothers in the country. An earlier letter to the editor titled “Poverty, Illness, and the Negro Child: A Dissenting Voice” by a C.G. Eschenburg presented an even more critical view of African American parents. Eschenburg stated that he worked in the South and that despite the availability of nutritious foods and formulas, many African American parents choose the easier and less nutritious options such as sugary drinks and snack foods. Besides implying that such parents were responsible for their children’s negative health outcomes, Eschenburg also argued that the cost of ending poverty through social legislation was too high and that jobs were available for those who wanted them. This critical view may have reflected the frustration that many pediatricians felt when working with poor non-White families. However, this view failed to recognize the disproportionate barriers to an increased quality of life that non-White families faced. In a 1973 symposium “A Practical Approach to the Protection of the Abused Child and Rehabilitation of the Abusing Parent,” Kempe stated “It is the poor, the people who have no money skills, who are expected to be perfect mothers seven days a week” pointing to the different expectations placed on wealthy mothers compared with mothers of lower socioeconomic status.

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167 See footnote 155.
169 See footnote 163. 804.
At the same time, the intersection between race and abuse was not explored. Researchers at the time were aware of the effect of environmental stressors such as poverty on rates of abuse. The 1974 commentary “Child Abuse and Neglect: The Role of the Pediatrician and the Academy” stated that early literature on child abuse and neglect “described cases almost exclusively among the poor” though it stated that abuse and neglect also occur among the middle and upper class.\(^{170}\) Other articles emphasized the need to ensure adequate resources and assistance for the poor in order to reduce the chances of abuse. In the 1978 letter to the editor titled “Child Abuse can be Prevented” by Jules Rako agreed with the commentary that low-income families need particular help prior to the arrival of a newborn in order to decrease the risk of abuse.\(^{171}\) However, the articles written during this decade did not connect race with environmental stressors as a sort of mediating variable affecting rates of abuse among different racial groups.

### Role of Parents

During the 1970s, a consensus was reached that abusive parents were not necessarily mentally disturbed. In the 1972 article “Resistance to Dealing with Parents of Battered Children” Wyman Sanders, a pediatrician and psychiatrist, stated that abuse was not rare and that it was not limited to the mentally disturbed.\(^{172}\) Kempe, in “A Practical Approach to the Protection of the Abused Child and Rehabilitation of the Abusing Parent,” estimated that only about 10% of abusive parents were mentally ill, but that 80% were “dependent, inadequate, yearning people.”\(^{173}\)

\(^{170}\) See footnote 117. 394.
\(^{172}\) See footnote 164. 853.
\(^{173}\) See footnote 163. 806.
Although it seems like this consensus should have led to increased scrutiny of parents, we instead see articles during this time period shifting blame away from parents. For instance, articles continued to detail cases which we would now describe as neglect without explicitly mentioning shortcomings in parenting or supervision. The 1971 article “Falls as Childhood Accidents: An Increasing Urban Risk” described a case of an infant falling from the top of the refrigerator and a case of two brothers falling from the same window within a few weeks of one another, but failed to acknowledge the inadequate caution displayed by caregivers during these incidents.\textsuperscript{174} The 1973 article “The Etiology of Child Abuse” stated that abusive parents have “had some kind of disastrous rearing experience when they were small,” again shifting blame from abusive parents to their past misfortunes.\textsuperscript{175} The article also used language that victimized the abusive parents. For instance, Ray Helfer stated “parents who abuse their small children do not use and have not developed the ability to use other people to bail them out when they are in trouble with their children.”\textsuperscript{176} He later quoted one of the abusive parents, who used “uptight” as a euphemism for “abusive” when speaking about themself and their spouse.\textsuperscript{177}

The discussion on Sudden Infant Death Syndrome (SIDS) represents the phenomenon of blame being shifted away from parents particularly well. Articles on SIDS were published far more frequently in the 1970s than in the previous decade, and none of these articles stated that parental neglect or child abuse were likely causes of SIDS. Unnecessarily, it would seem, some articles stated that abuse should not be suspected.\textsuperscript{178} A 1973 article “Prolonged Apnea and the

\textsuperscript{176} See footnote 175: 777.
\textsuperscript{177} See footnote 175: 777.
Sudden Infant Death Syndrome: Clinical and Laboratory Observations” by Steinschneider reported on a case of two siblings who passed without explanation and were deemed to have succumbed to SIDS. In a letter to the editor, John Hick stated that Steinschneider ought to have investigated the mother (such as her feelings about the loss of her children, and observed her mothering) and stated that perhaps the youngest sibling ought to have been placed in a foster home. Steinschneider responded to the letter stating that while the possibility of abuse should be considered in cases of SIDS, extreme restraint was necessary and that the diagnosis must not become one of exclusion. He stated that failure to define a cause of death could not be used to support a diagnosis of abuse. Perhaps these statements reflected the fact that pediatricians, in their private conversations, did suspect parental wrongdoing in cases of SIDS. However, the effect of these articles was to reinforce the idea that parents were not to be scrutinized in cases of SIDS. Even when specific pathology was not identified for the cause of an infant’s death, pediatricians were informed to not suspect parental wrongdoing or to assign blame to parents.

Next Steps

The paradox between the consensus that abusive parents were not necessarily mentally ill and the continuation of efforts to shift blame away from parents led to an ethical question about what next steps ought to be taken when abuse was identified. One point of discussion was whether mandatory reporting by physicians was helpful or harmful. Eli Newberger, in a book review of Fontana’s *The Maltreated Child*, then a new pediatrician, disagreed with Fontana’s recommendations about mandatory reporting, stating that “excepting a few passing references to

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studies which show the complexity of this phenomenon and the futility and danger of punishing parents and tearing families apart, there are few interludes from the hard protective line.”

Newberger’s views may have represented fears that many pediatricians at the time had regarding tearing families apart and exacerbating a tenuous situation, as several articles were written to allay fears about reporting. For instance, in the 1973 article “The Law and the Abused and Neglected Child,” insight into the new reporting laws and child protective proceedings was provided and pediatricians were assured that there was no danger to them when reporting, even if the charge was not sustained. Isaacs stated that “any person or institution participating in good faith in the making of a child abuse report is granted express statutory immunity from any liability...”

Second, even after reporting became mandatory in many states, there was discussion on why reporting sometimes did not occur. For instance, in the 1972 article “Resistance to Dealing with Parents of Battered Children” Wyman Sanders outlined eight reasons why pediatricians failed to report abuse that had been cited by writers before him. Sanders also suggested an additional reason for a lack of reporting, which was “the discomfort and resistance which the reporting person himself feels when he is confronted with a battered child and his parents.”

Overall, the discussion in the 1970s shifted from convincing pediatricians across the country that child abuse existed and that they were responsible for identifying it to what the most effective next steps ought to be.

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181 See footnote 161. 159.
182 See footnote 154. 784.
183 See footnote 164. 854.
During the 1970s, there was more explicit discussion of children’s rights. Pediatricians began suggesting that children had rights such as access to medical care or freedom from poverty. Children’s rights within the medical system were also discussed far more extensively than before. Trends from the 1960s continued, with adoption serving as a catalyst for the discourse on rights and pediatricians favoring children’s rights over family privacy.

However, many of the things which we would now consider rights were still not discussed as such, perhaps because they disproportionately affected non-White children. Additionally, pediatricians began viewing children and childhood as more complex than they initially believed, which may have contributed to their beliefs on why children deserved rights. Finally, pediatricians also began making value judgements on what parenthood entailed and what was owed to children by parents. The implications of these limitations were a lack of consideration for the experiences and rights of non-White, lower-class, and disabled children.

**Progress for Children’s Rights**

First, during this decade, pediatricians began using language such as ‘rights’ to describe things that children were entitled to such as medical care or freedom from poverty. For instance, an anonymous R.J.H stated in the 1975 article “Free Will, Ethics, and Health Care” that a recent publication had discussed the libertarian idea of freedom to choose whether and when to get medical care. R.J.H. noted some limitations to the libertarian view in regard to children and mentioned commentary by another scholar that children “should not be punished for their
parents’ failings.” R.J.H. concluded that “children should have that right to medical care.” The topic of children’s rights was discussed most frequently by pediatricians specifically within the context of health care. Several articles reflected the view that children should be granted more rights in terms of decision making, consent, and confidentiality. For instance, the 1973 model act for consent proposed by the Academy’s Committee on Youth sought to grant minors the ability to self-consent in situations where they would fail to seek services if parental consent was required. Such situations could include pregnancy, sexually transmitted disease, or substance abuse. The article “The Adolescent Patient’s Decision to Die” by several faculty at Yale School of Medicine’s Child Study Center discussed the dilemma faced by pediatricians when the adolescent patient chose to die rather than receive lifesaving treatment. They concluded that there were conditions under which such a request should be respected and supported. Finally, the 1976 article commentary by Adele Hofmann “Is Confidentiality in Health Care Records a Pediatric Concern?” addressed the topic of data protection and privacy of health records for the pediatric population. She encouraged pediatricians to look more closely at privacy and confidentiality when making decisions about data sharing with third parties.

These conversations led pediatricians to consider children’s rights more generally and outside the context of health care as well. For instance, there was increased discussion on corporal punishment during the 1970s than the previous decade. In a 1971 letter to the editor, Clifton Rothman wrote in solely to express a desire to see the subject of corporal punishment

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186 See footnote 185. Pg. 294.
discussed in terms of child-rearing and as it related to the use of violence among adults. He also mentioned that parents had asked him questions about the use and value of corporal punishment in child rearing. Wyman Sanders discussed the difficulty of drawing a line between maximal discipline and minimal abuse in “Resistance to Dealing with Parents of Battered Children” in 1972.

Some trends from the previous decade continued into the 1970s. For instance, adoption and the role pediatricians played with agencies continue to serve as a catalyst for new ways to think about children’s rights. The 1971 article “Identity Development in Adopted Children” by the Academy’s Committee on Adoptions encouraged the pediatrician and adoptive family to take every opportunity to “develop in the child a sense of worth, importance, and dignity – a true sense of identity.” Additionally, pediatricians’ views regarding the conflict between family privacy and children’s rights continued evolving in favor of children. Two articles during this decade encouraged the use of health visitors, prioritizing the needs of children over perceived rights of family privacy within the home. A 1973 article discussed the cost-effectiveness of home care services compared to in-hospital services and argued that public health nurses should visit homes and provide preventive and curative services as needed. A 1975 commentary by Henry Kempe titled “Family Intervention: The Right of All Children” also proposed a health visitor system where home environments and parent-child relationships could be assessed. Kempe explicitly stated that “visits from a health visitor do not significantly infringe on the parent’s right to privacy, but demonstrate that society has the obligation to assure access to the child

189 Rothman, Clifton B. “Corporal Punishment in Schools— or Anywhere.” *Pediatrics* 48, no. 6 (December 1, 1971): 998–998.
190 Sanders, R. Wyman. “Resistance to Dealing with Parents of Battered Children.” *Pediatrics* 50, no. 6 (December 1, 1972): 853.
192 Williams, Cicely D. “Health Services in the Home.” *Pediatrics* 52, no. 6 (December 1, 1973): 773–81.
during the first years of his life rather than waiting until he first enters school at the age of 5 or 6.”

Implications and Limitations

Despite the progress in the discussion on children’s rights compared to prior decades, pediatricians in the 1970s failed to discuss certain topics, such as pollution and safe housing using the language of children’s rights. The 1970 statement by the Committee on Environmental Hazards titled “Pediatric Aspects of Air Pollution” discussed the negative health impacts of air pollution but failed to offer any suggestions or action items to protect children beyond further research on the matter. The same Committee’s policy statement in 1972 titled “Pediatric Problems Related to Deteriorated Housing” acknowledged increasing concern about unsafe housing and stated that efforts to alleviate illnesses resulting from unsafe housing conditions up to the present day had been insufficient. The Committee made a weak call for pediatricians to support measures necessary to alleviate problems of lead poisoning and to urge landlords to improve housing conditions. Pediatricians during the 1970s did not yet consider the factors of air pollution and safe housing, which disproportionately affected non-White and lower-class children within the context of children’s rights. The Committee on Environmental Hazards did not argue that unsafe environmental conditions violated children’s fundamental rights or offer solutions to the existing issues.

Second, pediatricians concluded that childhood as a concept was more complex than they previously thought. Several articles discussed the way children had been viewed throughout history, with the assumption that such views were not supported at the time of publication. The 1973 article “The Duty of Parents Toward their Depraved Children” mentioned that people believed that children were innately wicked or depraved earlier in history, and that this idea had been rejected in American society just before the Civil War. The report on a conference held in Wisconsin in September of 1975 mentioned that the present society was evolving away from their old view of the child as chattel and that the majority of conference participants supported the view that the young should have equal rights. Additionally, multiple studies on death anxiety in children were conducted, and the results contributed to the idea that children’s experiences were much more complex than pediatricians previously believed. John Spinetta, a psychologist, evaluated children with leukemia in the inpatient setting and concluded that despite efforts to shield children from awareness of their fatal prognoses, children aged 6 – 10 were aware of the severity of their illnesses. Spinetta later conducted a similar study on children with leukemia in the outpatient setting and found that even outside the hospital, fatally ill children who had been shielded from the severity of their prognoses expressed greater levels of anxiety and dwelled on their illnesses compared with children who had non-fatal diagnoses. The studies concluded that even though children were not able to express themselves through adult mechanisms, their experiences were just as complex. These studies, conducted in the early and middle of the decade, may have shaped pediatricians’ views on children’s eligibility for

rights—both in a moral and legal sense—because they proved that children had a high level of awareness and consciousness of the world around them. This discussion among pediatricians on children’s experiences and on how children were viewed in society supported the movement for children’s rights. However, the implication of the idea that children might be more worthy of rights because of the complexity of their experiences rather than by mere virtue of existing was ominous for disabled children.

Finally, the progress in the discussion on children’s rights led some pediatricians to imply that not all adults were qualified to raise children. For instance, in the 1978 article “Forgotten Children: Maltreated Children of Mentally Retarded Parents” Lucy Crain, a pediatrician at the University of California discussed cases of neglect in children of developmentally disabled adults, some of whom were intellectually disabled.200 Crain argued that attempts to remove “at-risk” children (i.e. children of intellectually disabled parents) as a preventive measure were viewed as a violation of parental rights, but that these children were in need of advocacy. She stated that had the two children in the cases she discussed been “mentally or developmentally disabled, they would have qualified for additional special services, including a nursery or respite program..it is ironic that these potentially normal children were forgotten, not only by their parents, but also by our child advocacy system.”201 This discussion reflects the thinking that children had rights that parents had an obligation to fulfill. In making this argument, pediatricians were making a value judgement on what it meant to be a parent and what the obligations of a parent were. The implications of the medical academy making these judgements, however, could be dangerous, especially given that the majority of pediatricians were White and

201 See footnote 200. 132.
male, even during the 1970s. Extending the argument that some parents could not fulfill or uphold children’s basic rights would allow institutions to remove children from their biological families, as was done with Native Americans until the Indian Child Welfare Act was passed in 1978. Overall, this thinking reflected the idea that pediatricians conceived of themselves as defending children’s rights, but they were likely imagining the child they served as White, middle class, and not disabled, and were disregarding the experiences of children who did not fit that model.
Today, discussions about abuse and children’s rights in the pediatrics community have evolved and demonstrate increased inclusivity among pediatricians’ view of children. Pediatricians are also more aware of their own biases in providing care to patients, which reflects a recognition of the historical view of the child as primarily White and middle class. Additionally, the language of children’s rights is present in many articles, which shows progress from the 1960s and 1970s. However, many discussions today are framed in terms of economics rather than children’s rights. Additionally, children are often thought of as future adults, with their potential for productivity an important consideration for pediatricians.

**Awareness & Attitudes Towards Abuse**

The discussion of child abuse and neglect in the modern era reflects that pediatricians today are aware of these diagnoses. Literature in *Pediatrics* no longer seeks to explain the common findings and diagnostic markers of abuse or neglect. Rather, it is assumed that pediatricians are well aware of the signs and symptoms of abuse and neglect, and articles focusing on the topics are centered around specifics such as the risk profiles of specific groups of children. Abuse and neglect also appear in broader discussions on social determinants of health. Further, the calls to action published in *Pediatrics* today revolve around standardizing and adjusting protocols for diagnosing abuse rather than alerting pediatricians to the existence of abuse itself. For instance, in the 2015 study “Testing for Abuse in Children with Sentinel Injuries,” Lindberg et al concluded that increased routine testing for abuse in children with

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sentinel injuries could identify cases of abuse that would otherwise be missed and called for further trials of protocolized testing.\textsuperscript{203} Similarly, in “Critical Elements in the Medical Evaluation of Suspected Child Physical Abuse,” Campbell et al developed consensus guidelines based on expert opinions and concluded that the guidelines they outlined were a starting point for development of child abuse assessment protocols.\textsuperscript{204}

Secondly, abuse is viewed as being much more sinister than in previous decades, and this shift coincides with an increased awareness of children’s rights among pediatricians. Abuse and neglect are discussed in explicit terms without reservation, unlike in previous decades. Perhaps this is because as children’s rights are given greater consideration, anything that infringes on those rights is viewed as much worse.

Progress

One indicator of progress in the discussion on child abuse and neglect is that the conception of the ‘child’ that pediatricians believe they serve has evolved from primarily White and middle-class in the 1960s and 1970s to being much more inclusive in the present day. The modern discussion on abuse and neglect includes children with disabilities, minorities, and impoverished children. For instance, in the 2015 study “Maltreatment of Children Under Age 2 With Specific Birth Defects: A Population-Based Study,” Van Horne et al investigated the impact of several birth defects on the children’s risk of experiencing different forms of maltreatment, including neglectful supervision, physical abuse, physical neglect, medical


neglect, sexual abuse, abandonment, emotional abuse, and refusal to assume parental responsibility. They concluded that the risk of maltreatment was greater in children with cleft lip and spina bifida than in children without birth defects, but that risk of maltreatment was not increased in children with Down Syndrome.\textsuperscript{205} A 2017 study replicated the finding with regard to Down Syndrome and also investigated the impact of intellectual disability, behavioral problems, and conduct disorder on the child’s risk of experiencing maltreatment.\textsuperscript{206} Another study investigated the rates of exposure to abuse among Hispanics compared to US Natives.\textsuperscript{207} A case of abuse in a child with an incarcerated mother and unknown father was even discussed, demonstrating that pediatricians were aware that not all healthcare “interventions for children occur[red] in the framework of a supportive environment with loving parents…present at the bedside.”\textsuperscript{208}

Additionally, the increased focus on differentiating between abuse or neglect and issues such as poverty or parental mental illness reflects the increased nuance with which pediatricians view children’s myriad backgrounds. For instance, in “Parsing Language and Measures Around Child Maltreatment,” Campbell et al discussed how definitions of abuse could sometimes exclude some forms of maltreatment and other time capture factors beyond maltreatment such as poverty. They discussed the importance of differentiating between childhood maltreatment and

\begin{enumerate}
\item Mann, Paul C., Elliott Mark Weiss, Rebecca R. Seltzer, Rachel A. B. Dodge, Renee D. Boss, and John D. Lantos. “Child Abuse, Incarceration, and Decisions About Life-Sustaining Treatment.” \textit{Pediatrics} 142, no. 6 (December 1, 2018). \url{https://doi.org/10.1542/peds.2018-0430}. This paper presents the question of what to do when parents are precluded form being at the bedside due to legal entanglements.
\end{enumerate}
other forms of stress and focusing policy on the genuine issues.\textsuperscript{209} Overall, pediatricians today consider the needs and backgrounds of more types of children than in the 1960s and 1970s.

A second indicator of progress is an increased awareness of provider bias and the recognition that a physician’s instinct may not always be correct when diagnosing child maltreatment. The increased emphasis on the need for protocols discussed earlier reflects this view. Additionally, many studies have discussed provider bias since 2015. Within the discussion on abuse in particular, Keenan et al have discussed bias in “Social Intuition and Social Information in Physical Child Abuse Evaluation and Diagnosis.”\textsuperscript{210} They argued that pediatricians without access to an in-person interview with the family were twice as likely to perform the gold standard evaluations for abuse compared to those who interviewed the family in person. This shows that pediatricians’ reliance on their intuition after social interactions with the family could lead to lower rates of identifying abuse. The ongoing discussion on the need to establish protocols and reduce bias reflects the slowly changing historical conception of the child as White and middle class.

A final indicator of progress is the fact that many discussions among pediatricians today are framed in language of children’s rights. For instance, Halpern et al discussed the responsibility of social institutions such as schools had towards children and concluded that schools were obligated to protect children from bullying.\textsuperscript{211} They discussed the concept of negative rights and the idea of “a child’s right to an open future” which involved protection of


capacities needed to pursue future life prospects. Further, they stated that because society required children to attend schools, schools thus had a fiduciary responsibility toward children and were obligated to safeguard the child’s future opportunities. In “Protecting Children through Research,” Elizabeth Lowenthal and Alexander Fiks discuss the ethical principle of justice, articulating that certain groups such as children, should not be unfairly excluded from the potential benefits of research participation, and argued that more pediatric clinical trials were necessary to improve outcomes for pediatric care. Finally, in “The Rights of Children for Optimal Development and Nurturing Care,” Uchitel et al discussed early childhood development and nurturing care as important factors for upholding children’s rights. Overall, providing the context of children’s rights - both in discussions on abuse as well as on children’s wellbeing in general- strengthens pediatrician advocacy for all children.

Limitations

Although some discussions are framed in terms of children’s rights, many discussions on children’s wellbeing and on prevention of maltreatment, especially those that involve policy, are not. Many of these discussions instead focus on efficiency and how using funding to address abuse and neglect could reduce health care spending over the course of a child’s life.

For instance, in “Medicaid Expenditures for Children Remaining at Home After a First Finding of Child Maltreatment,” a retrospective cohort study, Campbell et al showed that maltreatment was associated with increased Medicaid expenditures after a finding of

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212 See footnote 211. S26.
maltreatment not resulting in the child’s removal from the home. In “Injury and Mortality Among Children Identified as at High Risk of Maltreatment,” Vaithianathan et al demonstrated that models predicting risk of physical abuse, emotional abuse, and neglect could also identify children who were more likely to be at risk for injury and mortality and they argued that using these models to direct resources towards children who were at risk would help focus the most costly intervention efforts towards the families most at risk. The implication of pediatricians using the language of cost effectiveness and efficiency rather than children’s rights when advocating for children in the policy realm is potentially dangerous. This framing implies that when spending aimed at improving children’s welfare is no longer economically efficient, that spending is not necessary.

The second limitation to the discussion on child abuse and children’s rights during the present day is the framing of children as “future adults.” In general, studies in Pediatrics often focus on long-term effects and adulthood outcomes. This is true within the realm of abuse as well. For instance, in “Child Maltreatment and Adult Living Standards at 50 Years,” Pinto-Pereira et al concluded that childhood maltreatment was associated with worse socioeconomic outcomes in adulthood. They stated that their study contributed to the evidence that full long-term costs of child maltreatment are important to determine policy priorities. In “Adverse Childhood Experiences and Protective Factors with School Engagement,” Robles et al showed that children’s attitudes toward school and academic performance declined as adverse childhood

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experience scores increased. This study demonstrates an example of pediatricians’ focus on improving academic performance, a factor that may be seen as a proxy for future productivity.

While understanding the long-term effects of various stressors is important, the framing of discussions around the adulthood outcomes rather than within the context of children’s rights is potentially dangerous. Although adulthood outcomes such as lower income may be more relatable to pediatricians conducting the research and reading it, discussing these factors may bring the focus away from children’s rights and instead emphasize the ability of adults to contribute to society and be productive. The valuing of adulthood productivity above children’s rights as a line of reasoning is problematic in that it can be used to justify arguments that pediatricians likely would not support. The implications for children with terminal illnesses who will not live to become adults or for disabled children who may never be “productive” are also dangerous, as they could be denied certain services since that spending would not contribute to future productivity. Further, that reasoning implies that the future adult matters more than the child does.

**Looking forward**

Current topics of interest for pediatricians regarding abuse include the impact of exposure to intimate partner violence at home as well as increased levels of abuse due to increased time spent at home during the pandemic. As pediatricians continue to advocate for children, discussing these topics and the policies surrounding them in terms of rights rather than in terms of economic benefits may be more fruitful.

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COVID-19 & The Discussion on Children’s Rights

Over the last decade, the topics of child abuse and neglect and children’s rights have been given increased attention by pediatricians. The COVID-19 pandemic has uncovered questions about where children’s rights fit within society and how we prioritize those rights during times of crisis such as a pandemic. Further, the medicalization of social issues (ranging from environmental exposures to media programming) has presented a complex challenge for pediatricians. While pediatricians view themselves as responsible for safeguarding children’s rights, it is increasingly clear that they cannot do so without significant external support from agents like social workers and governmental agencies.

The COVID-19 pandemic has brought attention to what priority American pediatricians place on children’s rights. On one hand, there has been increased concern for children of the most marginalized groups. For instance, *Pediatrics* articles about the impact of COVID-19 on children often discuss families struggling with low incomes or joblessness, homelessness, food insecurity, and those within the criminal justice system, as well as children with disabilities and complex medical condition.219 Discussions on child abuse and neglect also focused on the unique

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219 Kalluri, Nikita, Colleen Kelly, and Arvin Garg. “Child Care During the COVID-19 Pandemic: A Bad Situation Made Worse.” *Pediatrics* 147, no. 3 (March 1, 2021). [https://doi.org/10.1542/peds.2020-041525](https://doi.org/10.1542/peds.2020-041525). Kalluri et al discuss issues of child care for families struggling with food and housing insecurity, as well as preexisting socioeconomic and racial inequities.


challenges and increased risk that lower income and minority race children face.\footnote{Cho, Romy, Tanya Smith, Emma Cory, and Jennifer N. Smith. “Experiences of a Child Abuse Program in the Time of COVID-19.” \textit{Hospital Pediatrics} 11, no. 2 (February 1, 2021): 213–16. \url{https://doi.org/10.1542/hpeds.2020-001529}. For instance, Cho et al discuss the fact that children in marginalized groups are more likely to face abuse as a result of worsening inequalities due to the pandemic.} By recognizing the previously existing inequities now exacerbated by COVID-19, pediatricians have been forced to acknowledge the ways some children’s rights have not been protected. The act of turning the collective attention towards issues such as homelessness and food insecurity is not only practically important for ensuring children’s wellbeing but demonstrates pediatricians’ recognition of concern for the rights of marginalized children.

Despite this implicit recognition and concern for the rights of the vulnerable, the language of children’s rights has not been used as part of pediatricians’ arguments in discussing COVID-19 in \textit{Pediatrics}. Language about children’s wellbeing is instead focused on long term health effects and on practicality, rather than on children’s rights to not be harmed.\footnote{Thomas, Elizabeth York, Ashri Anurudran, Kathryn Robb, and Thomas F. Burke. “Spotlight on Child Abuse and Neglect Response in the Time of COVID-19.” \textit{The Lancet Public Health} 5, no. 7 (July 1, 2020):\url{https://doi.org/10.1016/S2468-2667(20)30143-2}. Thomas et al mention the long-term health outcomes of child abuse. See footnote 219. Masonbrink et al discuss the long term educational disparities that are being exacerbated by the virtual schooling during the pandemic.} The absence of children’s rights in articles on abuse and neglect can weaken the arguments made by pediatricians about how to address issues affecting children’s wellbeing, as mentioned earlier in this article. Although pediatricians recently have discussed children’s rights explicitly more than before, it seems that children’s rights have taken a back seat to more practical and pressing issues related to the Sars Cov-2 virus over the last year. For instance, many patients and health care providers now prefer telehealth appointments to in-person appointments, even though issues like abuse and neglect can be identified much more easily in person. Pediatricians must now ponder what status children’s rights hold during an emergency such as a global pandemic. Additionally,
they must try to identify what has caused the decline in the use of rights language, whether it is the result of attention on short-term goals, the increased physical distance between them and their patients, an increased reliance on parents to mediate their interactions with their patients, or anything else.

COVID-19 has also served as a catalyst for pediatricians to rethink notions of the “home,” family privacy, and their relationship with the family unit. Throughout the mid twentieth century, family privacy was respected and prioritized by pediatricians. Although this view has slowly shifted over time, COVID-19 has accelerated the changes and pediatricians are now very concerned with what children are experiencing behind closed doors. Pediatricians are beginning to view the lack of visibility of children as a problem. For instance, now that children have largely been confined to their homes given school closures, there is much less reporting of suspected neglect and abuse. Pediatricians are interpreting the drop in reporting as indicative of the importance that people outside the home (teachers, social workers, etc.) played in safeguarding children’s rights to not be abused, not as a true decline in the rates of abuse and neglect. Rather, pediatricians suspect an increase in these rates and are concerned about the inability for community members to report suspected abuse since children remain within their

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222 Over several months, various pediatricians have predicted and later demonstrated that the number of reports of suspected abuse are decreased during the pandemic.
Humphreys et al predicted that with school closures, the “largest source of reports to CPS will disappear, resulting in reduced detection of maltreatment.”

Ragavan et al stated that reports to Child Protective Services had decreased, likely due to decreased interaction between children and mandated reporters.

Voddi et al stated that during the pandemic, there have been fewer reports of child abuse.
homes much more than before.\textsuperscript{223} Pediatricians have recommended that ensuring access to primary care and prevention services such as home-visiting services and safe reopening of schools and daycares are important for ensuring children’s wellbeing.\textsuperscript{224} Overall, COVID-19 has illustrated that pediatricians now view it as their responsibility to be concerned about what may be happening behind closed doors and to advocate for the increased visibility of children.

However, medicalization of issues like abuse have led to the idea that medicine is the primary body grappling with the issue of child abuse during the pandemic. Over the last several decades, pediatricians have medicalized many topics from media programming to environmental issues and brought them into the purview of medicine. However, the limitation is that many of these issues, which are inherently social and political in nature, have become viewed by physicians as not only medical, but also as apolitical. COVID-19 has made it clear that issues such as child abuse and neglect are primarily social issues rather than medical ones and are beyond pediatricians’ capacity to address.

The response to concerns about abuse during the COVID-19 pandemic by pediatricians in \textit{Pediatrics} has centered around working within the existing system, where pediatricians and teachers are the two primary groups responsible for the majority of mandated reporting. However, the primary goal of hospitals and schools is not maintaining children’s rights or evaluating for abuse, and both sets of institutions have several other responsibilities. Thus, the disruption to both in-person learning and health visits has made it significantly harder for the

\textsuperscript{223} See footnote 222. Voddi et al predict that after shelter at home mandates are lifted, there will be an increase in reports of child abuse because surveillance will resume. They conclude that the decrease in reports of abuse is due to school closures rather than to a decrease in the incidence of abuse.

\textsuperscript{224} See footnote 222. Humphreys et al argue that reports of increased domestic violence after the quarantine was lifted in China has demonstrated that the risk of domestic violence is higher during isolation.

appropriate professionals to identify signs of abuse or protect the children who are most at-risk. For instance, *Pediatrics* articles discuss the importance of remaining vigilant for signs of abuse and ways to maximize telehealth appointments. This notion of optimizing the ability to detect abuse via virtual contact is practical, but pediatricians in *Pediatrics* have not used the pandemic as a catalyst for the discussion on children’s rights. They have not argued for governmental support in upholding children’s rights and evaluating for signs of abuse, nor have they pressured policymakers to address the presumed increase in abuse and neglect in any specific ways. The pandemic and the decreased levels of reporting also point to the issue around protecting the rights of homeschooled children or children with chronic diseases or disabilities who do not physically attend school. The *Academy* has not argued that social issues exacerbated by the pandemic such as child abuse are not within medicine’s capacity to solve and called on government for urgent help in addressing the matter. Whether this is due to a reluctance to relinquish authority over to government, an understanding that public health is a greater immediate priority than intervening in families at risk of abuse, a combination of these factors, or another reason altogether is unclear.

Together, the issues of children’s rights and the historical practice of increasing medicalization by pediatricians present a complex challenge given the current pandemic. The medicalization of abuse has prevented effective safeguarding of children’s rights simply because medicine does not have the capacity or resources required to handle the issue. An effective and comprehensive approach to child abuse involves social workers, funding to meet gaps in families’ needs through programs such as WIC or government housing, and occasionally even

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225 See footnote 222. Ragavan et al discuss the fact that screening for domestic violence is made more difficult by telehealth and recommend developing solutions and partnerships to support intimate partner violence victims. See footnote 222. Humphreys et al also discuss the limits that telehealth introduces in assessing patients and states that clinicians should be attuned to nonverbal signs of violence.
the foster care system. While hospital pediatricians and social workers can connect families with resources, they are not able to control the long wait times or strict requirements of these programs or to ensure families’ challenges are resolved long-term.

Safeguarding children’s rights also may require some disruption to the level of family privacy that people are accustomed to, and pediatricians must identify how they can best advocate for that cause. Pediatricians must also contemplate what right they have to access children when in-person visits are no longer required, and what right society has to access children to ensure their wellbeing without parental cooperation and consent. Finally, the pandemic has highlighted the challenge to safeguarding children’s rights during a time of crisis when no single institution has historically been responsible for the matter. With children’s rights being a secondary consideration for overwhelmed institutions like schools, the discussion on children’s rights has fallen by the wayside and no institution is held accountable for ensuring that children are not experiencing abuse.
Conclusion

Pediatricians today generally regard their commitment to be primarily to the child and hold children’s wellbeing as their overall goal. As such, it may be difficult for pediatricians to recognize that the profession has not always thought this way. However, literature in *Pediatrics* demonstrates a slow shift in pediatricians’ collective views about children’s rights, parental privileges, and child abuse in response to “The Battered Child Syndrome.”

Pediatricians in the time period immediately before and immediately after the publication of “The Battered Child Syndrome” did not explicitly write about child abuse in *Pediatrics* or other prominent journals. Many physicians at the time were unwilling to even accept the existence of abuse. Kempe’s article in 1962 provided new language about child abuse and formed the foundation of the pediatrician community’s understanding of abuse. The result of this shared understanding was a conversation in *Pediatrics* whereby pediatricians in general began to accept the reality of child abuse and figure out how to move forward. Several other prominent pediatricians and psychiatrists contributed knowledge on the physical exam and behavioral findings indicative of abuse and worked together to refine the parameters of abuse and neglect. By the 1970s, pediatricians’ major debates revolved around next steps, reporting, and what caused parents to mistreat children. By providing specific language to describe an abstract concept- child abuse, Kempe shaped the way that pediatricians behaved. Naming the phenomenon allowed pediatricians not only increased ability to identify abuse, but the ability to grapple with it and what it implied about human behavior. It allowed pediatricians to identify abuse as distinct from parental discipline and see it as a specific social ill. One result of this was a trend of pediatricians bringing an increasing number of health adjacent topics such as television advertisements targeting children into their purview throughout the 1960s and 1970s. This trend
reflected pediatricians’ belief that they were best suited to make judgements on what was appropriate behavior from caregivers (and society in general) towards children.

These changes shed light on how pediatrics as a profession might consider children’s rights in the present day. There were few publications in *Pediatrics* in the 1960s and 1970s specifically focused on children’s rights outside of the hospital setting. However, even today, pediatricians have not reached a consensus on what moral rights the profession should offer children. Jeffrey Goldhagen, a pediatrician and professor at the University of Florida, emphasized the importance of the United Nations Convention on the Rights of the Child (UNCRC) and stated in his 2003 *Pediatrics* article that all pediatricians “should address children’s rights as part of the core work of the and the RCPCH [Royal College of Paediatrics and Child Health].”

Goldhagen’s article is one of the only pieces published in *Pediatrics* that has commented on America’s failure to ratify the UN CRC. The lack of discussion on this topic, as well as the specialty’s lack of a defined set of children’s rights illustrates pediatricians’ uncertainty about how to approach the topic and has led to the framing of many arguments in terms of economics rather than in terms of rights. Discussions of rights within *Pediatrics* has largely focused on those rights that come into question in the hospital or clinical setting, for instance, rights to privacy or choice regarding treatment options. However, the discussion on rights in a more general sense has been sparse, which is surprising given the connection between child abuse (which has been paid a lot of attention) and children’s rights to not be harmed.

Looking forward, integrating children’s rights into pediatrics – in both practice and medical curricula – is an important goal for the coming decades. It is also important for pediatricians to begin using the language of rights as the basis for any political lobbying that

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aims to protect children from abuse and other harms. It will also be important for pediatricians to reach a consensus on what legal and moral rights American society ascribes to children, and what role pediatricians can play in upholding those rights, as that conversation is still incomplete. As the COVID-19 pandemic has demonstrated, it will also be important for pediatricians to acknowledge limitations to their role and to urge other institutions to do their part in maintaining the total health and wellbeing of children.
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Cal. Pen. Code 11110, 11161.5. 11160, 11161, 11162


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