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. 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.

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critics focus on the fact that most reports are not ultimately "substantiated." 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.

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. Indeed, federal funding for state child abuse programs is contingent upon the enactment of reporting requirements. 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. Bevan, Four Commentaries: How We Can Better Protect Children from Abuse and Neglect, 8 FAM.m. AND COMM. PROJ. 120, 120-21 (1998) (arguing that generating continuously increasing numbers of suspected child abuse reports is not the answer).


8 See Caroline Trust, Chilling Child Abuse Reporting: Rethinking the CAFRA Amendments, 51 Va. L. Rev. 183, 194 (1995) (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 Clarenthouse on Child Abuse and Neglect Information (listing the various state statutes and other compiled data), at http://www.calib.com/ncahrch/statutes/index/chm.html (last visited Jan. 13, 2003).

9 42 U.S.C. § 5106(a)(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).

10 See John M. Leventhal, The Challenges of Recognizing Child Abuse: Seeing Is Believing, 281 JAMA 657, 658 (1999) (reporting that physicians often times 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, 65 Pediat. 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, maturity, 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, 24 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).
Moreover, optimal investigations are rare because, as funding for child abuse programs steadily declines, workers are assigned almost superhuman volumes of caseloads. 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. 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. 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. 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, or are the bruises unusual markings, such as those on soft parts of the body like the flanks."

Or, "does the child who is not growing appropriately have a medical problem such as malabsorption or a dwarving condition, or is the child’s problem caused by not being fed enough?"

Even in 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. 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.

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. 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.

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

18 See David Stepe & Howard Jacob Kagan, Suffer the Children: How Government Fails Its Most Vulnerable Citizens – Abused and Neglected Kids, Warsaw University, June 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 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 196-97 (stressing the importance of physician involvement, in conjunction with child care workers and neighbors, in the abuse reporting process).

22 Id. (noting the importance of the physician’s opinion and the deference given to courts by physician testimony).


24 Id. (reporting that bruises found in "soft" sites, including the cheeks or trunk, suggest abuse).

25 Id. (citing major medical literature that "in children who are nine months or less, any soft tissue injury indicates possible abuse.")
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.

30 See generally Robert M. Reece & Robert Sege, Childhood Head Injuries: Accidental or Inflicted?, 154 ARCHIVES PEDIATRICS & ADOLESCENT MED. 11, 14 (2003) (concluding that retinal hemorrhages are “warily diagnostic” of child abuse); Carol Janoy et al., Analysis of Misdiagnosed 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); Anna-Christine Dahlsme et al., Neonatal Head Injury in Infants—The “Shaken-Baby Syndrome,” 338 NEV EN 8 J Med. 1822, 1823-24 (1998) (arguing that the group of injuries associated with shaken-baby syndrome—defined as inflicted subdural and subarachnoid hemorrhages, traction-type metaphyseal fractures, and retinal hemorrhages—cannot be caused by commonplace accidents such as falls from a low height). But see John Plumett, Fatal Pediatric Head Injuries Caused by Short-Distance Falls, 22 AMER. J. FORENSIC MED. & PATHOLOGY 1, 6 (2003) (arguing that retinal hemorrhaging and subdural hematomas has been witnessed in children who have fallen short distances from playground equipment).

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


31 Id.

32 Law Enforcement Response, supra note 27.
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.23 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 crime24 and is also a potential basis of civil liability.25 Yet recent studies reveal that physicians admit that they do not report all suspected cases of child abuse and neglect.26 They offer several justifications for this noncompliance. The most commons explanations are concerns about the way child protection agencies handle reported cases and beliefs that state involvement often does not help the child.28 Some physicians publicly admit that they do not want to get involved with the legal system, a sentiment probably held privately by many physicians.29

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.28 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.31 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


24 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).

25 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).


patent confidentiality. 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 unchallenged. 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. 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. 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. These cases are filed despite the fact that every state affords health care professionals threshold immunity from liability if they report in good faith.

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.

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-
icians' 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." Parents also expect that physicians will maintain confidentiality. 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. 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 the 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. 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

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41 See Vuillamy, supra note 37, at 1462, 1466-67.
42 See, e.g., Todd Ackerman, Medical Providers Ask for Closure of Privacy loophole, State Bills Could End Exemptions to Rules, HOUSTON CHRONICL, Jan. 22, 2001, at A1 (Highlighting the problems associated with a potential exemption that could allow patients' records to be shared with advertisers).
43 See supra note 46.
44 McLaughlin v. Clayton, No. 91-C-476 (Tenn. Ct. for Davidson County, Tenn., Aug. 20, 1991); T人は, Cos. A5. 827-31 (10th Cir.) (outlining the rule that "as 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.")
46 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 good 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.59

59 See, e.g., 2001 Tenn. Pub. Acts 351 § 2 (S.B. No. 983) (amending Tenn. Code Ann. § 37-1-4106), 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 not liable in any civil or criminal action that is based solely upon (A) the health care provider’s decision to report what he or she believed to be harm; (B) the health care provider’s belief that reporting such harm was required by law; or (C) the fact that a report was made.”