but may have undesirable consequences. For example, more than insignificant reliance on physicians to prevent parents' use of alternative therapies would drive a wedge between the parents and the conventional provider. The parents will either discontinue conventional care altogether else refuse to disclose what CAM treatments the child is receiving.

It is necessary to identify the least threatening interventions available to the state to protect children who are being exposed to significant risks from CAM. States should focus first on ensuring the safety of the CAM treatments and providers available to children. All consumers would be better served if the states prevented dangerous, contaminated, or mislabeled products from being sold. All consumers would benefit from access to more reliable information about alternative modalities. This is especially true for information on the World Wide Web.[105] Second, states should focus their efforts on preventing fraud in the practice. States, through licensing authority, could assess providers performing harmful procedures on children and review the representations made to parents regarding the nature and effect of various CAM treatments.

States should recognize that parents and physicians will continue to disagree about treatment in CAM. Thus, states should assist physicians in understanding when parents' decisions can be circumvented. It becomes necessary to balance the parent and states' notions of what is best for the child. I suggest that the proper result is to permit state intervention if using CAM either for prevention or actual treatment places children in serious risk of harm with no apparent benefit.

[105] *See* H. Juhling McClung et al., *The Internet as a Source for Current Patient Information*, 101(6) PEDIATRICS e2 (1998) (surveying sixty World Wide Web documents on how to treat children's acute diarrhea and concluding that only twenty percent of the sites conformed to current American Academy of Pediatrics guidelines for management).

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TO PROTECT CHILDREN FROM ABUSE AND NEGLECT, PROTECT PHYSICIAN REPORTERS

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COMMENTARY

In 1998, the most recent year for which national statistics are available, more than 2,800,000 cases of suspected child abuse and neglect were reported.[1] During that same year, it was estimated that slightly more than 900,000 children were actually victims of maltreatment.[2] In other words, slightly less than one-third of all reports were "indicated."[3] The numbers of reports generally and of "substantiated" cases specifically have been decreasing in recent years.[4] These statistics have engendered varying responses. For example, while emphasizing the need for further efforts to decrease child abuse and neglect, Donna Shalala, former Secretary of the Department of Health and Human Services, viewed these statistics as encouraging evidence that children actually are safer.[5] Meanwhile,

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[1] Department of Health and Human Services, Administration on Children, Youth and Families, *Child Maltreatment 1998: Reports from the States to the National Child Abuse and Neglect Data System*), *available at* http://www.acf.dhhs.gov/programs/cb/publications/cm98/cpt3.htm (last visited Mar. 20, 2001) [hereinafter *Child Maltreatment*] (explaining that maltreatment includes medical neglect, physical, sexual, and psychological abuse, abandonment, and congenital drug addiction).

[2] *Id.*

[3] *Id.*

[4] *Id.* (indicating that the rate of victimization also has allegedly declined, and that "[b]etween 1990 and 1993, the national victimization rate rose from 13.4 children per 1,000 to 15.3, declining to 12.9 children per thousand in 1998.").

[5] Department of Health and Human Services, *HHS Reports New Child Abuse and Neglect Statistics* (Apr. 10, 2001) (commenting that although the child abuse victimization rate is currently at a ten-year low, meanwhile the "numbers are still unacceptably high."), *available at* http://www.acf.dhhs.gov/news/april00.htm (last visited Mar. 20, 2001) [hereinafter *HHS Reports*].

critics focus on the fact that most reports are not ultimately "substantiated."[6] Such critics call for decreased reporting of suspected cases not only to alleviate the significant trauma that can accompany investigations by state agencies, but also to halt the diversion of resources away from protecting children in need.[7]

My purpose in this commentary is to suggest that the decreasing number of reports is not cause for unmitigated celebration; rather, the decreasing numbers warrant concern, particularly in regard to reports by health care providers. I will argue that physicians, in particular, should be granted absolute immunity from liability when making a report of child abuse or neglect, even though such report may not eventually prove "substantiated." Additionally, providers' interactions with child protection agencies, law enforcement officials, and the courts should also be shielded from liability. In making this case, I will rely on legal analysis, empirical studies, and my own experience as a physician who reports and evaluates cases of suspected abuse and neglect.

All states have a reporting statute that obligates specified individuals to report suspected cases of abuse or neglect to local child protection officials.[8] Indeed, federal funding for state child abuse programs is contingent upon the enactment of reporting requirements.[9] These reporting requirements typically are enacted for several reasons. First is the concern that people will not report these cases on their own because they are "messy" and time-consuming

[6] *See* Douglas J. Besharov, *Four Commentaries: How We Can Better Protect Children from Abuse and Neglect*, 8 THE FUTURE OF CHILDREN 120, 120-21 (1998) (arguing that generating continually increasing numbers of suspected child abuse reports is not the answer).

[7] Douglas J. Besharov & Lisa A. Laumann, *Child Abuse Reporting*, 33 SOCIETY 40 (1996) (contending that unfounded reports of child abuse breach parental and familial privacy and overwhelm the limited resources of child protective agencies), *available at* http://www.aei.org/ra/rabesharov7.htm (last visited Mar. 20, 2001).

[8] *See* Caroline Trost, *Chilling Child Abuse Reporting: Rethinking the CAFTA Amendments*, 51 VAND. L. REV. 183, 194 (1998) (discussing the uniformity in format and effect in state's reporting laws, and how such statutes usually require an indication of who must or may report under the statute, a description of how such reporting should occur, and an abrogation of certain privileged communications); National Clearinghouse on Child Abuse and Neglect Information (listing the various state statutes and other compiled data), *at* http://www.calib.com/nccanch/statutes/index/cfm.html (last visited Jun. 13, 2001).

[9] 42 U.S.C. § 5106a(b)(2)(A) (Supp. V 1999) (mandating that states certify that they have a statute in force that includes procedures for reporting child abuse, a provision providing immunity for reporters, and procedures for investigating allegations and ensuring the safety of the child).

for the reporter.[10] Second, the determination whether a child has suffered harm from abuse or neglect almost always involves a detailed assessment of the child's social setting.[11] Such a detailed observation is an impractical undertaking for third parties such as teachers, health care professionals, or neighbors and is better suited for a government investigator.[12] Third, our culture and legal system mandate that only the government can intervene to protect children.[13] Families, neighbors, churches, health care providers, and schools can support families in crisis, but only the state has the legal authority to remove children from a home.[14]

Compelling reasons exist, therefore, for requiring that suspected cases of child abuse or neglect be reported. However, a case is "indicated" or "substantiated" only after the state child protection agencies conduct an adequate investigation reveals appropriate proof, and a court finds by at least a preponderance of the evidence that the child was injured.[15] Inevitably, a gap will exist between the number of cases reported and the number of cases that meet this burden of proof.[16] For example, even after an optimal investigation, some suspicions will not materialize either because the abuse did not actually occur or because the evidence was insufficient to substantiate the claim.[17]

[10] *See* John M. Leventhal, *The Challenges of Recognizing Child Abuse: Seeing Is Believing*, 281 JAMA 657, 658 (1999) (reporting that physicians oftentimes do not wish to get involved in child abuse reporting situations, despite the fact that such actions are mandated by statute).

[11] Narendra Kini & Stephen Lazoritz, *Evaluation for Possible Physical or Sexual Abuse*, 45 PEDIATRIC CLINICS OF NORTH AMERICA 205, 207 (Feb. 1998) (detailing that the determination of child abuse must include consideration of a range of factors including family history, everyday behaviors, other sources of possible dysfunction, parental attitudes, discipline, child-rearing, nudity, and sexual norms).

[12] *Id.* at 205-06 (stating that there is no universal agreement on a definition for physical abuse, and due to the growing extent and complexity of child abuse situations, even health care professionals must constantly update their approaches for abuse determinations).

[13] *See* Scott A. Davidson, *When is Parental Discipline Child Abuse? The Vagueness of Child Abuse Laws*, 34 LOUISVILLE J. FAM. L. 403, 405-06 (1995-96) (stating that although parents have a right to inflict some degree of physical punishment on their children, "the state has considerable authority to limit that parental freedom when parents abuse their disciplinary privileges.").

[14] *Id.*

[15] The standard is even higher to obtain a criminal conviction; in that case, the specific perpetrator and his or her deeds or omissions must be proved beyond a reasonable doubt.

[16] *See Child Maltreatment*, *supra* note 1 (demonstrating a thirty percent gap in the number of reported cases and the number of cases deemed appropriate for investigation).

[17] *Id.*

Moreover, optimal investigations are rare because, as funding for child abuse programs steadily declines,[18] workers are assigned almost superhuman volumes of caseloads.[19] This increased workload contributes to extremely high turnover in these positions, and results in a constant influx of new workers who lack experience and expertise.[20] It is likely, then, that some cases of actual child abuse and neglect are reported but, for whatever reason, not proven.

It is important to recognize that different types of reporters play different roles when the state assesses reports of child abuse or neglect. While non-physician reporters, such as teachers, social workers, and neighbors, can file a report to which they testify in court, they are rarely the only people whom child protection personnel consult when assessing the case.[21] The reason these reporters are rarely the sole non-state "actor" is that the evaluation of suspected child abuse or neglect almost always requires a medical evaluation.[22] For example, practitioners might be asked "are the bruises seen on a child those that children ordinarily acquire in their daily lives, such as bruises on the shins of a toddler,[23] or are the bruises unusual markings, such as those on soft parts of the body like the flanks."[24] Or, "does the child who is not growing appropriately have a medical problem such as malabsorption or a dwarfing condition, or is the child's problem caused by not being fed enough?" Even in

[18] *See* David Stoesz & Howard Jacob Karger, *Suffer the Children: How Government Fails its Most Vulnerable Citizens – Abused and Neglected Kids*, WASHINGTON MONTHLY, Jun. 1996, at 20 (asserting that when adjusted for inflation, federal funding for child protection has been reduced to a fraction of what it was in the 1970s).

[19] *Id.* (noting that caseworkers in many cities handle as many as seventy cases at a time, despite recommendations by the Child Welfare League of America that a case worker handle no more than fifteen cases at once).

[20] *Id.* (reporting that in the 1980s, staff turnover of case workers exceeded fifty percent, and that inexperienced student interns were often promoted into the position of senior workers).

[21] Trost, *supra* note 8, at 186-87 (stressing the importance of physician involvement, in conjunction with child care workers and neighbors, in the child abuse reporting process).

[22] *Id.* (noting the importance of the physician's opinion and the deference given by courts to physician testimony).

[23] *See* R. F. Carpenter, *The Prevalence and Distribution of Bruising in Babies*, 80 ARCHIVES OF DISEASE IN CHILDHOOD 363 (1999) (reporting that in children over age one, accidental bruises tended to be found over bony prominences), *available at* http://adc.bmjjournals.com/cgi/content.html (last visited Mar. 21, 2001).

[24] *Id.* (reporting that bruises found in "soft" sites, including the cheeks or trunk, suggest abuse); Naomi F. Sugar et al., *Bruises in Infants and Toddlers: Those Who Don't Cruise Rarely Bruise*, 153 ARCHIVES OF PEDIATRICS & ADOLESCENT MED. 399, 402 (1999) (noting the assertion of current medical literature that "in children who are nine months or less, any soft tissue injury indicates possible abuse.").

cases where the presence of abuse or neglect should be apparent to virtually everyone (the obvious hand mark on the side of a child's face or the presence of five fractures of differing ages in a baby, which the mother claims occurred when the child was held down for immunizations), medical testimony is almost always sought in the investigation.[25] Thus, teachers, social workers, law enforcement officials, and neighbors are rarely the only people called upon to testify because their observations are almost never sufficient to sustain the necessary findings.[26]

On the other hand, reporting by physicians themselves is different because they can simultaneously report and provide the medical assessment to state child protection and law enforcement officials.[27] Several factors contribute to the frequency with which physicians, particularly those who work at medical referral centers, must serve in this dual capacity. Increasingly, community physicians and providers refer patients with signs of abuse or neglect to tertiary care centers for evaluation and report because these community providers believe that it will be better for the child if they maintain their relationship with the families to help them deal with the stress that typically accompanies an investigation.[28]

Outside physicians also justify the transfer of a child to tertiary care centers by noting the expertise of the tertiary physicians in evaluating cases of suspected abuse or neglect. However, such argument overlooks the fact that the community physician's own reasonable suspicion of injury makes him or her a mandated reporter, an obligation that cannot be erased by the rationale that the report

[25] *See* Saritha R. Angilvel, *Expert Testimony in Child Sexual Abuse Cases: Avoiding the "Profile" Trap*, 39 AIR FORCE L. REV. 133, 133-34 (1996) (stating that expert testimony is "inevitably required" to assist in understanding of facts and issues in a child abuse case, and that expert testimony serves as an educational process for the trier of fact).

[26] *See* Trost, *supra* note 8, at 194.

[27] *See* Department of Justice, National Criminal Justice Reference Service, *Law Enforcement Response to Child Abuse* (May 1997) (enumerating the responsibilities of the medical profession in cases of suspected child abuse, including identifying suspicious injuries, diagnosing problems of abuse, administering treatment to the child, reporting suspected incidents of abuse to the appropriate authorities, and testifying in subsequent legal proceedings), *available at* http://www.ncjrs.org/txtfiles/162425.txt (last visited Mar. 20, 2001) [hereinafter *Law Enforcement Response*].

[28] *See, e.g.*, McLaughlin v. Clayton, No. 91C-476 (3rd Cir. Court for Davidson County, Tenn., Aug. 20, 1991) (despite that physician's excellent interpersonal skills and efforts to separate himself from the reporting and assessment process, his relationship with the parents did not survive the referral).

will be made by the receiving hospital. The receiving institution's report would, however, ensure that the child will be protected.[29]

Another factor that increases the likelihood that the reporting physician will serve in a dual capacity is that child protective agencies and third party payers rarely pay for second opinions in abuse and neglect cases, believing that the treating physician has already provided the requisite medical evaluation. This is so, even if the treating physician requests a second opinion. Thus, the treating physician (or in some cases the advanced nurse clinician) who provides a preliminary evaluation is exposed to liability unlike other reporters.

Physicians can expect that they will be required to talk with child protection and law enforcement personnel,[30] to write detailed reports of their evaluations of the children they assess,[31] and perhaps to testify in child protection proceedings or even in criminal proceedings against the perpetrator.[32] This ongoing involvement of the physician reporter with state agencies makes it difficult for families to distinguish the role of the physician from that of the state. The physician is to provide a medical evaluation while the state is responsible for making decisions regarding child protection and prosecution of the accused. From a family's perspective, the actions of the physician and the state agencies can appear inextricably intertwined.

A case in which I am currently involved, although quite straightforward, demonstrates the complexity of the physician's role. I was asked to evaluate a baby who was admitted with severe head injuries, multiple complex skull fractures on both sides of the head, blood surrounding and extending into the brain, massive retinal hemorrhages (bleeding into the eyes), developing shiners around the eyes, and a large swelling on the side of the child's head. The injuries were so severe that the child died a few hours after admission despite very aggressive medical management. The story, as is so often the case, was that while in the care of the mother's new fiancé (not the father of the baby), a controlling person who had recently been laid off from work, the baby allegedly fell off the bed

[29] The subsequent report would also break the chain of causation for liability for failure to report.

[30] Adrea D. Theodore & Desmond K. Runyan, *A Medical Research Agenda for Child Maltreatment: Negotiating the Next Steps*, 104 PEDIATRICS 168, 174 (1999).

[31] *Id.*

[32] *Law Enforcement Response*, *supra* note 27.

onto the floor. Everyone involved in the evaluation and care of this baby agreed that that these injuries were caused by severe abuse and not from a fall. Our conclusion is abundantly supported by the medical literature.[33] As the child abuse consultant on-call that day, I wrote a comprehensive report summarizing (1) the family history that I obtained primarily from the mother who had recently separated from the child's father because he often beat her; (2) the child's physical, laboratory, and X-ray findings; (3) the consultations I had reviewed; and (4) my assessment that this child died as a result of non-accidental trauma. I did not speculate about who harmed the child, but merely indicated that the history offered did not account for the injuries observed, a disjunction that is the hallmark of non-accidental trauma. The coroner confirmed my assessment after autopsy. After investigation by law enforcement officials, the fiancé was charged with murder and stands trial for the death of the baby. This case is as self-evident as they come, barring a confession by the perpetrator.

But my role did not end in the hospital. I spent numerous hours reviewing the baby's medical records, the coroner's report, and the disturbing photographs with the assistant district attorney who will prosecute the case. I will appear in a criminal court, where I will be "grilled" by the fiancé's defense attorney who will try to impugn my expertise, evaluation, and good faith, if not with facts then perhaps by trying to "twist my words" as if inside a "legal subterfuge." We will "play games" with the hearsay rule to try to get as much of my colleagues' thought processes into evidence as possible by explaining that I always rely on both my discussions with my

[33] *See generally* Robert M. Reece & Robert Sege, *Childhood Head Injuries: Accidental or Inflicted?*, 154 ARCHIVES PEDIATRICS & ADOLESCENT MED. 11, 14 (2000) (concluding that retinal hemorrhages are "nearly diagnostic" of child abuse); Carol Jenny et al., *Analysis of Missed Cases of Abusive Head Trauma*, 281 JAMA 621, 626 (1999) (noting that the majority of abusive head trauma victims experience retinal hemorrhaging); Leventhal, *supra* note 10 (suggesting that a typical injury from falling off a bed is a short linear, parietal skull fracture); Ben Lloyd, *Subdural Hemorrhages in Infants: Almost All Are Due to Abuse But Abuse is Often Not Recognized*, 317 BMJ 1538, 1539 (1998) (reporting a British study that concluded that nearly all cases of subdural hemorrhages in its study were definitely or probably due to child abuse); Ann-Christine Duhaime et al., *Nonaccidental Head Injury in Infants—The "Shaken-Baby Syndrome,"* 338 NEW ENG. J. MED. 1822, 1823-24 (1998) (arguing that the group of injuries associated with shaken-baby-syndrome—defined as infantile subdural and aubarachnoid hemorrhages, traction-type metaphysical fractures, and retinal hemorrhages—cannot be caused by commonplace accidents such as falls from a low height). *But see* John Plunkett, *Fatal Pediatric Head Injuries Caused by Short-Distance Falls*, 22 AM. J. FORENSIC MED. & PATHOLOGY 1, 8 (2001) (arguing that retinal hemorrhaging and subdural hematoma has been witnessed in children who have fallen short distances from playground equipment).

colleagues and their reports to format my own expert opinion. The coroner's photographs of the child's injuries may be excluded as "too inflammatory," even though that is their true value. There is nothing like seeing a skull that has been cracked like a hard-boiled egg or a brain literally covered with congealed blood to make clear that something really bad was done to this child. The whole process of truth-seeking in the courtroom will bear no resemblance to the methods applied in the practice of medicine, a disparity that I understand but which baffles most of my physician colleagues and troubles even me at times.

This sort of case, even when a conviction is obtained, leaves me not with a warm feeling or satisfaction for a "job well done," but only with deep sadness. The child is still dead. If the literature about victims of domestic violence and my own experience hold true, the mother will probably continue to make poor choices about her life and her partners.[34] The alleged perpetrator, if convicted, will spend the rest of his life in prison and perhaps end up on death row. Perhaps to add one final affront to the total experience, neither the extensive preparation nor testimony is compensated in a time when academic physicians are constantly exhorted to "write more grants, see more patients" and generate revenue for institutions. It is difficult to imagine why any physician would voluntarily become involved in these cases. I do it because I am ethically, professionally, and legally required to do so.

Given the "messiness" and the tragic nature of this process, it is hardly surprising that physicians do not want to be involved. It is difficult to find reliable data on the number of suspected child abuse and neglect cases that are not reported. Failure to comply with mandatory reporting requirements is a crime[35] and is also a potential basis of civil liability.[36] Yet recent studies reveal that physicians admit that they do not report all suspected cases of child abuse and

[34] *See* James E. Hastings & L. Kevin Hamberger, *Anger, Aggression, and Violence*, 20 PSYCHIATRIC CLINICS OF NORTH AMERICA 323 (June 1997) (surveying the bulk of first and second generation studies on demographic predictors of violence); *U.S. Preventive Service Task Force, Guidelines from Guide to Clinical Preventive Service* (2d ed. 1996), at § 1, pt. 1 (asserting that abusive mothers are often themselves the victims of physical violence by a spouse or partner).

[35] *See* Trost, *supra* note 8, at 194 (reporting that all fifty states, the District of Columbia, American Samoa, Guam, Puerto Rico, and the U.S. Virgin Islands have reporting laws).

[36] Steven J. Singley, *Failure to Report Suspected Child Abuse: Civil Liability of Mandated Reporters*, 19 J. JUV. L. 236, 237-50 (1998) (noting that reporters are given criminal immunity for reporting but are exposed to civil liability for failing to report suspected cases of child abuse or neglect where the unreported child subsequently suffers further harm).

neglect.[37] They offer several justifications for this noncompliance. The most common explanations are concerns about the way child protection agencies handle reported cases and beliefs that state involvement often does not help the child.[38] Some physicians publicly admit that they do not want to get involved with the legal system, a sentiment probably held privately by many physicians.[39]

Two recent developments have increased the burden of reporting for physicians. First, the media frequently focuses on the parents' claim that they are falsely accused of child abuse.[40] For example, national news programs in Atlanta and prominent newspapers in Nashville focused on the parents of a young child who claimed that a report of suspected abuse was inappropriately submitted.[41] The child had liver disease and was admitted to the hospital with subdural and retinal hemorrhages. The physicians who were involved in the care of the child made a report of suspected abuse. These physicians could not respond to allegations made in the press that they had made the report in error and out of racial animus because they were bound by their obligation to maintain

[37] *See* Anne P. Vulliamy & Richard Sullivan, *Reporting Child Abuse: Pediatricians' Experiences with the Child Protection System*, 24 CHILD ABUSE & NEGLECT 1461, 1462-63 (2000) (exemplifying definitional and evidentiary confusion, ethical considerations, and cost as reasons for failure to report by Canadian physicians); Emalee Gottbrath Flaherty et al., *Health Care Providers' Experience Reporting Child Abuse in the Primary Care Setting*, 154 ARCH. PEDIATR. ADOLESC. MED. 489, 489-91 (2000) (citing low rate of presentation, non-recognition, and non-reporting of recognized cases as reasons for failure to report by office-based physicians); Alison R. Van Haeringen et al., *The Child Abuse Lottery—Will the Doctor Suspect and Report? Physician Attitudes Towards and Reporting of Suspected Child Abuse and Neglect*, 22 CHILD ABUSE & NEGLECT 159, 159-60 (1998) (demonstrating that physicians' decision not to report stems from the practitioner's recognition of signs of child abuse or neglect and a lack of faith in the state system's response to reports).

[38] *See* Vulliamy, *supra* note 37, at 1462 (arguing that child protection services are "overworked and underfunded" and should only be sought when it would benefit the family and the child); Flaherty, *supra* note 37, at 492 (reporting the results of a recent survey that concluded that negative experiences with child protective services caused providers to be more hesitant to report).

[39] Flaherty, *supra* note 37, at 491 (citing a recent study that found that thirty-three percent of professionals stated that common consequence of reporting was losing patients and spending time in court or other legal proceedings).

[40] *See, e.g.*, *Huge Tot's Mom Rips State/New Mexico had Seized 3-year-old, 120-pound girl*, HOUSTON CHRONICLE, Feb. 4, 2001, at A7; *Kin Awarded $5 Million in False-Memory Case*, HOUSTON CHRONICLE, March 18, 2001, at A12.

[41] *Couple Sues Hospital that Took Son Alleging Abuse*, REUTER INFORMATION SERVICES, Feb. 12, 1996, *at* http://www.footballserver.com/newsroom/ntn/nation/021296/nation6_8629.html (last visited Mar. 28, 2001).

patient confidentiality.[42] Of the people who commonly report suspected child abuse or neglect, health care professionals have the distinct requirement to remain silent thus leaving the charges uncountered.[43] The facts of this case later became matters of public record when the parents subsequently, and unsuccessfully, sued the physicians and the hospital for making the report.[44] However, the hospital and the physicians' reputations suffered irreparable harm.

The second reason for noncompliance by physicians is the fear of being sued. Recent statistics validate physicians' concern. Of the more than 2,800,000 reports made in 1998, only slightly more than ten percent were made by health care professionals.[45] An undefined portion of this ten percent was not "substantiated" upon investigation of the suspicion. Nevertheless, physicians represent the overwhelming majority of lawsuit defendants in cases seeking damages for allegedly inappropriate reports of child abuse or neglect.[46] These

[42] Patients and their families are free to talk about whatever they want to, but they can prevent their health care providers from discussing matters that were disclosed within the clinician-patient relationship. *See generally* Singley, *supra* note 36, at 255-56 (explaining the state law privilege for communications between a patient and his doctor). The reporting requirements are limited exceptions to this general rule and do not entitle clinicians to discuss these issues with anyone other than the entities identified in the reporting statute. *Id.* (explaining that the physician-patient privilege does allow for limited exceptions, which include disclosure of information based on the Reporting Act) *See, e.g.*, TEX. OCC. CODE § 159.002 (Vernon 1999) (detailing that communications between a physician and a patient are confidential and privileged and, absent an exception, may not be disclosed).

[43] *See, e.g.*, TEX. OCC. CODE §§ 159.002-159.004 (Vernon 1999) (confirming that the privilege is held by the patient).

[44] *See* Bryant-Bruce v. Vanderbilt Univ. Inc., 974 F. Supp. 1127, 1145 (M.D. Tenn. 1997) (noting that physicians are entitled to defend themselves in lawsuits that challenge the care they delivered, and that the filing of the suit waives all entitlement to confidentiality).

[45] *See HHS Reports*, *supra* note 5 (noting that of reported cases of child abuse or neglect, seventy-five percent were made by medical professionals, with the remainder being made by mental health professionals, who typically see different types of cases).

[46] *See, e.g.*, Brown v. Pound, 585 So.2d 885 (Ala. 1991) (grandmother who brought suit against physician and medical center for report of abuse); Stecks v. Young, 45 Cal. Rptr. 2d 475 (Cal. App. 1995) (grandparents brought libel per se, slander per se, and intentional infliction of emotional distress against grown daughter's psychologist who made report to child protection services regarding grandparents' possible abuse against grandchildren); Ferraro v. Chadwick, 270 Cal. Rptr. 379 (Cal. App. 1990) (suit brought by parents and daughter after doctor and hospital alleged that parents had abused and neglected their deceased son caused child protective services to take custody of daughter); Baldwin v. Trawick, 504 S.E.2d 708 (Ga. App. 1998) (mother sued hospital after it reported to Department of Family and Children Services that her four year-old child tested positive for drugs); Michaels v. Gordon, 439 S.E.2d 722 (Ga. App. 1993) (parents brought action against psychologist regarding a report concluded possible abuse); Nosbaum v. Martini, 726 N.E.2d 84 (Ill. App. 2000) (child, her mother, and mother's husband brought malpractice and negligence action against physician, medical group, and hospital after doctor's report

cases are filed despite the fact that every state affords health care professionals threshold immunity from liability if they report in good faith.[47]

Why are physicians being sued more frequently than other reporters? Several hypotheses come to my mind. Physicians generally have "deeper pockets" than most other reporters, such as teachers, social workers, and law enforcement personnel, all of whom report more frequently than do health professionals. Further, many non-physician reporters are employees of the state. Hence, under various theories of sovereign immunity, these employees often have broader immunity from liability than do private citizens, making them less attractive targets of litigation. Finally, workers at state child protection agencies and law enforcement personnel are protected by this broad immunity, which makes it more difficult to sue them successfully, even though they are more involved in the actual intervention than the physician.[48]

The reporting process is likely to be particularly disruptive to the physician-parent-child relationship. Parents usually expect that they and their children's physicians will work together to meet the needs of their children. Indeed, physicians have this expectation as well. Reporting requirements were put into place to overcome clini-

of "abnormal medical exam" was listed in social worker's report); Evans v. Torres, 1996 WL 5319 (N.D. Ill. 1996) (parents filed suit after DCFS removed their three children from their home); Hazlett v. Evans, 943 F. Supp. 785 (E.D. Ky. 1996) (negligence action brought against physician and hospital after incorrectly finding abuse); Awkerman v. Tri-County Orthopedic Group, 373 N.W.2d 204 (Mich. App. 1985) (mother filed suit against physician after misdiagnosing child for child abuse); D.L.C. v. Walsh, 908 S.W.2d 791 (Mo. App. 1995) (father and minor daughter filed malpractice suit after physician alleged sexual abuse); Rubinstein v. Baron, 529 A.2d 1061 (N.J. Super. 1987) (defamation suit brought against physician after alleging parents abused their child); Kempster v. Child Protective Services, 130 A.D.2d 623 (N.Y. App. 1987) (suit brought for libel, slander, infliction of emotional distress and prima facie tort after hospital acted upon belief of child abuse); Jones v. Snyder, 714 A.2d 453 (Pa. Super. 1998) (parents brought defamation action after hospital filed possible abuse charges after parent removed infant from hospital); Bryant-Bruce v. Vanderbilt Univ. Inc., 974 F. Supp. 1127 (M.D. Tenn. 1997) (parents brought claims after their child was removed from their home based on possible abuse); Walker v. Pollock, 981 S.W.2d 226 (Tex. App. — Houston [1st Dist.] 1998, no pet.) (parents brought medical malpractice action after son misdiagnosed as abused); Lesley v. State, 921 P.2d 1066 (Wash. App. 1996) (parents filed malpractice claim after physician mistook birthmarks to be bruises); Elmore v. Van Horn, 844 P.2d 1078 (Wyo. 1992) (father brought suit against counselor after allegations of sexual abuse).

[47] *See* Trost, *supra* note 8, at 194.

[48] Despite the general presence of broad immunity, state child protection agencies and their employees are frequently sued, often as codefendants with the reporting physician. *See, e.g.*, Bryant-Bruce v. Vanderbilt Univ. Inc., 974 F. Supp. 1127 (M.D. Tenn. 1997); Lesley v. State, 921 P. 2d 1066 (Wash. App. 1996).

cians' natural reluctance to believe that children are being harmed by their parents, as well as clinicians' belief that they can "work these problems out with families themselves."[49] Parents also expect that physicians will maintain confidentiality.[50] Reports by physicians, even though required by law, breach these expectations of collaboration and confidentiality and make parents angry, a well-known motivation for filing lawsuits.

So why are these lawsuits against physician reporters a problem? After all, physician reporters almost always prevail.[51] The problem lies in the time, effort, and money that are often required to resolve these suits. The reported cases are typically published appellate decisions, which means that substantial effort, expense, and anguish have already been invested in conducting discovery, preparing and defending motions, or even trial itself. The published opinions, of course, represent only the tip of the iceberg as cases that are settled or resolved prior to trial are not published.

To illustrate why a prolonged process is problematic, I will discuss some of the suits brought against physicians at my institution. These experiences are by no means unique, but are representative of lawsuits being brought with increasing frequency throughout the country. Each case has taken at least two years to resolve. For example, a case in which I was a defendant required an interlocutory appeal to an intermediate court to determine if the plaintiff had the burden to prove lack of good faith. The appellate court held that in Tennessee, reporters are entitled to a presumption of good faith when reporting suspected cases of child abuse or neglect.[52] This interlocutory appeal and suit were unnecessarily burdensome, costly, and time consuming considering the plaintiff did not even allege bad faith, a statutory requirement and prerequisite to filing suit.

Some of the cases have required a level of proof that eviscerates the immunity provision. One of my colleagues was sued because he reported a suspicion of abuse after he was asked by a

[49] *See* Vulliamy, *supra* note 37, at 1462, 1466-67.

[50] *See, e.g.*, Todd Ackerman, *Medical Leaders Ask for Closure of Privacy Loophole/ State Bills Could End Exemption to Rules*, HOUSTON CHRONICLE, Jan. 22, 2001, at A1 (highlighting the problems associated with a potential exemption that could allow patients' records to be shared with advertisers).

[51] *See supra* note 46.

[52] McLaughlin v. Clayton, No. 91C-476 (3rd Cir. Court for Davidson County, Tenn., Aug. 20, 1991); TENN. CODE ANN. § 37-1-410(a) (2000) (outlining the rule that "[a] person reporting harm shall be presumed to be acting in good faith and shall thereby be immune from any liability, civil or criminal, that might otherwise be incurred or imposed for such action.").

referring physician to evaluate a child with unusual subcutaneous nodules for possible Munchausen Syndrome by proxy.[53] After examining the child, my colleague actually called the child protection officials to determine whether the statutory threshold for child abuse had been met. The officials at the agency confirmed that circumstances met the statutory requirements. The child was subsequently given a diagnosis of dermatomyositis at another institution. After substantial discovery, the trial court ruled for my colleague, noting the fact that he had consulted with three other physicians at Vanderbilt as evidence of his good faith.[54] While the correct result was reached, the court's analysis was flawed because it was the obligation of the plaintiff to prove bad faith. Further, the legislature did not intend that people report only after they have made extensive efforts to confirm their diagnosis.

In our institution, all cases of suspected abuse or neglect are reviewed concurrently or retrospectively by a child protection committee, which is attended by physicians, social workers, nursing personnel, and legal counsel. The purpose of this committee is quality assurance and, if convened contemporaneously with the report or in response to a request of the evaluating physician, to advise the physician of steps to take to rule out alternative explanations. In the last three cases that have been brought against our institution, members of the child protection committee, including myself, have had to endure lengthy depositions and even personal opinion questions irrelevant to the case. Every one involved is repeatedly scrutinized for any scintilla of personal animus toward the patient's family, completely eviscerating the presumption of good faith reporting by suspecting physicians.

There is no evidence of an epidemic of bad faith reporting by health care professionals. That is not to say that health care providers are always compassionate toward families in cases of suspected abuse or neglect, particularly if it appears that a family member actually caused the harm. In my experience, medical personnel generally strive harder to be supportive and to maintain a professional attitude than would other types of reporters. Physicians, especially pediatricians who are predisposed to advocate on behalf of children, need to define their role clearly and adhere to making medical diagnoses rather than deciding the future disposition of the child. Nonetheless, even the "crusading physician" is not acting in bad

[53] McCawley v. Hickson, No. 93C-545 slip op. at 2 (Tenn. Ct. App. May 22, 1995).

[54] *Id.*

faith when reporting cases in which he suspects child abuse or neglect.

The result of the prolonged and frustrating process of resolving lawsuits against physician reporters has been to make the process of evaluating and reporting suspected abuse or neglect more distasteful than it has to be. It is not surprising that physicians, both inside and outside the tertiary care institution, increasingly want to have nothing to do with child abuse and neglect cases. The current state of affairs strikes the wrong balance. At present, it seems more likely that physicians will not report at all than that they will report in bad faith. The scale should be tipped in favor of physician reporting, not deterring it. Even though skeptics question the etiology of childhood injuries and the efficacy of state intervention to protect victims of abuse or neglect, states must enforce the presumption of good faith and immunity afforded physician reporters. One can be sure that more children will suffer serious harm or die if cases are not reported at all.

It is far too late for those children who have died as a result of child abuse or neglect, but I have to believe that reporting, detection of child abuse and neglect, and intervention can help our living children. Relieving the fear of litigation will promote appropriate reporting. No one can keep a disgruntled parent from filing a lawsuit, but improvements can be forged to expedite resolution of these cases. The way to achieve this goal is to grant physician reporters absolute immunity for their activities in reporting suspected abuse or neglect and in working with state officials.[55]

[55] *See, e.g.*, 2001 Tenn. Pub. Acts 351 § 2 (S.B. No. 983) (amending TENN. CODE ANN. § 37-1-410(a), to read, "If a health care provider makes a report of harm, as required by the provisions of § 37-1-403; and if the report arises from an examination of the child performed by the health care provider in the course of rendering professional care or treatment of the child; then the health care provider shall be not liable in any civil or criminal action that is based solely upon (A) [t]he health care provider's decision to report what he or she believed to be harm; (B) [t]he health care provider's belief that reporting such harm was required by law; or (C) [t]he fact that a report was made.").

COMMENTS AND NOTES