Duty to Report

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A few years ago, in a semi-rural town in Arizona, a woman brought her 4-year-old son to a physician assistant named James, who staffed a walk-in clinic. James knew the boy and his family very well. He was essentially their PCP and had treated the little boy in the past. In fact, he watched him grow from a toddler to a rambunctious little bundle of energy.

On this particular visit, the little boy had a low-grade fever and non-productive cough. James, being a conscientious, thorough provider, had the little boy disrobe down to his Superman underwear. James laughed with and tickled the little boy but when he exposed his back to palpate his flank and listen to his lungs, he noticed what appeared to be belt marks in varying stages of healing.

James was appalled and made it very clear to the little boy's mother that this "spare the rod, spoil the child" mentality was unacceptable. The mother confessed that her husband occasionally got "carried away" while disciplining the little boy and that she would make sure it never happened again.

James admonished her further and stated that he would be happy to speak to her husband if she felt that it would help. He also threatened her that he would notify the authorities if he ever saw any more signs of physical abuse on the child.

The woman assured James that she would take care of this and that it would never happen again. James dutifully recorded his physical exam findings and his discussion with the woman in the boy's medical record.

Five days later, the little boy was rushed to the emergency department after he collapsed during kindergarten recess. Ultimately, the little boy died of an acute epidural hematoma secondary to his skull fracture, which occurred after his father threw him into a wall when the little boy spilled his dinner plate.

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"Failure to report abuse can lead to both criminal and civil liability."

James was interviewed by the police, who did not believe the "fell out of his bunk bed" story the parents were describing.

James related his experience with the mother and her "confession" about the belt marks. When asked why he did not report his physical exam findings, James stated that, "he had a come-to-Jesus talk with the little boy's mother and believed that nothing further would happen to the little boy."

In the end, everybody lost. James lost his ability to practice medicine and was ultimately prosecuted as a criminal. The little boy's parents both went to jail. In fact, the father will spend the rest of his life in jail.

In 2003, the most recent year for which statistics are available, it is estimated there were more than 2.9 million cases of suspected child abuse in the United States, with an estimated 1,400 fatalities. And yet, more than 58% of child abuse reports to child protective agencies are found to be unsubstantiated.[1]

One cause for the difficulty in obtaining accurate statistics is that there is no universally accepted definition of "child abuse." Some states define abuse as an action resulting in actual injury, whereas in other states, the mere *potential* for injury is defined as child abuse.

Statutes may impose liability for excessive corporal punishment or exposure to drug-related activity, and may require "reasonable suspicion" or diagnosable mental or physical injury to prosecute.

In the landmark work, *The Battered Child*, Helfer and Kempe opine that the diagnosis of abuse "should be considered in any child exhibiting evidence of fracture of any bone, fail to thrive, soft tissue injury or skin bruising, and any child who dies suddenly, or where the degree and type of injury is at variance with the history given regarding the occurrence of the trauma."[2]

In addition, some authorities consider the physical exam findings of retinal hemorrhages to be pathognomonic of child abuse.

Historically, under common law, there was no duty to report even known cases of child abuse. Today, all 50 states mandate that specific individuals report suspected child maltreatment. Among those required to report are teachers, medical providers, nurses, mental health workers, sometimes clergy, and dentists. Check your specific state statutes to determine which agencies should be notified about suspected child abuse.

In addition, the Child Welfare Information Gateway offers advice and state-by-state reporting contact information on the How to Report Suspected Child Maltreatment page of its website, available at *www.childwelfare.gov/responding/reporting.cfm*.

Most states grant immunity to any professional who, in good faith, reports suspected child abuse. This means that the person reporting suspected abuse cannot be sued for alerting the authorities, provided that the report was made with a reasonable belief that abuse had occurred. Moreover, in at least 42 states, the *failure* to report abuse can lead to both criminal and civil liability upon professionals who fail to notify the authorities despite having a reasonable belief that the child has been mistreated.

The take-home point is this: Urgent care centers across the United States see children every day who are victims of abuse. In fact, I suspect that we see a disproportionate number of abused children inasmuch as the abusers bring their children to these centers knowing that urgent care providers may not be as familiar with patterns of abuse as their emergency department counterpart.

If you suspect abuse, report it to the appropriate state agency as defined in your state's statutes. Doing so may save the child's life. Not doing so may end your career and, more importantly, the precious life of a child.

As I write this, a little girl I treated in the emergency department last month lies in a persistent vegetative state, trached and on a ventilator, in a long-term pediatric hospital in Phoenix. She presented posturing and unresponsive via paramedic ambulance after 911 was called by the mother's boyfriend, who stated the child was "not acting right." I intubated her and sent her emergently for a CT scan; she was found to have multiple skull fractures, an acute subdural hematoma, and diffuse cerebral swelling.

She, too, "fell out of bed." ■

References

1. U.S. Department of Health and Human Services National Clearinghouse on Child Abuse and Neglect Information. *Fatalities: Statistics and Interventions*. 2004.
2. Helfer RE, Kemp CH. *The Battered Child*. Chicago: University of Chicago Press, 1968; page 105.

4. Consider a low-cost/high-impact public relations blitz. Set aside one hour starting at 6 p.m. (or over a weekend) and leave 50 or more employer contacts a message such as:

> *"Hello, this is Dr. Maginnis calling from Downtown Urgent Care. I am calling to thank your company for your business, find out how we are doing, and see if you have any problems that we can address. I am available most afternoons at 453-1834; call me if I can be of help."*

Getting Started

Begin developing a communications strategy by creating a list of communication actions that are amenable to a generic document or script.

Generic e-mails
1. Confirming a meeting
2. Meeting follow-up
3. Confirming a "closed" account
4. Just checking in
5. Announcing a new service, location, or employee

Generic letters
1. Annual thank you plus questionnaire
2. Introductory letter
3. Contractual cover sheet (as appropriate)

Scripted voicemail messages
1. Just checking in (alternate with e-mails)
2. Confirming a meeting
3. Thank you for meeting/summary follow-up

Generic documents
1. Formal proposals
2. Reference list (updated constantly)
3. Staff profiles

Summary

In order to get the most out of your communications strategy, you must:

- proactively develop a communications plan.
- develop a generic document and/or script in support of each plan component.
- execute the plan as an integral part of each workday.

The slogan, "reach out and touch someone," applies more than ever in an increasingly impersonal, frenzied world. Such an "in their face" approach increases the probability of potential clients knowing who you are and using your clinic when the time is right. ■