

Chapter 56

Child Abuse

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The mistreatment of children is sadly limited neither by time nor space: the problem has been found in every nation and in every period.¹ Here, however, the focus will be upon the problem of abuse in the United States.

STATISTICS

In 2003, the most recent year for which national statistics are available, there were reports of more than 2.9 million cases of suspected child abuse and neglect in the United States.² The National Child Abuse and Neglect Data System (NCANDS) reported an estimated 1400 child fatalities in 2002.³ In that same year, more than one-third (38%) of child maltreatment fatalities were associated with neglect alone. Physical abuse alone was cited in more than one-quarter (30%) of reported fatalities. Another 29% of fatalities were the result of multiple types of maltreatment.⁴ Reliable statistics, however, are hard to find. There is risk of error both in underreporting and overreporting.⁵ It has been reported that 85% of the deaths attributable to child abuse and neglect were not recorded as such, resulting in serious underestimates of fatalities from abuse and neglect.⁶ On the other hand, 58% of reports to child protective services agencies in the United States in 2003, including those that were intentionally false, were found to be unsubstantiated.⁷

DEFINITION

One reason for this uncertainty is that there is no universally accepted definition of child abuse. Statutes may impose liability for “excessive corporal punishment” or “drug-related activity,” or may require “reasonable suspicion” or “mental injury,” yet fail to define such terms.⁸ Moreover, pediatricians and others obliged to report possible abuse on the basis of “reasonable suspicion” vary widely in their interpretation of that concept.⁹ Some definitions of neglect classify a failure to provide for a child’s needs as negligence, whereas others require a harmful outcome or at least the potential of a harmful outcome before neglect can be found. Still others demand the availability of a societal alternative to the deprivation before neglect can be established.

Even physical abuse, which may seem a fairly straightforward concept, is not an unambiguous term. Some states

define physical abuse as actions resulting in actual injury, whereas others define it to include the mere potential for injury.¹⁰ The harms to a developing fetus from maternal substance abuse during the pregnancy are well described,¹¹ but whether the mother is abusing the baby as she abuses those substances is debated.¹² Psychological abuse is even less amenable to ready definition. In one report, 45% of parents in a nationally representative sample of 1250 parents reported insulting or swearing at their children that year.¹³ Whether such behavior is abusive may depend on the severity and frequency of such conduct, but may also depend upon subjective judgments on the proper rearing of children.¹⁴ Sexual abuse may also be a concept more elusive than it appears. Statutory rape, for example, may or may not fit within the definition of sexual abuse.¹⁵

Even assuming one knows what is and is not abuse, child protection workers and health care providers often disagree about the nature of appropriate reports and the relevant legal requirements for making them.¹⁶ Contributing to this problem is the repression of memories of abuse by some victims. An important legal application of repressed memory is the ability to toll the applicable statute of limitations on a civil suit. Most jurisdictions have an exception that allows a bypass of the normal statute of limitations if the plaintiff was unaware of his or her damages until after the limitation period has run.¹⁷ The majority of states allow memory repression to toll the statute;¹⁸ other states expressly bar this reasoning and others have made no ruling.¹⁹ Tolling sometimes allows suits to proceed over 25 years after the abuse occurred. This of course presents several challenges to both parties when bringing a case.

If a case involving repressed memory survives to trial, victim and expert witness testimony become especially important. A jurisdiction’s application of memory repression as a basis for tolling is not a guarantee that recovered memories will be allowed as testimony.²⁰ Some jurisdictions have found the testimony too unreliable to allow at trial, while others consider it no different from other forms of witness testimony.²¹ A number of courts take a middle position, qualifying the testimony or allowing it only when it was recovered without the aid of hypnosis or drugs.²²

Expert witnesses are often utilized by one or both sides of a case to discuss recovered memories and the recovery

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process. Several stances have been taken by trial courts regarding this issue.²³ *Daubert* analysis is the general standard in federal courts for judging the validity of scientific evidence.²⁴ Owing to the controversial nature of recovered memories, it is difficult for experts to satisfy the general acceptance leg of the *Daubert* analysis.²⁵ Even so, some courts applying this standard do allow expert testimony on the subject even though this leg of the analysis is not satisfied.²⁶ Some jurisdictions that allow such testimony have placed limitations on who may testify as an expert.²⁷

RELIGIOUS EXEMPTIONS

As discussed above, many groups eschew medical interventions on religious or philosophical grounds. Among those best known in the United States are Christian Scientists and Jehovah's Witnesses. Somewhat less well known are the Faith Assembly, the End Time Ministry of South Dakota,²⁸ the General Assembly and the Church of the First Born, the Faith Tabernacle Church, the Church of God of the Union Assembly Incorporated, and the No Name Fellowship and Faith Assembly Church.²⁹ Members of these faiths believe that a proposed medical intervention forces them to choose between obeying the law of man and obeying the law of God.³⁰ The courts may have to decide whether withholding medical care on religious grounds is permitted under the United States Constitution or forbidden by state child abuse laws.

Under fundamental First Amendment principles, religious practices are seldom scrutinized, and rarely constrained, by American law. Yet there have been cases in which parents motivated by religious beliefs have been prosecuted for child abuse when they rely upon spiritual means of healing rather than upon allopathic medicine. As one observer has written, however, while the First Amendment is the constitutional defense most often raised in these circumstances, it is also the least successful.³¹ When medical care is withheld, charges of neglect are most common, but in some circumstances allegations of active abuse may also be raised. For example, even though female circumcision provides no medical benefits,³² and may cause significant harm,³³ and even though performance of such procedures on children under 18 years of age is unlawful,³⁴ some religious groups promote the practice.³⁵ In addition, at least one church reportedly beats teenagers during services.³⁶ At another church, an autistic child died during an exorcism.³⁷

Some traditional ethnic remedies may cause more damage than the results of mere ineffectiveness. They may be dangerous, as with lead used for constipation and other problems.³⁸ The consequences of reliance upon folk remedies or faith healing can be quite serious.³⁹ It has been reported that from 1975 until 1995, at least 172 children died because of their parents' refusal on religious grounds to utilize conventional medical treatment.⁴⁰

The tension between those deeply cherished First Amendment rights and moral duties and cultural imperatives to protect children is not easy to resolve. Except for Hawaii, Maryland, Massachusetts, Nebraska, and North Carolina,

all states are said to provide some form of religious exemption to child abuse and neglect laws.⁴¹ These provisions often exempt parents who rely upon prayer from requirements that medical care be promoted for their minor children.⁴² For the most part, religious exemption laws originated after enactment of the Child Abuse Prevention and Treatment Act of 1974,⁴³ which in pertinent part conditioned a state's receipt of federal funds to combat child abuse upon enactment of such an exemption in substantially this form:

*[A] parent or guardian legitimately practicing his religious beliefs who thereby does not provide specific medical treatment for a child, . . . for that reason alone shall not be considered a . . . negligent parent or guardian; however, such an exception shall not preclude a court from ordering that medical services be provided to the child, where his health requires it.*⁴⁴

Between 1974 and 1983, states failing to create such exemptions were ineligible to receive federal funds appropriated to fulfill the intent of the act: the establishment of preventive programs to reduce the incidence of child abuse.⁴⁵ In regulations promulgated in 1983, this requirement was lifted, but religious exemption clauses allowing parents to withhold care were still permitted:

*[n]othing in this subchapter . . . shall be construed . . . to require that a state find, or to prohibit a state from finding, abuse or neglect in cases in which a parent or legal guardian relies solely or partially upon spiritual means rather than medical treatment, in accordance with the religious beliefs of the parent or legal guardian, provide a child any medical service or treatment against [his] religious beliefs.*⁴⁶

Most states have retained these religious exemptions.⁴⁷ Exemptions vary widely with respect to whether the statute prohibits child neglect or endangerment, requires reporting of abuse, imposes criminal sanctions for failing to secure medical care for a child in need of it, or some combination of these provisions.⁴⁸ On the other hand, the Department of Health and Human Services has required states to provide that, regardless of religious belief, all cases of medical neglect be reported and investigated.⁴⁹

State courts have taken inconsistent approaches to cases involving religious exemptions. In *Walker v. Superior Court*,⁵⁰ the California Supreme Court held parents criminally liable for trying to treat meningitis with Christian Science, holding that the religious exemption for misdemeanor child neglect was no defense against felony child endangerment and involuntary manslaughter. In *Commonwealth v. Barnhart*,⁵¹ parents rejecting medical care on religious grounds were convicted of involuntary manslaughter and endangering the welfare of their child when they treated his cancer with prayer alone.⁵² In Minnesota, however, a different result was reached. A Minnesota statute defines manslaughter in the second degree as arising from, among other circumstances, "the person's culpable negligence whereby the person creates an unreasonable risk, and consciously takes chances of causing death or great bodily harm to another. . . ." ⁵³

In *State v. McKown*,⁵⁴ Christian Science parents were charged with second-degree manslaughter for the death of their diabetic child, who died without benefit of medical care. The parents relied upon Minnesota's child neglect statute, under which

*[a] parent . . . who willfully deprives a child of necessary food, clothing, shelter, health care, or supervision appropriate to the child's age . . . [which] deprivation harms or is likely to substantially harm the child's physical, mental, or emotional health . . . [shall be] guilty of neglect of a child. If a parent . . . in good faith selects and depends upon spiritual means or prayer for treatment or care of disease or remedial care of the child, this treatment shall constitute "health care."*⁵⁵

Because the state manslaughter and child neglect statutes had different purposes, the court refused to read them together, and held that the religious exemption defense could not be applied to the manslaughter charge. Nevertheless, it also held that the manslaughter indictments violated the parents' due process rights because "the child neglect statute did not provide fair notice" of the potential criminal liability they could face by actually relying on the alternative healing methods that the neglect statute clearly prohibited.⁵⁶ Ironically, the minor child's father successfully sought compensatory damages for negligence causing the death of the child.⁵⁷

For health professionals, reliance upon faith healing and other nonscientific approaches may seem irrational and barbaric. Certainly the outcome can be appalling. Some courts have ruled that the religious exemptions are unconstitutional.⁵⁸ Even so, religious freedom is rightly seen as one of the great achievements of Western liberal thought.⁵⁹

DIAGNOSIS

An enormous volume of literature exists to help clinicians identify possible child abuse. Only a superficial treatment of the subject is possible here. The work of Helfer and Kempe remains an excellent guide to the diagnosis of abuse. In their classic work *The Battered Child*, they wrote that "the syndrome should be considered in any child exhibiting evidence of fracture of any bone, failure to thrive, soft tissue swellings or skin bruising, and any child who dies suddenly, or where the degree and type of injury is at variance with history given regarding the occurrence of the trauma."⁶⁰ They supplied additional details:

The battered-child syndrome may occur at any age but, in general, the affected children are younger than three years. . . . [T]he child's general health is below par and he shows evidence of neglect including poor skin hygiene, multiple soft tissue injuries, and malnutrition. One often obtains a history of previous episodes suggestive of parental neglect or trauma. A marked discrepancy between clinical findings and historical data as supplied by the parents is a major diagnostic feature. . . . The fact that no new lesions . . . occur while the child is in the hospital . . . lends added weight to the diagnosis. . . . Subdural hematoma, with or without fracture

*of the skull, is . . . an extremely frequent finding. . . . The characteristic distribution of these multiple fractures and the observation that the lesions are in different stages of healing are of additional value in making the diagnosis.*⁶¹

The authors have since concluded that knowledge of the symptoms and signs of child abuse has greatly increased within the health care community.⁶²

In children 9 months of age or less, any soft tissue injury suggests possible abuse.⁶³ In children over age 1 year, accidental bruises tend to be found over bony prominences. Bruises in less typical locations, such as the abdomen, suggest abuse.⁶⁴ Some consider retinal hemorrhages to be nearly diagnostic of child abuse.⁶⁵ Pattern scars or bruises, such as cigarette or immersion burns; lacerations or abrasions of areas not normally so injured, such as the palette or external genitalia; and behavior changes, including noncompliance, anger, isolation, destructiveness, developmental delay, excessive attention-seeking, and lack of separation anxiety, are also characteristic.⁶⁶ Abuse may be serial, or inflicted upon siblings.⁶⁷

In contrast to physical abuse, neglect is more apt to present as malnutrition, recurrent pica, chronic fatigue or listlessness, poor hygiene, inadequate clothing for the circumstances, or lack of appropriate medical care, such as immunizations, dental care, and eyeglasses.⁶⁸ Behavioral signs, including poor school attendance, age-inappropriate responsibility for tasks such as housework, drug or alcohol abuse, and a history of repeated toxic ingestions, may also be present.⁶⁹

Sexually abused children may have difficulty walking or sitting; thickened or hyperpigmented labial skin; torn, stained, or bloody underclothing; bruised or bleeding private parts; vaginal discharge, pruritus, or both; recurrent urinary tract infections; venereal disease; pregnancy; and lax rectal tone. It is reasonable to believe that these unfortunate children may be at increased risk for acquired immunodeficiency syndrome (AIDS), although its most common cause in children is undoubtedly maternal-fetal infection.⁷⁰ A vaginal opening greater than 4 mm in horizontal diameter is said to be characteristic of the sexual abuse of prepubescent girls.⁷¹ Victims of sexual abuse may also have poor self-esteem, attempt suicide, display regressive behavior such as enuresis, masturbate excessively, engage in sexual promiscuity, withdraw from reality, express shame or guilt, and experience distortion of body image.⁷²

If the child's caretaker was abused as a youngster, the child in his care is at higher risk of abuse. Abusive mothers are often themselves victims of physical abuse by a husband or partner.⁷³ Adult sex offenders were also often themselves victims of abuse.⁷⁴ An Iowa study indicated that 58% of shaken baby syndrome patients had evidence of prior abuse, and 33% had been shaken before, corresponding to a 33% recidivism rate reported for child abuse generally.⁷⁵ A 1999 study by the National Center on Addiction and Substance Abuse found children of substance-abusing parents three times more likely to be abused and four times more likely to be neglected than

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children of non-substance-abusing parents.⁷⁶ Parents of psychologically abused children are themselves more likely to be stressed⁷⁷ and to have been verbally abused as children.⁷⁸

Abuse most often occurs at the hands of parents. In more than 75% of reported cases of abuse, the parents are the perpetrators, and in another 10%, the perpetrators are other relatives of the victim.⁷⁹ People in other care-giving relationships to the victim, such as foster parents, account for only about 2% of all reported cases of child abuse.⁸⁰ About 80% of all perpetrators are under age 40, with women more likely to be perpetrators of physical abuse and men more often perpetrators of sexual abuse.⁸¹ Physicians concerned about possible child abuse may wish to inquire about caretakers' tendencies toward alcoholism, drug abuse, sexual promiscuity, unstable marriages, and criminal activity.

The examining physician should strive to strike an appropriate balance, and set the index of suspicion neither too high nor too low. Not all cases present in classic fashion, and typical findings are not always caused by child abuse. "Any one may coincidentally show a variety of types of physical marks (e.g., a black eye, cut lip, bruised ears, scratches and diaper rash burns), even though their parents may be loving, concerned and reasonably careful."⁸² Thus, the diagnosis may not be straightforward, particularly since the history is unlikely to be obtained easily from intimidated young patients or from their guilt-ridden parents.

Differential Diagnosis

To explain head injuries, parents will often report accidents such as falls from small heights. This explanation is suspect, and such injuries are likely to result from abuse.⁸³ "When children who are said to have had minor falls are found to have life-threatening multiple or severe injuries, the reliability of the history should be seriously questioned."⁸⁴

Some disorders can mimic abuse, but they are rare. Osteogenesis imperfecta (OI) is "an inherited disorder of connective tissue resulting from abnormal quality and/or quantity of Type 1 collagen."⁸⁵ Sometimes referred to as "brittle-bone disease," OI is said to occur in 1 in 15,000 to 1 in 16,000 births and to have four main features: (1) abnormal bone fragility with osteoporosis, (2) blue sclerae, (3) defective dentition (dentinogenesis imperfecta)—a defect in the number, kind, and arrangement of teeth—and (4) presenile hearing impairment.⁸⁶

Glutaric aciduria is a metabolic disorder caused by an enzyme deficiency (glutaryl-coenzyme A dehydrogenase) characterized by an often fatal inability to process amino acids. The condition affects 1 in every 30,000 births. Glutaric acid is an intermediate in the degradation of lysine, hydroxyglycine, and tryptophan. Symptoms are said to mimic those of child abuse.⁸⁷ Colorado now requires that all infants be tested for glutaric aciduria at birth.⁸⁸ Menkes disease, an X-linked inherited disorder of intestinal copper absorption, can be complicated by

progressive macrocephaly following development of subdural hematomas, which can be confused with shaken baby syndrome.⁸⁹ A theory that is sometimes offered, usually with but little justification, is that CPR could cause retinal hemorrhage.⁹⁰ In infancy, CPR generally causes neither such hemorrhages nor rib fractures.⁹¹

REPORTING LAWS

At common law, there was no duty to report, even when child abuse was recognized.⁹² Today, all states obligate specified individuals to report suspected cases of abuse or neglect to local child protection officials. Among those required to report may be house staff, dentists, podiatrists, nurses, and mental health professionals.⁹³ Teachers are often required to report as well.⁹⁴ Federal law provides for funding to the states for surveillance, prevention, treatment, training, and law enforcement functions related to child maltreatment.⁹⁵ Federal funding for state child abuse programs depends upon state enactment of reporting requirements.⁹⁶ Evidence of the severity of the problem may well have contributed to the decision to require reporting.⁹⁷

In general, reporting statutes identify those who must report child abuse, describe how reporting should occur, and limit or abrogate certain privileges. These statutes are far from uniform, however. Consider, for example, those statutes mandating reports of sexual abuse. While a number require reports of abuse and neglect by parents, family members, or caretakers only,⁹⁸ other statutes include required reporting of abuse by non-family members as well.⁹⁹ Still other statutes include statutory rape among the types of abuse to be reported, but grant the health care provider some measure of discretion in whether to report this type of abuse.¹⁰⁰

Most states grant immunity to any professional who reports such information as required by law.¹⁰¹ This immunity is typically a powerful bulwark against attack. In *Myers v. Lashley*,¹⁰² for example, a father and grandmother wrongly identified as child abusers brought separate claims against a clinical psychologist for slander, negligent infliction of emotional distress, intentional infliction of emotional distress, and professional negligence. The plaintiffs attempted to describe their claim as one for malpractice. The court rejected this characterization, because such a claim would seek vindication for injury to the children, whereas the plaintiffs sought to recover for injury to themselves. The privilege shielding medical and other professionals from claims arising out of statutorily mandated reporting, however, extended across all cognizable theories of liability. The court held that the plaintiffs' failure to prove that the defendant psychologist had reported in bad faith, and that he released the report before submitting it to the state agency, barred recovery. Similarly, in Pennsylvania, a plaintiff alleging a false report must prove that the defendant acted in bad faith when filing the report. In *Heinrich v. Conemaugh Valley Memorial Hospital*,¹⁰³ the court held that under Section 6318 of the Pennsylvania Consolidated Statutes, Immunity from Liability, a court should

presume the reporter's good faith, and did so presume in that case. The plaintiff must overcome this presumption to recover.¹⁰⁴ Some states, such as Virginia, impose criminal penalties on health care professionals who fail to make reports despite having reason to believe that a child has been abused.¹⁰⁵ The policy justifications for encouraging reporting are obvious and compelling. They must be weighed, however, against the pernicious effect on the lives of innocent people alleged to have engaged in reprehensible conduct.

In *Heinrich*, emergency room physicians suspected child abuse after observing swelling around a child's eye and ear. Without discussing their suspicions with the patient's mother, his pediatrician, or any staff pediatrician, the emergency physicians notified the state's Department of Children and Youth Services. Eventually, pediatricians established that an accidental fall, rather than an abusive blow to the head, had caused the child's injuries. The plaintiff failed to allege bad faith in reporting suspected child abuse, and his claim failed. He contended that the bad faith issue was for the jury, but the court rejected this argument, relying on the plain language of the statute, which provided that the good faith of a reporter was presumed.¹⁰⁶

Privacy, Reporting, and HIPAA

Under the federal Privacy Rule, "health care operations" include "general administrative activities of the entity."¹⁰⁷ If a covered entity has no lawful choice but to report suspected abuse, then making the report is one of the entity's general administrative activities. More importantly, specific regulatory authority makes disclosures required by law a permitted public health activity under HIPAA.¹⁰⁸ Hence, in making a required report, there would appear to be no risk of violating the HIPAA Privacy Rule. On the other hand, physicians and others may be accustomed to making the required reports by phone. Under the Privacy Rule, it may be necessary to add a step to enable the institution to capture the event through some centralized mechanism.

HIPAA provides for disclosure of protected health information (PHI) to family members, but pursuant to 45 C.F.R. §164.510(b), covered entities are given discretion to determine that PHI not be disclosed. The rule provides that when, as a result of incapacity or an emergency, an individual is unable to agree or object to disclosure, a covered entity must determine, based on the exercise of professional judgment, whether it is in the individual's best interest to disclose the information. 45 C.F.R. §164.512(c) specifically addresses uses and disclosures of PHI in cases of abuse, neglect, or domestic violence. Covered entities are generally required to inform the individual when they disclose PHI to authorized government authorities. By informing a victim of abuse or domestic violence of a disclosure to law enforcement or other authorities, covered entities give victims the opportunity to take appropriate safety precautions. In most instances involving victims of abuse, neglect, or domestic violence, a covered entity must obtain an individual's agreement before disclosing PHI.

HIPAA requires an accounting of disclosures. The preamble to the Rule notes that some commentators had sought an exception from the accounting requirement for mandatory disclosures. The Department responded that "[w]hile it is possible that informing individuals about the disclosures made of their health information may on occasion discourage worthwhile activities, [the Department] believe[s] that individuals have a right to know who is using their health information and for what purposes."¹⁰⁹

Apart from the Privacy Rule, providers have a duty under state common or statutory law or both to protect patient privacy. The extent to which physician-patient privilege is abrogated by abuse reporting statutes varies by state. For example, in Colorado, physician-patient privilege is abrogated to the extent that communications upon which a required report is based are no longer privileged. The Colorado Supreme Court interpreted the Colorado law to reflect a legislative intent to protect children from future harm, yet to encourage patients to seek counseling with the knowledge that communications with the psychologists would remain confidential.¹¹⁰ As such, Colorado limits the abrogation to a description of wounds, as distinct from verbal communications between physician and patient.¹¹¹ In Maryland, compelled disclosure of diagnosis and treatment records exempts some matters pertinent to reporting allegations of child abuse.¹¹² The statute, entitled "Reporting of Abuse and Neglect—By Health Practitioner" provides in pertinent part:

*(a) In general—Notwithstanding any other provision of law, including any law on privileged communications, each health care practitioner . . . acting in a professional capacity: (1)(i) who has reason to believe that a child has been subjected to abuse, shall notify the local department or the appropriate law enforcement agency; or (ii) . . . neglect, shall notify the local department. . . .*¹¹³

In North Dakota, the statute abrogating privileged communications in child abuse and neglect proceedings abrogates physician and psychotherapist patient privileges in cases involving reports of alleged child abuse and neglect even when the petition to terminate parental rights invokes the Uniform Juvenile Court Act as a basis for action.¹¹⁴

Underreporting

Cases of abuse do not always present for diagnosis or treatment. Even when they do, they may not be recognized. When recognized, they may not be reported.¹¹⁵ Many abused children refrain from reporting because they consider themselves responsible for their own plight.¹¹⁶ Others fear threats from their abusers if they report.¹¹⁷ Victims of sexual abuse may be particularly reluctant to come forward, in part because memories of such events may be repressed.¹¹⁸

Physicians may fail to report because of confusion about definitions and evidence,¹¹⁹ ethical considerations, and cost.¹²⁰ Some physicians express a lack of faith in the state's responsiveness to reports.¹²¹ Other health professionals

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may fear reprisals or the loss of patients.¹²² Still others may believe they can help the family solve the problem without outside assistance.¹²³ The media's focus on parental claims of false accusations also contributes to the failure of some to report.¹²⁴ Other factors discouraging reports include the extent of appropriate family concern, compatibility between physical findings and the parent's explanation for the injury, the child's behavior, the severity of the injury, the presence of additional injuries, the doctor's familiarity with the family, and the physician's own attitudes about physical discipline.¹²⁵

Finally, of course, physicians may fail to report in an effort to avoid being drawn into litigation. Of 1.6 million reports made in 2003, only 8% were made by health care professionals.¹²⁶ Even so, physicians represent the overwhelming majority of defendants in cases seeking damages for allegedly inappropriate reports of child abuse and neglect.¹²⁷

The extent to which reporting physicians are protected against liability claims has been eroded somewhat in recent years. The New Hampshire Supreme Court has held that a therapist owes to an accused parent a duty of care in diagnosis and treatment of an adult patient for sexual abuse when public accusations of sexual abuse and criminal charges are made. This duty is breached when the therapist uses techniques not generally accepted or lacks professional qualifications.¹²⁸

Value of Immunity

The duties of doctors confronting child abuse cases are heavy.¹²⁹ This list includes identifying suspicious injuries, diagnosing abuse, administering treatment, reporting suspected incidents to the appropriate authorities, and testifying.¹³⁰ Expert testimony is nearly always required in child abuse cases.¹³¹ As such, reporting physicians can reasonably anticipate that they will be called to serve as witnesses. Immunity is critical to protect the system of reporting and investigating child abuse without fear of reprisal.¹³²

Limitations of Immunity

Not surprisingly, a report submitted in bad faith may not be privileged.¹³³ The burden of proof on a claim of bad faith is on the plaintiff, but other limitations in the immunity defense may be less obvious. In *Searcy v. Auerbach*,¹³⁴ a child's mother was allowed to sue a psychologist for libel, professional negligence, and intentional as well as negligent infliction of emotional distress after the psychologist told her ex-husband, in writing, that he suspected their child was abused while in her custody. Merely telling the father, who related those suspicions to Texas authorities, did not comply with the California statute, and therefore no immunity attached. Similarly, a Missouri physician could not rely on the immunity granted under a child abuse reporting statute because he reported the abuse he erroneously suspected to the police, and not, as the statute required, to the Division of Family Services.¹³⁵

An attorney can be publicly censured, rather than suspended, for failing to disclose to a trial court that a case worker had found an abuse allegation "unsubstantiated." In representing a former wife in a postdissolution motion to restrict her former husband's parental contact with their child, counsel alleged the former husband had physically abused the child.¹³⁶ The court concluded that the attorney's failure to inform the court of the existence of the case worker's letter stating that the child abuse report was unsubstantiated violated Colorado R.C.P. 3.3(a)(1).¹³⁷

Overreporting

There is evidence that many reports, indeed most, are not ultimately "substantiated."¹³⁸

Liability for Failure to Report

In at least 42 states, failure to report child abuse can result in criminal prosecution.¹³⁹ As has been true for many years, civil liability can also be found.¹⁴⁰

In some states, civil liability arises only when the defendant actually suspected or believed child abuse had occurred, yet failed to report his suspicions. Most states use an objective test to determine whether to impose civil liability for failure to report child abuse, i.e., whether under similar circumstances another professional in the same field would have suspected abuse.¹⁴¹ In *Ham v. Hospital of Morristown, Inc.*,¹⁴² for example, a child presenting for nausea and vomiting was found to have blisters on the palms and fingers of both hands and an abrasion of the forehead. The emergency physician concluded that there had been no abuse. Whether his conclusion was reasonable presented a genuine issue of material fact.¹⁴³

Where there was evidence that a child's life could have been saved if the doctor had reported potential abuse, a jury question was created on the issue of proximate cause.¹⁴⁴ A witness opined that the doctor should have called the Department of Human Services, which would have then notified the child's father and others acquainted with the child. Testimony was also presented that such a report could have saved the child's life by exposing the abuser. In the court's view, that opinion was buttressed by evidence that when an outside person was present in the mother's home, the abuse did not occur.

The Maryland Supreme Court has refused to allow a plaintiff alleging negligent failure to discern that she had been sexually abused to offer expert testimony that the cause of her symptoms was the abuse, but did permit a jury instruction on the reporting requirements of the Child Abuse Act.¹⁴⁵ The court decided that if the defendant physicians had violated the act by failing to report and such violation caused the injuries or damages suffered by the abused child, then a finding of statutory violation would be evidence of negligence.¹⁴⁶ Even if the doctors had complied with the statute, the court decided, compliance would not necessarily preclude a finding of negligence if a reasonable person would have taken precautions beyond the measures statutorily required.¹⁴⁷ The court held that by

placing a statutory reporting duty on physicians, the Maryland Child Abuse Act had become incorporated as part of the general standard of care for the medical profession in the treatment of children.

On the other hand, an Oklahoma Appeals Court ruled that a custodial parent could not sue a psychologist for referring a patient to a second psychologist whose evaluation of the child led to allegations of abuse.¹⁴⁸ At a custody hearing, the child's psychologist testified that the child may have been sexually abused by the father. The father later sued the testifying psychologist, as well as the child psychologist who referred the patient to the testifying psychologist, alleging malpractice. The court determined that the testifying psychologist owed no duty to the father. Moreover, since the evaluation was conducted for a court proceeding, the communications made preliminarily for proposed judicial or quasi-judicial proceedings were absolutely privileged, barring an action for intentional infliction of emotional distress.¹⁴⁹

Some courts have held that no private right of action arises under child abuse reporting statutes. In *Cechman v. Travis*,¹⁵⁰ an administratrix sued a hospital and treating physicians on behalf of a deceased child who was killed by her abusive father after being treated at the defendant institution.¹⁵¹ Although a criminal statute required that a licensed physician report suspected cases of abuse, the court held that the statute created no private right of action in tort in favor of a victim of abuse. Moreover, at common law the physician had no duty to protect the child from the father, so no common law medical malpractice claim would lie.¹⁵² Similarly, in *Valtakis v. Putnam*,¹⁵³ the Minnesota Court of Appeals held that Minnesota's Child Abuse Reporting Act did not create a private right of action.¹⁵⁴

State Liability

Under abuse-reporting statutes, some state agencies have been held liable for abuse by foster parents selected by those agencies when the agencies knew, or should have known, of the abuse.¹⁵⁵ In other cases, courts have found that the state lacked a nexus to the child sufficient to establish a duty and, therefore, liability. For example, a mother brought a wrongful death action against a psychologist after discovering that the father had murdered their child. As part of a court proceeding initiated by the mother to modify child custody in response to allegations of paternal child abuse, the psychologist examined both the mother and father. A social worker's alleged failure to properly investigate child abuse allegations against the father did not violate the child's due process right to be free from bodily harm caused by third parties, even though the father later murdered the child. Social workers had authority and discretion in how to conduct their investigations, said the court, and they had no special or fiduciary relationship to the child, who was not in state custody. The child was not injured by a state act or a state-created danger. The psychologist had no confidential relationship with the mother that would establish a duty to disclose any facts about the father's relationship with the child.¹⁵⁶

Liability for Reporting

Just as a health care professional may be held liable for failing to report, there are circumstances under which liability can be imposed for reporting. Traditionally, reporting was not actionable absent bad faith. In *Russell v. Adams*,¹⁵⁷ for example, an adult patient's mother alleged that her daughter's therapist had falsely told the daughter that the mother had abused her. The mother also alleged that the therapist recommended that the daughter sever all ties with her. The court ruled that the statute of limitations had not run on the mother's claim for infliction of emotional distress. The defense raised the fact that the therapist did not treat the plaintiff. The court wrote:

We are aware that the treatment of the emotional problems of the patient may, in some instances, have adverse consequences on the patient's relationships with others It does not follow, however, that the affected third party should have a cause of action for malpractice against the health care provider. Health care providers must "be free to recommend a course of treatment and act on a patient's response to the recommendation free from the possibility that someone other than the patient might complain in the future."

In *Tuman v. Genesis Assoc.*,¹⁵⁸ however, plaintiffs sued the therapist treating their 20-year-old daughter. They alleged that the defendant had implanted false memories that the plaintiff belonged to a satanic cult, and had ritually murdered their daughter's twin brother, and that her father had raped and impregnated her. The parents had paid for the therapy, and the court declined to dismiss their claim for breach of contract. Based on specific undertaking to the parents, the court found the negligence claim to be viable. The court rejected the argument that the plaintiffs' theory required the doctor to serve two masters. The court wrote:

The therapist's two duties dovetail to a singular duty to provide reasonably acceptable mental health therapy to the patient Further, my narrow holding does not subject therapists to negligence liability whenever parents experience emotional injury that may result when a child seeks mental health counseling. There is a vast difference between using acceptable therapy to help a patient understand emotional wounds suffered as a result of her parents' inadequate caregiving, and negligent techniques that create false memories of severely abusive parenting that necessarily injure the parents and the patient.

The court went on to find that even if the defendants owed no duty to the plaintiffs with respect to their daughter's mental health counseling, they did have independent duties not to intentionally inflict emotional distress upon the plaintiffs. Similarly, in *Caryl S. v. Child & Adolescent Treatment Services*,¹⁵⁹ the court upheld a cause of action by grandparents against a therapist who had alleged that the grandmother had sexually abused their grandchild.

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Endnotes

1. See, e.g., Radbill, *Children in a World of Violence: A History of Child Abuse*, in R.E. Helfer & R.S. Kempe eds., *The Battered Child* 3 (4th ed. 1987).
2. The Administration for Children and Families, U.S. DHHS, calculated this estimate by multiplying the national referral rate (39.1%) by the national child population for all 50 states and the District of Columbia (73,043,506), and then rounded to the nearest 100,000. See <http://www.acf.hhs.gov/programs/cb/pubs/compendium/index.htm>.
3. National Clearinghouse on Child Abuse and Neglect Information, *Child Abuse and Neglect Fatalities: Statistics and Interventions* (2004), <http://nccanch.acf.hhs.gov/pubs/factsheets/fatality.cfm>. Fatalities typically occur in younger children. N. Kini, & S. Lazoritz, *Evaluation for Possible Physical or Sexual Abuse*, 45(1) *Pediatr. Clin. N. Am.* 205–19 (1998).
4. *Id.*; see also Table of Child Abuse and Neglect Fatalities by Maltreatment Type, <http://nccanch.acf.hhs.gov/pubs/factsheets/fatalitydlinks.cfm#dlinktwo>.
5. R. Deisz, et al., *Reasonable Cause: A Qualitative Study of Mandated Reporting*, 20(4) *Child Abuse & Neglect* 275–87 (1996).
6. McClain et al., *Estimates of Fatal Child Abuse and Neglect, United States, 1979–1988*, 91 *Pediatrics*. 338 (1993).
7. National Clearinghouse on Child Abuse and Neglect Information, *Child Maltreatment 2003: Summary of Key Findings* (2005), <http://nccanch.acf.hhs.gov/pubs/factsheets/canstats.cfm>. This figure has not changed enormously over time; in 1992, it was 54%. National Center on Child Abuse and Neglect, *Child Maltreatment 1992: Reports from the State to the National Center on Child Abuse and Neglect*, Washington, D.C.: U.S. DHHS, Administration for Children, Youth, and Families (1994). A lack of substantiation does not establish that maltreatment did not occur, however; only that it could not be substantiated. L. Bethea, *Primary Prevention of Child Abuse*, 59(6) *Am. Fam. Physician* (Mar. 1999), <http://www.aafp.org/afp/990315ap/1577.html>.
8. See S. Loue, *Legal and Epidemiological Aspects of Child Maltreatment*, 19 *J. Legal Med.* 471 (1998). Often, the statutes provide little guidance to reporters on what is and is not reportable. D. Besharov *Doing Something About Child Abuse: The Need to Narrow the Grounds for State Intervention*, 8 *Harv. J. Law & Pub. Pol'y* 545, 550–58, 567–81 (1985).
9. B.H. Levi & G. Brown, *Reasonable Suspicion: A Study of Pennsylvania Pediatricians Regarding Child Abuse*, 116(1) *Pediatrics* e5–e12 (July 2005), <http://pediatrics.aappublications.org/cgi/content/full/116/1/e5>; Deisz et al., *supra* note 5.
10. See Kini & Lazoritz, *supra* note, at 207.
11. See, e.g., I.J. Chasnoff, et al., *Prenatal Cocaine Exposure is Associated with Respiratory Pattern Abnormalities*, 143 *Am. J. Dis. Child.* 583 (1989); K. Wisborg et al., *Exposure to Tobacco Smoke in Utero and the Risk of Stillbirth and Death in the First Year of Life*, 154(4) *Am. J. Epidemiol.* 322–27 (2001); M.B. Meyer et al., *Perinatal Events Associated with Maternal Smoking*, 103 *Am. J. Epidemiol.* 464 (1976).
12. In *Whitner v. State*, 492 S.E. 2d 777 (S.C. 1997), the court upheld the conviction of a mother who abused cocaine during her pregnancy on a charge of child abuse and endangerment. For an argument that the South Carolina holding was correct, see R.M. Coady, *Extending Child Abuse Protection to the Viable Fetus: Whitner v. State of South Carolina*, 71 *St. John's L. Rev.* 667 (1997).
- For an argument that, as a last resort, criminal sanctions may play a valuable role in protecting infants from the harms of controlled substances, see C. Hunt, *Criminalizing Prenatal Substance Abuse: A Preventive Means of Ensuring the Birth of a Drug-Free Child*, 33 *Idaho L. Rev.* 451 (1997). Most courts have refused to accept similar theories. See, e.g., *Reinesto v. Superior Court*, 894 P. 2d 733 (Ariz. Ct. App. 1995); *Sheriff v. Encoe*, 885 P. 2d 596 (Nev. 1994), *Johnson v. State*, 578 So. 2d 419 (Fla. Dist. Ct. App. 1991), *Kentucky v. Welch*, 864 S.W. 2d 280 (Ky. 1993), *Nevada v. Encoe*, 885 P. 2d 596 (Nev. 1994), *Washington v. Dunn*, 82 916 P. 2d 952 (Wash. Ct. App. 1996). There is some empiric evidence to support the value of the recommendation of the American Academy of Pediatrics that newborns should be screened for antenatal substance exposure and that all infants so identified be reported to the authorities. J.R. McMahon, *Perinatal Substance Abuse: The Impact of Reporting Infants to Child Protective Services*, 100(5) *Pediatrics* e1 (Nov. 1997). For further analysis of this controversy, see K.T. Parks *Protecting the Fetus: The Criminalization of Prenatal Drug Use*, 5 *Wm. & Mary J. Women & Law* 245 (1998).
13. D. Daro & R. Gelles, *Public Attitudes and Behaviors with Respect to Child Abuse Prevention*, 7 *J. Interpersonal Violence* 517–31 (1992).
14. Authors differ widely in how they define emotional and psychological abuse, and states vary greatly in the clarity of their definitions of abusive behavior. S. Loue, *Redefining the Emotional and Psychological Abuse and Maltreatment of Children*, 26 *J. Legal Med.* 311, 314, 322 (Sept. 2005).
15. A. English & C. Teare, *Statutory Rape Enforcement and Child Abuse Reporting: Effects on Health Care Access for Adolescents*, 50 *DePaul L. Rev.* 827 (Spring 2001). In most states, a reasonable mistake of age is no defense; see, e.g., *Hodge v. State*, 866 So. 2d 1270, 1272 (Fla. 2004). In others, however, it is; see, e.g., *People v. Hernandez*, 393 P. 2d 673, 678 (Cal. 1964).
16. See, e.g., U.S. DHHS, Administration for Children and Families, *A Nation's Shame: Fetal Child Abuse and Neglect in the U.S.: A Report of the U.S. Advisory Board on Child Abuse and Neglect* (1995), available at http://ican.ncfr.org/documents/Nations_Shame.pdf.
17. At least 32 states have such laws. See P. Smith, *The Mass. Discovery Rule and its Application to Non-Perpetrators in Repressed Memory Child Sexual Abuse Cases*, 30 *N.E. J. on Crim. & Civ. Con.* 179, 184 n.38 years.
18. *Id.*
19. See, e.g., *Starnes v. Cayoutte*, 419 S.E. 2d 669, 675 (Va. 1992) (holding the retroactive application of a tolling statute unconstitutional).
20. Tolling statutes have no bearing on the admissibility of testimony that may be considered suspect. Applicable rules of evidence govern admissibility. See, e.g., *Fed. R. Evid.* 601, 602.
21. See *State v. Hungerford*, 697 A. 2d 916 (N.H. 1997) (barring witness from testifying about recovered memories due to unreliability). *But see Shahzade v. Gregory*, 923 F. Supp. 286 (D. Mass. 1996).
22. *Contreras v. State*, 718 P. 2d 129, 139–40 (Ak. 1986); *State v. Collins*, 464 A. 2d 1028, 1044 (Md. 1983).
23. While some courts have applied *Daubert* analysis (see *infra* note 24), others have used their own reasoning for allowing or disallowing testimony of experts. There does not appear to be any consensus on the use or qualification of experts on repressed memory.
24. See *Daubert v. Merrell Dow Pharm.*, 509 U.S. 579 (1993) (holding that only reliable and relevant scientific evidence may be admitted as testimony, and that reliability is determined by the judge based on a multifactor analysis).
25. *Id.* Generally, scientific evidence must have a degree of general acceptance in the scientific community.
26. See *Shahzade v. Gregory*, *supra*, note 21.

27. See *Commonwealth v. Frangipane*, 744 N.E. 2d 25 (Mass. 2001) (holding that social workers were barred from testifying as experts despite first-hand experience).
28. R.A. Hughes, *The Death of Children by Faith-Based Medical Neglect*, 20 J. L. & Religion 247, 247 (2004–05).
29. J.L. Hartsell, *Mother May I . . . Live? Parental Refusal of Life-Sustaining Medical Treatment for Children Based on Religious Objections*, 66 Tenn. L. Rev. 499 (Winter 1999). Parents invoking religious principles to defend withholding medical care may raise vexing questions about which religious groups may do so legitimately and which may not. See, e.g., *Walker v. Superior Ct.*, 763 P. 2d 873, 856 (Cal. 1988). Some states limit exemptions to Christian Scientists. E.A. Lingle, *Treating Children by Faith: Colliding Constitutional Issues*, 17 J. Legal Med. 301, 306 (1996); see also J. Stanfield, *Faith Healing and Religious Treatment Exemption to Child-Endangerment Laws: Should Parents be Allowed to Refuse Necessary Medical Treatment for their Children Based on their Religious Beliefs?*, 22 Hamline J. Pub. L. & Pol'y 45, 82 (2000). For a discussion of the courts' efforts to define religion and distinguish it from nonreligion, see C.B. Gilbert, *Harry Potter and the Curse of the First Amendment: Schools, Esoteric Religions, and the Christian Backlash*, 198 Ed. Law. Rep. 399 (July 28, 2005).
30. See A.D. Lederman, *Understanding Faith: When Religious Parents Decline Conventional Medical Treatment for Their Children*, 45 Case W. Res. L. Rev. 891, 892 (1995).
31. Lingle, *supra* note 29, at 306; see also R. Munns, *Christian Scientists Challenged: Children's Rights Debated*, New Orleans Times-Picayune (Apr. 25, 1996) at A12.
32. N. Toubia, *Female Circumcision as a Public Health Issue*, 331 N. Engl. J. Med. 712, 715 (1994).
33. M.M. McSwiney & P.R. Saunders, *Female Circumcision: A Risk Factor in Postpartum Hemorrhage*, 38(3) J. Postgrad. Med. 136–37 (1992); see also C.A. Baker et al., *Female Circumcision: Obstetric Issues*, 169(6) Am. J. Ob. & Gyn. 1616 (1993).
34. Illegal Immigration Reform and Immigrant Responsibility Act of 1996, Pub. L. No. 104-208, §645(b)(1), codified at 18 U.S.C.S. §116 (2005).
35. AMA Council on Scientific Affairs, *Female Genital Mutilation*, 274 J.A.M.A. 1714 (1995); S. Rushdie, *Simple Truths and Apostles of Death*, N.Y. Times (July 14, 1994) at A23. It is estimated that 74 million females (children and adults) are circumcised in Africa alone, but the practice is said to exist on every continent and to be particularly common in the Muslim world. McSwiney and Saunders, *supra* note 33. On the other hand, the practice is not referred to in the Qur'an, is not required in Islamic theology, and is rarely seen in such Muslim countries as Saudi Arabia, Iran, or Pakistan. International Association for Maternal and Neonatal Health, *Female Circumcision*, 17 Mother & Child Int'l. Newsletter 4–5 (1991).
36. S. Visser & J.Y. Miller, *Strong Words and Church Trial*, Atlanta J. Const. (Oct. 15, 2002) at B1.
37. D. Nunnally, *Minister Gets 30 Months in Boy's Death*, Milwaukee J. Sentinel (Aug. 18, 2004) at 1B.
38. Anonymous, *Lead Poisoning Associated with Use of Traditional Ethnic Remedies—California, 1991–1992*, 270 J.A.M.A. 808 (1993).
39. J.C. Merrick, *Spiritual Healing, Sick Kids and the Law: Inequities in the American Health Care System*, 29 Am. J. L. & Med. 269 (2003) (collecting and analyzing epidemiologic data demonstrating increased morbidity and mortality among those relying on spiritual healing as compared with those under the care of physicians).
40. S. Asser & R. Swan, *Child Fatalities from Religion-Motivated Medical Neglect*, 101 Pediatrics 625, 626–29 (Apr. 1998); see also R. Swan, *Children, Medicine, Religion, and the Law*, 44 Adv. Pediatrics 491 (1997). For an argument that the law should be more receptive to the views of parents wishing to treat their children with folk remedies, see S.H. Dudley, *Medical Treatment for Asian Immigrant Children: Does Mother Know Best?*, 92 Geo. L.J. 1287 (Aug. 2004). *Contra*, M. Boyer, *Death by Religious Exemption: Parents Refusing Their Child Necessary Medical Treatment Based Upon Their Own Religious Beliefs—Should States Endorse a System That Denies Necessary Medical Treatment to Children?*, 4 Whittier J. Child & Fam. Advoc. 147 (Fall 2004). The American Academy of Pediatrics opposes spiritual healing exemptions. *Religious Objections to Medical Care*, 99 Pediatrics 279 (1997).
41. Hughes, *supra* note 28, at 248, n. 9; see also, *Legal Aspects of Faith Healing, Religious Exemptions in Child Abuse Laws*, <http://www.religioustolerance.org/medical11/htm#>; B. Nobel, *Religious Healing in the Courts: The Liberties and Liabilities of Patients, Parents and Healers*, 16 U. Puget Sound L. Rev. 599, 644 (1993).
42. Some states permit parents to assert their religious beliefs as an affirmative defense to murder. See Ark. Code Ann. §5-10-101(a)(9)(B); Or. Rev. Stat. §163.115(4); and W.Va. Code §61-8D-2(d).
43. Publ. L. No. 93-247, 88 Stat. 8 (1974) (codified as amended at 42 U.S.C. §§5101–5107 (2000)). See W. Wadlington, *David C. Baum Memorial Lecture: Medical Decision Making for and by Children: Tensions Between Parent, State, and Child*, 1994 U. Ill. L. Rev. 311, 324 (1994).
44. H.R. Rpt. 93-685 (Nov. 30, 1973).
45. Wadlington, *supra* note 43.
46. See Child Abuse and Neglect Prevention and Treatment Program, 48 Fed. Reg. 3698, 3700 (Jan. 26, 1983), codified at 45 C.F.R. §1340.2(d)(2)(ii). See also 42 U.S.C. §5106(a)(1).
47. A.M. Massie, *The Religion Clauses and Parental Health Care Decision-Making for Children: Suggestions for a New Approach*, 21 Hastings Constr. L.Q. 725, 735 (1994). For an argument that such statutes should be repealed, see Stanfield, *supra* note 29.
48. Stanfield, *supra*, note 29, at 57.
49. D.K. LeClair, *Faith-Healing and Religious-Treatment Exemptions to Child-Endangerment Laws: Should Parental Religious Practices Excuse the Failure to Provide Necessary Medical Care to Children?*, 13 U. Dayton L. Rev. 79, 96 (1987); Hardy, Letter to Congressman Berkley Bedell (Iowa) (July 18, 1983) cited in Swan, *supra* note 40, at 513. Moreover, states must be able to seek court orders compelling care "to prevent or remedy serious harm to the child." 42 U.S.C. §5106(i).
50. 763 P. 2d 852 (Cal. 1988). *Accord*, *Commonwealth v. Nixon*, 718 A. 2d 311 (Pa. Super. Ct. 1998), *Hall v. State*, 493 N.E. 2d 433 (Ind. 1986); *People v. Rippenberger*, 283 Cal. App. 3d 111, 113 (1991). *Contra*, *Hermanson v. State*, 604 So. 2d 775 (Fla. 1992) (listing statutes at 776–77 n.1). Even in California, however, religious healers engaged by a child's father are not liable in negligence for the child's death, and were under no duty to seek medical care for him. *Quigley v. First Church of Christ, Scientist*, 76 Cal. Rptr. 2d 792, 796 (1998).
51. *Commonwealth v. Barnhart*, 497 A. 2d 616 (Pa. Super. Ct. 1985).
52. *Id.* at 620. *Accord*, *State v. Norman*, 808 P. 2d 1159 (Wash. Ct. App. 1991).
53. Minn. Stat. §609.205 (1988).
54. *State v. McKown*, 475 N.W. 2d 63 (Minn. 1991).
55. Minn. Stat. §609.378(a)(i) (1988).
56. *McKown*, 475 N.W. 2d at 65.
57. *Lundman v. McKown*, 530 N.W. 2d 807 (Minn. Ct. App. 1995).
58. *McCarthy v. Boozman*, 212 F. Supp. 2d 945 (W.D. Ark. 2002); *State v. Miskimens*, 22 Ohio Misc. 2d 43 (Ohio C.P. 1984).
59. See J.E. Wood, Jr., *The Relationship of Religious Liberty to Civil Liberty and a Democratic State*, 1998 BYU L. Rev. 479, 488.

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60. R.E. Helfer & Kempe, C.H., *The Battered Child* 105 (1968).
61. *Id.* at 106. See also C.H. Kempe et al., *The Battered Child Syndrome*, 181 J.A.M.A. 17 (1962). The most common cause of subdural hematoma and effusion in infancy is said to be nonaccidental head injury, and such hematomas are in the differential of any child who is ill. G. Hobbs et al., *SDH and Effusion in Infancy: An Epidemiologic Study*, 90 B.M.J. 952-955 (2005). Among infants and toddlers with SDH, only one-fifth resulted from unintentional trauma. Of those without obvious unintentional trauma, 71% were abused. K.W. Feldman et al., *The Cause of Infants and Toddler Subdural Hemorrhage: A Prospective Study*, 108(3) Pediatrics. 636-47 (2001). To evaluate a subdural hematoma, an ophthalmic exam, a skeletal survey, a coagulation screen, and CT, and an MRI may be useful. See S. Datta et al., *Neurological Aspects of Subdural Haemorrhages*, 90 Arch. Dis. Child. 947-51 (2005); A. Jayawant et al., *Subdural Haemorrhages in Infants: Population Based Study*, 317 B.M.J. 1558-61 (1998).
62. Helfer, et al., eds., *The Battered Child* (5th ed. 1997).
63. N.F. Sugar et al., *Bruises in Infants and Toddlers: Those Who Don't Cruise Rarely Bruise*, 153 Arch. Pediatr. & Adolesc. Med. 399 (1999).
64. See Carpenter, *The Prevalence and Distribution of Bruising in Babies*, 80 Arch. Dis. Child. 363 (1999). For a review of the literature, see S. Maguire et al., *Are there Patterns of Bruising on Childhood which are Diagnostic or Suggestive of Abuse? A Systematic Review*, 90 Arch. Dis. Child. 182-6 (2005). But see J.F. Geddes & J. Plunkett, *The Evidence Base for Shaken Baby Syndrome: We Need to Question the Diagnostic Criteria*, 328 B.M.J. 719 (2004).
65. R.M. Reece & R. Sege, *Childhood Injuries: Accidental or Inflicted?*, 154 Arch. Pediatr. & Adolesc. Med. 11, 14 (2000); The Ophthalmology Working Party, *Child Abuse and the Eye*, 13 Eye 3-10 (1999).
66. Council on Scientific Affairs, *supra* note 35, at 797-98.
67. R. Alexander et al., *Serial Abuse in Children Who Are Shaken*, 144(1) Am. J. Dis. Child. 58-60 (1990).
68. Council on Scientific Affairs, *supra* note 35, at 798.
69. *Id.*
70. *Id.*
71. See H. Cantwell, *Vaginal Inspection as it Relates to Child Sexual Abuse in Girls Under Thirteen*, 7 Child Abuse and Neglect 171 (1983).
72. Council on Scientific Affairs, *supra* note 35, at 798.
73. U.S. Preventive Service Task Force, *Guide to Clinical Preventive Service*, section 1 (2d ed. 1996), <http://cpmcnet.columbia.edu/texts/gcps/gcps0061.html> (citing L. McKibben, E. De Vos & E.H. Newberger, *Victimization of Mothers of Abused Children*, 84 Pediatrics 531-35 (1989)).
74. R.C. Katz, *Psychosocial Adjustment in Adolescent Child Molesters*, 14 Child Abuse and Neglect 567 (1990).
75. Alexander et al., *supra* note 67.
76. J. Reid et al., *No Safe Haven: Children of Substance-Abusing Parents* (National Center on Addiction and Substance Abuse of Columbia University, New York, 1999).
77. A. Hickox & J.R.G. Furnell, *Psychosocial and Background Factors in Emotional Abuse of Children*, 15 Childcare, Health & Dev. 227 (1989).
78. D. Black et al., *Risk Factors for Child Psychological Abuse*, 6 Aggressive & Violent Behav. 189, 198-99 (2001).
79. U.S. Department of Health and Human Services, National Center on Child Abuse and Neglect, *Child Maltreatment 1997: Reports from the States of the National Child Abuse and Neglect Data System* (U.S. Government Printing Office, Washington, D.C., 1999).
80. *Id.*
81. *Id.*
82. Ganley, *The Battered Child: Logic in Search of Law*, 8 San Diego L. Rev. 364, 365 n.2 (1971); see also L.B. Silver et al., *Child Abuse Syndrome: The "Gray Areas" in Establishing Diagnosis*, 44 Pediatrics 594 (1969); *In Re Jertrude O.*, 466 A. 2d 885 (Md. App. 1983).
83. R.C. Alexander et al., *Abusive Head Trauma*, in R.M. Reece & S. Ludwig, eds., *Child Abuse: Medical Diagnosis and Management* (Williams & Wilkins, 2001) at 66. But see D.M. Macgregor, *Injuries Associated with Falls from Beds*, 6 Injury Prevention 291-92 (2000).
84. T.J. Lyons & R.K. Oates, *Falling Out of Bed: A Relatively Benign Occurrence*, 92 Pediatrics 127 (1993).
85. D.S. Ablin et al., *Differentiation of Child Abuse from Osteogenesis Imperfecta*, 154 Am. J. Roentgenol 1035 (1990).
86. *Id.* A child with a broken bone is about 24 times more likely to have been abused than to have an OI-related fracture. A. Marlowe et al., *Testing for Osteogenesis Imperfecta in Cases of Suspected Non-Accidental Injury*, 39 J. Med. Genet. 382-91 (2002). Other conditions may also need to be considered on occasion, such as Ehlers-Danlos syndrome and abnormalities of vitamin D or calcium metabolism. Kini and Lazoritz, *supra* note 3.
87. See, e.g., L.M. Hartley et al., *Glutaric Aciduria Type 1 and Nonaccidental Head Injury*, 107 Pediatrics 174 (2001).
88. Colo. Rev. Stat. §10-16-104.
89. M-C. Nassogne et al., *Massive Subdural Hematomas in Menkes Disease Mimicking Shaken Baby Syndrome*, 18 Child. Nerv. Syst. 729 (2002).
90. See, e.g., A. Odom et al., *Prevalence of Retinal Hemorrhages in Pediatric Patients After In-Hospital Cardiopulmonary Resuscitation: A Prospective Study*, 99(6) Pediatrics E3 (June 1997), <http://pediatrics.aappublications.org/cgi/content/full/99/6/e3>; M.G. Goetting & B. Sowa, *Retinal Hemorrhage After Cardiopulmonary Resuscitation in Children: An Etiologic Reevaluation*, 85(4) Pediatrics 585-88 (Apr. 1990); A.S. Botash et al., *Child Abuse and SIDS*, 10 Curr. Opin. Pediatr. 217-23 (1998). Cf. C.J. Bacon et al., *Extensive Retinal Haemorrhages in Infancy—An Innocent Cause*, 1 B.M.J. 281 (Feb. 1978).
91. M.R. Spevak et al., *CPR and Rib Fractures in Infants: A Post-Mortem Radiologic-Pathologic Study*, 272 J.A.M.A. 617-18 (1994). Although accidents can certainly cause rib fractures, most are the result of abuse. B. Bulloch et al., *Cause and Clinical Characteristics of Rib Fractures in Infants*, 105(4) Pediatrics E48 (2000), <http://pediatrics.aappublications.org/cgi/content/full/105/4/e48>.
92. *Landeros v. Flood*, 123 Cal. Rptr. 713, 720 (Cal. Ct. App. 1975), *vac. on other grounds*, 551 P. 2d 389 (Cal. 1976).
93. See, e.g., Ohio Rev. Code Ann. §2151.421.
94. See Trost, *Chilling Child Abuse Reporting: Rethinking the CAPTA Amendments*, 51 Vand. L. Rev. 183 (1998). For a collection of the statutes obliging various groups of individuals to report child abuse, see the National Clearinghouse on Child Abuse and Neglect, <http://nccanch.acf.hhs.gov/general/legal/statutes/mandata.cfm>. See also Richardson, *Physician/Hospital Liability for Negligently Reporting Child Abuse*, 23 J. Leg. Med. 131 (2002). For a listing of health care professionals who must report child maltreatment, by state, see Kim, *How Physicians Respond to Child Maltreatment Cases*, 11 Health and Soc. Work 95, 98-99 (Table 1) (1986). For a discussion of an attorney's obligation to report, see Boyer, *Ethical Issues and the Representation of Parents in Child Welfare Cases*, 64 Fordham L. Rev. 1621 (1996).
95. Child Abuse Prevention and Treatment Act, 42 U.S.C. §5101, as amended.
96. 42 U.S.C. §5106A(b)(2)(a) (Supp. V 1999).
97. See Veilleux, Annotation, *Validity, Construction, and Application of State Statute Requiring Doctor or Other Person to Report Child Abuse*, 73 A.L.R. 4th 782 (1989).

98. See, e.g., 325 Illinois Comp. Stat. Ann. 5/4 (West 1993); 325 Illinois Comp. Stat. 5/3(c) (West 1993) (defining an abused child to include one whose parent, caretaker, or family member "commits or allows to be committed any sex offenses [as defined in the criminal code], extending those definitions to include children under 18 years of age").
99. See, e.g., Oregon Rev. Stat. Ann. §419B.010 (West 1993).
100. See, e.g., La. Children's Code Ann. art. 609A(1) (West 1994 and Supp. 2000) (professionals must report when they have reasonable cause to believe that the child's physical or mental health or welfare is in danger as a result of abuse and neglect).
101. See, e.g., Cal. Penal Code §11172. See generally Trost, *supra* note 94, at 194.
102. *Myers v. Lashley*, 44 P. 3d. 553 (Okla. 2002).
103. *Heinrich v. Conemaugh Valley Mem. Hosp.*, 648 A. 2d 53 (Pa. 1994).
104. 23 Pa. Const. Stat. §6318(b).
105. Virginia Code Ann. §63.2-1509.
106. See also, *Baldwin County Hosp. Auth. v. Trawick*, 504 S.E. 2d 708 (Ga. App. 1998); *Brown v. Farkas*, 511 N.E. 2d 1143 (Ill. App. 1986).
107. 45 C.F.R. §164.501.
108. 45 C.F.R. §164.512(b)(1)(ii).
109. *Id.*
110. See *Dill v. People*, 927 P. 2d 1315, 1321 (Colo. 1996).
111. *People v. Covington*, 19 P. 3d 15 (Colo. 2001).
112. See Maryland Code (1984) (1991 Repl. Vol., 1998 Cum. Supp.), §5-704 of the Family Law Article.
113. Cited in *Laznovsky v. Laznovsky*, 745 A. 2d 1054 (Md. 2000).
114. N.D.C.C. 27-20-01, *et seq.*, 50-25.1-10; Rules of Evidence, Rule 503, cited in *In Re R.O.*, 631 N.W. 2d 159 (N.D. 2001). For additional discussion regarding privacy laws and reports of suspected child abuse, see J. Jones, *Maintaining Unsubstantiated Records of "Suspected" Child Abuse: Much Ado About Nothing or a Violation of the Right to Privacy?*, 1995 Utah L. Rev. 887 (1995) (discussing the notion that under existing law, the privacy interests of those accused of abuse may be invaded by states' record-keeping practices with respect to claims of abuse not substantiated).
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116. *Hammer v. Hammer*, 418 N.W. 2d 23, 24 (Wis. App. 1987).
117. *E.W. and D.W. v. D.C.H.*, 754 P. 2d. 817 (Mont. 1988).
118. See, e.g., Elliott & Briere, *Posttraumatic Stress Associated with Delayed Recall of Sexual Abuse: A General Population Study*, 8 J. Traumatic Stress 629 (1995). For a discussion of discovery rules in the context of child sexual abuse and repressed memory, see Foster, *Repressed Memory Syndrome: Preventing Invalid Sexual Abuse Cases in Illinois*, 21 So. Ill. U. L. J. 169 (1996). For a discussion of the risk that innocent parents and others could be harmed by provoking false "repressed memories" of imaginary abuse, see Finer, *Therapists' Liability to the Falsely Accused for Inducing Illusory Memories of Childhood Sexual Abuse—Current Remedies and a Proposed Statute*, 11 J. Law & Health 45 (1996-97).
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123. Saulsbury & Campbell, *Evaluation of Child Abuse Reporting by Physicians*, 139 Am. J. Dis. Child. 393 (1985); Vulliamy & Sullivan, *supra* note 120, at 1466-67.
124. See, e.g., *Huge Tot's Mom Rips State: New Mexico Had Seized 3-Year-Old, 120-Pound Girl*, Houston Chron. (Feb. 4, 2001) at A-7.
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127. See, e.g., *Brown v. Pound*, 585 So. 2d 885 (Ala. 1991) and numerous other cases collected by Clayton, *supra* note 120.
128. *Hungerford v. Jones*, 722 A. 2d 478 (N.H. 1998).
129. The Department of Justice, National Criminal Justice Reference Service, *Law Enforcement in Response to Child Abuse* (March 2001), <http://www.ncjrs.gov/txtfiles/162425.txt>.
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131. See Angil Vel, *Expert Testimony in Child Sexual Abuse Cases: Avoiding the "Profile" Trap*, 39 Air Force L Rev. 133 (1996).
132. See *B.W. v. Meade County*, 534 N.W. 2d 595, 597 (S.D. 1995).
133. *Myers v. Lashley*, 44 P. 3d 553 (Okla. 2002).
134. *Searcy v. Auerbach*, 980 F. 2d 609 (9th Cir. 1992).
135. *Comstock v. Walsh*, 848 S.W. 2d 7 (Mo. Ct. App. 1992).
136. *People v. Rolfe*, 962 P. 2d 981 (Colo. 1998).
137. *Id.*
138. See Besharov, *Four Commentaries: How We Can Better Protect Children From Abuse and Neglect*, 8 The Future of Children 120, 120-21 (1998); see also Besharov & Laumann, *Child Abuse Reporting*, 33 Soc. Sci and Mod. Society 40 (1996) (arguing that unfounded reports of child abuse breach parental and familial privacy and overwhelm the limited resources of child protective agencies).
139. Besharov, *The Vulnerable Social Worker: Liability for Serving Children and Families* (National Association of Social Workers, 1985). See, e.g., California Penal Code §11166.5(b) (West 1997).
140. See, e.g., *Landeros v. Flood*, 551 P. 2d 389 (Cal. 1976); see also Singley, *Failure to Report Suspected Child Abuse: Civil Liability and Mandated Reporters*, 19 J. Juv. L. 236-37, 250 (1998); Besharov, *Child Abuse and Neglect: Liability for Failing to Report*, 22 Trial 67 (1986).
141. See, e.g., Ark. Code Ann. §12-12-507; Colo. Rev. Stat. Ann. §19-3-304; Iowa Code Ann. §232.69.
142. *Ham v. Hospital of Morristown, Inc.*, 917 F. Supp. 531 (E.D. Tenn. 1995).
143. *Id.*
144. *Stecker v. First Commercial Trust Co.*, 962 S.W. 2d 792 (Ark. 1998).
145. *Bentley v. Carroll*, 734 A. 2d 697 (Md. 1999).
146. *Id.* (citing Md. Code 1957, Art. 27, Sec. 35A).
147. *Id.*
148. *Paulson v. Sternlof*, 15 P. 3d 981 (Okla. Civ. App. 2000).
149. See *Kirschstein v. Haynes*, 788 P. 2d 941 (Okla. 1990).

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150. *Cechman v. Travis*, 414 S.E. 2d 282, 284 (Ga. Ct. App. 1991).
151. *Id.*
152. *Id.*
153. *Valtakis v. Putnam*, 504 N.W. 2d 264 (Minn. Ct. App. 1993).
154. *Marcelletti v. Bathani*, 500 N.W. 2d 124 (Mich. Ct. App.) (citing Michigan's child protection law MCL §722.621, *et seq.*; MSA §25.248(3)(1)).
155. *See, e.g., Bartels v. County of Westchester*, 429 N.Y.S. 2d 906 (N.Y. App. Div. 1980); *but see Blanca C. v. Nassau County*, 480 N.Y.S. 2d 747 (N.Y. App. Div. 1984), *aff'd.*, 481 N.W. 2d 545 (N.Y. 1985).
156. *Purdy v. Fleming*, 655 N.W. 2d 424 (S.D. 2002).
157. *Russell v. Adams*, 482 S.E. 2d 30 (N.C. Ct. App. 1997).
158. *Tuman v. Genesis Assoc.*, 894 F. Supp. 183, 189 (E.D. Pa. 1995).
159. *Caryl S. v. Child & Adolescent Treatment Serv.*, 614 N.Y.S. 2d 661 (N.Y. Sup. Ct. 1994); *see also* Finer, *supra* note 118 (discussing successful suits against health care professionals for reporting alleged child abuse by those claiming the accusations were false).