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THE FORUM

Case Vignette: Mandated Child Abuse Reporting. Martha Harris has been a licensed mental health professional for nearly a decade. As she arrived at her office early this morning, the phone was ringing. Speaking in a tremulous voice, the caller stated, "I was given your name by my internist, Dr. Williams. I think my husband may be abusing our 5-year-old sexually. Can you help?" After a few minutes of conversation, Martha offers to schedule a prompt appointment. The caller interrupts and asks, "You won't have to report this will you?" As a mandated reporter under the state's child protection statute, Martha has no choice but to inform the authorities; she tells the caller, who immediately hangs up. Suddenly, Martha realizes that she does not have the name or any other identifying information about the caller. A call to Dr. Williams results in a response that the internist does not want to "get involved."

Discussants. Our commentators on this case are Richard Bourne, JD, PhD; Eli H. Newberger, MD; and C. Sue White, PhD. Dr. Bourne is Associate Professor of Sociology at Northeastern University and an attorney in the Office of the General Counsel at Children's Hospital in Boston. One of his special areas of expertise is child protection and related professional obligations. Dr. Newberger is a pediatrician with a special interest in child maltreatment. He is Associate Professor of Pediatrics at Harvard Medical School and Director of the Family Development Program at Children's Hospital in Boston. In addition to many writings in this topic area, Dr. Newberger is also the current President of the American Orthopsychiatric Association. Dr. C. Sue White is Associate Professor of Psychology in Psychiatry at Case Western Reserve University School of Medicine and serves on the staff of MetroHealth Medical Center as a pediatric psychologist. One of her primary interests is how clinicians may inappropriately use techniques to interview children suspected of child sexual abuse, causing contaminating influences to interfere with children's memories for their own experiences.

A Lawyer's Perspective

Richard Bourne, JD, PhD

"Hold your head up. . . . Look what you've done."
—"Martha My Dear"
White Album
The Beatles

Poor Martha. In all states, mental health professionals are "mandated reporters" required to involve child protection agencies if they suspect abuse or neglect. In this case, despite concerns of sexual molestation, Martha should hesitate before filing—She lacks identifying information about the family; the mere allegation of abuse may prove insufficient to trigger agency response; and any action on her part is likely to anger Dr. Williams.

On the other hand, Martha as a caring professional cannot ignore a child's possible exploitation, and legally she knows that mandated reporters who fail to file when the law demands risk a fine and civil liability. That is, if a clinician fails to involve the state, and victimization thereby continues, the failure may become defined as the "intervening cause" of the abuse, thereby making the clinician responsible. If, however, mandated reporters allege abuse and the report proves erroneous, there is usually absolute immunity from legal action. For self-protection, therefore, even if the case data are ambiguous, it is legally preferable to notify protective services.

Martha should gently inform Dr. Williams that, given the relationship to the patient and the referral, Dr. Williams is already "involved." Dr. Williams must share identifying information so that Martha can attempt to reengage the mother or, preferably, directly urge the mother to reengage Martha. In the latter instance, the internist might say to the mother, "I know that you care about your daughter and want to do what is best for her . . . I also know that you are afraid . . . The important thing now is to arrange for a psychosocial assessment."

If the mother rejects this suggestion, Dr. Williams might consider filing a protective report alleging maternal neglect. If Dr. Williams refuses to contact the mother or to release information to Martha, Martha might file a report despite her reasonable hesitation. The standard for reporting, after all, is belief or suspicion, not knowledge. She would communicate to protective services the allegation of abuse, the mother's concern about reporting, and the fact that Dr.

Williams can identify the parties. Her assumption of reporting responsibility might cause Dr. Williams to play a more direct role.

One might argue that once Martha relates the mother's phone conversation to Dr. Williams, the doctor becomes as much a mandated reporter as she. Most statutes, however, require that data triggering a reporting responsibility be within one's professional capacity. Here the existing data, and those to be developed, are more psychosocial than medical.

Dr. Williams's desire to remain uninvolved is not surprising: The doctor does not want legal entanglements or angry clients, and the possibility of sexual abuse is more than the internist can bear. At this stage, of course, the mother's motivations and credibility are unknown and the clinical data corroborating abuse remain to be developed.

Given the mother's anxiety about calling and her fear about reporting, Martha might have responded differently from "I have no choice but to inform the authorities." The clinician cannot make a commitment not to report without violating her legal and ethical responsibility. The law often requires that confidentiality be sacrificed for a "higher value"—from involving protective services in abuse to involving the police in a possible patient suicide.

On the other hand, at the time of phone communication, Martha lacks sufficient facts to determine whether the standard of "reasonable belief or suspicion" will be satisfied. Her goal should have been to get both mother and child into her office so that she could properly assess the situation. Once the family is physically present, and before her examination, she could have informed the mother of the confidentiality of professional–client communications and the exceptions to confidentiality. It is easier for a caller to hang up a phone than to leave an office.

The Obligation to Protect

Eli H. Newberger, MD

I think that Ms. Harris has an obligation to pursue the protection of the child. As a mandated reporter, it appears that she has been given reasonable cause to believe that the child is a victim of abuse. Thus, she has information that rises over the legal threshold for case reporting.

How aggressively should Ms. Harris pursue information to establish the identity of the child? From the information given in the case vignette, it appears that the only likely source of the information is the internist, Dr. Williams. I think that a good faith effort should be made to inform Dr. Williams of the obligation to report. This can be done in a face-to-face meeting, perhaps with participation by a more sympathetic medical colleague, such as a pediatrician connected with the local chapter of the American Academy of Pediatrics (which now has a section on child abuse and neglect) or the County Medical Society.

In this conversation, the physician could be informed of the ethical and legal requirements to report, as well as the now substantial body of malpractice law that attaches liability to physicians who fail to report. (In these cases, failure to fulfill the reporting obligation is interpreted as an intervening cause of a child's subsequent abuse.) If the physician maintains an obdurate position, I think Ms. Harris still should inform the agency mandated to receive child abuse case reports of the information she has received, including the name and telephone number of the internist.

It is worth noting that, in the recently published survey of professional child abuse case reporting by Zellman and Bell (1990), mental health professionals (child psychiatrists, clinical psychologists, and social workers) appeared, in comparison to other professionals who were mandated reporters, to be least likely to report child abuse. The prevalence of consistent reporting in the physician sample was 43.5%, compared to 33.3% of child psychiatrists, 27.9% of clinical psychologists, and 31.2% of social workers.

In this case, I believe that priority should be given to action to protect the child. Fulfilling the reporting mandate appears to be Ms. Harris's best way to honor this ethical obligation. Among the reasons mental health professionals may hesitate to get involved are: a desire to maintain one's professional relationship with a child and family, a need to protect oneself from time-consuming collateral contacts and court appearances, and previous bad experiences

with child protection service agencies and personnel. Indeed, in these situations, it is often difficult to determine whether one is sufficiently addressing one's obligations to the ethical doctrines of maintaining confidentiality, informed consent, and the axiom first of all to do no harm, even though the reporting laws make clear one's legal obligation.

I think that it should be the child's interest and welfare that define one's course of action. The situation here seems to me to be clear. Protecting the child means making the report.

REFERENCE

Zellman, G. L., & Bell, R. N. (1990). *The role of professional background, case characteristics, and protective agency response in mandated child abuse reporting.* Santa Monica, CA: The RAND Corporation.

Response to Dr. Harris Versus Dr. Williams

C. Sue White, PhD

In this situation, Dr. Harris has to consider her ethical obligations to three individuals: the child, Dr. Williams, and herself.

CHILD

When considering the child, her primary concern, of course, is for the child's physical safety and long-term psychological development. If the information she has been given by the mother of the child leads her to have any suspicion about these issues, she has an obligation to act for the child's protection. In states where the mandatory reporting agency is also the one that is required

to do face-to-face contacts with the child, regardless of who has interviewed him or her previously, the practitioner may recommend that the mother be educated as to why initial reporting to county welfare is advantageous to her child's overall adjustment. Because Dr. Harris no longer has access to the mother, she could provide this information to Dr. Williams and/or indicate to Dr. Williams that she herself would be willing to talk to the mother a second time to explain the protective procedures more fully.

Dr. Harris must acknowledge that many recent charges of child sexual abuse perpetrated by the father are based in custody/visitation disputes. Although this does not give her an excuse *not* to make sure that the case is reported to the authorities, she may, however, proceed with certain guidelines that may alleviate some of the stresses the child may face rather than just report the case "on the first bounce." These special guidelines dealing with custody/visitation issues recommend that the child be seen by someone who will represent the child's interests in court rather than representing just one side (Melton, Petrila, Poythress, & Slobogin, 1987; Weithorn, 1987; White, Santilli, & Quinn, 1988). Such an independent evaluation should allow for fewer actual interviews/evaluations of this child.

DR. WILLIAMS

The second ethical obligation is to Dr. Williams, who is acting on behalf of all present and future patients. If Dr. Harris is convinced by the information provided by the mother that the father may indeed be sexually abusing the child, Dr. Harris has several paths she should address with regard to Dr. Williams. First, she should attempt to ascertain just what Dr. Williams really knows about the case. Assuming that the mother has told the doctor everything she told Dr. Harris may be a mistake. Dr. Williams may have no information of significance to make a report, which may be one reason for the doctor's reluctance to get involved. If, however, Dr. Williams does have adequate information for a report of suspected child sexual abuse to the legal authorities, Dr. Williams needs a short continuing education effort by Dr. Harris for the protection of this child as well as for future children who come to the attention of Dr. Williams. Included in this educational curriculum should be some basics about (a) the need to protect the child, in both a legal and a psychological sense; (b) the use of sexual abuse allegations in some custody disputes; and (c) how an inexperienced interviewer can contaminate or destroy the child's data bank, rendering the child's information useless for future protection (Quinn, White, & Santilli, 1989; White & Quinn, 1988). These issues could be discussed by telephone should Dr. Williams be agreeable. If not, Dr. Harris has the obligation to provide the information in written form.

If Dr. Williams is still convinced that there is no professional obligation to report the case, Dr. Harris can also provide Dr. Williams with a list of

knowledgeable attorneys, from which Dr. Williams can obtain a second opinion regarding the rights and responsibilities regarding mandatory reporting.

If Dr. Williams is still unconvinced after all of these attempts at education and Dr. Harris continues to be concerned, she has the obligation to inform Dr. Williams that she feels it is her responsibility to report the lack of reporting to their state's proper authorities. This may be the county prosecutor and/or the state medical licensing board. Even if this information is delivered by telephone to Dr. Williams, it also should be put in writing.

HERSELF

When considering her own situation, Dr. Harris has several routes to pursue. If she is just not sure what to do regarding the reporting of the child's seeming plight or the reporting of Dr. Williams's lack of involvement, she has the option of contacting the state licensing board for psychology, the state association's committee on ethics, or the American Psychological Association's Office on Ethics. Individuals in these offices should give her guidance regarding her own decisions.

SHOULD DR. HARRIS HERSELF REPORT?

I am of the opinion that unless Dr. Williams can document to Dr. Harris that appropriate state-reporting guidelines have been followed, Dr. Harris should report. Unless Dr. Harris is 100% sure that Dr. Williams will indeed follow through with the stated course of action, she should take some action, including contacting the appropriate state licensing board. Dr. Williams may choose to "forget" to make the referral to the mandated agency once Dr. Harris has made her call.

In addition, Dr. Harris should document all of her telephone contacts with the mother, Dr. Williams, and the state agency.

ADDITIONAL FACTORS TO BE CONSIDERED

In addition to the aforementioned issues, there are several more factors that should be considered in Dr. Harris's decision to make her various reports to state agencies. First are the previous experiences Dr. Harris has had with Dr. Williams. If Dr. Williams is new to the area/state or has just begun practicing, approaching Dr. Williams in a supportive and nonaggressive fashion may provide more protection for this child and future children than becoming aggressive and calling the state agency immediately after Dr. Williams's first negation of responsibility. If, however, Dr. Williams has demonstrated over

time an unwillingness to comply with the reporting laws, a more harsh and firm action is needed.

As noted before, the amount of information Dr. Williams supposedly has is critical in evaluating the necessity to report a possible lack of compliance with the state law.

Another critical issue that must be addressed is protecting the child from multiple, unnecessary interviews that may distort information and/or establish a further rift between child and father. Every effort must be made to have the evaluation completed but in a nonadversarial manner. The father must be made part of the evaluation process, as the child's interests are tied to his side just as to the mother's. It is not up to the mother to decide how the father is to interact with the child. It is up to the courts in sexual abuse and/or custody/visitation disputes (Bulkley, 1988; Melton et al., 1987; Weiner, Simons, & Cavanaugh, 1985; Weithorn, 1987).

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NOTES

This section of the journal features a case vignette that embodies one or more important and complex ethical dilemmas with professional or public policy overtones. Each case is accompanied by two or more independently crafted

commentaries of approximately 1,000 words by experts with diverse backgrounds and perspectives. Readers are invited to submit cases and brief follow-up commentaries that raise new and important issues.

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