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# Medicolegal aspects of child abuse and neglect

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Since the publication 40 years ago of the classic article by Kempe et al [1] describing the battered child syndrome, physicians of all specialties have had to include the differential diagnosis of all forms of child abuse and neglect in their education and continuing education. Battered children were generally children who had been chronically abused and neglected. Some were emaciated children who had many bruises, scars, and evidence of old fractures. Over time, the understanding of child abuse and neglect has broadened to include physical abuse, sexual abuse, emotional or psychologic abuse, physical neglect, emotional neglect, medical care neglect, and educational neglect. Abuse or neglect can occur within the family or in any setting in which there are children.

Physicians as a group of professionals have four potential roles in caring for children who are abused or neglected: (1) recognition and reporting, (2) treatment, (3) prevention, and (4) advocacy. Neurosurgeons are always involved in recognition and reporting, in the treatment of children with abusive central nervous system injury, or in adults with the sequelae of abusive injury [2], and may be involved in advocacy. This article reviews medicolegal information needed by neurosurgeons in their practices.

## Reporting laws

All states in the United States have laws that mandate the reporting of suspected cases of child abuse and neglect by all physicians and other professionals who have contact with children [3]. The wording of the statutes varies as to whether physicians "suspect," "have reason to believe," or some other wording, but none require that the physician "know" that child abuse exists before reporting.

Imposition of mandatory reporting laws was based in reasoning almost identical to mandatory reporting of suspected infectious diseases to designated state agencies (ie, the goal was to identify possible vectors of harm to allow prevention of further avoidable injury). Given that a confidential relationship exists between physicians and patients, absent another overriding obligation, mandatory child abuse reporting laws remove doubt as to the physician's duty to guard the child's safety over a duty of nondisclosure. To reinforce the importance of this duty to report suspected child maltreatment, each of the 50 states immunizes reporters from civil or criminal liability when a report is made, even if the report is wrong, so long as the report was not made with either no basis or with deliberate bad intentions.

There are physicians, however, who are resistant to reporting for a number of reasons. One reason, more common in the past, is a lack of knowledge or understanding of the diagnosis of abuse and its prevalence. There are some individuals who practice "gaze aversion" and, irrespective of the facts of the case, do not consider abuse as a possibility. Avoiding making this diagnosis has consequences similar to those in missing a brain tumor.

Another reason for nonreporting is that some physicians worry that by reporting a family, they are accusing or charging an individual with abusing a child, and the consequences of such a charge without proof are too great. There are several

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reasons why this line of reasoning is faulty and hazardous to children and physicians. For one thing, in suspected intrafamilial abuse, the report generally goes to child protective services agencies in county or state department's of social services. These agencies are the agencies designated to investigate reports of suspected abuse and neglect, and make a determination as to whether the report is substantiated or founded, or unsubstantiated or unfounded. If there is a court action leading to the substantiation decision, that court is the juvenile or family court. These courts are civil, not criminal in their jurisdiction and approach. Their purpose is to ensure that children are protected from further harm and that treatment for the child and parent occurs when appropriate. The standard of proof the civil court judge requires for the report substantiation decision is "more likely than not" in most states, or "clear and convincing evidence" in a few states. In criminal court, the standard of proof required to convict the accused of a crime is "beyond a reasonable doubt." If a physician gets a subpoena for civil court, it says or has words to the effect: "The People of the State of—in the interests of [the children]." In contrast, if criminal charges are filed, the subpoena says "The People of the State of—vs. [the accused]." It is true that in most jurisdictions, child protective service agencies cross-report to law enforcement agencies and in cases of extrafamilial (third party) abuse, there may be no social service involvement (except in cases of abuse in licensed day care facilities in which the social service agency is responsible for licensure of day care). It is also true that criminal charges are placed against parents in some cases, including child murders, but these cases are a very small percentage (less than 10%) of confirmed child maltreatment. Further, in considering whether to focus on a specific parent, rather than simply diagnosing that a child has been abused, it is important to remember that children are placed in a variety of settings during their day. The individual who brings the child in to the hospital or emergency room may not be the individual who caused the injury. The following case illustrates this.

A mother picks up her 5-month-old child at day-care at 3:30 PM. The child is fully dressed and asleep in the car seat. While on the way home 10 minutes later, the mother hears a gurgling sound and turns to see her child have a grand-mal seizure. She drives immediately to the emergency room where the child is found to have subdural, subarachnoid, and retinal hemorrhages. The emergency room physician calls the police and social services telling them that he believes that the mother must have abused the child.

The diagnosis of abuse in this case is accurate; the assumption that the mother did it is inaccurate. Reporting the case to the designated authorities is appropriate; identifying the mother as the abuser is inappropriate. Physicians should always take a supportive, nonaccusatory approach to parents of abused children even when the parents are suspected of being the abusers. It has been said that abusive parents love their children very much, but not very well. The role of physicians is to help parents understand the need to report and leave the investigation to child protective services and law enforcement agencies.

It should also be noted that there are penalties for failure to report. In most states, failure to report is a misdemeanor criminal offense. The authors are not aware of any physicians who have been successfully prosecuted under these statutes, but are aware of successful malpractice actions brought against physicians for failing to diagnose and report abuse cases properly. The following case illustrates this situation.

A mother brought her 20-month-old baby to her physician at 5:00 PM on a Friday. She had come home from work at 4:30 and found him to have two parallel bruises on the left side of his head. The baby sitter had told her that the baby had been jumping in his crib at the end of his nap, and he must have fallen into the crib bars. The physician, who knew the mother well, knew that she could not have abused the child, and when the mother told him that the baby sitter had been with them since his birth and "loved him as if he were her own," he decided that the injury was accidental, and sent the baby home without further work-up. Five days later, the mother came home at 4:00 PM and found the police at her home investigating her son's death. It became clear that the baby sitter's boyfriend, who had a long history of assault of adults and abuse of children, had been over to the house visiting the previous Friday and that Wednesday afternoon. When the baby awoke from his nap both days, he jumped vigorously in his crib, making a lot of noise. The baby sitter had asked her boyfriend to "go up and take care of him." He did so the first day by throwing him down in the crib hitting his face against the bars. The last day, he smashed his head into the crib post, killing him.

The mother's question to us, having filed a wrongful death suit against her physician, was:

"If my pediatrician had reported this case the first night, do you think my baby would be alive today?" The answer to her question, like many such questions, was "it depends." The death may well have been prevented if there was a report and the investigator talked with the baby sitter and obtained the history that her boy friend was visiting during the time the injury occurred. A conversation with the boyfriend might have led to the truth (or at least a computer check of his criminal record). For that to happen would have required a thorough investigation, and the reality is that in many counties in the United States, cases such as this one might be triaged and never investigated. For the physician not to report because child protective services is unlikely to do anything is a self-fulfilling prophecy and should not happen.

## Record keeping

The business-like documentation of the diagnosis of the child's condition is the best possible approach to any eventual courtroom presentation of the same information [4]. The neurosurgeon may include either "nonaccidental trauma" as one of the diagnoses (along with subdural hemorrhage, cerebral contusion, and so forth), or rule out nonaccidental trauma. Records of the initial contact with the child, with particular attention to the history offered by the individual caring for the child, the physical findings, and operative findings are most important. The more detailed, clear, and legible one's notes are in the medical record, the easier it is to testify from them in later months (or years). In a typical civil or criminal child abuse or neglect case, there is at least one supportive attorney in the courtroom that needs your testimony to help a judge or jury understand why a particular legal outcome is appropriate. Law enforcement or child protective services may request copies of the records soon after the initial contact.

## Role of the county attorney or district attorney

In many states, there are separate attorneys' offices for the civil and criminal systems. County attorneys generally represent departments of social services in the civil (juvenile or family) court. In some jurisdictions, the district or state's attorneys' office is responsible for both civil and criminal actions. It is the civil court that determines whether a child has more likely than not been abused and is in need of protection. As noted previously, the standard of proof for these actions is "probable" or, at most, "clear and convincing evidence." Physicians may be asked to give opinions as to whether abuse occurred "to a reasonable degree of medical probability." The civil court may order that the child be placed in protective custody and may also order that the caretakers undergo mental health and social service evaluations to assess their present competency to care for the child. A treatment plan may be ordered, and if complied with, the child is likely to be returned home. Failure to complete the treatment plan or a court assessment that the caretakers are untreatable may result in the termination of the parent-child relationship and the freeing of the child for adoption, generally not a frequent occurrence.

District attorneys are responsible for filing criminal child abuse proceedings. In these cases, an individual is accused and charged with a crime and an effort is made to convict that person. The standard of proof in this court is "beyond a reasonable doubt" or, in the case of physician testimony, "to a reasonable degree of medical certainty."

## Being an effective witness

A physician may have two roles in court in child abuse cases: factual witness or expert witness [4]. In the former situation, the physician is asked to testify only to what he or she observed and did in the case. When called as an expert, there may be an extensive voir dire process by which the credentials of the physician are presented to the court for the court's determination as to whether the physician can include opinions for the court's consideration, which are based on the facts of the case at hand, or can help the court reach the appropriate decision. In either case, the attorney who has issued the subpoena has the physician recite his or her credentials in medicine and neurosurgery, the number of cases like the one at hand that have been seen, the number of times the physician has testified in court, and whether the individual has been certified as an expert in that or another court. In the factual witness situation, the physician is asked to testify about the specifics of the interaction he or she had with the child, the parents, and those investigating the case. The details of the child's presentation, condition, statements made by the caretakers, whether other professionals were consulted, and whether a report was made to child protective services may all be asked.

The opposing attorney may provide either a brief or extensive cross-examination. Physicians who testify have the obligation to be factual and truthful and, should they be qualified as an expert, to give opinions that are within the scope of their expertise. Physicians who testify, whether as experts or not, have certain rights they should expect to be provided to them when they testify [5]. Some of these are discussed next.

*The right not to know*

It is possible that a question will be asked to which one does not know the answer. It is perfectly acceptable to say, "I do not know," rather than to speculate or reach for an answer.

*The right to understand the question*

Effective cross-examination can make witnesses feel guilty or that they should understand something they do not. The witness can say, "I do not know what you mean," and ask for the question to be restated or clarified.

*The right to ask for a question to be repeated*

This technique should be used when one is not clear as to what is being asked, or it can be used effectively to slow down questions that may be coming too quickly.

*The right not to be confused*

If questions are worded in ways that are confusing (either deliberately or because some attorneys articulate poorly), the witness can ask for clarification (if the opposing attorney has not already objected to the question).

*The right to refresh one's memory*

If questions are asking for specifics of which one is not sure, it is permissible to refresh your memory by asking to refer to your records (eg, was the hematocrit of the cerebrospinal fluid 13%?).

*The right to ask if a factual statement or an opinion is being requested*

One of the more effective ways to cross-examine a witness is to ask a mixed fact-opinion question. "Are you saying that there is no other possible explanation for the child's condition?" Physicians will rarely say that something is or is not impossible. The witness can ask the attorney asking this question whether he or she is looking for a factual answer or an opinion. Whichever response one gets can provide a clearer path toward the answer.

In addition, those who testify often have developed experience in being able to deflect the occasional pejorative question with more appropriate answers. "How much are you being paid for your testimony here today, Doctor?" is a common question. "I (or my practice) am being reimbursed for the time I have spent on this case" is a reasonable answer.

## Summary

Neurosurgeons that see children and care for those with traumatic injury are highly likely to see cases of child abuse and neglect. That fact makes it inevitable that they will encounter the legal system. It is hoped that this article has demystified the legal process and systems that one encounters in day-to-day practice. Avoiding the diagnosis of abuse because of lack of knowledge or phobia of the legal system is hazardous to the health and well-being of children.

## References

[1] Kempe CH, Silverman FN, Steele BF, Droegemueller W, Silver HK. The battered child syndrome. JAMA 1962;181:17–24.

[2] Rosenberg DA, Krugman RD. Epidemiology and outcomes of child abuse. Annu Rev Med 1991;42: 217–24.

[3] Child Abuse and Neglect State Statutes Series, vols. 1–6. Washington: National Clearinghouse on Child Abuse and Neglect Information, Administration for Children and Families, US Department of Health and Human Services. Available at http://www.calib.com/nccanch.

[4] Dubowitz H, Bross DC. The pediatrician's documentation of child maltreatment. Am J Dis Child 1992;146:596–9.

[5] Bross DC. Witness preparation for trials related to child abuse or neglect. In: King L, Ventrell MR, editors. Improving the professional response to children in the legal system. Denver: National Association of Counsel for Children; 2000. p. 143–52.