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The Battered Child and Other Assaults Upon the Family:
Part One†

In recent years the medical profession and social service personnel have devoted increasing effort to defining the "battered child" or "maltreatment syndrome." Along with these and other groups the legal profession, both in the courts and in the legislatures, must bear substantial responsibility for meeting and alleviating this ancient, but only recently publicized social phenomenon. This article, the first portion of a comprehensive three part study, deals with the problem of identifying and reporting the syndrome. The author analyzes the rationale and the effectiveness of the current identification device of mandatory reporting statutes. Forthcoming issues of this Review will contain articles concerning prevention and remedies in relation to the "battered child" syndrome.

Allan H. McCoid*

Although child beating and similar abuse of children are not modern innovations, the problem of child abuse has been receiving more attention during the past decade than ever before. In

†The origins of this study lie in a symposium on "The Battered Baby" presented as part of the annual meeting of the Minnesota Civil Liberties Union, in Saint Paul, Minnesota, on December 7, 1963. The author acknowledges his indebtedness to the participants in that symposium: Dr. Tague Chisholm, M.D., Clinical Associate Professor, University of Minnesota Medical School; Mr. Earl Beatt, Family & Children's Service, United Fund of Hennepin County, Inc., Minneapolis, Minnesota; Professor Maynard Pirsig, University of Minnesota Law School; and Dr. Reynold Jensen, Director, Division of Child Psychiatry, University of Minnesota Hospitals and Medical School, both for their presentation in that program and for their assistance in the course of this study. The author owes an even greater debt of gratitude to his colleague, Professor Robert J. Levy, University of Minnesota Law School, whose advice in the development of this study and whose provision of materials used have made much of the research meaningful.

This is the first of three parts of a study dealing with the Battered Child. Parts two and three will appear in forthcoming issues of this Review.

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1. See 1 Blackstone, Commentaries* 452:
The ancient Roman laws gave the father a power of life and death over his children; upon this principle, that he who gave had also the power
article after article since the mid-fifties, the medical profession has been developing a description of what is sometimes called the "battered child syndrome." During this same period there has been a considerable amount of publicity given by social and welfare publications to the problems of abused and neglected children.²

Yet, little or no comment on the problem is found in the literature of the legal profession as such.³ This is not to say that the members of the legal profession have been totally unaware of the problem or wholly inactive in its solution, for those who have been working with juvenile courts and other welfare agencies have been dealing with the problems of child abuse on a day-to-day basis and have been contributing to the development of programs designed to alleviate such abuse. Indeed, the fruit of some legal labor may be found in the laws of more than 20 states which have in a period of two or three years enacted special statutes dealing with child abuse. But this work has not been publicized to our profession as a whole, and the workers, legal and social, have been

of taking away. But the rigour of these laws was softened by subsequent constitutions; so that we find a father banished by the Emperor Hadrian for killing his son, though he had committed a very heinous crime, upon this maxim, that "patria potestas in pietate debet, non in atrocitate, consistere. . . ." [Parental authority should consist or be exercised in affection, not in atrocity.]

The power of a parent by our English laws is much more moderate; but still sufficient to keep the child in order and obedience. He may lawfully correct his child, being under age, in a reasonable manner; for this is for the benefit of his education.

For this proposition he cites 1 HAWKINS, PLEAS OF THE CROWN 130; cf. Commonwealth v. Stoddard, 91 Mass. (9 Allen) 280 (1864); Commonwealth v. Blake, 1 Brewst. 311 (Phila. Q. Sess. 1867); Johnson v. State, 21 Tenn. (2 Humph.) 283, 36 Am. Dec. 322 (1840). (These cases were prosecutions of parents for abuse of children under the criminal law.)

2. The Children's Bureau, U.S. Dept of Health, Education and Welfare, Bibliography on the Battered Child, originally published in August, 1962 and revised in July, 1963 and December, 1964, lists all articles and books dealing with the problem of the battered child, together with papers presented at various conferences and lists of research in progress.

compelled to deal with the problem without the understanding support of a large portion of the legal profession.

While the medical profession plays a major role in the identification of the battered child and will have a primary role in the alleviation of the consequences of parental abuse and the rehabilitation of the abuser, and while welfare and social workers must play major roles in the resolution of the problem, ultimately the solution must be legal, in the form of legislation and judicial decisions and the machinery of the state designed for the protection of the child. The legal apparatus must be designed and operated not only to protect the individual child but also to prevent unnecessary disruption or interference with the vital family relationship between parent and child. All this must be a matter for concern on the part of the entire legal profession.

The function of this article, and those which are to follow, is to bring to the attention of a broader range of the legal profession the problem of the battered child and the solutions which are currently available for its resolution. Though the author claims no expertise in the area of family law, and even less in the fields of medicine and social work, hopefully the discussion which follows will provide some new insights and may be part of a beginning of a broader consideration and resolution of the battered baby problem.

The study has been undertaken from three differing aspects:
(1) how to identify the battered child or the "battered child syndrome";
(2) how to prevent child battery or abuse by parents or others; and
(3) how to remedy those wrongs already done to the child.
This opening portion seeks to review the development of the medical-social concept of the "battered child syndrome" as a background for the study of the legal aspects of the problem, and then discusses the first of the three aspects: identification and reporting of battered children.

INTRODUCTION: THE MEDICAL-SOCIAL CONCEPT OF THE BATTERED CHILD SYNDROME

The concept of the "battered child syndrome," or perhaps a more descriptive title "the maltreatment syndrome," is a rela-

4. This portion of the article is derived from materials listed in the Children's Bureau, Bibliography on the Battered Child, note 2 supra, and a paper prepared by Dr. Tague Chisholm in connection with the symposium-program referred to in note 1 supra and a projected symposium that was to
tively recent phenomenon in medical literature. It has developed within the past decade through the joint efforts of doctors of medicine and social service workers connected with hospitals and other welfare agencies.

The earlier publications in the medical field concentrated primarily upon the description of the physical aspects of the child, notably the 1946 article by Dr. John Caffey, a distinguished specialist in the field of pediatric radiology.\(^7\) Caffey presented a series of cases of multiple fractures of the long bones of infants in various stages of healing, found in conjunction with subdural hematoma.\(^8\) He hypothesized a relationship between the two conditions; but, though he seems to have assumed that the conditions were traumatic in origin, he did not attempt to define the source of the trauma. Others followed the same technique of concentration upon the physical condition of the child rather than the origin of the trauma.\(^9\)

During the early part of the fifties, articles appeared which began to refer to the role of the parents. In 1951, Doctors Bar- 

meyer, Alderson and Cox, in reporting their own experience with cases of multiple injuries to the bones of small children, made reference to ordinary childhood accidents as potential sources of

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5. The term “battered child syndrome” appears to have been coined in Kempe, Silverman, Steele, Droegemueller & Silver, The Battered Child Syndrome, 181 A.M.A.J. 17 (1963).

6. The alternative term “maltreatment syndrome” was offered in Fontana, Donovan & Wong, The “Maltreatment Syndrome” in Children, 269 New England J. Medicine 1389 (1963). Though it may be more apt, since it focuses attention upon the maltreater or abuser rather than the victim, the term has not been widely adopted and therefore in this study reference is made to the more widely used “battered child syndrome.”

7. Dr. Caffey was Professor of Clinical Pediatrics at the College of Physicians and Surgeons, Columbia University, and Pediatrician at the Babies’ Hospital, New York City, during a major portion of his career. He is the author of Pediatric X-Ray Diagnosis, one of the leading treatises in the field.


such injuries. Two years later Dr. Silverman, of the Department of Pediatrics and Radiology of the University of Cincinnati College of Medicine and the Children’s Hospital in Cincinnati, discussed the use of X ray in discovery and diagnosis of “unrecognized skeletal trauma” and referred to parental carelessness as a possible cause of such injury, though without suggesting willful abuse. Dr. Harry Bakwin, writing in 1956 on the multiple skeletal injuries in small children, tended to play down the “guilt” of parents though recognizing parental conduct as a source of such injuries.

Finally, in an article published in 1955, Doctors Woolley and Evans of the Children’s Hospital and College of Medicine of Wayne University, Detroit, made reference to parental indifference, alcoholism, irresponsibility, and immaturity manifested by uncontrollable aggressions as a cause of child injury. Dr. Caffey, writing in 1957, returned to the subject of multiple injury to young children and now emphasized trauma as a cause, coupling this with the inadequate histories frequently obtained in such cases and indicating the possibility of parental misconduct as a source of injury.

In the last years of the fifties, the medical profession became much more aware of the abusive character of the injuries which they had been seeing. In quick succession and from a variety of sources the focus of attention was directed to parental abuse.

12. Bakwin, Multiple Skeletal Lesions in Young Children Due to Trauma, 49 J. PEDIATRICS 57 (1956).
15. Fisher, Skeletal Manifestations of Parent-Induced Trauma in Infants and Children, 51 So. MEDICAL J. 956 (1958) (Dr. Fisher is a radiologist at the Greenville General Hospital, Greenville, South Carolina); Kempe & Silver, The Problem of Parental Criminal Neglect and Severe Abuse of Children, 98 J. DISEASES OF CHILDREN 522 (1959) (Drs. Kempe and Silver are respectively heads of the Divisions of Pediatrics and Radiology at Children’s Hospital, Denver, and this paper was read to the American Pediatric Society at its annual meeting, May, 1959); Miller, Fractures Among Children: I. Parental Assault as Causative Agent, 48 MINN. MEDICINE 1209 (1959) (Dr. Miller is chairman of the Department of Orthopedics and Traumatology at Chicago Medical School and a member of the staff of the Cook County Hospital).
In each of these papers emphasis was placed on the importance of roentgenological examination of children suffering from multiple injuries and the importance of careful and adroit history-taking to confirm suspected parental cause. As Dr. Miller phrased this last point:

History-taking must not be routine; it must not be perfunctory; it must not be the duty of the inexperienced; it must be painstaking and probing. The child in many cases cannot speak for himself; he is either too young or too frightened to tell what really happened. The immature adult who speaks for him, no matter how evasively, cannot long elude a knowing interrogation. The examiner, however, must guard against having an accusing attitude so as not to lose control over the case before constructive measures can be accomplished, and particularly so that in the meantime the child will not become the target of vengeance.  

He went on to indicate that in Chicago at the Cook County Hospital the records of children suspected to be victims of parental assault were referred to the social service department of the hospital or to a public assistance agency; the family court was informed by phone with a detailed explanatory letter following; and the Juvenile Protective Association in most instances assumed responsibility for evaluation and disposition of the child.

In the early sixties, a series of articles was published which reported more deliberate surveys and studies of the problem. Miss Elizabeth Elmer, supervisor of the social service department of Children's Hospital in Pittsburgh, Pennsylvania, reported on six cases of injured infants brought to the hospital within one week in which there was suspicion that the injuries were due to abusive treatment. This suspicion led to a detailed study of each case by the social service department, but not all cases proved abusive in character. Miss Elmer noted that little systematic study had been devoted to abused children and their families and suggested that this lack arose from a combination of "the repugnance felt by most of our society for the entire subject of abused children" and the reluctance or resistance of physicians to accept the diagnostic impressions of radiologists. She also noted that it was difficult to deal with suspected child abusers in an objective manner and that precipitative accusation frequently heightened the parents' defensiveness and made the study more difficult. This represents one of the early contributions by social service workers, and the technique described parallels markedly the type of investigation described by Dr. Miller at the Cook County Hospital.

18. Id. p. 100.
In mid-1961, Dr. Lester Adelson, pathologist and chief deputy coroner of Cuyahoga County and Professor of Forensic Pathology at Western Reserve University School of Medicine, reported on a study of 46 child homicides in and around Cleveland, Ohio. He stated: "Frank psychosis in the assailant was the single most common factor in precipitating the fatal incident." Of the 46 cases studied, 17 of the assailants were mentally ill, four were borderline psychotic but adjudged legally sane, and nine were emotionally unbalanced individuals whose attacks were triggered by frustration and aggravation. These findings reflected some of the suggestions of earlier authors as to the emotional instability of the parents who assaulted children.

At about the same time, Doctors Gwinn, Lewin and Peterson of the Department of Radiology of the Children’s Hospital and the School of Medicine at the University of Southern California in Los Angeles, published an article in the Journal of the American Medical Association in which they laid particular emphasis upon the willful trauma which produced "unsuspected or unrecognized trauma in infancy."

They too stated that there was little appreciation of the problem because of the relative rarity of the experience of private physicians, the misleading history which was almost always given, and the "physician-shopping" which the parents engaged in to avoid detection. They described, as had others, the use of roentgenology to demonstrate multiple traumatic changes in various locations and different stages of healing, demonstrating repetitive trauma. One critical paragraph from this article is:

In dealing with the problem, it is important to be aware of the danger that exists for the child in a home situation where such trauma has occurred in the past. Repeated injuries are the rule rather than the exception. Serious injury and even death are not at all uncommon after

20. Id. at 1346.
21. See, e.g., Fisher, supra note 15, at 960: out of six cases “two of these [trauma] were in children accidently injured in stable home environments and four were in children whose parents were emotionally ill”; Woolley & Evans, supra note 18, at 542: “The general environmental factors surrounding infants who suffer osseous discontinuity range from ‘unavoidable’ episodes in stable households through what we have termed an unprotective environment, to a surprisingly large segment characterized by the presence of aggressive, immature, or emotionally ill adults”; id. at 541: “Emotional instability on the part of one or both parents was the rule rather than an isolated finding when adequate sources of information could be reached . . . .”
these infants have been returned to the home environment. In the state of California the physician is required by law to report all such cases to the appropriate law-enforcement agency. Social service agencies and juvenile authorities investigate all such situations, but the results have not always been satisfactory. Conflicting reports from different physicians as to the presence or absence of injury may be responsible for the dismissal of legal action.\textsuperscript{23}

Here, as in the Miller and Elmer articles before, the emphasis is not only upon diagnosis of the multiply injured child but upon the treatment or prophylactic procedures which may be followed to prevent further injury.

Within six months there was another report from Los Angeles, this time from Miss Helen Boardman, director of social services at the Children's Hospital in Los Angeles.\textsuperscript{24} She described a study undertaken in the hospital in 1959 beginning with review of the records of 12 suspected cases of child abuse, all involving children under 3\(\frac{1}{2}\) years and six under 12 months and all but one of which had a history of repeated injuries. The one exception had third degree burns involving the entire body, for which the mother had been charged with pouring boiling water over the child. All had been returned to parental custody after the injuries had healed sufficiently; on review it appeared that three were dead, two had died of injuries sustained after the parents were placed on probation, and only one had been removed from the parental home. The frustration of the hospital staff and the law enforcement officers at their inability to protect the child appeared to arise from a variety of factors: the inability of the child to communicate, the unwillingness of the adults to admit any abuse on their own part or on the part of others in the family, the absence of reliable witnesses, and the inability of probation officers to protect the child if returned to the custody of the parents. The study developed the following conclusions:

1. Medical evidence and doctors' opinions on the inflicted nature of the injuries must be clearly stated on behalf of the child. . . .
2. An adult who inflicts injuries is not reacting to the specific behavior of the child, but to his own feelings.
3. Experiences with the repetitive nature of injuries indicate that an adult who has once injured a child is likely to repeat. Police warnings, court action, and probationary status have not been adequate deterrents. The child must be considered to be in grave danger unless his environment can be proved to be safe. The adult, too, needs protection from the consequences of his own explosive behavior.

\textsuperscript{23} Gwinn, Lewin & Peterson, supra note 3, at 930, in 2 TORT & MEDICAL YEARBOOK at 571.
\textsuperscript{24} Boardman, A Project To Rescue Children From Inflicted Injuries, Social Work, Jan. 1962, p. 43.
4. The community needs to define more clearly the point at which the right of the infant or young child to be healthy, perhaps even to live, takes precedence over the rights of parents.\footnote{Id. pp. 48-49.}

Miss Boardman then described a conference of the hospital staff with the presiding judge of the juvenile court, the chief probation officer, the district attorney, and other law enforcement officers of Los Angeles, in which a program was developed to give greater protection to the child. This program included the development of new reporting procedures and sharing of reports on injured children by several hospitals in the community, improved supplemental histories, more comprehensive radiological examinations of suspected cases and more complete explanations of reported findings to the parents, coupled with telephone calls and follow up written reports in nonmedical terminology to the law enforcement agencies and the juvenile authorities. The effectiveness of this procedure was evidenced by the experience in 1960 when of 14 cases of suspected abuse, there were petitions to the juvenile court for action of a noncriminal nature in nine cases, and seven of these were placed in an environment offering greater safety, while two were returned to the mother on condition of termination of the relationship with men suspected of inflicting the injuries on the children and under the close supervision of the probationary authorities. The cooperation of medical, social and legal personnel appeared to be successful.

In July of 1962, Doctors Kempe, Silverman, Steele, Droegemueller, and Silver published in the \textit{Journal of the American Medical Association} their study, “The Battered Child Syndrome.”\footnote{Supra note 5; see Editorial, \textit{The Battered Baby}, 181 A.M.A.J. 42 (1962). Doctors Kempe and Silver, who had delivered the paper to the American Pediatric Society in May, 1959, are described in note 15 supra. Dr. Silverman is described in text accompanying note 11 supra. Dr. Brandt Steele was an Associate Professor of Psychiatry at the University of Colorado School of Medicine and on the staff of the Children’s Hospital there, and Dr. William Droegemueller was a resident in obstetrics and gynecology at the University of Colorado and at the Children’s Hospital in Denver.}

This represented by far the most comprehensive study up to this time, and appears to have become the landmark discussion in this area as well as giving a name to the phenomenon being described. The article was based on a nationwide study of 71 hospitals’ experience with abused children as well as reports from 77 district attorneys on charges of child abuse handled by their offices, in addition to a review of the cases reported in the literature already described.
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 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.27

The article went on to describe the incidence of the phenomenon: in a single year, 71 hospitals had reported 302 cases, including 33 deaths, and 85 cases of permanent brain injury. A third of these cases had resulted in legal action, yet the 77 district attorneys reported 447 cases of child abuse, involving 45 deaths and 29 instances of permanent brain injury, 46 percent of the total number resulting in legal action. This suggested that the hospitals were either not seeing all of the cases which occurred or were not identifying cases of child abuse which did come to them.

Although the authors found that the clinical manifestations were somewhat variable, they said,

the syndrome should be considered in any child exhibiting evidence of possible trauma or neglect (fracture of any bone, subdural hematoma, multiple soft tissue injuries, poor skin hygiene, or malnutrition) or where there is a marked discrepancy between the clinical findings and the historical data as supplied by the parents. In cases where a history of specific injury is not available, or in any child who dies suddenly, roentgenograms of the entire skeleton should be obtained in order to ascertain the presence of characteristic multiple bony lesions in various stages of healing.28

Although the information on the parents was not as complete as that obtained with regard to the injuries to the children, the authors pointed to extreme situations which were found in the study: direct murder by frankly psychotic parents on the one hand, and on the other the absence of any overt harm to the child but the presence of overly anxious parents. Between these extremes fell a broad range of cases, some involving parents of low intelligence, some psychopathic-sociopathic individuals, with instances of alcoholism, sexual promiscuity, unstable marriages, and minor criminal activity being common. The conclusions of the authors as to the characteristics of the parents were: “They are

27. 181 A.M.A.J. at 17.
28. Id. at 24. This particular statement is from the summary section, but reflects fairly accurately the section on “Clinical Manifestations.”
immature, impulsive, self-centered, hypersensitive, and quick to react with poorly controlled aggression.” And even among the non-sociopathic, middle and higher socio-economic class “from the scant data that are available, it would appear that in these cases, too, there is a defect in character structure which allows aggressive impulses to be expressed too freely.”

Psychiatric factors are probably of prime importance in the pathogenesis of the disorder, but our knowledge of these factors is limited. Parents who inflict abuse on their children do not necessarily have psychopathic or sociopathic personalities or come from borderline socioeconomic groups, although most publicised cases have been in these categories. In most cases some defect in character structure is probably present; often parents may be repeating the type of child care practiced on them in their childhood.

The authors then discussed the reluctance of physicians to believe that parents or others having custody of a child could or would have attacked the child and the reluctance of the physician to undertake the necessary interrogation or investigation, “to assume the role of policeman or district attorney and start questioning patients as if he were investigating a crime.” The use of the terminology of “policeman,” “district attorney” and “crime” on the one hand and “patients” on the other may suggest that even these investigators tended to identify with the parents. At any rate, they suggested a sympathetic attitude or approach, welcoming a full disclosure to help the child (and to atone for the past wrongs of the parent), and indicating a willingness and interest in helping the parents as well as the child. They emphasized a non-hostile interrogation with firm assurances that the diagnosis of child abuse is based on objective findings such as the roentgenograms and presence of inconsistencies between the physical findings of the physician and the recitation of history by the parents. “The principal concern of the physician should be to make the correct diagnosis so that he can institute proper therapy and make certain that a similar event will not occur again.”

Finally the authors turned to the protective activities of the physician to make certain of nonrepetition:

He [the physician] should report possible willful trauma to the police department or any special children’s protective service that operates in his community. The report that he makes should be restricted to the objective findings which can be verified and, where possible, should be

29. Id. at 18.
30. Id. at 24.
31. Id. at 19.
32. Id. at 23.
supported by photographs and roentgenograms. . . . In many states the hospital is also required to report any case of possible unexplained injury to the proper authorities.33

They referred to agencies offering "protective services" which along with the police authorities maintain a close association with the juvenile courts and might be of assistance in bringing the case of willful trauma before the court,

which alone has the legal power to sustain a dependency petition for temporary or permanent separation of the child from the parents' custody. In addition to the legal investigation, it is usually helpful to have an evaluation of the psychological and social factors in the case; this should be started while the child is still in the hospital. If necessary, a court order should be obtained so that such investigation may be performed:

In many instances the prompt return of the child to the home is contraindicated because of the threat that additional trauma offers to the child's health and life. . . . [T]he bias should be in favor of the child's safety; everything should be done to prevent repeated trauma, and the physician should not be satisfied to return the child to an environment where even a moderate risk of repetition exists.34

It is apparent from this last portion of the article that the medical profession, or at least these representatives of it, see their role as a rather far-reaching one. One might point out that (as they have indicated) it is the juvenile court which has the power and the physician's satisfaction or dissatisfaction may not be the governing criterion. However, the concern expressed here may properly motivate the physicians to identify more clearly the "battered child syndrome" and to overcome some of their reluctance expressed earlier in order to obtain the type of information and proof which will become critical in the court's ultimate decision not to return the child to the "kind mercy" of his parents.

During 1962, two major conferences on the problems of the abused child were held. The first was a meeting sponsored by the Children's Bureau of the United States Department of Health, Education and Welfare, on January 15, 1962.35 This was attended by a large number of the authorities already mentioned in this paper and by others who were concerned with the problem of protecting the infants from abuse. Out of this meeting came a substantial amount of activity. The Kempe, Silverman, Steele, Droegemueller and Silver study, which had been reported to this

33. Ibid.
34. Id. at 24.
group, was published and commented on favorably by editors of the *Journal of the American Medical Association*, who urged upon all members awareness of the problem and cooperation with the legal authorities as recommended by the authors. Another result was the publication in *Pediatrics* of a series of articles or essays which confirmed the findings of earlier writers and agreed with their conclusions as to the role of the physician in cooperation with social services and legal authorities. Another outgrowth of this meeting was the drafting by the Children's Bureau of a proposed reporting statute, which will be discussed at some length in a later section.

The second conference was jointly sponsored by the Children's Division of the American Humane Association, the American Public Welfare Association and the Child Welfare League of America, on May 31, 1962. At this conference four papers were presented which were subsequently published under the title, *Protecting the Battered Child*. Mr. Edgar J. Merrill of the Lawrence-Lowell District of the Massachusetts Society for the Prevention of Cruelty to Children, reported on a study by the Massachusetts SPCC of over 100 cases involving 200 children referred to it during 1960. Based on data from 115 families with 180 children, the study led to the following conclusions: (1) While relatives and law enforcement authorities each had made about 23–24 percent of the referrals and while physicians had seen about 30 percent of the cases involved, only 9 percent of the referrals

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37. Bain, *The Physically Abused Child*, 31 Pediatr. 895 (1963), noting the importance of reporting for purposes of determining the real incidence of the physical abuse and to set in motion some protective program to prevent further injuries (Dr. Bain was Deputy Chief of the Children's Bureau at the time); Harper, *supra* note 3, approving the requirement of physician reports and commenting on the proposed draft of legislation referred to below (the late Fowler Harper was, of course, not only a leading expert in the law of torts but in the field of family law); McHenry, Girdany & Elmer, *Unsuspected Trauma With Multiple Skeletal Injuries During Infancy and Childhood*, 31 Pediatr. 903 (1963) (Doctors McHenry and Girdany are members of the Department of Pediatrics at the University of Pittsburgh School of Medicine and on the staff of Children's Hospital in Pittsburgh; Miss Elmer was supervisor of social services at Children's Hospital).


40. *Id.* at 1.
came from the medical profession; (2) the families involved tended to be nontransient and self-supporting, but showing no great integration into the communities in which they had lived for years and relatively few group associations within the community, coupled with premarital conception in slightly less than 50 percent of the cases and other causes of marital discord prominent; (3) parents represented about 80 percent of the abusers; (4) the personality characteristics of the abusive mothers fell into three well-defined groups: (a) those manifesting hostility and aggressiveness with continual anger at something or some persons or the world in general, (b) those manifesting rigidity, compulsiveness, and lack of warmth, reasonableness, and pliability in thinking and beliefs, coupled with marked child rejection attitudes in many mothers, and (c) those showing strong feelings of passivity and dependence coupled with a general depression, with a fourth group consisting of abusive fathers who generally were either fully or partially unable to support their families; (5) the children were of all ages, though half were under seven, and were not unusual children in terms of mental deficiency, physical disability and psychosis, but without exception had seriously impaired relationships with the abusive parent, with the pattern being that one child in the family was the focus of all the abuse; (6) the use of the protective services of the society did not preserve the families in all cases but did retain intact about 66 percent of the families and provided other treatment such as placement with relatives or removal of the child by court order or the removal of a parent from the family. The implications drawn from the study were the importance of the caseworker, the need for public education, and the possible need for some clearly defined lines of responsibility and communication for the identification, referral, and protection of the abused child. The other three papers, dealing with the psychiatric, medical, and legal implications of physical abuse of children were primarily commentaries on the agency study reported by Mr. Merrill, and added little to the overall picture of the battered child syndrome as developed in the materials already cited, though some of the ideas expressed (particularly Dr. Kauf-

41. Kaufman, *Psychiatric Implications of Physical Abuse of Children*, in *Protecting the Battered Child* 17. (Dr. Irving Kaufman was director of the Center for Child and Family Study in Boston.)

42. Dodge, *Medical Implications of Physical Abuse of Children*, in *Protecting the Battered Child* 23. (Dr. Philip Dodge was Assistant Professor of Neurology at Harvard Medical School.)

43. Schoepfer, *Legal Implications in Connection With Physical Abuse of Children*, in *Protecting the Battered Child* 26. (Mr. Schoepfer was Assistant General Counsel to the Boston Legal Aid Society.)
man's discussion of the psychiatric aspects of parental abuse) bear directly on the appropriate measures to be taken in dealing with the syndrome once identified.

Approximately a year later, Vincent De Francis, Director of the Children's Division of the American Humane Association, presented to another meeting a report on a year-long study undertaken by the Humane Association. The study was based on newspaper reports of child abuse throughout the country during calendar year 1962. The incidence was 662 cases in all but two of the states, involving some 557 families. Only 10 percent of the children were over age 10 and a preponderance fell below age four. Of 178 children who died as a result of abuse, over 80 percent were under age four and 53.98 percent were under age two. The parents were shown to be responsible for about 72.5 percent of the cases and 75.85 percent of the fatalities, with fathers being responsible for more total injuries, but mothers being responsible for a higher number of the fatalities. The description of the abuse can best be presented in Mr. De Francis' own words:

**TYPES OF ABUSE**

The forms or types of abuse inflicted on these children is a negative testimony to the ingenuity and inventiveness of man. By far the greater number of injuries resulted from beatings with various kinds of implements and instruments. The hairbrush was a common implement used to beat children. However, the same purpose was accomplished with deadlier impact by the use of bare fists, straps, electric cords, T.V. aerials, ropes, rubber hose, fan belts, sticks, wooden spoons, pool cues, bottles, broom handles, baseball bats, chair legs, and, in one case, a sculling oar. Less imaginative, but equally effective, was plain kicking with street shoes or with heavy work shoes.

Children had their extremities—hands, arms and feet—burned in open flames as from gas burners or cigarette lighters. Others bore burn wounds inflicted on their bodies with lighted cigarettes, electric irons or hot pokers. Still others were scalded by hot liquids thrown over them or from being dipped into containers of hot liquids.

Some children were strangled or suffocated by pillows held over their mouths or plastic bags thrown over their heads. A number were drowned in bathtubs and one child was buried alive.

To complete the list—children were stabbed, bitten, shot, subjected to electric shock, were thrown violently to the floor or against a wall, were stamped on and one child had pepper forced down his throat.

**TYPES OF INJURIES**

What kinds of injuries were inflicted on them?

The majority had various shapes, sizes and forms of bruises and contusions. There was a collection of welts, swollen limbs, split lips, black eyes and lost teeth. One child lost an eye.

Broken bones were common. Some were simple fractures; others compound. There were many broken arms, broken legs and fractured ribs. Many children had more than one fracture. One five month old child was found to have 30 broken bones in his little body.

The grimmest recital of all is the listing of internal injuries and of head injuries. The head injuries particularly were a sizeable group. Both the internal injuries and the head injuries were responsible for a great many of the fatalities. In this group we find damage to internal organs such as ruptured livers, ruptured spleens and ruptured lungs. Injuries to the head were concussions or skull fractures, with brain hemorrhage and brain damage a frequent diagnosis.

This is indeed a grim, sad, sordid and horror-filled recital of what happens to children in communities in almost every State of the Union. It is made all the more so by the fact that this represents a compilation of specific situations—a cumulative report of the findings in 662 different cases.

De Francis went on to describe a second “in depth” examination of the family and environmental characteristics of the cases reported and of the community attitudes and approaches to the needs of the children and families. Almost a third of the families had both parents living in the home and with the addition of a stepparent the total was 80.79 percent; it appeared that the battered child was not peculiar to any single economic or social group but was found in the poorer slum areas and the “country club districts” and came from both culturally deprived families and families in higher business and professional groupings. Teenage parents were in the minority, with the average of the mothers being 26 and the average of the fathers a little over 30, and with about two-thirds of the mothers in the age bracket 20–30 and about half of the fathers in the age bracket 20–35. However the emotional maturity of the parents was “probably the greatest single cause for destructive parental behavior.” The sociological information about the families pointed to the same gamut of social problems as are found in the “inadequate family” in most communities: marital difficulty, drinking problems, some adult crime and delinquency among older siblings. There was a significant group of parents with underlying mental illness. Where the father was the abuser, the conclusion of those making the study was that the abuse arose from an immediate emotional explosion in most instances, particularly where an attempt at discipline got out of control. With the mothers their actions seemed to be more influenced by deeper psychological pressures and somewhat more disturbed, imbalanced and irrational thinking.

The conclusions tentatively reached by De Francis were a need

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45. Id. at 5–7.
for greater community concern, increased use of "protective services," and greater reliance on these welfare agencies than on law enforcement officials in dealing with the problem.

One outgrowth of both the May, 1962 conference and the year-long study was the development by the Children's Division of the American Humane Association of *Guidelines for Legislation to Protect the Battered Child* which were published in 1963.\(^{46}\)

Like the earlier mentioned proposal of the Children's Bureau, emphasis is placed on the reporting of suspected cases by physicians and hospital staff personnel. There was, however, no specific language proposed and the reports were to be made to a public or private welfare agency providing "Child Protective Service."

During the past two years there has been a continuing flow of literature on the subject of the abused child: reports on cases observed by individual doctors, comments on the suggestions made by the prior writers, and comments on the growing number of statutes patterned on the Children's Bureau proposed language or the Children's Division guidelines.\(^{47}\) In 1964, after a number of

46. [Hereinafter cited as GUIDELINES.] The precise timing of this proposal and that of the Children's Bureau is not quite clear. Both were "published" to the public in pamphlet form during 1963. The Guidelines, however, carries an internal date of October 1962, and the statement on the proposals for mandatory reporting of inflicted injuries in children was adopted by an advisory committee of the Children's Division at a meeting held on October 26, 1962. *The Abused Child* was issued by the Government Printing Office in September 1963 according to its monthly catalogue, but is referred to in the mimeographed *Bibliography on the Battered Child*, July 1963 (rev.), which in turn was issued in October 1963 and which does not refer to the Guidelines though it does refer to the earlier *Protecting the Battered Child*. One final piece of evidence is the presentation of proposed language in the June 1963 issue of *Pediatrics*, which contained the articles arising out of the January 1963 conference held by the Children's Bureau. See Bain, *supra* note 87; Harper, *supra* note 7.

states had passed such statutes, De Francis made a review of the existing legislation with comments on its deficiencies and merits from the point of view of the proponents of child protective services. 48

From this review, it appears that by early 1965, there had come a recognition of a distinctive phenomenon called "the battered child syndrome" which, though it begins with a pattern of injuries to the child, is really descriptive of a pattern of conduct on the part of the parents or others who are to guard the welfare of the child. The medical description can perhaps best be summarized as multiple injuries in various stages of healing, primarily to the long bones and soft tissues and frequently coupled with poor hygiene and malnutrition, but peculiarly identified by the marked discrepancy between the clinical or physical findings and the historical data provided by the parents. 49 Described in terms of the conduct of the parents or their characteristics, the studies seem to confirm that the abuser is likely to be an emotionally immature individual from almost any walk or stratum of society, a person who probably suffers from the pressures of marital difficulties or economic circumstances or other emotional pressures not directly related to the child himself, so that the child becomes merely a focus for gen-


The term "battered child" does not refer to a disease, is hardly a syndrome, and is at best a poorly defined entity, because that which constitutes willful, detrimental injury to a child is subject to individual interpretation. The term encompasses circumstances varying from surface scratches to murder and from welts to incineration. If the term "abused child" is used, it may also be interpreted as including such facets as suboptimal nutrition, undue emotional stress or deprivation, and many others.
eralized frustration or anger and an outlet for the poorly controlled aggressiveness of the parent.

The development of the concept of the battered child syndrome has moved from the initial identification of physical phenomenon to concern with the causative factors outside of the body of the child to a growing concern by the medical profession and by social workers with the prophylactic measures which can be taken to prevent recurrent injury to the child. The voluntary procedures adopted in such locales as Cook County, Illinois, Los Angeles or Pittsburgh have pointed the way to a more formalized legal procedure for dealing with the problem of the battered or abused child.

I. IDENTIFICATION: MANDATORY REPORTING STATUTES

A medical definition of the "battered child syndrome" involving multiple injuries manifesting repeated traumata seems now to be fairly well established. It is less clear that a large proportion of the actual cases of child abuse are in fact identified by physicians who treat them or that physicians are called upon to deal with many cases of "minor trauma." Even so, medical identification is a most likely source of information concerning repeated child abuse and the legal machinery for dealing with the problem of child battery must depend heavily upon the medical profession's cooperation in this regard.

A. THE REPORTING STATUTES

Although a number of states have had for some time statutory requirements that physicians report to police authorities cases of gunshot or knife wounds, and in some states the required re-

50. See text accompanying notes 27 & 49 supra.
51. See, e.g., Bain, supra note 37, at 896; Braun, Braun & Simonds, supra note 47, at 98; Fontana, Donovan & Wong, supra note 6, at 1392; Griffiths & Moynihan, supra note 47, at 1558; Gwinn, Lewin & Peterson, supra note 49, at 926, in 2 Tort & Medical Yearbook at 564; Kempe, Silverman, Steele, Droegemueller & Silver, supra note 5, at 19; McHenry, Girdany & Elmer, supra note 37, at 903; tenBensel & Raile, supra note 47, at 981.
porting was extended to injuries or wounds resulting from criminal conduct or to injuries inflicted by other means of violence, within the past two years there have appeared in over 30 states specific statutes which require physicians and others engaged in related healing professions and occupations to report cases of injury or abuse to children.

A substantial number of these reporting acts appear to have been motivated by the efforts of the Children's Bureau of the United States Department of Health, Education and Welfare, which has proposed a model act 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. 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 age of [the maximum age of juvenile court] 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 the Act; provided that when the attendance of a physician with respect to a 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.

55. ARIZ. REV. STAT. ANN. § 13–842.01 (Supp. 1964); CAL. PEN. CODE § 11161.5 (Supp. 1964); COLO. REV. STAT. ANN. §§ 22–13–1 to –7 (1963); FLA. STAT. § 828.041(2) (1963); IDAHO CODE ANN. § 16–1641 (Supp. 1963); ILL. ANN. STAT. ch. 23, §§ 2041 ff. (Supp. 1963); Ind. Laws 1965, ch. 268; Iowa Acts 1955, Senate File 50; KANSAS LAWS 1965, ch. 386; KY. REV. STAT. ANN. § 199.335 (Supp. 1965); LA. REV. STAT. ANN. § 14:403 (Supp. 1964); ME. REV. STAT. tit. 21, ch. 1056, added by Maine Laws 1965, ch. 65; MD. ANN. CODE art. 27, § 11A(b) (Supp. 1964); MASS. ANN. LAWS ch. 119, § 39A (1965); MICH. STAT. ANN. § 14.564(1)–(5) (Supp. 1964); MINN. STAT. ANN. § 626.554 (Supp. 1965), as added by Minn. Laws 1965, ch. 769, § 2; N.J. STAT. ANN. §§ 9:6–8.1 to
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.

However, a number of the early reporting statutes appear to have been independent ventures. The California act, passed in May, 1963, provides:

In any case, in which a minor is brought to a physician and surgeon for diagnosis or treatment, or is under his charge or care, and it appears to the physician and surgeon from observation of the minor that the minor may have been a victim of a violation of Section 273a, he shall report such fact by telephone and in writing to the head of the police department of the city or county, if the observation is made in a city or city and county, or to the sheriff, if the observation is made in unincorporated territory, or to the nearest child welfare agency offering child protective services. The report shall state, if known, the name of the minor, his whereabouts, and the character and extent of the injuries.

The physician and surgeon shall not be required to report as provided herein if in his opinion it would not be consistent with the health, care or treatment of the minor.57

The language of this enactment should be read in the light of an earlier, and more general, provision enacted in 1953 which required that any person conducting a hospital or pharmacy to which shall come or be brought, or any physician who shall have under his charge or care "... any person suffering from any wound or other injury inflicted by his own act or by the act of another by means of a knife, gun, pistol or other deadly weapon, or in cases where injuries have been inflicted upon any person in violation of any penal law of this state..." to make a report to the police authorities indicating the name of the injured person, his whereabouts, and the character and extent of his injuries.58 It was under this earlier provision that a "test case" was made by a group of physicians and hospital personnel in Los Angeles59 which suggested such mandatory disclosure on the part of all physicians of all battered child cases and which ultimately led to the more precise language of the 1963 act.

In March 1963 the Idaho legislature enacted a broad act dealing with child protective services, which contained the following provision:

Physicians and hospitals within this state shall immediately report to the department [of public assistance] all cases of physical injury to children when the injury appears to have been caused as a result of physical abuse by a parent, guardian or legal custodian of the child.

57. CAL. PEN. CODE § 11161.5. CAL. PEN. CODE § 273a provides:

(1) Any person who, under circumstances or conditions likely to produce great bodily harm or death, willfully causes or permits any child to suffer, or inflicts thereon unjustifiable physical pain or mental suffering, or having the care or custody of any child, willfully causes or permits the person or health of such child to be injured, or willfully causes or permits such child to be placed in such situation that its person or health is endangered, is punishable by imprisonment in the county jail not exceeding 1 year, or in the state prison for not less than one year nor more than 10 years.

(2) Any person who, under circumstances or conditions other than those likely to produce great bodily harm or death, willfully causes or permits any child to suffer, or inflicts thereon unjustifiable physical pain or mental suffering, or having the care or custody of any child, willfully causes or permits the person or health of such child to be injured, or willfully causes or permits such child to be placed in such situation that its person or health may be endangered, is guilty of a misdemeanor.

58. CAL. PEN. CODE §§ 11160, 11161.

59. See Boardman, supra note 24.
Complete immunity from civil liability shall be accorded physicians and hospital personnel testifying in any proceedings under this chapter. Either parent may testify for or against the other regardless of consent in cases of physical injury to the child where the injury has been caused by physical abuse by one or both of the parents.  

At the same session the Idaho legislature amended the statutes creating testimonial privileges to exempt testimony in child abuse cases from the marital privilege and the physician-patient privilege.  

At about the same time as the California legislature was acting, Minnesota amended its existing law requiring every physician, surgeon or person authorized to engage in the practice of healing, every superintendent or manager of a hospital, every nurse and every pharmacist to report gunshot or similar wounds which they were called upon to treat, by adding:  

Every person required to report such wounds shall, in the same manner as required for the reporting of gunshot or similar wounds, report injuries or evidence of injuries appearing to arise from the beating or similar maltreatment of any minor under age of 16 years, whose injuries the person is called upon to treat or bandage. No such report shall be made the subject matter or basis for any suit for slander or libel.  

Since the above was an amendment to the existing statutory provisions dealing with “Investigation, Apprehension: Bureau of Criminal Apprehension,” it must be read in conjunction with the next succeeding section of the Minnesota Statutes:  

The report required... shall be made forthwith by telephone or in person, and shall be promptly supplemented by letter, enclosed in a securely sealed, postpaid envelope, addressed to the sheriff of the county in which the wound is examined, dressed or otherwise treated; except that, if the place in which the patient is treated for such injury or his wound dressed or bandaged be in a city of the first, second or third class, such report shall be made and transmitted as herein provided to the chief of police of such city instead of the sheriff. The office of any such sheriff and of any such chief of police shall keep such report as a confidential communication and shall not disclose the name of the person making the same, and the party making the report shall not by reason thereof be subpoenaed, examined or forced to testify in court as a consequence of having made such a report.  

While this article was in progress, a revision of the Minnesota reporting statute was proposed and enacted. This revision, which appears to be modeled on the Children's Bureau act but differs from it in some ways, begins by repeal of the 1963 amendment to section 626.52 and goes on in a second section to create a new reporting statute, section 626.554:

626.554 REPORTING OF MALTREATMENT OF MINORS
Sec. 2. Subdivision 1. DECLARATION OF PURPOSE. The purpose of this section is to provide for the protection of minor children who have had physical injury inflicted upon them, by other than accidental means, where the injury appears to have been caused as a result of physical abuse or neglect.

Subd. 2. WHO MAKES REPORT AND TO WHOM MADE. Any physician, surgeon, person authorized to engage in the practice of healing, superintendent or manager of a hospital, nurse and pharmacist, whether such physicians, surgeons, persons engaged in the practice of healing, superintendent or manager of any hospital, nurse and pharmacist be licensed or not, shall immediately report all cases of physical injury to children which come to their attention where the injury appears to have been caused as a result of physical abuse or neglect. Such cases shall be reported to the appropriate police authority and the county welfare agency. The appropriate police authority, upon receiving such a report, shall immediately notify the county welfare agency.

Subd. 3. NATURE AND CONTENT OF REPORT. An oral report shall be made immediately by telephone or otherwise and followed as soon thereafter as possible by a report in writing, to the appropriate police authority and the county welfare agency. Such report 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.

Subd. 4. RESPONSIBILITY OF COUNTY WELFARE AGENCY. The county welfare agency shall investigate complaints of neglect and abuse of children and offer protective social services in an effort to protect the health and welfare of these children and to prevent further abuses.

Subd. 5. IMMUNITY FROM LIABILITY. Anyone participating in good faith in the making of a report pursuant to this section 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.

Subd. 6. 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 section.

Subd. 7. PENALTY FOR VIOLATION. Anyone knowingly and willingly violating the provisions of this section is guilty of a misdemeanor.

65. Ibid.
A comparison with the model act quoted earlier will indicate that the principal variations here occur in the definition of the reportable injury, the addition of reporting to the welfare agency, and a section referring to the obligation of that agency to make an investigation and provide services for the protection of the child, though the latter is adverted to in the purpose section of the model act.

Other variations appear in the statutes of other states. But in spite of variations in the language used to describe the manner in which the physician comes into contact with the abused child, the nature of the injuries which he discovers, or the possible source of such injuries, and variations in the mode and content of the report, the basic thrust of all these statutes is that physicians and hospitals\textsuperscript{60} are required to report cases of apparent child abuse.

\textsuperscript{60} All of the statutes would cover physicians and surgeons, though the Utah statute noted below, Utah Laws 1965, ch. 166, uses broader terms. The overwhelming number of the statutes refer also to the specific obligation of hospitals and similar institutions, the California, Maryland, Massachusetts, Texas and Wisconsin statutes being exceptional in referring only to physicians and the North Carolina and North Dakota statutes not specifying an obligation of the hospital as an institution to make a report as distinct from the obligation of its professional staff personnel.

In some states a number of individual “reporters” have been specified in addition to physicians and surgeons (usually including interns and residents in training) and hospitals: osteopathic physicians in Colorado, Florida, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, New Jersey, New York, North Carolina, North Dakota, Oklahoma, Pennsylvania, Rhode Island, Washington and Wyoming; nurses in Indiana, Iowa, Kansas, Minnesota, North Carolina, North Dakota (public health nurses), Oklahoma, Oregon, Tennessee and Wyoming; dentists in Illinois, Iowa, Kansas, New York, Oklahoma, South Dakota and Washington; chiropractors in Illinois, Indiana, Iowa, Kansas, Maine, North Dakota and Washington; pharmacists in Indiana, Minnesota, Pennsylvania, Tennessee and Wyoming; chiropodists or podiatrists in Illinois, Iowa and Washington; laboratory technicians in Indiana and Wyoming; Christian Science practitioners in Illinois; optometrists in Iowa; embalmers or undertakers in Tennessee; social or case workers in Kansas; employees of the county department of welfare in North Carolina; peace officers in Oregon and South Dakota; school teachers, principals and administrators in public schools in North Carolina. Minnesota also encompasses “all persons authorized to engage in the practice of healing,” Minn. Stat. Ann. § 626.554, subd. 2 (Supp. 1965), which may include in addition to the specified physicians, surgeons, nurses, superintendents and managers of hospitals and pharmacists, the categories of osteopathic physicians and surgeons, dentists, Christian Science practitioners, chiropractors, midwives, masseurs, optometrists, barbers and cosmeticians. Oregon’s statute is similarly broadly phrased to cover “any practitioner of any healing are licensed in this state.” Ore. Rev. Stat. § 146.720(1).

Wyoming, which appears to have actually enacted the first of the reporting statutes referring specifically to child abuse, in February, 1963, includes
coming to their attention. Throughout the remainder of this article the primary references will be to the model act proposed by the Children’s Bureau and to the Minnesota act, as set forth above, with references to other state statutes where their provisions are specifically relevant to the discussion.

B. THE RATIONALE OF THE REPORTING STATUTES

Why were such statutes deemed necessary or advisable? The answer appears to lie in (1) the belief that the physician and hospitals provided a most ready source of information leading to

“any other person having cause to believe that a child . . . brought before him or coming before him for examination, care or treatment,” Wyo. Stat. Ann. § 14-28.1 (1963). Other states have used somewhat similar broad language, “other persons furnishing medical aid and assistance,” Ind. Laws 1965, ch. 268, § 1, and “other person called upon to render aid or medical assistance to an infant,” Tenn. Code Ann. § 38-601 (1964). Kentucky refers to “other persons having reasonable cause to suspect that a child . . . brought to his attention,” Ky. Rev. Stat. § 199.35(2) (Supp. 1964). All of these suggest a class of required reporters somewhat less limited than the general population.

Iowa, however, specified that “any other person who believes a child has had physical injury inflicted upon him as a result of abuse or neglect may make a report . . .” though under no specific obligation, Iowa Legis. Serv. 1965, Senate File 50, § 3.

Utah, which has the broadest statute of all refers simply to “Any person having cause to believe that a minor has had physical injury as a result of unusual or unreasonable physical abuse or neglect, shall report or cause reports to be made in accordance with the provisions of this act.” Utah Laws 1965, ch. 166, § 2.

67. Although most of the statutory provisions speak in mandatory terms in describing the obligation of the physician and others to report cases of child abuse, only a slight majority impose specific sanctions for failure to make a report: The model act and the statutes of Florida, Kansas, Kentucky, Louisiana, Maine, Minnesota, New Jersey, South Dakota, Utah and Wyoming declare that “knowingly and willfully violating the provisions of this act” is a misdemeanor, while Oregon and Pennsylvania make wilful failure to report a misdemeanor and Arizona, California, Michigan, Ohio and Tennessee make any violation of the reporting act a misdemeanor; Oklahoma declares it “unlawful” to knowingly and wilfully fail to make the proper report. California, however, qualifies its obligation by allowing the physician to refrain from reporting if in his opinion it would not be consistent with the health, care and treatment of the minor, see note 57 supra. Those states which lack any reference to penalty or sanction, though speaking in mandatory terms are Colorado, Idaho, Illinois, Indiana, Iowa, Maryland, Massachusetts, New York, North Dakota, Rhode Island and Wisconsin. The statutes of North Carolina, Texas and Washington are phrased in terms of “may report” and impose no sanction for non-reporting, apparently leaving it to the professional discretion of the physician or other persons specified who observe the signs of abuse whether the report is to be made.
identification of abused children and (2) the apparent failure of physicians and hospitals to make disclosures of information concerning possible child abuse to the legal authorities.

1. Reporting by Physicians as a Class

There has been some question as to why physicians and surgeons as a class should be singled out as mandatory "informers."\(^{68}\) Such a question is based on two differing points of view. First, others than physicians are also in a position to learn of child abuse, including law enforcement officers, social workers, school teachers, counsellors, and lawyers engaged in dealing with family problems, yet the statutes have been directed largely at requiring reporting only by members of the medical profession or related personnel.\(^{69}\) Second, the long-established ethical principle of confidentiality may preclude the physician from making disclosures of information acquired in the course of his professional care and treatment. Without purporting to reflect the actual thinking of the various legislatures, the following may be an appropriate rationale for the "class legislation" here involved.

(a) Physicians and Hospitals as a Class Are Specially Equipped To Detect Instances of Child Abuse

As a substantial amount of the medical literature has pointed out, child abuse is likely to occur in the privacy of the home and the results of such abuse are likely to be explained away by the parents or guardians as having been caused by "accidents" of childhood. The fact of injury is more likely to be brought to the attention of the doctor than to others outside the immediate

\(^{68}\) The question is raised by an Editorial in 188 A.M.A.J. 386 (1964), prepared by the office of the general counsel in which the following statements and questions appear:

The medical profession believes something must be done to protect the children. But is compulsory reporting the answer? Is reporting by only one group the answer? Does the battered child always come to the physician's attention? Is a mandatory report on highly technical grounds effective? ... What is done when evidence accumulates at school, indicating a threat to a child's safety?

This is a social problem in which the physician plays but a part. Visiting nurses, social workers, school teachers and authorities, lawyers, marriage and guidance counselors, and others frequently learn of cases before medical care is demanded or received. To wait until the child requires medical attention is too late. To compel reporting by the physician alone may single him out unwisely. Knowing of this requirement, the parent or guardian may, for his own protection, put off seeking medical care.

\(^{69}\) See note 66 supra.
family. The physician more than any other individual is able to determine whether the child's injuries are consistent with the parent's recital of a history of nontraumatic events or of minor "accidental" injury. It is the physician who is best able to discover the evidence of multiple injuries in various stages of healing which have come to be recognized as "signs" of the battered child syndrome. Indeed, the very fact that the medical profession has seen fit to describe the problem as the battered child syndrome, or the "maltreatment syndrome," and to emphasize the role of the medical practitioner in its detection may explain why legislators have looked to the medical profession as the class most likely to make disclosures of child abuse.

Others than physicians may in fact make observations which might lead to discovery of child abuse or may become aware of child abuse in the course of professional activities or everyday contact with the child or its guardian. But the class of potential observers may be almost unlimited, including not only law enforcement officers, school personnel, and those engaged in family counselling, but also neighbors, other members of the family, or those who have merely casual contact with the child and family. It is desirable to focus the responsibility for reporting on a class of persons having special competence for observation and evaluation of child injury. Provision for mandatory reporting by this special group does not and should not preclude voluntary reporting on the part of others having information concerning potential child abuse.  

(b) Others Who May Observe Child Abuse or Learn the Fact of Abuse May Have Strong Independent Motivations for Disclosure

Law enforcement officers, school teachers and administrators, school and visiting nurses, social workers in state or local agencies

70. This point is clearly brought out in the explanation accompanying the Children's Bureau's proposal for model legislation:

Parents have the primary responsibility for meeting the needs of their children. Society has an obligation to help parents discharge this responsibility. Society must assume this responsibility when parents are unable to do so.

Children who have suffered physical abuse at the hands of parents or other persons responsible for their care and protection are most frequently brought or come to the attention of physicians, either in private practice or at hospitals, for care and treatment. Physicians, because of the nature of the injuries and the case histories of these children, are in an optimum position to form reasonable, preliminary judgments as to how the injuries occurred. Although the proposed legislation is
and similar sources of information within the governmental structure itself are already under an obligation arising from their official positions to make disclosures or to invoke the machinery of government to remedy and deal with the problem of child abuse. There may be less necessity to impose a specific obligation of disclosure upon such individuals. To the extent that social workers and others engaged in activities in nongovernmental welfare or social agencies are involved in dealing with family problems, they may be motivated by their desire to remedy the entire family problem in making disclosures or invoking governmental machinery. Moreover, such social agencies may themselves provide much of the remedial and preventative functions which the government machinery would provide if invoked. The traditions of professional confidentiality, though not absent, may be far less strong than in the medical profession. Also the psychological reluctance of doctors to acknowledge that the parents present a hazard to their children, a fact noted by many of the medical authorities, may be less likely to be present among those who are daily concerned with intra-family frictions.

(c) The Impact of “Confidentiality”

Lawyers, members of the clergy, social workers and other counsellors dealing primarily with the adult members of the family may be less inclined to volunteer information concerning child abuse. Their omission from the statutes may be explained by the fact that they are less likely than the physicians to have close contact with the child and are far less likely to become involved with or be competent to resolve questions of the nature of injuries or the source of such injuries. But, in addition, their omission from the requirement of mandatory reporting may reflect their confidential relationship to the adult members of the family.

It has long been recognized that the attorney’s fiduciary relation to his client forecloses or should foreclose disclosure of information acquired in the course of that relationship. The ethical, not intended to prevent or discharge voluntary reporting by others, because of the seriousness of the situation for children and for society, it makes reporting mandatory on physicians or institutions where physicians’ services are provided, as is the case with gunshot wounds. The Battered Child 5–6.

71. The obligation of confidentiality is reflected in the “attorney-client privilege” against testimonial disclosure, see Minn. Stat. § 595.02(2) (1961); 8 Wigmore, Evidence § 2292 (McNaughton rev. ed. 1961) [hereinafter cited as Wigmore]. This testimonial privilege is limited to communications
if not the legal, obligation of confidentiality has also been recognized on the part of members of the clergy and social workers and is urged for all counsellors by some.72

Where the lawyer or counsellor is dealing with the adult abuser and as a result of that relationship learns the fact or facts which indicate past abuse of a child, he may be prevented by his professional activity. See Hickman v. Taylor, 329 U.S. 495, 508 (1947); 8 Wigmore § 2317(2). Moreover, the communication must have been "made in confidence" and the mere relation of attorney and client does not render all forms of communication privileged unless the circumstances indicate that the communication was of a sort intended to be confidential. McCormick, Evidence § 95 (1954) [hereinafter cited as McCormick]; 8 Wigmore § 2311.

Finally, though descriptions of past criminal conduct fall squarely within the privilege, it seems well established by judicial decision, if not by statutory language, that the privilege does not cover communications in furtherance of a future intended crime or fraud. McCormick § 99; 8 Wigmore § 2298.

The scope of the ethical principle of confidentiality may be broader than the protection afforded by the testimonial privilege. As phrased by the ABA Canons of Professional Ethics, canon 6 refers to "the obligation to represent the client with undivided fidelity and not to divulge his secrets or confidences" while canon 37 states,

It is the duty of a lawyer to preserve his client's confidences. This duty outlasts the lawyer's employment, and extends as well to his employees . . . . The announced intent of a client to commit a crime is not included within the confidences which he [the lawyer] is bound to respect. He may properly make such disclosures as may be necessary to prevent the act or protect those against whom it is threatened.

In Cromwell Foundation, Opinions of the Committees on Professional Ethics of the Ass'n of the Bar of the City of N.Y. and the N.Y. County Lawyers' Ass'n, Opinion 316, it appears that the lawyer is ethically precluded from disclosing information which would not be "privileged" by law because of the presence of third parties. Fisk, Cases on Professional Responsibility 14 (1965), concludes that the ethical principle is in fact broader than the evidentiary privilege. Even though there may be no statutory or common law privilege covering information acquired from other than the client, one may question whether the attorney should make public disclosure of facts adverse to his client's interests, so long as the information was acquired in the course of his professional services for the client. If disclosure, without reservation, of all facts relevant to the client's interests is the desideratum of the attorney-client privilege and lies at the base of the ethical principles of the profession, this same concern for unreserved disclosure should be applicable to sources of information other than the client.

72. See McCormick § 8; 8 Wigmore §§ 2286, 2294-96; Louisell, The Psychologist in Today's Legal World (pt. 2), 41 Minn. L. Rev. 731 (1957); Note, Functional Overlap Between the Lawyer and Other Professionals: Its Implications for the Privileged Communications Doctrine, 71 Yale L.J. 1226 (1962).
fessional obligation from making disclosure to legal authorities adverse to the interests or desires of his client. Where the client is not the abuser but another member of the family, the immediate disadvantage to the client may be less obvious, but the professional confidence may be nonetheless significant. Where the client’s interest is advanced by disclosure and the imposition of legal authority between the abuser and the child, or the imposition of some sanctions against the abuser, the disclosure may be compelled by the professional obligation of the attorney or other counsellor to serve the client’s interests. But even here the desire or dictate of the client as to the maintenance of confidentiality may prevail.

A difficult question would arise where the information concerning past abuse led to an inference of continuing abuse and therefore the possibility of preventing further criminal conduct. An exception to the obligation of professional confidentiality has been recognized as to future criminal conduct on the basis that the attorney should not by virtue of consultation become an accessory or participant in such criminal conduct. It may be less clear that the obligation of confidentiality does not exist where the attorney or any other counsellor is not being consulted in relation to the possibility of future abuse and when he is not being asked to assist in concealment of the abuse of the child.\(^3\)

73. In ABA Comm. on Professional Ethics and Grievances, Opinions (1947), compare opinion 23 (January 24, 1930) with opinions 155–56 (May 4, 1936). In the former, a client had fled before trial and gone into hiding, his bond was forfeited and the court had issued a warrant for his arrest; the relatives requested the attorney to endeavor to locate the client and gave the attorney confidential information as to places where he might be found; and the attorney eventually located the client and advised him to return and surrender, which the client did. The committee held that there was no ethical obligation to disclose the information concerning the client’s whereabouts and that the confidence was one of those which the attorney was bound to respect, saying:

It is in the public interest that even the worst criminal should have counsel, and counsel cannot properly perform their duties without knowing the truth. To hold that an attorney should reveal confidential information which he has obtained, by virtue of his professional employment, from members of the family of a criminal, would prevent such frank disclosure as might be necessary to a proper protection of the client’s interest.

In the latter cases, the committee ruled that where a defendant in a criminal case fled the jurisdiction after indictment and later communicated with his attorney and where a convicted criminal, released on probation, violated the terms of the probation by leaving the jurisdiction and then communicated with his attorney in relation to civil matters, the communications were not privileged and it was the ethical obligation of the attorney
The physician also is bound by an ethical principle of confidentiality to refrain from disclosure of medical confidences or secrets, which has been expressed by the American Medical Association:

A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or to make disclosure of the clients' whereabouts. The committee here said:

It is the duty of an attorney to maintain the confidence and preserve inviolate the secrets of his client, and it is the general rule that when a client gives his address to his attorney while consulting him in a professional capacity on a business matter for the purpose of enabling the attorney to communicate with him in respect thereto, it is a privileged communication. However, there are some circumstances under which such a communication is not privileged for reasons founded on sound public policy. In such cases the attorney may not remain silent.

When the communication by the client to his attorney is in respect to the future commission of an unlawful act or to a continuing wrong, the communication is not privileged. One who is actually engaged in committing a wrong can have no privileged witnesses and public policy forbids that an attorney should assist the commission thereof, or permit the relation of attorney and client to conceal the wrongdoing. . . . In failing to disclose his client's whereabouts as a fugitive under these circumstances the attorney would not only be aiding his client to escape trial on the charge for which he was indicted, but would likewise be aiding him in evading prosecution for the additional offense of escape. . . .

A similar question was considered by the committee in Opinion 23. What was said in that Opinion, as applied to the facts then before the committee, is not in conflict with the views here stated.

Opinion 155, of ABA COMM. ON PROFESSIONAL ETHICS AND GRIEVANCES, OPINIONS (1947). And see Opinion 274 (October 25, 1946) where an attorney learned from his client, a woman seeking a divorce, that her husband had in fact deserted her some six years earlier but had made false statements to the draft board that he was living with her in order to escape the draft. The committee ruled that the communication was in confidence and relevant to the matter in which the attorney was employed to represent the client:

For the attorney to divulge any of the information about her husband's conduct, communicated to the attorney by the client would be a breach of that most important duty owed by the attorney to the client, to keep inviolate the confidence of his client. Further, for a lawyer to undertake to divulge the information about her husband, given in confidence by the client, undoubtedly also would disclose that the client had been covering up her husband and thereby helping him to evade military service.

From these opinions, one may draw the conclusion that where the attorney is not being asked to affirmatively assist in the continuing criminal conduct and is not being consulted in relation to the future conduct of the miscreant, he may have a professional obligation to maintain confidences.
or unless it becomes necessary in order to protect the welfare of the individual or of the community.\textsuperscript{74}

As with the lawyer, the ethical principle is undoubtedly broader than the technical evidentiary privilege against compulsory disclosure on the witness stand, recognized by some two-thirds of the American jurisdictions.\textsuperscript{75} The rationale of both the privilege and the ethical principle is to

encourage the utmost confidence between the patient and his physician and to preserve it inviolate, so that the patient will freely and frankly reveal to his physician all of the facts, circumstances, and symptoms of his malady or injury, or lay bare his body for examination and thus enable his physician to make a correct diagnosis of his condition and treat him more safely and efficaciously.\textsuperscript{76}

\textsuperscript{74} A.M.A., PRINCIPLES OF MEDICAL ETHICS § 9 (1957); FLETCHER, MORALS AND MEDICINE 55–60 (1954); HADFIELD, LAW AND ETHICS FOR DOCTORS 55–59 (1958); MARSHALL, THE ETHICS OF MEDICAL PRACTICE 37–39 (1960); Clegg, Professional Ethics, in MEDICAL ETHICS, A GUIDE TO STUDENTS AND PRACTITIONERS 51, 43–44 (Davidson ed. 1957); Cohen, The Doctor-Patient Relationship, in MEDICAL ETHICS, A GUIDE TO STUDENTS AND PRACTITIONERS 47, 51 (Davidson ed. 1957).

\textsuperscript{75} See generally DE WITT, PRIVILEGED COMMUNICATIONS BETWEEN PHYSICIAN AND PATIENT passim (1958); McCormick §§ 101–08; 8 WIGMORE §§ 2380–91. Those states which retain the common law rule are Alabama, Connecticut, Delaware, Florida, Georgia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, Rhode Island, South Carolina, Tennessee, Texas, Vermont and West Virginia (except in justice of peace court).

Where it is accepted, the privilege precludes the physician (and in some cases nurses or other practitioners of the healing arts) from disclosing on the witness stand information obtained in attending a patient, which is necessary to enable him to act in a professional capacity. See, e.g., CAL. CIV. PROC. CODE § 1881(4); MINN. STAT. § 595.03(4) (1961); N.Y.C.P.L.R. 4504(a).

See Quarles v. Sutherland, 389 S.W.2d 249 (Tenn. 1965), in which, though the question is not directly presented, the court's opinion does recognize that the professional obligation is broader than a statutory testimonial privilege.

\textsuperscript{76} DE WITT, op. cit. supra note 75, at 27; see CAL. CIV. PROC. CODE § 1881; COLO. REV. STAT. ANN. § 154–1–7 (1963); MONT. REV. CODES ANN. § 93–701–4 (1964); ORE. REV. STAT. § 44.040 (1955); UTAH CODE ANN. § 78–24–8 (1953): “There are particular relations in which it is the policy of the law to encourage confidence and preserve it inviolate. . . .”

HADFIELD, op. cit. supra note 74, at 55–56, states as follows:

The general interest and common welfare require that the patient shall be able to rely with full confidence upon the secrecy of all communications made to a doctor. Frank speech is frequently essential to the proper practice of medicine and should be assured of a confidential reception. . . . The essence of professional secrecy is that the patient should be able to tell the practitioner everything that is necessary for his medical assessment and treatment. This means that the doctor must hear many things that otherwise would remain in the knowledge of the patient alone. The patient must be entirely confident.
Yet within the medical profession itself there appears to have been recognition of limits upon this obligation of confidentiality, where disclosure is necessary to protect others from either the hazards of disease or threats to their well-being. Similarly, the profession has acknowledged its ethical obligation to comply with mandatory reporting of disease or criminal conduct.

In contrast to those who deal primarily with the adult members of the family, the physician's confidential relationship is with the patient and the patient is the child. It is for the welfare of the abused child that the physician is obligated to use his profession that nothing he reveals will go forth. Once there is a suspicion among patients that their confidences are not safe with a doctor the relationships between them become seriously impaired and quite unsuited to the proper practice of medicine.

77. See authorities cited note 74 supra; Dawson, The Doctor as a Citizen, 2 British Medical J. 1474 (1954).

78. See A.M.A., Principles of Medical Ethics § 9 (1957). Hadfield, op. cit. supra note 74, at 59 says:

Where there is any question or suspicion of crime the tenets of professional confidence will be stretched to the utmost. In some cases they will have to be set aside. A practitioner is not bound to answer questions put to him by the police nor is he bound to pass on information of his own accord. . . . If the practitioner becomes aware that a crime is contemplated by his patient he is entitled to take what steps he can to prevent the crime, though he suggests, id. at 60, that there may be a distinction between reporting of felonies and reporting a misdemeanor. Konold, A History of American Medical Ethics 1827-1912, at 45 (1962), refers to the refusal of physicians in the District of Columbia during the nineteenth century to certify the nature of a patient’s disability for pension applications or to report birth defects, congenital or hereditary diseases, or illegitimacy on birth certifications, though subsequently the medical profession came to acknowledge the importance of reporting certain diseases and hazards to public welfare.


80. Though the question is rarely litigated, it is clearly stated in In re M—P—S—, 342 S.W.2d 277 (Mo. App. 1961), a child neglect case in which the mother charged with physical abuse of the child had sought to
sional skill, judgment, and discretion. Since the primary purpose of the reporting statutes, expressly set out in the preamble or "pur-
pose" section in Minnesota and several states and implicit in all, is the protection of the abused child, the disclosure by the physician is consistent with and in furtherance of his obligation to his patient.

The question of the propriety of requiring mandatory reporting by physicians appears, then, not so much one of the require-
prevent the physician who examined the child from testifying. The trial court sustained the objection, but the appellate court found this to be error, saying,

Dr. Thiele's patient in this case was the child, not the appellant. It is undoubtedly true that under ordinary circumstances a parent, as the natural guardian, would have the right to claim the privilege on behalf of his child when it would be to the best interests of the minor to do so. But the circumstances here were far from ordinary. The child was not a litigant, but the subject of the proceedings, the purpose of which was to protect his interests and safeguard his welfare. In one sense, appellant stood in an adversary position, and the objection was made on her behalf and in the furtherance of her interests, not that of her child. And, in view of the nature of the proceedings, it was clearly not to his best interests to have excluded the doctor's testimony.

Id. at 283. State v. Tornquist, 254 Iowa 1135, 120 N.W.2d 483 (1965), denied to defendant in a criminal prosecution for the death of the child the right to assert the privilege as to communications made by himself to the hospital personnel. Though the court in the latter case relied in part on the fact that the child was dead on arrival and therefore no physician-patient relation ever was established, and that the communication was not necessary or of use in the doctor's efforts to revive the child, it also said, quoting from an earlier case, State v. Grimmell, 116 Iowa 596, 600, 88 N.W. 342, 343 (1901),

"This, as will be observed, is a criminal case, and it surely will not do to hold that a statute intended to protect a patient should operate as a shield for one who is charged with murder. . . ."

... We agree with the holding in the Grimmell case that the statute was not intended to be used as a shield for one accused of her murder . . . we think it points to a desirable standard of application of the privilege statute. . . .

254 Iowa at 1153, 120 N.W.2d at 493-94. See also Vance v. State, 182 Miss. 840, 183 So. 280 (1938).

ments of professional ethics, as of the wisdom of requiring one group of persons to make reports of injuries while not imposing similar obligations on others. As has been noted, the physicians are by the nature of their profession more likely to be aware of the existence of child abuse. Their ethical principles would appear to require a report which would result in greater protection for the child-patient. Yet, at the same time, there may be apprehension lest the possibility of such reports may deter parents from bringing their children to medical practitioners for treatment. This is a matter for serious concern, since the welfare of the abused child may be as greatly imperiled by failure to seek adequate medical care for existing injuries as by the potentiality of future injury. California, at least, has apparently sensed this by qualifying the obligation with the proviso: “The physician and surgeon shall not be required to report as provided herein if in his opinion it would not be consistent with the health, care or treatment of the minor.”

To what extent this proviso will be invoked by physicians and to what extent the mandatory reporting elsewhere will prove a deterrent to seeking medical care probably may never be determined by any statistical studies.

2. Overcoming Factors Deterring Reporting

The mandatory reporting acts appear to be designed to overcome the disinclination of physicians and hospital personnel to make reports of cases of possible child abuse, a disinclination noted by a number of authors. Some of the failure to report undoubtedly arises from lack of recognition of child abuse by individual physicians or uncertainty as to the “diagnosis” of child abuse. Another factor frequently mentioned is the psychological barrier to admission that such abuse is done by parents or those entrusted with the care of the child. Even when the physician does recognize the possibility of parental abuse there may be reluctance to report such circumstances based on fear of

82. CAL. PEN. CODE § 11161.5.
83. See articles cited in note 51 supra.
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Civil or criminal responsibility for erroneous reports. Similarly, reluctance to report may arise from a belief that the confidential relationship between the physician and his patient requires that the physician refrain from disclosures of "privileged communication" or confidential information. Finally, there may be reluctance to become involved in the legal proceedings which would follow reports to the police or welfare authorities.

The enactment of a reporting statute does not assure that physicians will recognize cases of child abuse. However, the existence of the statute and the continuing publicity given in medical journals to the problem of child abuse may well increase the recognition by physicians and hospital personnel of the existence of child abuse generally. By pointing to the problem and imposing a duty on the physician to make reports, the statute may serve to alert the physician to signs of abuse which might otherwise be ignored or overlooked. Surely this is one of the objectives of the acts already passed. How effective they are in giving rise to recognition of otherwise undetected cases of abuse cannot be determined in so short a time, and perhaps never.

It is even less clear to what extent the statutes or the publicity given to them and the problem of child abuse will reduce the psychological barriers to individual recognition of child abuse. Certainly the creation of a formalized machinery for the identification of child abuse and the provision of legal machinery for dealing with the case of the abused child once identified may help in preparing the individual physician to acknowledge the potential existence of child abuse. It seems likely, however, that intra-professional education may be a more important factor in overcoming this barrier than statutory enactments.

Apprehensions as to potential liability, which might lead to reluctance on the part of physicians or hospitals to report cases of suspected child abuse, are probably exaggerated. Such potential liability might be in the nature of civil or criminal responsibility for defamation, civil liability for invasion of privacy by dis-

86. See Boardman, supra note 84, p. 46; Braun, Braun & Simonds, supra note 47, at 100.
87. See Bain, supra note 84, at 896; tenBensel & Raile, supra note 47, at 981.
88. See Bain, supra note 84, at 896; Boardman, supra note 84, p. 46; Braun, Braun & Simonds, supra note 47, at 100; Fontana, Donovan & Wong, supra note 85, at 1392; tenBensel & Raile, supra note 47, at 981.
89. "Defamation is ... that which tends to injure 'reputation' in the popular sense; to diminish the esteem, respect, goodwill and confidence in which the plaintiff is held, or to excite adverse, derogatory or unpleasant feelings
closing of "private facts" or by placing parents in a false light,\textsuperscript{90} or the possible civil liability for breach of confidence.\textsuperscript{91} Yet every reported American case in which a physician has made disclosures concerning patients for the protection of third parties has resulted in recognition of a privilege on the part of the physician and a denial of liability.\textsuperscript{92} There seems little doubt that where the physician or hospital makes disclosures which are beneficial to

or opinions against him." \textsc{Prosser, torts} \textsection{} 106, at 756 (3d ed. 1964). Civil defamation is generally restricted to false statements, or, to put it another way, all jurisdictions recognize that proof of truth published with good motive is an absolute defense, though criminal defamation may include truthful publications made without justification. \textsection{} 111, at 824--25.

There may be some question as to whether an oral report of facts which is likely to be reduced to writing by the legal authorities to whom reported would constitute "slander" or "libel." See Peterson v. Western Union Tel. Co., 65 Minn. 18, 67 N.W. 646 (1896), 72 Minn. 41, 74 N.W. 1062 (1898), 75 Minn. 368, 77 N.W. 988 (1899); Ostroe v. Lee, 256 N.Y. 36, 175 N.E. 505 (1931); Valentine v. Gonzales, 190 App. Div. 490, 179 N.Y.S. 711 (1920). Undoubtedly, however, a report that a parent had abused his child would fall within the category of defamation per se, actionable without proof of special damages because of imputation of a crime of moral turpitude. See \textsc{Prosser, torts} \textsection{} 107, at 773--74, 781--82 (3d ed. 1964).

\textsuperscript{90} See \textsc{id.} \textsection{} 113, at 834--39, for a description of these aspects of invasion of privacy.


\textsuperscript{92} See Simonsen v. Swenson, \textit{supra} note 91 (disclosure of patient's communicable disease to owner of hotel in which he lived); Clark v. Geraci, \textit{supra} note 91, (disclosure of alcoholism to federal employer of patient in explanation of absenteeism); Berry v. Moench, \textit{supra} note 91. In \textit{Berry} the court found no liability for disclosure of patient's physical and mental deficiencies made to family of fiance, though it said liability might be imposed for disclosure made without good faith belief or without reasonable care in determining the facts. See Note, \textit{Medical Practice and the Right to Privacy}, 43 Minn. L. Rev. 943 (1959), referring to earlier English and Scottish cases in which liability was imposed even though the doctor purported to be acting to protect the "morals" of third parties. Boyd v. Wynn, \textit{supra} note 91, and Smith v. Driscoll, \textit{supra} note 91, found no liability where the doctor made the disclosure as a witness in litigation, apparently limiting the patient's claim to assertion of a physician-patient testimonial privilege in these circumstances. \textsc{Cf.} Iverson v. Frandsen, 237 F.2d 898 (10th Cir. 1956), and Shoemaker v. Friedberg, 80 Cal. App. 2d 911, 183 P.2d 818 (Dist. Ct. App. 1947), which denied liability for dis-
the child patient or which may prevent future abuse of this child or others, the courts will recognize at least a qualified privilege which can be overcome only by a showing of malice or lack of good faith belief in the facts reported.93

Even though the ultimate success of a defense of privilege may be well assured, the existence of even a vague threat of liability may act as a deterrent to some physicians.94 A statutory rejection of liability may, therefore, be desirable, though certainly not a complete solution to the problem of physicians’ reluctance through fear of liability.95 Clearly no statute will prevent the filing of a groundless claim or avoid some form of litigation vindicating the physician.

93. There may be some question as to whether reports to public authorities concerning suspected criminal or tortious conduct is "absolutely privileged." See 1 HARPER & JAMES, TORTS § 5.22, at 424 (1959); PROSSER, TORTS § 109, at 800 (3d ed. 1964). However, there is clearly a qualified privilege for "informers." GATELY, LIBEL AND SLANDER 210–16 (5th ed. 1960); 1 HARPER & JAMES, TORTS § 5.26, at 448 (1966); PROSSER, TORTS § 110, at 811 (3d ed. 1964); RESTATEMENT, TORTS § 598 (1988).

94. For example, even though there appear to be almost no reported decisions holding a physician liable for malpractice in rendering first aid or emergency medical treatment at the scene of an accident, a survey of a representative sample of active physicians throughout the United States made by the Legal Department of the American Medical Association in 1963 disclosed that almost one-half answered yes to the question “Does fear of liability claims make you unwilling to furnish emergency medical care away from your office or hospital to strangers injured in accidents or stricken with sudden illness?” See First Results: 1963 Professional-Liability Survey, 189 A.M.A.J. 859, 864–65 (1964). Of some 14,176 physicians answering this portion of the survey, 6,611 or 46.7% answered “Yes” and 7,556 or 53.3% answered “No.” When the answers were weighted in relation to the population of physicians in active practice in the United States the ratio of “yes” to “no” answers was 50:50.

95. Within the past few years, some thirty-odd states have followed the lead of California in 1959 in enacting “good samaritan statutes” which immunize physicians from civil liability for negligence in rendering first aid of emergency medical treatment at the scene of an accident. See Note, Good Samaritans and Liability for Medical Malpractice, 64 COLUM. L. REV. 1301 (1964). Yet the survey mentioned in note 94 supra indicates that even in states which have enacted such statutes, almost the same percentage of physicians in 1963 were deterred from rendering emergency care by the apprehension of civil liability. See First Results: 1963 Professional-Liability Survey, 189 A.M.A.J. 859, 865 (1964). The breakdown of answers to the question asked, weighted in terms of the population of actively practicing physicians in the United States was as follows:
The great majority of the mandatory reporting acts do specifically negate any civil liability on the part of the physician or others participating in making the report, following the pattern set by the Children's Bureau. The exceptions are California, Oregon, Tennessee and Wisconsin. Though the Massachusetts act (like the original Minnesota statute) refers only to liability for defamation, it seems certain that the courts will interpret this as covering the related claims for "invasion of privacy" or "breach of confidence" to the extent these are recognized as independent causes of action. A somewhat slimmer majority of statutes, not including California, Idaho, Maryland, Oregon, Tennessee, Washington and Wisconsin, exempt the reporting physician or institution from criminal liability as well, though again Massachusetts refers to defamation. In view of the mandatory nature of the obligation to make the report, even in the absence of an explicit immunity granted by the statute, the courts should recognize at least a qualified privilege to make the report in good faith. Similarly, the mandatory nature of the report must be recognized as making inapplicable the statutes of some 22 states (including Minnesota) providing that betrayal of a professional secret constitutes unprofessional conduct for which the physician's license...
may be suspended or revoked.\textsuperscript{98}

Closely related to the question of liability is the issue of confidentiality. As already developed above,\textsuperscript{99} there is no substantial argument that the legal recognition of a physician-patient testimonial privilege or the professional ethics of the medical profession generally should preclude the physician from making a report to the legal authorities of suspected child abuse. Even so, some affirmative reassurance to the physician and to hospital personnel may be desirable to overcome any individual scruples concerning "informing."\textsuperscript{100} Many of the mandatory reporting acts, including Minnesota's recent revision, contain explicit negations of any physician-patient privilege. The exceptions are those states in which the privilege has never been recognized,\textsuperscript{101} and California and Oregon in which there is recognition of the privilege.

The omission of any specific language of negation of the privilege in California and Oregon may be explained in part by the fact that those states permit assertion of the privilege only in civil actions and not in criminal proceedings\textsuperscript{102} coupled with a belief that criminal prosecution was likely to be the result of the report. Moreover, in California the bringing of a civil action for damages or wrongful death constitutes a waiver of the privilege,\textsuperscript{103} and it may have been thought that any action brought primarily on behalf of the child would be treated in the same way, including juvenile court proceedings. But perhaps the best explanation for the omission in these states was the fact that even in a juvenile court proceeding involving protection of the child or termination

\textsuperscript{98} See Minn. Stat. § 147.02(4) (1961) and the entire list in Stetler & Moritz, Doctor and Patient and the Law 273, nn.4, 6 (4th ed. 1962), discussed at 269-70.

\textsuperscript{99} See notes 76, 78, 79 & 80 supra and text accompanying notes 74-81 supra.

\textsuperscript{100} See Watson, Some Psychological Aspects of Teaching Professional Responsibility, 16 J. Legal Ed. 1, 8 (1963).

\textsuperscript{101} Maine, Maryland, Massachusetts, New Jersey, Rhode Island, Tennessee and Texas. Although the New York reporting statute makes no specific reference to the privilege, the privilege statute itself, N.Y.C.P.L.R. § 4604(b), specifically excludes from the scope of the statutory privilege "information indicating that a patient who is under the age of sixteen years has been the victim of a crime."


of parental rights it appeared unlikely that the privilege could be asserted successfully by the charged parents.

Although there is some suggestion in Wigmore's treatise that a special confidential privilege may arise from disclosures made to governmental authorities, the cases in which such a privilege has been recognized must be distinguished from that of the physician reporting a wound or injury. The doctor complying with a mandatory reporting statute, or even volunteering information in those states which lack the statutes, appears readily distinguishable from the "informer" who seeks to conceal his identity and thereby protect himself from retaliation by the criminal elements on whom he has informed. Similarly, the physician making a mandatory or voluntary report is not to be equated with the citizen required to make possible adverse disclosure in his own tax returns or in an accident report. Moreover, if the physician's testimony were to be treated as privileged, a significant avenue for information necessary to resolve the battered child problem would be foreclosed. It is dubious whether a sufficiently strong public interest in maintaining the physician's anonymity or in motivating voluntary disclosures justifies recognition of a privilege asserted by the physician himself and certainly none asserted by the party against whom the information is to be used. The revision of the Minnesota statute removing any question of a privilege as to the testimony of the physician is clearly justified and desirable.

104. 8 Wigmore §§ 2374 (informer's privilege), 2377 (communications to government), 2385a (death certificates), though in the latter case Wigmore and McNaughton argue that the only justification must be the policy of a preexisting physician-patient privilege. Id. at 789-91 n.14.

105. 8 Wigmore § 2374 indicates that the privilege is limited to the identity of the informer and not to the contents of the information, since the latter "are intended to be used and published in the course of prosecution." Id. at 766. In any event the court may compel disclosure "in order to avoid the risk of false testimony [and] . . . to secure useful testimony." Id. at 768. Also the privilege would be inapplicable where the identity of the informer were in fact known. Id. at 766.

106. See the statement of Professor David Louisell in another context: "Even in jurisdictions where the [physician-patient] privilege is generally acknowledged, it gives way to various statutory exceptions. E.g., Minn. Stat. § 626.52 (1959) (obligation on physician to report bullet wounds treated by him) . . . ." Louisell, supra note 72, at 740 n.28. See People v. Lay, 254 App. Div. 372, 5 N.Y.S.2d 325 (1938), rejecting the physician-patient privilege in New York where the physician was required to make a report of a bullet wound.

107. As noted in text note 62 supra, the original Minnesota requirement of reports of child abuse was made in an amendment to the existing statute dealing with gunshot wounds, Minn. Sess. Law 1963, ch. 480, § 1 (Minn. Stat.
The mandatory character of the reporting acts may have the effect of removing some of the psychological barriers to acting as an “informer” though the difficulty of establishing failure to comply and the absence in some statutes of any penalty for non-compliance may raise questions as to how efficacious the “mandatory” feature is. The author has been led to believe that somewhat similar requirements for the reporting of venereal disease have been ignored or circumvented by a “diagnosis” of another condition. But the child abuse cases may present a distinguishable situation inasmuch as the failure to make a report and to initiate some legal machinery may permit further abuse or injury to the child. Certainly the members of the medical profession who have been most concerned with the problems of child abuse have not foreseen any substantial attempt at avoidance of mandatory reporting.

The final factor which may deter reporting, reluctance to become involved in litigation, is an understandable one. However understandable, it is not sufficient to justify nonreporting. Here the mandatory character of the acts, coupled with the express recognition that the reporting physician will be expected to become involved in litigation may serve to overcome some of the hesitancy of physicians by manifesting a community decision that involvement is necessary to help resolve the problem of the battered child.

ANN. § 626.52 (Supp. 1964)), and might therefore be read in conjunction with the following section, § 626.53, see text accompanying note 68 supra, which seemed to require that the report and reporter be kept confidential and that the reporter was protected from any required testimony. There has been no adjudication of this latter section and it may only have been intended to preserve a preexisting physician-patient privilege, which would not present any bar to testimony in the case of child abuse. However, it may also have been intended or might be interpreted as creating a specific privilege which could be asserted by the physician himself. The 1965 act which appears to sever the child abuse report from the provisions for gunshot wounds and which is explicit in referring to testimony in judicial proceedings and in negating the physician-patient privilege, avoids these difficulties.

108. See, e.g., the Colorado, Idaho, Illinois, Indiana, Iowa, Maryland, Massachusetts, New York, North Dakota, Rhode Island and Wisconsin statutes cited in notes 55 and 67 supra, which impose no sanction, and the California, North Carolina, Texas and Washington statutes cited in notes 55 and 67 supra, making the report discretionary.

109. Those statutes which specifically negate the physician-patient privilege clearly anticipate the physician’s appearance in litigation. The statutes of Minnesota and a number of other states provide immunity to anyone participating in the making of the reports or anyone participating in a judicial proceeding resulting from such reports. See Arizona, Colorado, Florida, Idaho,
C. Some Questions About the Reporting Statutes

Notwithstanding the obvious desirability of encouraging identification and reports to legal authorities of cases of child abuse, one may question the precise form of the reporting statutes as recommended by the Children’s Bureau and as enacted in a number of the states.

1. Definition of Reportable Injuries

There is no real uniformity as to the character of the injury which must be reported. The model act and twelve of the state statutes refer to injuries “inflicted upon . . . [the child] other than by accidental means,”110 while three statutes refer to injuries “not explained by the available medical history as being accidental in nature.”111 Three statutes speak of injuries intentionally caused or inflicted112 or “caused by blows, beatings, physical violence or abuse where there is some cause to believe that such physical injury was intentionally or wantonly inflicted.”113 Three other states define the reportable injuries in terms of violations of their criminal codes.114 A substantial group qualify the reportable injuries in terms of parental abuse.115 Tennessee speaks of a wound or injury which “appears to be unusual or of such nature, so as to


111. Arizona and Ohio statutes, cited in note 55 supra.


113. ORE. Rnv. STAT. § 146.710(2) (Supp. 1963).

114. California, Maryland and Pennsylvania statutes, cited in note 55 supra. Though the California penal provision begins by reference to “willfully causes or permits any child to suffer,” it also includes any person “who inflicts thereon unjustifiable physical pain or mental suffering, and [who] . . . causes or permits the life or limb of such child to be endangered.” CAL. PEN. CODE § 273a. The Maryland penal section speaks of “maliciously beats, strikes or otherwise mistreats such minor child to such degree as to require medical treatment.” MD. ANN. CODE tit. 27, § 11A (Supp. 1964). The Pennsylvania penal sections to violation of which reference is made are not specified and would apparently include “assault and battery” which requires some form of intent, PA. STAT. ANN. tit. 18, § 4708 (1963), as well as “cruelty to minors,” PA. STAT. ANN. tit. 18, § 4728 (1963), which specifically declares criminal “whoever cruelly ill-treats, abuses or inflicts unnecessarily cruel punishment upon any minor child . . . .

115. The statutes differ somewhat: Kansas, New York, North Carolina and Oklahoma refer to injuries “inflicted . . . as a result of abuse or neglect,”
indicate, or to have been caused by child brutality, child abuse, or indication or suspicion of child brutality, or child abuse .... 1116 Minnesota, though referring in its "purpose" provision to "physical injury inflicted ... by other than accidental means," requires a report of "all cases of physical injury to children ... where the injury appears to have been caused as a result of physical abuse or neglect." 1117 All of these descriptions require the physician to make some determination as to the existence of a human assailant and in some instances as to his state of mind. 1118

The model act and 12 of the state statutes further limit the scope of reportable injuries in terms of the identity of the assailant, usually the parent, guardian, or custodian of the child. 1119

Kan. Laws 1965, ch. 386, § 2; N.Y. Pen. Law § 483-d (Supp. 1964); N.C. Gen. Stat. § 14-318.2 (Supp. 1965); Okla. Stat. Ann. tit. 21, § 846 (Supp. 1965); Idaho refers to "all cases of physical injury to children where the injury appears to have been caused as a result of physical abuse," Idaho Code Ann. § 10-1041 (Supp. 1965); Iowa refers to "physical injury inflicted ... as a result of abuse or willful neglect," Iowa Leg. Serv., Senate File 50, § 3 at 210 (1965); Massachusetts refers to "serious physical injury or abuse," Mass. Gen. Laws Ann. ch. 119, § 39A (1965); Texas refers to "injury ... other than accidental and ... due to maltreatment or neglect," Tex. Rev. Civ. Stat. Ann. art. 695c-1, § 1 (Supp. 1965); Utah speaks of physical injuries "as a result of unusual or unreasonable physical abuse or neglect," Utah Laws 1965, ch. 166, § 2; Washington adds to its initial definition of the injuries in terms of other than accidental, "or who is found to be suffering from physical neglect or sexual abuse," Wash. Laws 1965, ch. 13, § 8.

Though some of these statutes do not refer specifically to the identity of the assailant in the description of the obligation of the physician or others to report, two do refer in their preambles to children "who ... may be further threatened by the conduct of those responsible for their care and protection." Kan. Laws 1965, ch. 386, § 1. See Okla. Stat. Ann. tit. 21, § 845 (Supp. 1965).

116. Tenn. Code Ann. § 38-601 (Supp. 1964). Tennessee has no definition of "child brutality" or "child abuse" and no specific statutory offense for "child beating," though assault upon one's wife is a misdemeanor, Tenn. Code Ann. § 39-602 (1955), and willful exposure of a child to inclement weather with intent to cause injury or leaving a child locked or fastened in a house or room so as to prevent his escape in the event of fire or calamity are declared to be criminal, Tenn. Code Ann. §§ 39-1001 (1955).


118. The terms "other than by accidental means" or "not explained ... as being accidental" may refer only to inadvertent or negligent conduct, but may also be interpreted as referring to consciously and deliberate acts. The references to "brutality" and "abuse" in the Tennessee statute, and to "physical abuse" in Idaho and Massachusetts, "abuse" in Iowa, and to "abuse or neglect" in Kansas, Minnesota, New York, North Carolina, Oklahoma and Washington, raise similar questions as to whether the conduct must be deliberate or merely inadvertent but unjustified.

119. Indiana, Kentucky, Louisiana, Massachusetts and South Dakota refer to parent or other person responsible for his care; Colorado, Idaho and Washington to parent, stepparent, legal guardian or any other person having custody
Though the revised Minnesota act does not specifically limit reportable injuries in this fashion, the content of the report includes the identity of the parent or other person responsible for the child's care and the references to "abuse or neglect"\textsuperscript{120} implies that only injuries at their hands are expected to be reported.

In terms of the basis for the physician-reporter's conclusions, a large number of the statutes refer to him "having reasonable cause to suspect"\textsuperscript{121} or "cause to believe"\textsuperscript{122} that the defined types of injuries have occurred. A few refer to an examination which "discloses evidence of"\textsuperscript{123} reportable injuries or that "it appears to the physician . . . from observation of the minor"\textsuperscript{124} that abuse has occurred. Other statutes, including Minnesota's, refer to injuries which "appear to have been caused" by abuse\textsuperscript{125} or to "circumstances which indicate" violation of the child abuse statutes.\textsuperscript{126} Only a relative few refer to the existence of the injuries without regard to cause to believe, reasonable cause or appearance of child abuse.\textsuperscript{127}

The physician is undoubtedly a skilled observer of physical phenomena and is well equipped to determine whether the physical manifestations which he discovers square with the medical history given by the parents or the description of the events leading up to the present condition of the child. The physician may be trained by his education or experience to achieve psychological

\begin{itemize}
\item Florida, Maine and Wyoming to "parent or caretaker";
\item Maryland to "any parent, adoptive parent or other person who has the permanent or temporary care or custody of a minor child";
\item Michigan to "any person responsible for his care";
\item New Jersey to "parent, parents, guardian or person having custody and control of the child";
\item North Carolina to persons "in loco parentis" as well as the other terms;
\item Rhode Island to "parent, stepparent, legal guardian, or other person having custody or care of such child."
\end{itemize}

\textsuperscript{120} Minn. Stat. Ann. § 626.554, subd. 2 (Supp. 1965).

\textsuperscript{121} The model act's use of "reasonable cause to suspect," is repeated in Kentucky, Louisiana, New Jersey and South Dakota; Illinois, Maine, Massachusetts and North Dakota substitute "believe" for "suspect"; Iowa, Kansas, New York and Oklahoma refer to "having reason to believe," and Wisconsin to "an examination [that] . . . creates a reasonable ground for an opinion of the physician."


\textsuperscript{123} Arizona and Ohio, cited in note 55 supra.

\textsuperscript{124} Cal. Pen. Code § 11161.5. See also Indiana's reference to "determine by diagnosis and findings," Ind. Laws 1965, ch. 268, § 2.


\textsuperscript{126} Md. Ann. Code art. 27, § 11A(b) (Supp. 1964).

\textsuperscript{127} Michigan and Pennsylvania, cited in note 55 supra.
insight into the motivations and drives of patients. But a lawyer may legitimately question whether the licensed physician is trained to differentiate between "accidental" and "intentional" or "wanton" or "criminal" injuries, or whether he is equipped by his experience to determine whether those injuries were inflicted by a parent or others responsible for the child's care rather than by some irresponsible sibling or some other third person. "Multiple lacerated wounds due to blows by a blunt instrument" seems a permissible medical opinion. "A blow wilfully or non-accidentally struck by A.B." is not, in this author's view, a permissible medical opinion.

Treatises on "forensic medicine" or "legal medicine" designed to assist the physician in augmenting his medical skills with certain forensic knowledge do not appear to give much guidance toward the latter type of conclusion. 128 Examination of medical literature generally may even suggest some question as to the iden-

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128. See, e.g., GLAISTER, MEDICAL JURISPRUDENCE AND TOXICOLOGY 218-19 (11th ed. 1962). Chapter IX, dealing with the medical-legal aspects of wounds, contains a discussion of "wounds in relation to culpability" which does not indicate that medical evidence established either the culpability of the wunder or his identity, though other materials in the same chapter suggest that medical expertise might be used to establish the physical character of the wounds and the probable nature of the instrumentality inflicting them. Also, CAMPS & PURCHASE, PRACTICAL FORENSIC MEDICINE (1957), especially the discussion of wounds at 323-68. The materials at 340-42, 343-44 and 362-67, on "homicidal, suicidal and accidental stab wounds" might lend some weight to the claim that medical expertise is useful in determining culpability, but the expertise seems to be largely in the area of defining the physical possibility and probability of self-inflicted or accidental wounding. In referring to the examination of the scene of the wounding (which all of the authors emphasize should be examined carefully for clues), the authors say: "The examination of the scene is essentially a police investigation, and the practitioner should avoid at all costs any tendency to assume such a role. His opinion should be limited to the medical aspect, and he will be well advised to be guided by the officer in charge, and especially avoid touching things." Id. at 362. GONZALES, VANCE, HELPERN & UMBERGER, LEGAL MEDICINE 188-90 (2d ed. 1954), deals primarily with the role of the medical examiner in death cases. They discuss homicidal suicidal, or accidental deaths from blunt forces, noting that it is not always possible to identify what is the cause of death. Though referring to the physician's obligation (under New York law) to report cases of suspected criminal violence, id. at 206, 307, they do not seem to give any specific criteria or assistance in determining when such a case exists, though the existence of multiple wounds may be taken as one possible "key." See id. at 358. GRADWORTH, LEGAL MEDICINE 248-47 (1954), deals with "accident, suicide or murder," including the investigation of the scene of the injury and consideration of "defense wounds" on the victim, but the discussion sheds little light on the medical expert's competence to identify the perpetrator or nonphysical aspects of the injury.
tity of the "battered-child syndrome" or "maltreatment syndrome." 129 Neither appears in the established medical dictionaries in their tables of syndromes: 130 neither is found in the Standard Nomenclature of Diseases and Operations published by the American Medical Association, 131 though these omissions may reflect only the modernity of the terms.

Of more significance is a second edition of a text on Pediatric Diagnosis published in 1962. 132 In dealing with the subject of fractures of the extremities generally, the authors say: "Caffey and others have recently properly emphasized the relatively frequent occurrence of skeletal trauma for which no history may be obtained, especially initially. Such lesions may be the result of physical abuse of the baby by a parent, baby-sitter or sibling." 133 In discussing the causes of limp, the same authors report:

Simple trauma is probably the most frequent cause of limp in young children. Caffey, Silverman and others have emphasized the bizarre roentgenographic findings which may appear after unreported trauma to the long bones in children. Often a history of trauma is elicited in these instances only by careful requestioning of the parents. 134

But such references are scarcely an affirmative recognition of a distinguishable medical phenomenon; and a later section dealing with "health supervision" and accidental injuries, as well as accident prevention, states the following:

"..."
the physician can help reduce the incidence of accidents by interpreting to the parents the hazards to which children may be exposed. . . . Parents . . . have the responsibility to provide a secure environment for the child. . . .

When accidents occur repeatedly to the same child, the physician should concern himself with the parental attitudes which permit such repetitions. . . .

In general, however, the problem is related to general unawareness of hazards. . . .

Such a statement does not suggest a complete recognition of the syndrome.

At the same time, one cannot afford to ignore the fact that medical literature has been augmented rapidly with case histories of battered children and that more and more physicians are undertaking to identify the examples of this syndrome. The pattern which emerges from these case histories is one of multiple injuries to soft tissues and skeletal structures, discrepancies between the history of the child as given to the physician and the objective findings of injury, and repeated injuries of a type not expected in a nonabused childhood. Where these elements coexist, at least a suspicion of child abuse may be justified. Certainly this may be sufficient basis on which to justify some further investigation of the family situation by welfare agencies or other agencies of the state concerned with the protection of the child.

What may be doubted is whether the foregoing provides sufficient basis for a conclusion by the physician that the child has been the subject of any intentional or wanton misconduct of parents or others, or is the victim of “physical abuse or neglect,” in the language of the Minnesota statute. The reluctance or inability of physicians to come to these conclusions may well lead to inadequate reporting, and therefore, undermine the purpose of the statutes themselves. In this regard the language of the Arizona, North Dakota and Ohio statutes which refer only to injury or physical neglect not explained by the available medical history as being accidental may be closer to the desirable criteria, though still subject to some question as to whether the doctor must make an evaluation of the character of the conduct of others.

What appears to be even more doubtful is the possibility under the statutes of two states that the physician in connection with a law enforcement agency may remove a child from the parents’ control on the basis of the belief that the child has had physical injuries inflicted upon him other than by accidental means by a parent, stepparent, legal guardian or other person.
having custody of the child, and that such removal is necessary to protect the child from continued abuse. 136 While this type of provision may be intended only to impose restraints upon the law enforcement agents by requiring the concurrence of the reporting physician, it represents, in the view of this author, a misapprehension of the expertise of the physician and a misapplication of that expertise.

A more desirable provision covering the same problem appears in the Illinois statute requiring the welfare agency to whom the report is made to provide protective services to prevent further abuse of the child and specifically providing that the welfare agency may petition the court to seek removal of the child from the custody of its parents "whenever it believes removal of the child to be necessary . . . ." 137 Similarly the Iowa statute spells out the power of the department of social welfare to report to the juvenile court and to take all lawful action necessary to protect the child. 138 The North Dakota law provides that if immediate action is necessary to protect the child, the person making the report should make it to the juvenile commissioner or the states' attorney "who shall take immediate and suitable action . . . ." 139 Each of these latter provisions envisions some formalized procedures in which the rights of parents as well as the welfare of the child may be protected.

One final point on the nature of the injury. Though no conscious differentiation may have been intended, the language of "serious physical injury," used in the model act and some of the state statutes, 140 as contrasted with "physical injury" or "wound or injury" 141 may be undesirable. The early identification of the

136. No child upon whom a report is made shall be removed from his parents, stepparents, guardian or other persons having custody by a law enforcement agency without consultation with the . . . [county department of welfare] unless, in the judgment of the reporting physician and the law enforcement agency, immediate removal is considered essential to protect the child from further injury or abuse. COL. REV. STAT. ANN. § 22-13-4(2) (1963) (Emphasis added.); see R.I. GEN. LAWS ANN. tit. 40, § 14.13.1-5(2) (Supp. 1964).

137. ILL. ANN. STAT., ch. 23, § 2047 (Supp. 1965).


139. N.D. LAWS 1965, ch. 327, § 1.

140. See Kansas, Kentucky, Louisiana, Massachusetts, New Jersey, New York, North Dakota, Oklahoma and South Dakota statutes cited in note 55 supra.

141. See Colorado, Florida, Idaho, Illinois, Indiana, Iowa, Maine, Michigan, Minnesota, North Carolina, Oregon, Rhode Island, Texas, Utah and Wyoming refer to "physical injury"; Pennsylvania and Tennessee to "wound
pattern of abuse may mean an early and effective breaking of that pattern forever. The Children's Bureau may have had in mind avoiding the invocation of a cumbersome machinery of reports and investigation in the absence of substantial showing of abuse. It may also have felt that superficial injuries were unlikely to be brought to the attention of a physician or hospital. While it may be true that no criminal charges, or perhaps no case in juvenile court, could be based on minor injuries, if the physician is alerted by early signs of repeated trauma to the child's body which are inconsistent with the medical history, the case may be identified as one of potential "battered child syndrome" and some prophylactic measures may be taken before serious injury occurs.

2. To Whom Reports Are Made

There are suggestions that physicians are more reluctant to make reports to the police or law enforcement officers than they would be to report suspected cases of child abuse to welfare agencies or child-protective societies. The full extent of this reluctance is not clear. Considering the scepticism with which many physicians seem to view "the law" and the increasing emphasis upon prevention and rehabilitation of the family rather than penal sanctions, it may be substantial.

In view of such reluctance, it is unfortunate that the Children's Bureau model act and those of a substantial number of the states provide only for reports to police or similar law enforcement authorities. Explanations for such limited reporting may come from two factors. One is the need for further investigation in order to determine the source of the physical injuries discovered by the physician, an investigation that law enforcement agencies might be expected to make. The other is the desire to

or injury”; Arizona and Ohio to “evidence of injury or physical neglect”; Wisconsin to “abused or injured minor.”


143. Hoel, Editorial, 46 Minn. Medicine 1001 (1963), suggesting the misplaced emphasis upon the penal aspects of reporting to police authorities rather than to a child welfare agency; De Francis, Review of Legislation To Protect the Battered Child 8 (1964).

144. Arizona, Colorado, Louisiana, Maryland and Ohio refer to peace officers or police authorities; New Jersey requires a report to the county prosecutor; Tennessee to the police, sheriff or district attorney; Washington to police, prosecuting attorney or the sheriff; Wisconsin to the district attorney or sheriff. Oregon requires the report to be made to the coroner or medical investigator for the county, who is required to report his conclusion that a crime may have been committed to the district attorney.
have some uniformity throughout the state or nation and the universal presence of some law enforcement agency to whom a report may be made at any time. Yet, of the states which require reports to law enforcement agencies alone, only four have made specific provision for investigation or have described the obligations of the law enforcement officials to whom the report is made. In Colorado the law enforcement agency is to refer the report to the county department of welfare, which in turn makes the investigation and determines the circumstances surrounding the injury and what further steps should be taken for the protection of the child. At the same time, as noted earlier, the law enforcement officials in combination with the reporting physician may cause the child to be temporarily removed from the control of the parents to prevent further injury. In New Jersey, the county prosecutor to whom the original report is made conducts an investigation and has discretion to proceed with criminal prosecution or to file a complaint with the Bureau of Children's Services or any other public or private agency providing protective services for children. As a consequence both of these states have recognized the role of the welfare services as a primary one in the resolution of the child abuse problem. Oregon, which provides for reports to the county coroner or medical investigator, also provides for investigation by that official. Whenever he finds that the injury was to a child of 12 or under and "was caused in a manner which could place the child under the jurisdiction of the juvenile court," he is to report the circumstances to that court. Washington makes it the duty of the law enforcement agency to whom the report is made to investigate and refer the report to the juvenile department of the superior court.

California, which originally provided only for reports to police authorities, amended its statute in 1963 to provide for alternative reports to the nearest child welfare agency offering child protective services. Nineteen other states originally provided for reports either to the welfare agency alone or to the welfare agency as

147. COLO. REV. STAT. ANN. § 22-13-4(2) (1963), quoted and discussed in note 138 supra and accompanying text.
149. ORE. REV. STAT. §§ 146.730, 740(2) (Supp. 1963).
150. WASH. LAWS 1965, ch. 13, § 5.
151. CAL. PEN. CODE § 11161.5.
well as law enforcement agencies\textsuperscript{153} or to the court having jurisdiction over juveniles and neglected children.\textsuperscript{154} Several of these statutes make specific reference to further investigation by the welfare agencies.\textsuperscript{155} The Idaho reporting provision is a part of a comprehensive act dealing with the protection of children through state and county departments of public assistance.\textsuperscript{156} Three of the states direct the welfare agency to conduct an investigation

\textsuperscript{153} The Illinois statute provides that a report may be made to the law enforcement agency as well as to the welfare agency, Ill. Ann. Stat. ch. 23, § 2043 (Supp. 1965). The Indiana statute provides for a report either to the Department of Welfare or to law enforcement officers, Ind. Laws 1965, ch. 268, § 3. The Iowa statute provides that the primary report is to be made to the county department of social welfare but that if there is reason to believe that immediate protection for the child is necessary, there may be an oral report to the law enforcement agency, Iowa Acts 1965, Senate File 50, § 4 at 209 (1965). In Kentucky, a copy of the written report sent to the police authorities is to be forwarded to the Department of Child Welfare for investigation, Ky. Rev. Stat. Ann. § 199.335(3) (Supp. 1965). Maine provides for reports to both the department of health and welfare, division of child welfare, and to the county attorney, Me. Rev. Stat. Ann. tit. 22, § 3852 (Supp. 1966). In Michigan the report is to be made in triplicate, one copy going to the prosecuting attorney, one to the department of social welfare of the county in which the physician believes the injury to have been inflicted, and the third copy to the state department of social welfare, Mich. Stat. Ann. § 14.564(2) (Supp. 1964). North Dakota, like Iowa, provides for a special report to the juvenile commissioner or the state's attorney, if the circumstances warrant immediate action to protect the child, but makes the mandatory report go to the division of child welfare, N.D. Laws 1965, ch. 327, § 1. Oklahoma provides for a report either to a public child protective agency, a public welfare agency with responsibility for enforcing laws related to child welfare or protection, the sheriff, the county attorney or the police. Okla. Stat. Ann. tit. 21, § 846 (Supp. 1965). In Pennsylvania, the report is to be made initially to the presiding judge of the juvenile court or to the community child protective service, where such court or service exists, and in their absence to the police authorities. Pa. Stat. Ann. tit. 18, § 4830(b) (Supp. 1964). Texas provides that the report may be made to the judge of the juvenile court, the district attorney, county attorney, local law enforcement agency or the probation officer of the county. Tex. Rev. Civ. Stat. Ann. art. 695c-1, § 1 (Supp. 1965). Utah provides that the report shall be made to the local police, the county sheriff or the office of the state welfare department, Utah Laws 1965, ch. 166, § 3.

\textsuperscript{154} Florida provides for reports directly to the juvenile court judge. Fla. Stat. § 828.041(2) (1969); Kansas also requires the report to be made to the juvenile court, Kan. Laws 1965, ch. 386, § 2; South Dakota provides for reports to the county court, which has jurisdiction over the children, S.D. Laws 1964, ch. 90, § 2. The statutes of Pennsylvania and Texas referred to in note 153 supra provide for reports to the juvenile court authorities in the alternative.


\textsuperscript{156} Idaho Code Ann. §§ 16-1624 to 16-1648 (Supp. 1965).
and then to make a report to the court or district attorney. Others are more explicit in requiring that the welfare agencies provide protective services. Illinois provides that the Department of Children and Family Services shall offer "protective social services to prevent further abuses to the child, to safeguard his welfare, and to preserve and stabilize family life wherever possible" and that in performing these functions the department may make use of the protective services of voluntary social agencies and may petition the appropriate court for removal of the child from the custody of the parent or other adult with whom he is living.

Iowa provides for a thorough investigation, including inquiry into the home environment and a visit to the child's home, assisted by court orders to authorize the investigators to enter and examine the home. A report is to be made to the juvenile court and the county attorney as well as the law enforcement officials, all of whom are directed to assist and cooperate in the investigation and to "take any other lawful action which may be necessary or advisable for the protection of the child." Massachusetts has provided that if the department of public welfare finds that a parent or person responsible for the care of the child inflicted the injury or abuse, it shall take action necessary to prevent further abuse or injury, including a provision that if the parent or custodian cannot or will not make proper provisions for the care and protection of the child, the department shall take action "in accordance with law, as may be necessary for the care and protection of the child" including reference of the case to the district attorney. North Carolina provides that after investigation to determine the cause of the abuse, the county welfare directors shall take such action "in accordance with law" as is necessary to prevent the child from being subjected to further abuse or neglect. North Dakota, after directing that the division of child welfare shall make further investigation, requires a report in writing to the juvenile court judge and provides that the state division and the county welfare board shall provide protective services not only for the injured child but other siblings "as may be necessary for their well-being and shall offer such other social


160. Ibid.


services, as the circumstances warrant, to the parents or other persons serving in loco parentis with respect to such child or siblings.\textsuperscript{163} Rhode Island, with a statute much like that of Colorado, provides for an initial report and investigation by the division of community services of the department of social welfare, which is to advise the law enforcement agency of its investigation and at the same time to provide social services or other services necessary to protect the child and preserve the family.\textsuperscript{164} The law enforcement agency is to make its own investigation and take such action as it deems appropriate, including possible removal of the child from the family to prevent further abuse.\textsuperscript{165} While in most cases this latter power is limited by requiring consultation with the department of social welfare, in case the law enforcement agency and the reporting physician concur in the belief that immediate removal is essential to protect the child, no such consultation is required. As already indicated, this author has serious doubts as to the wisdom of such a provision, involving as it does no protection of judicial proceedings subject to rules of evidence and burden of proof and the protection of adversary procedures with counsel, and turning upon the conclusions of a physician based on medical findings.

The Minnesota statute, which like California originally provided for reports to the police authorities, was recently amended to require the report to be made to the appropriate police authority and to the county welfare agency.\textsuperscript{166} The welfare agency is then directed to make an investigation of complaints of neglect and abuse of children and to offer protective social services in an effort to protect the health and welfare of the children and to prevent further abuse.\textsuperscript{167} The precise role of the police authorities in dealing with the abused child problem is not spelled out in the statute. It may be believed that they can provide additional investigation and will be more readily available to deal with emergency cases than might the county welfare agencies in nonurban communities. Since there is no specific reference in the reporting statute to the possibility of removal of the child from parental control, this aspect of the protective services is discussed later in this article. For the moment it seems sufficient to note that the Minnesota law, and that of a majority of the states having mandatory reports, appears to be consistent with the medical

\textsuperscript{163} N.D. Laws 1965, ch. 327, §§ 2, 3.
\textsuperscript{166} Minn. Stat. Ann. § 626.554, subd. 3 (Supp. 1965).
\textsuperscript{167} Id. at subd. 4.
viewpoint emphasizing rehabilitation and prevention rather than the penal aspects of the law.

3. Nature of the Report

A substantial majority of the statutes, including Minnesota’s and others based on the Children’s Bureau model, are explicit in regard to the necessity for both an immediate oral report and a more comprehensive written report to the proper authorities. The combination of oral and written reports is desirable in view of the possible necessity for immediate action to protect the welfare of the child and the need for a formal record of the report made by the physician. Statutes which do not provide for both forms of report may fail to achieve these dual objectives.

Those statutes which are modeled on the Children’s Bureau proposal, such as Minnesota’s, detail the information to be given in the report including the name and address of the child and his parent or other persons responsible for his care, the child’s age, the nature and extent of his injuries and evidence of prior injuries, and any other information believed to be helpful in establishing the cause of injuries and the identity of the perpetrator. Two of the states do not specify information relating to the identity of the perpetrator, but require the other elements. Two require “a description of his injuries” but are not explicit as to the evidence of prior injury, and while speaking of information as to the “cause of injuries and the manner in which they were inflicted” are not explicit as to information regarding the identity of the perpetrator. Three statutes specify a report of the name of the child and his whereabouts and the character and extent of injuries, but do not require the physician to report the name of the parents or others, nor information as to the cause of injury. Wisconsin requires a report of the fact of injury and the physician’s opinion

168. Only the statutes of Idaho, Maryland, Massachusetts, New York, North Carolina, Oregon, Tennessee and Wisconsin are silent on the question whether the report is to be in writing. Florida, Louisiana and Maine refer only to written reports; while Michigan speaks of an “immediate” report which is to be made in triplicate, obviously requiring that it is to be written.


170. Arizona and Ohio statutes, cited note 55 supra.

171. Michigan and Texas statutes, cited note 55 supra.

that the condition was intentionally caused by another as well as the facts and circumstances leading to the formation of that opinion. Maryland specifies that the report shall be of "all circumstances surrounding [the] treatment" of a child under circumstances which indicate violation of the statute making child abuse a felony. By contrast, the statutes in Idaho, Massachusetts, New York, and Oregon are relatively general in requiring only a report of "all cases of injury," "such injury or abuse," "the matter," or "any injury," though the qualifications already noted on the type of injury which is to be reported in these states suggest that the report might contain reference to those factors which indicate that the injuries apparently arose from "physical abuse by a parent . . . ," "serious physical injury or abuse inflicted by a parent . . . ," "abuse or neglect," or "blows, beatings, physical violence or abuse where there is some cause to believe that such physical injury was intentionally or wantonly inflicted."

No matter what use is ultimately made of the facts reported, it is desirable that any report contain as much information relevant to the identification and ultimate resolution of an instance of suspected "battered child syndrome" as is feasible. If the physician or another making the report has information which indicates the probable cause of injury to the child or the identity of the perpetrator, he should report this. Yet, in view of the limitations on the ability of the physician to acquire such information in all cases, there should be no requirement that he delay his report until he has made an investigation beyond that necessary to develop the medical facts: the existence of injury, evidence of prior injuries, inconsistency of injuries with the purported medical history, or other factors which indicate the probability or possibility of "battered-child syndrome." In this regard, the Children's Bureau proposal might make it clearer that the immediate report of suspicious facts need not be as complete as the written report and that in any event it is only the identity of the child and the medical facts which are required of the physician. At the same time, all state statutes would more fully accomplish the purpose of protection of the child by encouraging as full a report of relevant information as the physician can make.

177. N.Y. Penal Law § 483-d.
The questions just raised as to the details of the mandatory reporting statutes should not be taken as criticism of their primary thrust. The attempts to formulate programs of identification are indeed admirable. The variety of formulations has served to suggest a number of desirable provisions which might be included in any future legislation. The experience in Minnesota, with its early attempt to provide for identification and its subsequent revision of the statute to incorporate provisions which had found wider acceptance, deserves special commendation, as does the pioneering effort in California. These experiences indicate an alertness on the part of public officials and legislators to the need for continuing work in this area. The same conscientious attitude also must prevail in continuing attention to the further problems of prevention and protection of the child once the identification process has functioned.