Despite the disheartening upward trend in cases, Metz, Patno, Wagner, Hagan, and Rafuse all agree about the reason they were ultimately drawn to and remain committed to the field of child abuse medicine—hope.

Behind that 12 years later, he’d return to his alma mater and home state as one of only two board-certified child abuse pediatricians in Vermont.

Now a Lerner assistant professor of pediatrics and the sole child abuse specialist at UVM Children’s Hospital, Metz, along with his team at the UVM Medical Center’s Child Safe Program, is making a positive impact on health care for mistreated children in the state. But Metz is quick to admit that, without a solid framework created by the medical professionals and educators who came before him, that impact wouldn’t be possible.

A New Field of Medicine
Child maltreatment—including neglect and physical, sexual, and psychological abuse—is not new, nor is the need for trained medical professionals to treat these victims, says Metz’s mentor Joseph Hagan, M.D., a Vermont pediatrician, clinical professor of pediatrics and national pediatric leader. Hagan notes that it wasn’t until C. Henry Kempe, M.D.’s article, “The Battered-Child Syndrome,” was published by the Journal of the American Medical Association in 1962, that the issue of child abuse was recognized by the medical community as one that needed to be clinically researched, diagnosed, and treated. At the time, this duty largely fell to primary care pediatricians.

It’s a duty that Hagan and Karyn Patno, M.D., Metz’s other role model, earnestly dove into early in their careers—Hagan in the early 60s and Patno in the early 80s. Over time, Hagan and Patno, who is Vermont’s only other board-certified child abuse pediatrician, became the “go-to” doctors for Vermont clinicians, caregivers, and social workers who were seeking guidance in complex cases of suspected child abuse and neglect. For years, the two covered all calls for child abuse clinical specialists in the state. Patno, in St. Johnsbury, covered the east side of the state and Hagan, in Burlington, covered the west. It was Patno who first created Vermont’s Child Safe Program in 2008. Until Metz’s recent arrival, Patno ran the Child Safe clinics first from St. Johnsbury. She subsequently expanded the program to UVM Children’s Hospital and later worked in tandem with Hagan in Burlington.

Over four decades following the publication of Kempe’s JAMA article, a small group of clinicians around the country—including Patno and Hagan—unofficially surfaced as specialists in evaluating abuse cases and assisting child protective agencies in their work. By the mid-1980s, the field was officially recognized by the American Board of Medical Specialties as child abuse pediatrics. That year, the American Board of Medical Specialties officially recognized child abuse pediatrics as a pediatric subspecialty. Three years later, the American Board of Pediatrics held its first board certification examination.

Looking to Science for Guidance
The creation of the subspecialty and relatively new availability of fellowship programs is one that Patno, Hagan, and Metz agree has pushed the field forward in necessary and ground-breaking ways. Most important, the three say, is the increase in field-specific research and literature.

“One of the biggest values of having a subspecialty is that it supports and encourages research in the field,” says Patno. “Before, we knew how to evaluate injuries, but now we have so much more information—which leads to fewer mistakes in terms of under- or over-diagnosing of injuries.”

It doesn’t take long before the full weight of what Patno says next sinks in. “If you fail to recognize child abuse, you send a child into danger. If you over-call it, you destroy a family.”

Tracey Wagner, R.N., MBCN, CPN, a forensic nurse who has worked in the UVM Department of Pediatrics since 1996, agrees. “In the past, decision-making was more subjective,” she says, adding that the key change to the field has been a growing foundation of scientific knowledge and research-based evaluation, diagnosis, and recommendations.

“It’s extremely high-stakes,” Metz adds, emphasizing, “this is an area that should require additional specialized training, just like cardiology or gastroenterology. There are so many aspects of child abuse medicine that we don’t learn very much of in medical school or residency—social, legal, medical, and forensic. The need for additional training is both necessary and apparent.”

Standardization to Reduce and Eliminate Bias
Why are standardization and evidence-based protocols in the field of child abuse pediatrics so important? One reason, says Metz and his colleagues, is systemic inherent bias rooted deep in our society.

“As a team, we know that there is inherent bias, including systemic racism, built into the child welfare system,” says Mary Ellen Rafuse, MSW, who was a social worker for the Vermont Department for Children and Families (DCF) for 10 years and now works full-time for the Child Safe Program. “We need to make sure we’re not compounding that problem and are actively working to diminish it,” Rafuse says. “That’s why we’re so focused on creating standardized guidelines and protocols.”

So, what does standardization in the field look like and how does Metz and his team work to enact it within the program and throughout Vermont? First and foremost, says Metz, “every child needs to be assessed based on their injury, not their social context.”

Child abuse pediatricians look at the biomechanics of injuries to understand, for instance, the type of head trauma that would occur as the result of shaking versus a car accident. By looking at the forensic evidence, clinicians like Metz and his team can train social workers, emergency medicine professionals, and primary care physicians how to identify sentinel injuries—injuries that are concerning for abuse, and therefore require what they refer to as “a work up.”

An example of a sentinel injury, says Metz, could be a small bruise on a four-week-old baby versus a broken femur in a four-year-old child. One is much less likely to occur as an accidental injury in a non-abusive versus-abusive child.

If a sentinel injury is identified using researched-based standardized assessment criteria, the child is treated, and further processes are enacted in a specifically prescribed way. Ensuring suspected abuse cases are evaluated and treated in a standardized manner limits the impact of social bias on decision-making among all providers.

Two Pandemics Converge
Unfortunately, child abuse cases have increased across the country and within the state over the last ten years, particularly among younger children, says Rafuse. Metz and his colleagues attribute the increase, in part, to the opioid crisis.

“We’re seeing many more children in care of relatives and increased cases of accidental ingestions and neglect,” says Rafuse. “It remains to be seen if the ongoing COVID-19 pandemic has contributed to the increase; the team at the Child Safe Program thinks that, based on the compelling evidence of the past, it probably will. We know that during times of economic stress, incidence of abuse goes up,” says Metz. “Unfortunately, there’s no reason to believe it will be different this time.” Wagner notes that the increasingly individualistic nature of our society and the isolation created by necessary social distancing measures are additionally concerning factors.

Still, it will probably be another year, well into 2021 before reliable statistics show the true story of how COVID-19 has affected the field, says Patno.

A Hopeful Future
Despite the disheartening upward trend in cases, Metz, Patno, Wagner, Hagan, and Rafuse all agree about the reason they were ultimately drawn to and remain committed to the field of child abuse medicine—hope.

“There are so many opportunities and ways to tackle the problem,” says Metz.

Hagan agrees and says that the formal creation of the subspecialty has contributed greatly to the current and future momentum of the field. “Now, we have a group of people whose full-time work is seeing these children and families, working with their peers around the country, developing policy, creating training programs, and actively advocating,” he says. He stresses, however, that it remains the responsibility of every clinician to identify and report suspected child abuse and neglect.

Wagner adds that the field is becoming increasingly multidisciplinary and collaborative, and Rafuse says the arrival of Metz has allowed the Child Safe Program to become a formal hub for consistent response and information delivery to child protective professionals around the state.

“We are so fortunate to have James with us,” says Lewis First, M.D., M.Sc., Lerner College of Medicine professor and chair of pediatrics and UVM Children’s Hospital chief. “He recognizes that we’ll only succeed if we continue to connect and build partnerships with state agencies, organizations, schools, and all those interested in advocating for the health, safety, and well-being of children across Vermont and upstate New York. His efforts to build a truly collaborative program is helping our state become a national leader in child abuse prevention and treatment.”

Currently, there are 136 board-certified child abuse pediatricians in the United States. Metz and his colleagues agree that the field is in need of urgent growth.

“Ensuring children are empowered and raised to become healthy, happy, productive members of our communities is one of the most important things we can do,” says Metz. “Child abuse needs to be brought out from the underbelly of society. It’s easy for people to say ‘the problem is too big, it’s too difficult, it’s too sad.’ But that’s when you need to step into a problem, not away from it.”