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Legislation as Protection for the Battered Child

Various Editors

COMMENTS

LEGISLATION AS PROTECTION FOR THE BATTERED CHILD

I. THE PROBLEM AND ITS HISTORY

> At the age of 1 year [the patient] was taken to a hospital emergency room with a history of having fallen out of her crib. X-ray study revealed fractures of the right and left wrists. . . . Several weeks later the mother took her to another hospital, where the mother stated that she had "tripped" with the baby and noted swelling of the ankles. Fractured right and left ankles were noted on x-ray examination. Two months later the patient was admitted to a 3d hospital with a fractured left arm and signs of malnutrition. . . . At the age of 2 this patient was admitted to the hospital with multiple fractures and symptoms strongly suggesting rickets or scurvy. . . . Six months later the child was taken to the emergency room of a hospital, where she was pronounced dead on arrival.

The above case history, quoted from a medical report,[1] is a classic example of the battered child syndrome. Although the problem of "child beating" or "child abuse" is not new to society,[2] only recently has the scope of the problem been realized and have attempts been made to correct it.

Medical awareness of the problem of the physically abused child has been a slow process, since most people, and physicians in particular, are reluctant to believe that parents would intentionally harm their own children.[3] Cases of severe trauma[4] to infants that improved spontaneously and could not be identified with any known disease were reported in medical literature as early as 1888.[5] The reporting doctors attributed these injuries to unrecorded accidental injuries or the trauma of birth. In 1946, Dr. John Caffey, a specialist in the field of pediatric radiology, presented a study of cases of multiple fractures of the long bones of infants

1. Fontana, Donovan & Wong, *The "Maltreatment Syndrome" In Children,* 269 NEW ENGLAND J. OF MEDICINE 1389, 1390, case 1 (1963).

2. See Shepherd, *The Abused Child and The Law,* 22 WASH. & LEE L. REV. 182, 184 (1965).

3. The reluctance of doctors, especially of young interns and residents, to believe that parents would abuse their child is a reason frequently given for their failure to report possible cases of abuse. See, *e.g.,* Fontana, Donovan & Wong, *The "Maltreatment Syndrome" In Children,* 269 NEW ENGLAND J. OF MEDICINE 1389, 1392 (1963).

4. "Trauma" is defined as an injury or wound to a living body caused by the application of external force or violence. WEBSTER, THIRD NEW INTERNATIONAL DICTIONARY (1965).

5. West, *Acute Periosteal Swellings In Several Young Infants of the Same Family, Probably Rickety in Nature,* 1 BRITISH MEDICAL J. 856 (1888).

in various stages of healing found in conjunction with subdural hemotomas.[6] While Dr. Caffey assumed that the injuries were traumatic in origin, he did not speculate as to the source of the trauma. Later studies were also directed at the physical condition of the child, but no effort was made to determine the origin of the injuries.[7] Gradually, however, medical investigators began to turn their attention to the possible causes of the trauma. In 1951 a report[8] dealing with cases of multiple injuries to the bones of small children suggested ordinary childhood accidents as potential sources of such injuries; and two years later, a paper[9] presented on unrecognized skeletal damage in infants hypothesized possible traumatic episodes which had not been disclosed as a source of the injuries in the medical histories taken from parents. All of these reports described variations of the same condition — repeated injury to infants without a history of trauma sufficient to support such injury.[10] In the latter half of the fifties, parental aggression was finally recognized as the cause of the trauma, and the medical profession subsequently became acutely aware of the abusive character of the injuries inflicted.[11]

In the early sixties Social Service workers[12] and physicians[13] began extensive studies and surveys of suspected cases of child abuse in order to determine the exact nature and extent of the problem. This research was culminated in July 1962, when an article[14] appeared in the *Journal of the American Medical Association* which represented the most comprehensive study of the problem to that date. The article began:

> The battered-child syndrome is a term used by us to characterize a clinical condition in young children who have received serious physical abuse, generally from a parent or foster parent. The condition has also been described as "unrecognized trauma" by radiologists, orthopedists, pediatricians, and social service workers. It is a significant cause of childhood disability and death. Unfortunately, it is

6. Caffey, *Multiple Fractures in the Long Bones of Infants Suffering From Chronic Subdural Hematomas,* 56 AMERICAN J. ROENTGENOLOGY 163 (1946). An excellent history of the development of medical awareness to the problem of child abuse is contained in McCoid, *The Battered Child and Other Assaults Upon the Family: Part One,* 50 MINN. L. REV. 1, 3-15 (1965). The outline of the history presented here is in part derived from that article.

7. See Lis & Frauenberger, *Multiple Fractures Associated with Subdural Hematoma in Infancy,* 6 PEDIATRICS 890 (1950).

8. Barmeyer, Alderson & Cox, *Traumatic Periostitis in Young Children,* 38 J. PEDIATRICS 184 (1951).

9. Silverman, *The Roentgen Manifestations of Unrecognized Skeletal Trauma in Infants,* 69 AMERICAN J. ROENTGENOLOGY, RADIUM THERAPY AND NUCLEAR MEDICINE 413 (1953).

10. See Woley & Evans, *Significance of Skeletal Lesions in Infants Resembling Those of Traumatic Origin,* 158 A.M.A.J. 539 (1955). See generally Barta & Smith, *Willful Trauma to Young Children — A Challenge to the Physician,* 2 CLINICAL PEDIATRICS 545, 546 (1963).

11. The Children's Bureau of the Department of Health, Education and Welfare, has compiled a *Bibliography on The Battered Child,* revised in 1963, which lists forty-four publications on the subject. Fourteen were published in the 1950's.

12. Elmer, *Abused Young Children Seen in Hospitals,* 5 SOCIAL WORK 98 (1960).

13. Adelson, *Slaughter of the Innocents — A Study of Forty-Six Homicides in Which the Victims Were Children,* 264 NEW ENGLAND J. MEDICINE 1345 (1961).

14. Kempe, Silverman, Steele, Droegemueller & Silver, *The Battered-Child Syndrome,* 181 A.M.A.J. 17 (1962).

frequently not recognized or, if diagnosed, is inadequately handled by the physician because of hesitation to bring the case to the attention of the proper authorities.[15]

II. THE SCOPE OF THE PROBLEM

An editorial in the same issue of the *Journal of the American Medical Association* that presented "The Battered Child Syndrome" predicted that the syndrome will "be found to be a more frequent cause of death than such well recognized and thoroughly studied diseases as leukemia, cystic fibrosis, and muscular dystrophy, and it may well rank with automobile accidents and the toxic and infectious encephalitides as causes of acquired disturbances of the central nervous system."[16] Several surveys which have attempted to discover the extent of child abuse support this prediction. In one of the two nationwide surveys[17] conducted to date, 71 hospitals reported 302 cases of abuse in one year, resulting in 33 deaths and 85 instances of brain injury. In the same period 77 district attorneys reported knowledge of 447 cases, including 45 deaths and 29 cases of brain injury. The fact that these reports contained only a small fraction of the number of cases of actual abuse is illustrated by various state and county surveys. One study revealed that 71 cases of abuse were reported in Iowa in a six-month period,[18] while another survey showed that Cook County Hospital admits abused children at the rate of approximately 10 a day.[19] But even these statistics represent, at best, a conservative estimate since many cases of child abuse do not come to the attention of the police or hospitals,[20] and many of those that do are not recognized as falling within the battered child syndrome.[21]

The seriousness of the problem presented by the battered child is illustrated more graphically by an examination of the type of injuries inflicted.[22] The majority of injuries result from beatings inflicted with instruments ranging from bare fists, hairbrushes and straps to rubber hoses, electric cords, and baseball bats.[23] Other injuries have resulted from parents forcing their children to rinse their mouths with drain cleanser, take a bath in slush and snow, crawl across the grate of a floor furnace or

15. *Ibid.*
16. 181 A.M.A.J. 42 (1962).
17. Kempe, Silverman, Steele, Droegemueller & Silver, *The Battered-Child Syndrome,* 181 A.M.A.J. 17 (1962). The other nationwide study was conducted by the Children's Division of the American Humane Association and appears in Child Abuse — Preview of a Nationwide Survey 3 (1963). The results of this study are reported in Shepherd, *The Abused Child and the Law,* 22 WASH. & LEE L. REV. 182, 186 (1965).
18. *The Child-Abuse Problem in Iowa,* 53 J. OF IOWA MEDICAL SOC'Y 692 (1963).
19. Shepherd, *The Abused Child and the Law,* 22 WASH. & LEE L. REV. 182, 187 (1965).
20. *Battered Child Legislation,* 188 A.M.A.J. 386 (1964).
21. *Ibid.*
22. See DE FRANCIS, CHILD ABUSE PREVIEW OF A NATIONWIDE SURVEY (1963). This report also lists the type of injuries inflicted with these instruments. They range from bruises, contusions, welts, and lost teeth to broken arms, legs and ribs. One five month old child was found to have 30 broken bones.
23. *Id.* at 5-7.

drink boiling milk.[24] These abused children may not be taken to a physician or hospital until they are in acute distress or their parents fear impending death and act to avoid legal entanglements or criminal prosecution.[25]

Abused children, although bearing the distinctive marks of the individual tortures described above, display sufficient similarities for medical authorities to classify the characteristic clinical condition as a syndrome.[26] Although the generalizations made with regard to the syndrome are not always accurate,[27] the battered child is usually below three years of age, and shows evidence of neglect, including poor skin hygiene, malnutrition, multiple soft tissue injuries and "failure to thrive."[28] Subdural hemotomas,[29] with or without skull fractures, are frequent, as are multiple injuries to the bones of the arms and legs in various stages of healing. Those with the most severe injuries may arrive at the hospital or physician's office in a coma, in convulsions or dead.[30] In most cases there will be discrepancies between clinical findings and the medical history provided by the parents.[31]

Medical analysis of the battered child problem began with a description of the physical injuries involved and proceeded to a realization of the

24. Gillespie, *The Battered Child Syndrome: Thermal and Caustic Manifestations*, 5 J. OF TRAUMA 523, 524–25 (1965). This report is perhaps the most shocking of all the medical reports cited in this Comment. The mechanisms used reflect the tormentive capacities of the parents, while the case histories illustrate the helplessness of a child subjected to repeated tortures.

25. Fontana, Donovan & Wong, *The "Maltreatment Syndrome" In Children*, 269 NEW ENGLAND J. MEDICINE 1389, 1390 (1963). The term "Maltreatment Syndrome" was suggested in this article as a more accurate description of the condition than the term "battered child syndrome" coined in the Kempe article (see *supra* note 14 and accompanying text). However, the term "battered child" has remained in common usage.

26. A "syndrome" is defined as "the pattern of symptoms in a disease or the like; a number of characteristic symptoms occurring together." AMERICAN COLLEGE DICTIONARY (1957).

27. Barta & Smith, *Willful Trauma to Young Children — A Challenge to the Physician*, 2 CLINICAL PEDIATRICS 545, 551 (1963); Editorial, *The Battered-Child Syndrome*, 181 A.M.A.J. 130 (1962). It must be remembered that the syndrome, although it indicates the pattern of injuries found in the child, is really describing a course of conduct by the parents.

28. This is a medical term used to describe an infant's failure to achieve normal development for his age.

29. The dura matter is a fibrous membrane forming the outermost of the three coverings of the brain. A hematoma is a swelling containing blood forced out of its regular channels. This type of injury often results from severe blows on the head.

30. Fontana, Donovan & Wong, *The "Maltreatment Syndrome" In Children*, 269 NEW ENGLAND J. MEDICINE 1389, 1390 (1963).

31. Suggestions for approaches to be taken by physicians when obtaining a medical history from parents suspected of abuse are included in Kempe, Silverman, Steele, Droegemueller & Silver, *The Battered-Child Syndrome*, 181 A.M.A.J. 17, 20 (1962). The authors state that the physician should assume a sympathetic attitude toward the parents. He should give his assurance that the diagnosis is well-established on the basis of objective findings, and indicate to the parents that they have an obligation to avoid a repetition of the incident. He should also stress the idea that the parents can atone for their past acts and help the child by giving a complete history. The authors, aware of the normal physician's reluctance to get involved, emphasize the importance of immediate and complete investigation so that a decision can be made regarding the child's safety.

cause of the injury. The logical third step is from identification of the injury to the protection of the child from further harm. It is at this point that the medical problem also becomes a legal one.

III. THE REPORTING STATUTES

Before anything can be done to protect the battered child, the problem must be brought before public agencies with the power to take action. Physicians, however, are reluctant to report possible cases of abuse for a variety of reasons. Diagnosis of intentional injury is difficult since it requires a physician to go beyond the mere diagnosis of a physical condition and attempt to ascertain intent and motive. This type of judgment is alien to a physician's training and experience, and he is reluctant to attempt it.[32] Furthermore, doctors, and especially young interns and residents, often have difficulty believing that parents would inflict such punishment on their children.[33] Many doctors have regarded reporting as a breach of the special confidential relationship between physician and patient,[34] while others have failed to report suspected cases of abuse because they did not know to whom to report, or because they had no reason to believe that the reporting would result in benefit to the child.[35] Perhaps, the chief reason for the physician's reluctance to take anything resembling legal action lies in his fear of being sued.[36] A physician who erroneously reports a case of child abuse may be subject to liability for defamation,[37] invasion of privacy[38] or breach of confidence.[39]

When the enormity of the battered child problem became known, and it was realized that nothing could be done for the abused child unless suspected cases of abuse were reported, the Children's Bureau of the Department of Health, Education and Welfare drafted model legislation to encourage and assist states in enacting statutes which would bring cases of abuse to the attention of proper authorities.[40] The Bureau realized that

32. McCoid, *The Battered Child and Other Assaults Upon the Family: Part One,* 50 MINN. L. REV. 1, 49 (1965).

33. Bain, Milowe, Wenger, Fairchild & More, *Child Abuse and Injury,* 130 MILITARY MEDICINE 747, 748 (1965).

34. *Id.* at 756.

35. *Id.* at 748.

36. *Id.* at 757. The medical profession's fear of legal action is already famous. The physician's reluctance to render first aid or emergency medical treatment at the scene of an accident, even though there are almost no reported decisions holding a physician liable for malpractice in such cases, has forced a majority of the states to pass "good samaritan statutes." In 1963 the Legal Department of the American Medical Association took a survey of physicians throughout the country and found that almost half of those in the sample would refuse emergency treatment because of fear of malpractice suits. An interesting fact disclosed by this survey was that even in those states with "good samaritan statutes" almost the same percentage of doctors would refuse to render emergency aid because they feared civil liability. See *First Results: 1963 Professional Liability Survey,* 189 A.M.A.J. 859, 864–65 (1964).

37. PROSSER, TORTS § 106, at 756 (3d ed. 1964).

38. *Id.* at 834.

39. Such a tort is implicit in cases such as those cited in note 66 *infra.*

40. The text of the model act is as follows:

1. Purpose. The purpose of this Act is to provide for the protection of children who have had physical injury inflicted upon them and who are further threatened by the conduct of those responsible for their care and protection.

the reporting statutes would not eliminate the problem of child abuse,[41] but insisted that the statutes were a vital first step toward alleviating the problem. Medical commentators were quick to note the disadvantages of the proposed mandatory reporting statute.[42] One of their major criticisms was that the publicity given the mandatory reporting laws could result in fewer children being brought to the doctor. If parents thought that criminal prosecution might result, they would hesitate to obtain medical attention for their child. Furthermore, a parent who had been reported might feel angered and affronted because of the report and vent his anger upon the child who was the cause of his harassment. It is even conceivable that an entirely well-meaning parent who had inadvertently

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Physicians who become aware of such cases should report them to appropriate police authority thereby causing the protective services of the State to be brought to bear in an effort to protect the health and welfare of these children and to prevent further abuses.

2. Reports by Physicians and Institutions. Any physician, including any licensed doctor of medicine, licensed osteopathic physician, intern and resident, having reasonable cause to suspect that [a] child under the [maximum age of juvenile court jurisdiction] brought to him or coming before him for examination, care or treatment has had serious physical injury or injuries inflicted upon him other than by accidental means by a parent or other person responsible for his care, shall report or cause reports to be made in accordance with the provisions of this Act; provided that when the attendance of a physician with respect to the child is pursuant to the performance of services as a member of the staff of a hospital or similar institution he shall notify the person in charge of the institution or his designated delegate who shall report or cause reports to be made in accordance with the provisions of this Act.

3. Nature and Content of Report: to Whom Made. An oral report shall be made immediately by telephone or otherwise, and followed as soon thereafter as possible by a report in writing, to an appropriate police authority. Such reports shall contain the names and addresses of the child and his parents or other persons responsible for his care, if known, the child's age, the nature and extent of the child's injuries (including any evidence of previous injuries), and any other information that the physician believes might be helpful in establishing the cause of the injuries and the identity of the perpetrator.

4. Immunity from Liability. Anyone participating in good faith in the making of a report pursuant to this Act shall have immunity from any liability, civil or criminal, that might otherwise be incurred or imposed. Any such participant shall have the same immunity with respect to participation in any judicial proceeding resulting from such report.

5. Evidence not Privileged. Neither the physician-patient privilege nor the husband-wife privilege shall be a ground for excluding evidence regarding a child's injuries or the cause thereof, in any judicial proceeding resulting from a report pursuant to this Act.

6. Penalty for Violation. Anyone knowingly and willfully violating the provisions of this Act shall be guilty of a misdemeanor.

CHILDREN'S BUREAU, U.S. DEP'T OF HEALTH, EDUCATION AND WELFARE, THE ABUSED CHILD — PRINCIPLES AND SUGGESTED LANGUAGE FOR LEGISLATION AND REPORTING OF THE PHYSICALLY ABUSED CHILD (1963). The act is also reproduced in McCoid, *The Battered Child and Other Assaults Upon The Family: Part One*, 50 MINN. L. REV. 1, 20 (1965), and in *The Child Abuse Problem in Iowa*, 53 J. IOWA MEDICAL SOC'Y 692, 694 (1963).

41. There is even some doubt as to how effective reporting statutes will be in punishing the abusers or in protecting the child. In the first prosecution brought as a result of reporting statutes in Nebraska, insufficient evidence resulted in a dismissal of the complaint. The child involved was taken to the hospital at the age of two months with a severe head injury. Two months later the child was again taken to the hospital, this time suffering from pneumonia and dehydration, and with two cracked ribs in the healing stage. The parents kept the child. Omaha Sunday World Herald, Sept. 19, 1965, p. 19–B, cols. 1 & 2. It is quoted in Paulsen, *The Legal Framework For Child Protection*, 66 COLUM. L. REV. 679, 697 n.117 (1966).

42. Reinhart & Elmer, *The Abused Child*, 188 A.M.A.J. 358, 360 (1964).

failed in the protection of his child would prefer to avoid the doctor rather than risk possible accusation and humiliation.

But despite the criticism of some commentators, the response of state legislatures to the suggestions of the Children's Bureau was almost instantaneous. Since 1963, 48 states and the Virgin Islands have enacted reporting statutes.[43] However, the problem of drafting an adequate statute, even with the guidance of the model act, has proved to be more difficult than it first appeared. Many differences are apparent in the various state statutes, and a great deal of controversy has arisen over what should or should not be included in the acts.[44] A comparison of the major provisions of these statutes with the model act from which they were derived may prove to be of value in the enactment of more effective laws in the future.

A common fault of both the model act and those of several states[45] lies in a failure to recognize that an infant may be subjected to numerous forms of abuse which result from neglect rather than action.[46] These statutes are limited by their statements of purpose to physical abuse inflicted upon a child. Since courts applying the act could use the statement of purpose to determine legislative intent, it is possible that a court would hold that an act which limited its scope to *inflicted* abuse was not meant to cover cases of neglect. Such a possibility can easily be prevented by the inclusion of an express statement that the act is intended to cover physical injury resulting from neglect as well as injury directly inflicted upon a child.

The second provision of the model act and most state statutes is the most important, and perhaps the most controversial, provision of these acts. This section requires that injuries suffered by a child as a result of willful abuse be reported and usually specifies the type of injuries to be reported and the class of people required to make reports. Although there is little dispute as to the former classification,[47] a great deal of discussion

43. These statutes are listed in Paulsen, *The Legal Framework for Child Protection*, 66 COLUM. L. REV. 679, 711 n.174 (1966). An analysis of each of these statutes is contained in the chart in the appendix to this Comment. This chart was obtained from the Legal Department of the AMA.

44. See, *e.g.*, Note, 15 DEPAUL L. REV. 453, 460–61 (1966); Legislation, 18 U. FLA. L. REV. 503, 511 (1965).

45. *E.g.*, COLO. REV. STAT. ANN. § 22-13-1 (1963); N.J. STAT. ANN. § 9:6 (Supp. 1966).

46. See case reported in Adelson, *Homicide by Starvation*, 186 A.M.A.J. 458, 459 (1963).

47. There are, however, faults with the language used in the model act and in many state acts. Several states require only the reporting of *serious* injury. *E.g.*, MASS. ANN. LAWS ch. 119, § 39A (1965); N.J. STAT. ANN. § 9:6-8.3 (Supp. 1966). It might be that the states were trying to avoid reports when there was no substantial injury, but it would seem that a report when a child shows early signs of repeated trauma inconsistent with his medical history might prevent serious injury in the future. Also, a large number of state acts refer to injuries the physician has "reasonable cause to suspect" were non-accidental. *E.g.*, N.J. Statute *supra*. Such a requirement forces the physician to make a judgment as to intent. There might be some hesitation on the part of doctors to make such a judgment, and also some question as to whether they are qualified to do so.

has arisen over the latter.[48] The model act limits the reporting requirement to physicians, and only a few states have extended the requirement beyond members of the health professions.[49] There are strong arguments in favor of this limitation, since the medical profession is best-equipped to make the difficult diagnoses required in many cases of child abuse.[50] Furthermore, doctors and hospitals are those most likely to come in contact with abused children. A provision for mandatory reporting by them does not prevent voluntary reporting by others.[51] But in spite of this argument, it would appear to be the better course to broaden the class required to report. The plight of the battered child is a social problem in which the physician plays only a part. While it would be unrealistic to require everyone to report,[52] visiting nurses, social workers, school teachers, lawyers and marriage counselors frequently learn of cases of abuse before medical care is either required or requested. Since the purpose of the statute is the protection of children, it would seem illogical to ignore the opportunity to offer those persons in professions working closely with the family the same incentive and protection offered the medical profession.

The provision which has the greatest effect on the child's welfare is the one designating the agency to whom the reports must be made. The model act provides only for reports to the police. Several reasons are advanced by the Children's Bureau for this limitation,[53] but it is due primarily to the fact that there is a law enforcement agency of some kind everywhere in the United States whose services are available twenty-four hours a day to investigate incidents of child abuse. It is unfortunate that a large number of states have adhered closely to this suggested provision.[54] Police investigation casts a premature criminal shadow on parents for infliction of an injury that may have been caused by a sibling or baby-sitter, or be the result of a true accident. Furthermore, while investigation by law enforcement agencies may determine who committed the act, it is not likely to determine why the act was committed, how the child can be protected, or whether the child can remain safely with his parents. The intervention of a trained social worker is more likely to be beneficial to both child and family, since it appears that every abused or grossly neglected child represents an accumulation of acute psychological and social problems.[55] In any event, the social worker can always refer cases that warrant prosecution to the police.

48. See publications cited in note 40 *supra.*
49. See Appendix for a breakdown of the provisions of each state statute.
50. Barta & Smith, *Willful Trauma to Young Children — A Challenge to the Physician,* 2 CLINICAL PEDIATRICS 545, 551 (1963).
51. The reluctance of the average citizen, especially in a large city, to "get involved" would seem to negate such a possibility.
52. Several states, however, have done so. *E.g.,* TENN. CODE ANN. 37-1202 (Supp. 1966); UTAH CODE ANN. 55-16-2 (Supp. 1965).
53. See Bain, et al., *Child Abuse and Injury,* 130 MILITARY MEDICINE 747, 748 (1965). Catherine Bain, M.D., is the Assistant Chief for International Cooperation, Children's Bureau, HEW, and was formerly Deputy Chief, Children's Bureau, Washington.
54. See Appendix.
55. See Reinhart & Elmer, *The Abused Child,* 188 A.M.A.J. 358, 360 (1964).

The Children's Bureau, recognizing the validity of these arguments, has modified its original proposal and now recommends that public welfare agencies offering child protective services be designated to receive reports.[56] Several states have followed this advice, and have designated public welfare departments as investigative agencies and the primary recipient of reports.[57] Illinois, for example, not only requires reports to be made to the Department of Children and Family Services, but also has initiated an emergency service providing twenty-four hour protection.[58] Since the various states, and even the counties within a state, may have different welfare agencies, each state will have to select the agency best suited to carry out the provisions of its act. But even if reports are required to be made to a designated child protective agency, there is still a problem presented by parents taking their child to a succession of different hospitals in order to avoid detection.[59] A central statewide registry containing a record of reported cases of suspected abuse is an invaluable aid in identifying repeated cases or in confirming suspicions that the parents abused the child, and can also provide statistical data and help gather more information about the nature and cause of child abuse. At present the central registry is in use in only four states — California,[60] Illinois,[61] Virginia,[62] and New York.[63]

The model act and the vast majority of the state acts[64] require an immediate oral report, followed by a written report stating certain particulars about the child and his parents, the nature and extent of his injuries, and any other information the reporter believes might be helpful in establishing the cause of the injuries and the identity of the perpetrator. It is submitted that the statutes should make clear that the oral report need not be as complete as the written one, and that even the latter need only contain "medical facts." Such a provision would encourage physicians to report their observation of facts which constitute the "battered-child syndrome" when they have no knowledge as to who might be the culprit.

The last three provisions of the model act are designed to act as incentives for compliance with the reporting law. The immunity from liability clause found in the vast majority of statutes is designed to relieve the physician's reluctance to report because of his fear of being sued.[65]

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56. CHILDREN'S BUREAU, PROPOSALS FOR LEGISLATION 6.
57. *E.g.*, IDAHO CODE ANN. § 16-1641 (Supp. 1963); MASS. ANN. LAWS ch. 119, § 39B (1965). Pennsylvania provides for reports to be made either to the presiding judge of the Juvenile Court or the Community Child Protective Service where such court or service exists. In the absence of both, the report is made to the police. PA. STAT. ANN. tit. 18, § 4330(b) (Supp. 1965).
58. ILLINOIS DEP'T OF CHILDREN & FAMILY SERVICES, THE ABUSED CHILD (1965).
59. See case history which appears at beginning of this Comment.
60. CAL. PEN. CODE 11161.5.
61. ILL. ANN. STAT. ch. 23, § 2041-47 (Supp. 1965).
62. VA. STAT. of 1966, ch. 577.
63. N.Y. SOCIAL WELFARE LAW § 383-a.
64. *E.g.*, statutes cited in note 57 *supra*.
65. See note 36 *supra*.

Such a fear is probably groundless, for every reported American case in which a physician has made disclosures concerning patients in order to protect third parties has resulted in recognition of a privilege on the part of the physician and a denial of liability.[66] It also seems likely that where a physician discloses information that is beneficial to the child patient or which may prevent his further abuse, the courts will recognize at least a qualified privilege which cannot be overcome in the absence of malice or a lack of a good faith belief in the facts as reported.[67] Since, however, a statutory rejection of liability will help physicians overcome their reluctance to report, it serves a valuable purpose and should be included in all acts.

The vast majority of state acts also contain a provision proscribing the assertion of privilege as a ground for excluding evidence regarding a child's injuries or their probable cause.[68] The benefit of this provision as it affects the physician-patient relationship is obvious, but it also has broader implications that are not at once apparent. The physician is bound by an ethical principle of confidentiality to refrain from the disclosure of confidences or secrets revealed to him in the course of treatment,[69] and feels strongly bound by this commitment. The abrogation of any statutory privilege, especially when included in a mandatory reporting statute alleviates the physician's fear that he is compromising his ethics and emphasizes his duty to report. It has also been asserted that the physician does not violate any confidential communication by reporting since his relationship is with his patient, and the patient is the child. Since the purpose of the reporting acts is the protection of the child, the disclosure of any suspected abuse is consistent with the physician's duty to his patient.[70] This argument has some validity, but it ignores the problem faced by persons in other professions who may also be required to report. The lawyer and social worker also have ethical principles of confidentiality, and their contact is primarily with the adult member of the family. It has been suggested that the omission of such professions from the requirement of mandatory reporting may reflect a recognition of their confidential relationship with the adult member of the family.[71] The provisions denying the assertion of privileged communication and the mandatory requirement to report will enable people in these professions to assist the child without violating their professional ethics.

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66. Simonsen v. Swenson, 104 Neb. 224, 177 N.W. 831 (1920); Clark v. Geraci, 29 Misc. 2d 791, 208 N.Y.S.2d 564 (Sup. Ct. 1960); Barry v. Mverch, 8 Utah 2d 191, 331 P.2d 814 (1958); Smith v. Driscoll, 94 Wash. 441, 162 Pac. 572 (1917).

67. PROSSER, TORTS § 110, at 811 (3d ed. 1964); RESTATEMENT, TORTS § 598 (1938).

68. See Appendix for a list of those state statutes containing such a provision. The omission by California and Oregon of such a clause may be explained by the fact that these states allow the privilege to be asserted only in civil actions, while criminal actions would normally result from the report. See CAL. CIV. PROC. CODE § 1881(4); OREGON REV. STAT. § 44.040(1)(d) (1963).

69. AMA PRINCIPLES OF MEDICAL ETHICS 9 (1957).

70. See McCoid, *The Battered Child and Other Assaults Upon The Family: Part One*, 50 MINN. L. REV. 1, 34 (1965).

71. *Id.* at 29.

Finally, the model act and a large number of state enactments make it a misdemeanor to wilfully violate the provisions of the act.[72] This provision has been criticized because of the seemingly harsh penalty it imposes for the failure to report cases of abuse in which identification of the condition is difficult and because such a provision is practically unenforceable and therefore useless.[73] The purpose of the statutes is not to punish people who fail to report, but to obtain information as to possible cases of child abuse. A mandatory reporting provision which insulates the reporter from any criticism that he violated his professional ethics by reporting would appear to be a sufficient incentive for compliance without the penalty clause.

IV. CONCLUSION

Mandatory reporting statutes are not a solution to the problem of child abuse. They merely establish a procedure through which the proper authorities can be made aware of the condition. Protection for the abused child must be provided through a complete legal framework including provisions in our criminal laws which can be used to punish persons who have harmed the child, juvenile court acts which permit a court to undertake protective supervision of the child or order his removal from the home, and legislation which establishes protective services for abused children as a part of a comprehensive public program of child welfare services.[74] If such a system does not exist in all states, or if, in conjunction with the reporting statutes, it does not offer the abused child complete protection, it is the responsibility of the legal profession to correct it.

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72. *E.g.*, PA. STAT. ANN. tit. 18, § 4330(b) (Supp. 1965).

73. Shepherd, *The Abused Child And The Law*, 22 WASH. & LEE L. REV. 182, 192 (1965).

74. See Paulsen, *The Legal Framework For Child Protection*, 66 COLUM. L. REV. 679 (1966). The author discusses in detail the various provisions relating to child protection.

APPENDIX

BATTERED CHILD REPORTING LAWS[75]	Date	Mandatory	Permissive	Immunity from Suit	Reports to:	Reports by:	Physician-Patient privilege not a bar to testimony
Alabama	1965	x		x	2, 5	1, 2, 3, 4, 6, 7	x
Alaska	1965		x	x	1, 2	1, 2, 3, 4	x
Arizona	1964	x		x	2, 4	1	x
Arkansas	1965	x		x	2, 4	1, 2, 3, 6	x
California	1963	x			2, 5	1	
Colorado	1963	x		x	2, 4	1	x
Connecticut	1965	x		x	1, 2	1	
Delaware	1965	x		x	3, 4	1	x
Florida	1963	x		x	3, 4	1	x
Georgia	1965	x		x	2, 4, 5	1, 2, 3	
Hawaii	Legislation pending.						
Idaho	1965	x		x	1	1	
Illinois	1965	x		x	2, 5	1, 8, 10, 11	x
Indiana	1965	x		x	1, 2, 4	1, 5, 6	x
Iowa	1965	x		x	1, 2, 4	1, 8, 11, 2	x
Kansas	1965	x		x	3, 4	1, 3	x
Kentucky	1965	x		x	1, 2, 4	1, 7	x
Louisiana	1964	x		x	2, 4	1	x
Maine	1965	x		x	1, 2, 4	1	
Maryland	1964	x		x	2	1	
Massachusetts	1964	x		x	1	1	
Michigan	1964	x		x	1, 2, 4	1	x
Minnesota	1965	x			2	1, 2, 6	
Mississippi	1966			x		1, 2, 8	
Missouri	1965		x	x	2, 4	1	x
Montana	1965	x		x	2, 4	1, 2, 3, 4	x
Nebraska	1965	x		x	2	7	
Nevada	1965	x		x	2, 4	1, 8, 2, 3, 4, 12, 13	x
New Hampshire	1965	x		x	4, 5	1	x
New Jersey	1964	x		x	2, 4	1	
New Mexico	1965		x	x	2, 4	1, 2, 3, 4, 13	x
New York	1964	x		x	5	1, 8	
North Carolina	1965		x	x	1	1, 2, 3, 4	x

APPENDIX *(Continued)*

BATTERED CHILD REPORTING LAWS[75]	*Date*	*Mandatory*	*Permissive*	*Immunity from Suit*	*Reports to:*	*Reports by:*	*Physician-Patient privilege not a bar to testimony*
North Dakota	1965	x		x	5	1, 2	x
Ohio	1963	x		x	2, 4	1	x
Oklahoma	1965	x		x	1, 2, 4	1, 8, 2	x
Oregon	1965	x			6	1, 2	
Pennsylvania	1963	x		x	2, 3	1	x
Rhode Island	1964	x		x	1, 4	1	
South Carolina	1965	x		x	2, 5	1	
South Dakota	1964	x		x	3, 4	1, 8, 9	x
Tennessee	1965	x		x	5	7	
Texas	1965		x	x	2, 3	1	
Utah	1965	x		x	4	7	x
Vermont	1965	x		x	1, 4	1	
Virginia	1966	x		x	2, 3, 4	1, 2	x
Washington	1965		x	x	2, 4	1	x
West Virginia	1965	x		x	2, 4	1, 2, 3, 4	
Wisconsin	1963-65	x			2	1	x
Wyoming	1963	x		x	1, 4	1, 2, 5, 6, 7	x

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EXPLANATION OF CHART ON BATTERED CHILD REPORTING LAWS

Column headed "Reports by"

1. Healing arts personnel (includes one or all of the following: physicians, surgeons, osteopaths, chiropractors, interns, residents, hospital administrators, clinics).
2. Nurses (registered, practical, public health).
3. Social workers.
4. Teachers, principals, etc.
5. Laboratory technicians.
6. Pharmacists.
7. Any person.
8. Dentists.
9. Law enforcement officers.
10. Christian Science practitioners.
11. Pediatrists
12. Attorneys.
13. Clergymen.

Column headed "Reports to"

1. Department of Health, Social Welfare, Welfare, Health and Welfare, Public Health, etc.
2. Police and law enforcement officers (police, sheriff, states attorney, county attorney, etc.)
3. Family Court, Juvenile Court, County Court, etc.
4. Hospital or institution in which child is located.
5. Child Welfare Agency.
6. Coroner or Medical Examiner.

75. This chart was supplied by the Legal Department of the AMA and has been made current.