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Forensic Emergency Medicine:

Practitioners Must Consider Roles as Investigators, Reporters

By **Christopher Todd, JD,** Assistant Vice President, Seak Legal and Medical Information Systems, Falmouth, MA

Editor's note: *Sherlock Holmes would be proud of the advances in forensic medicine. Who would believe the advances in evidence collection and DNA identification that have developed during the last 10 years? The role of physicians in evidence collection seems to be ever-increasing. Emergency physicians have a role not only in evidence collection, but also in preventing the destruction of evidence. Emergency department (ED) personnel must recognize forensic situations; collect the evidence and document the proper historical information thoroughly and accurately; and simultaneously provide care for patients. Because impartiality is essential in all forensic cases, physicians must document without bias in order to remain credible.*

This article will serve as a starting point for ED health care providers seeking to understand their forensic role and the legal issues that accompany that role. This issue of ED Legal Letter *describes methods of evidence collection and preservation. The author presents a summary of physician and nurse reporting obligations in regard to crime victims, including elder and child abuse, and the potential civil and criminal repercussions of not reporting.*

What is forensic emergency medicine? Generally, forensics is the science that deals with the relationship and application of scientific knowledge and fact to legal issues and proceedings. More generally, it simply means "pertaining to legal proceedings." Thus, forensic emergency medicine is the application of forensic medical knowledge and appropriate techniques to living patients in the ED. The legal proceedings most often invoked in the ED are, of course, those in the criminal justice system. Because many trauma patients in the ED are victims of crime, treatment in the ED has a forensic aspect. As Dr. W.S. Smock wrote, "What was once considered confounding clutter that gets in the way of patient care (such as clothing and surface dirt) takes on a whole new significance when recognized for what it really is — evidence."[1] ED professionals who previously were trained to

provide medical care without regard for forensic issues now must appreciate their forensic role, because they play a crucial role in the legal process and almost always are among the first to encounter victims of crimes.

The first part of this article presents examples and illustrations of forensic situations that relate to physical evidence. The second part of the article explains two evidence-related issues: chain of custody and proper documentation. The third part of the article is devoted to a discussion of legal obligations that arise in "forensic situations," particularly as created by state mandatory reporting statutes.

Collection, Preservation, and Identification

Ultimately, the ED's forensic role revolves around collection and preservation of evidence and the identification of patients as victims. Naturally, saving lives remains the highest priority. However, as the nature of wounds changes as society becomes more violent, ED management of trauma patients necessarily includes a forensic aspect. ED practitioners must know basic wound mechanics, pattern injuries, and the indicators for abuse and battery.[2] Identifying victims and taking the proper management steps will save lives. Collecting and preserving evidence will lead to convictions, which also may save lives.

This article touches on a few of the issues that arise when a victim of violent crime presents to the ED with a gunshot wound. This is intended to illustrate the issues an ED practitioner will need to consider. As forensic emergency medicine training programs proliferate, and specific programs such as the Sexual Assault Nurse Examiners (SANE) program continue to gain momentum, these issues likely will receive more attention and relevant information will become more available.

In the evaluation and treatment of patients who are victims of gunshot wounds, assault, or trauma, the ED practitioner often has the opportunity to preserve and collect short-lived evidence. First, however, he or she must recognize it as such.

Gunshot Wounds and Other Forensic Examples

Because ED personnel evaluate a gunshot wound before therapeutic or surgical intervention affect the wound's appearance, they are in an ideal position to evaluate and document it. Documentation of gunshot wounds in the medical record by the treating physician should include the number, location, size, shape, and characteristics of the wound. A useful description of a gunshot wound requires a basic understanding of ballistics and a familiarity with forensic terminology.[3]

The victim's clothing may yield information about the range of fire and help distinguish entrance wounds from exit wounds. Clothing fibers will deform in the direction of the passing projectile, while gunpowder and soot will deposit on clothing. Thus, when articles of clothing are removed from a wounded patient, they should be packaged separately (to avoid cross-contamination) and placed in paper bags (to minimize the risk that static electricity will lift fragile evidence off their surfaces). The clothes can be examined for "bullet wipe," a residue left on clothing after a bullet has passed through it.[4] Similarly, if soot is noted on the patient's hand, or if a gunshot residue (GSR) test is to be performed, paper bags should be placed over the patient's hands. Practitioners should avoid washing the skin with alcohol or povidone-iodine, placing tape on the skin, rubbing the hands against clothing, and placing plastic bags over the

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patient's hands, all of which will affect sensitivity to the GSR test.

ED practitioners must be careful not to compromise the markings on the bullet (created by the rifling of the gun's barrel) when removing the projectile. Handle bullets with gloves. Cover surgical instruments (like hemostats or pickups) with gauze to preserve the microscopic markings on the bullet. Bullets must be collected in breathable containers (paper boxes or envelopes). Airtight containers will collect moisture and allow bacteria proliferation.

Avoid using the terms "entrance" or "exit" wound in the medical record; these could cause confusion later if the practitioner must testify in court. Moreover, the ED practitioner should not speculate in the record about the direction of fire, or on the caliber of the bullet. Descriptions based on incorrect forensic terms will not help. Photographs of the wound, however, are helpful in the legal process. The ED practitioner should remember that no one person knows everything about gunshot wounds and ballistics. Numerous experts may be required to make the final analysis in court.[5] In the meantime, the more the ED practitioner knows about the forensics of gunshot wounds, the more he can contribute — and the less likely he is to inadvertently destroy evidence.

Blunt Traumatic Pattern Injuries – Bite Marks

Because the pattern of a bite injury is the most useful evidence for identifying the individual who inflicted it, the ED practitioner must guard against destroying residual evidence when an acute bite mark is identified on a patient. The skin surface should be swabbed with a sterile, cotton-tipped applicator moistened with sterile water or normal saline. This procedure may succeed in collecting some of the assailant's buccal cells. These cells can be analyzed for DNA and blood group antigens. Blood group antigen is only detectable for a short time. This test should be sent to a crime lab as soon as possible. Because the bite pattern can be used to identify suspects, it is ideal to have consultation by a forensic odontologist, who can evaluate a bite mark to determine if an accurate identification may be made from it. Only a forensic odontologist should render an opinion that includes or excludes a suspect.[6]

Of course, these types of issues vary according to the injury and the associated crime. Sexual assault management, for example, will have a particular protocol that includes forensic evidence gathering. There are time limits for collection of bodily fluids, proper maintenance of evidence, consent forms, photographic documentation, and preservation of the chain of custody. The ED practitioner should understand that these issues directly will influence the legal resolution of the sexual assault case.

Documentation

It is important to understand that ED health care practitioners can help patients win cases in court against attackers and abusers by carefully documenting the patients' injuries. (It is equally important that examiners remain impartial and present information and evidence in a non-biased fashion.) Many health care protocols and training programs now note the importance of such documentation, but only if medical documentation is accurate and comprehensive can it serve as useful evidence in legal proceedings.

Documentation does not provide good evidence; thus, medical records are not used in legal proceedings to the extent they could be. In addition to being difficult to obtain, the records often are incomplete or inaccurate, and the handwriting may be illegible. These flaws can make medical records more harmful than helpful.

Generally, health care providers have received insufficient training about how medical records can help in certain cases. They often are not aware that admissibility is affected by subtle differences in the way they record the injuries. Even poor handwriting on written records can affect their admissibiltiy. By making some fairly simple changes in documentation, physicians and other health care professionals can dramatically increase the usefulness of the information they record.

Utility of Thorough Documentation

The utility of well-maintained records is wide-ranging. It will aid in prosecution of the offender, of course, and can assist the victim in obtaining civil recourse. In domestic violence situations, for example, medical records as evidence may help victims obtain protective relief, such as grants of temporary protective orders, permanent restraining orders, and child custody requests. Victims also can use medical documentation in less formal legal contexts to support their assertions of abuse. Persuasive, factual information may qualify them for special status or exemptions in obtaining public housing, welfare, health and life insurance, victim compensation, and immigration relief related to domestic violence, and in resolving landlord-tenant disputes. For formal legal proceedings, the documentation needs to be strong

enough to be admissible in a court of law. Typically, the only third-party evidence available to victims of domestic violence is police reports, but these can vary in quality and completeness. Medical documentation can corroborate police data. It constitutes unbiased, factual information recorded shortly after the abuse occurs, when recall is easier.

Medical records can contain a variety of information useful in legal proceedings. Photographs taken in the course of the examination record images of injuries that might fade by the time legal proceedings begin, and they capture the moment in a way that no verbal description can. Body maps can document the extent and location of injuries. The records also may hold information about the emotional impact of the abuse. It is essential that the practitioner understand the way the information is recorded can affect its admissibility in court. For instance, a statement about the injury in which the patient clearly is identified as the source of information is more likely to be accepted as evidence in legal proceedings. Dictating chart entries, rather than handwriting them, increases the detail of the descriptions and eliminates the potential that an illegible document may be excluded.

Obstacles to Good Medical Record-Keeping

There are several reasons medical record keeping generally is not adequate. Health care providers are concerned about confidentiality and liability. They are concerned about recording information that might inadvertently harm the victim. Many are confused about whether, how, and why to record information about domestic violence, so in an effort to be "neutral," some use language that may subvert the patient's legal case — and even may support the abuser's case. Some health care providers are afraid to testify in court. They may see the risks to the patient and themselves as possibly outweighing the benefits of documenting abuse.

Hearsay Exceptions — Medical Treatment

Even health care providers who are reluctant to testify can submit medical evidence. Although the hearsay rule prohibits out-of-court statements, an exception permits testimony about diagnosis and treatment. Statements made to a physician for the purpose of receiving medical treatment have long been received under an exception to the rule that excludes hearsay. The theory of the exception in its archetypal form is straightforward: A patient's selfish interest in receiving appropriate treatment guarantees the trustworthiness of the statement. In this archetypal form, the exception is among the most solidly founded within the hearsay rules. Courts increasingly have been willing to admit out-of-court statements under the medical treatment or diagnosis exception to the hearsay rule. *(Fed. R. Evid. 803[4] advisory committee's note.)*

As an example, North Carolina's medical treatment exception to the hearsay rule admits "statements made for purposes of medical diagnosis or treatment and describing medical history, or past or present symptoms, pain, or sensations, or the inception or general character of the cause or external source thereof insofar as reasonably pertinent to diagnosis or treatment." *(N.C. R. Evid. 803[4].)* The medical treatment or diagnosis exception to the hearsay rule is premised on the critical assumption that a patient receiving medical treatment has an incentive to speak truthfully to the caregiver, thereby ensuring the reliability of the testimony.

In addition, some states also allow the diagnosis and treatment elements of a certified medical record to be entered into the evidentiary record without the testimony of a health care provider. Thus, in some instances, health care providers can avoid appearing in court.

Hearsay Exceptions — Excited Utterances

The patient's "excited utterances" or "spontaneous exclamations" about the incident are another exception to the prohibition of hearsay. These are statements made by someone during or soon after an event, while in an agitated state of mind. They have exceptional credibility because of their proximity in time to the event and because they are not likely to be premeditated. Excited utterances are valuable because they allow the prosecution to proceed even if the victim is unwilling to testify. Therefore, these statements need to be documented carefully. A patient's report may be admissible if the record demonstrates that the patient made the statement while responding to the event that prompted the utterance (i.e., the act or acts of violence or abuse).

Noting the time between the event and the time the statements were made, or describing the patient's demeanor as he or she made the statement, can help show that the patient was responding to the stimulating event. Such a showing is necessary to establish that a statement is an excited utterance or spontaneous exclamation, and thus an exception to the hearsay rule.

Inadequacies in the Records

Many medical records are not documented sufficiently to provide adequate legal evidence of sexual assault or domestic violence. Reports suggest that, for all assaults, more than half of the information that potentially is obtainable at the time of the patient visit is not recorded on the medical record. Several studies note inadequacies in ED record-keeping:

• A study of 288 ED charts of intentional assault victims treated in a Level 1 trauma center revealed absence of assailant identification in 67% of cases, no documentation of force or object used in 13%, and no documentation of place of assault in 79%;[7]

• In a review of 100 patients who presented to a Level 1 trauma center in California, improper or inadequate documentation was found in 70% of the charts. In 38% of those cases, potential evidence was improperly secured, incorrectly documented, or inadvertently discarded;[8]

• A study of 184 visits for medical care in which an injury or other evidence of abuse was noted revealed major shortcomings in the records. For the 93 instances of injury, the records contained only one photograph. There was no mention in any record of photographs having been filed elsewhere (e.g., with the police). Body maps documenting the injuries were included in only three of the 93 instances. Drawings of the injuries appeared in eight of the 93 instances. Doctors' and nurses' handwriting was illegible in key portions of the records in one-third of the patients' visits in which abuse or injury was noted. All three criteria for considering a patient's words an excited utterance were met in only 28 of the more than 800 statements evaluated (3.4%). Most frequently missing was a description of the patient's demeanor, and often the patient was not identified clearly as the source of the information.[9]

Suggestions for Practitioners[10]

Minor changes in the way practitioners document cases can render the medical records much more useful to victims of violence in legal proceedings. Practitioners can do the following:

• Take photographs of injuries, especially those known or suspected to have resulted from assaults or domestic violence;

• Write legibly. Computers also can help overcome the common problem of illegible handwriting;

• Set off the patient's own words in quotation marks or use such phrases as "patient states" or "patient reports" to indicate that the information recorded reflects the patient's words. To write "patient was kicked in abdomen" obscures the identity of the speaker;

• Record any reason the practitioner's observations might conflict with the patient's statements; conversely, if forensic exam findings match the history given by the victim, the examiner also should document, "there is congruence between the victim's story and her injuries;"

• Document weapon use. It is important for the physician or nurse to document weapon use, the threat of force, and the use of force, because practitioners are allowed to report this information to the court during testimony;

• Describe the person who hurt the patient by using quotation marks to set off the statement. The practitioner would write, for example: "The patient stated, 'My boyfriend kicked and punched me;'"

• Avoid summarizing a patient's report of abuse in conclusive terms. If such language as "patient is a battered woman," "assault and battery," or "rape" lacks sufficient accompanying factual information, it is inadmissible;

• Do not place the term "domestic violence" or abbreviations such as "DV" in the diagnosis section of the medical record. Such terms do not convey factual information and are not medical terminology. Whether domestic violence has occurred is determined by the court;

• Describe the patient's demeanor, indicating, for example, whether he or she is crying or shaking, or seems angry, agitated, upset, calm, or happy. Even if the patient's demeanor belies the evidence of abuse, the practitioner's observations of that demeanor should be recorded;

• Record the time of day the patient is examined and, if possible, indicate how much time has elapsed since the abuse occurred. For example, the practitioner might write, "Patient states that early this morning his boyfriend hit him."

Chain of Custody and Maintaining Evidence

Chain of Custody. To ensure the legal validity of evidence, a chain of custody must be maintained. To maintain this chain, there must be careful and proper handling and transfer of the collected evidence, with documentation to verify who collected the evidence, who picked up and transported the evidence, and that the evidence was

sufficiently guarded. The purpose of establishing a chain of custody is to prevent inauthentic or altered evidence. Failure to maintain this chain means that the forensic evidence collected can be thrown out of court. Discrepancies in the chain of custody do not always render evidence inadmissible, but certainly make a case more difficult for the prosecution. Since many cases rotate around forensic evidence, maintaining a chain of custody can make or break a case. Without complete documentation, with signatures, of a chain of custody beginning with the individual who collected the evidence and extending to the evidence's presentation in the courtroom, the admissibility of the evidence will be questioned and could be excluded.

A recent study confirmed that chain-of-custody procedures require improvement in many EDs. In a study of sexual assault evaluations performed by emergency physicians or obstetric/gynecology residents in an urban ED, the chain of custody was documented properly in only 6% of cases.[11]

The American College of Emergency Physicians Handbook for Treating Sexual Assault suggests that at the initial collection point, all specimens should be properly sealed, initialed, and labeled with:

- hospital name, patient name, and patient identification number;
- date and time of collection of evidence;
- description and location of the body part of origin of the evidence; and
- name and signature of the person collecting the evidence.

All transfers of custody of evidence must be accountable by keeping written records of the name and signature of the person transferring custody and the name and signature of the person receiving the evidence, and the date and time of the transfer.

In the sexual assault context, if the examiner must leave the room for any reason during the exam, the evidence must go with him or her. Moreover, to maintain proper chain of custody, it is neither necessary nor appropriate for law enforcement personnel to be in the exam room when the evidence is collected. The police can leave the area and the examiner can call them to return and pick up the evidence when the exam is completed and the reference samples, swabs, and slides are dry. When the police cannot return immediately, the examiner can place the evidence in a locked storage area with limited access — in a refrigerator, when appropriate. When the police return, any available nurse can sign to release the evidence.[12]

Maintaining Evidence Integrity. It is vital that ED practitioners determine the proper storage techniques for certain types of evidence. Bullets, blood, and urine require different storage procedures. For example, SANEs are advised that urine specimens collected from a rape victim be refrigerated for long-term storage to prevent deterioration, and that "it is essential that the evidence be kept in an area of less than 75°F and that the blood not be frozen. This means that storage in an air-conditioned room is sufficient for short-term storage."[13] ED practitioners should determine proper storage procedures for common types of forensic evidence.

Mandatory Reporting

State law imposes numerous reporting requirements on health care practitioners. Acts for which mandatory reporting statutes exist include certain types of interpersonal violence (e.g., assault with weapons, domestic violence), child abuse, elder abuse, or abuse of certain persons with disabilities. These reporting statutes share general characteristics — they require the reporter to make the report to law enforcement or a state agency, they grant some form of immunity to the reporter, and they override privileges such as the physician-patient privilege. The practitioner must learn applicable state law and remain abreast of changes. Commentators suggest evaluating mandatory reporting statutes with certain questions in mind:[14]

- What is the purpose of the statute?
- What is to be reported?
- Who makes the report?
- Who receives the report and what is their response?
- Are there penalties for failing to report?
- Is immunity from liability provided?
- Are there provisions for confidentiality of reports?
- Are provider-patient privileges explicitly revoked?
- Is there case law interpreting provider liability?

The following section discusses several of these questions under the law of certain jurisdictions. This is not intended to be a complete survey – rather, it is intended to illustrate some existing legal obligations and the potential for liability stemming from those obligations.

Illustration of Mandatory Reporting Statutes

Interpersonal Violence, Child Abuse, Elder Abuse. Almost all states require physicians to make a report when a patient is injured by a gun, knife, or other deadly weapon.[15] All jurisdictions have mandatory child abuse

reporting statutes, while most have similar statutes covering elder abuse and abuse of the disabled. jurisdictions have mandatory reporting laws that specifically address domestic violence, while in others, domestic violence is addressed through the other abuse statutes, or through a generalized injury-with-a-weapon statute.[16] For example, in Colorado, physicians must report to the police any injury caused by a firearm, knife, or other sharp instrument, or "any other injury which the physician has reason to believe involves a criminal act, including injuries resulting from domestic violence."[17]

Kentucky health care personnel who have "reasonable cause to suspect that an adult has suffered abuse, neglect, or exploitation" or have "reasonable cause to believe that a child is dependent, neglected, or abused" must report ("or cause reports to be made") to the Cabinet for Human Resources, which then notifies law enforce-ment.[18] As in most states, abuse reporters are immune from civil or criminal liability for reporting in good faith, and traditional privileges like the physician-patient privilege are abrogated by the reporting requirement.

Another approach is found in New Hampshire, which mandates reporting of injuries believed to be caused by a criminal act. However, if the victim of abuse or sexual assault is 18 years of age or older and objects to such reporting, a report does not need to be made unless the victim is "being treated for a gunshot wound or other serious bodily injury."[19]

A Child Abuse Reporting Statute

In California, a "health practitioner" is required to report child abuse when the practitioner "has knowledge of or observes a child in his or her professional capacity, or within the scope of his or her employment whom he or she knows or reasonably suspects has been the victim of child abuse . . . ."

"Reasonable suspicion" occurs when "it is objectively reasonable for a person to entertain such a suspicion, based upon facts that could cause a reasonable person in a like position, drawing when appropriate on his or her training and experience, to suspect child abuse." The statute also requires that the report be made as soon as possible by phone, followed by a written report within 36 hours of receiving information regarding the incident.[20] The report must be made to a "child protective agency," which is designated as a county welfare or probation department or a police or sheriff's department.[21] As with all child abuse reporting statutes, mandated reporters are granted immunity from criminal or civil liability for reporting as required. (P.C. 11172[a].) In California, for instance, immunity does not eliminate the possibility that actions may be brought against reporters. Thus, the legislature allows mandated reporters to make a claim to the state for reimbursement of reasonable attorney's fees incurred in any action against the reporter on the basis of making a required report, if the reporter prevails in the action.

California further safeguards mandated reporters by precluding supervisors or administrators from impeding or inhibiting a report or subject the reporting person to any sanction. (P.C. 11166[f].) Moreover, mandated reporters and others acting at their direction are not liable civilly or criminally for photographing the victim and disseminating the photograph with the report. (P.C. 11172[a].) The scheme also provides that a physician may take skeletal x-rays of the child without the consent of the child's parent or guardian for purposes of diagnosing the case as one of possible child abuse and determining the extent of such child abuse. (P.C. 1117[b].) As in all mandatory reporting schemes, the California statute provides that the physician-patient privilege does not apply to "information reported pursuant to [the mandatory reporting statute] in any court proceeding or administrative hearing." (P.C. 11171[b].)

Elder Abuse Reporting Statutes

Currently, 42 states and the District of Columbia mandate health care professionals to report known or suspected cases of elder abuse. Several others make reporting voluntary.[22] For example, Arkansas Code Ann. 5-28-203(a)(1) states, "Whenever any physician . . . registered nurse, hospital personnel, . . . social worker . . . [or] mental health professional . . . has reasonable cause to suspect that an endangered adult has been subjected to . . . abuse . . . he shall immediately report or cause a report to be made in accordance with the provisions of this section." The "endangered adult" is an adult who is "found to be in a situation or condition which poses an imminent risk of death or serious bodily harm to that person and who demonstrates a lack of capacity to comprehend the nature and consequences of remaining in that situation or condition," while an "impaired adult" means an adult "who, as a result of mental or physical impairment, is unable to protect himself or herself from abuse, sexual abuse, neglect, or exploitation, and as a consequence thereof is endangered." A.C.A. § 5-28-101 (2001).

Liability Arising from Mandatory Reporting

Though failure to comply with mandatory reporting requirements is both a crime and a potential basis for civil liability, many — if not most — health practitioners do not report all suspected cases of abuse and domestic violence.[23] The reasons are multifold, and include professional ethical concerns, vague statutes, doubt over the benefit of reporting, and failure to recognize certain types of abuse. A major impediment to mandatory reporting, however, is a (not unjustified) fear of civil liability. The remainder of this article will discuss criminal and civil liability for the health care practitioner arising from or relating to mandatory reporting statutes. Professional ethical conflicts may arise from the mandatory reporting requirement due to conflicts between legal mandates and stated wishes of the patient. That discussion, however, is beyond the scope of this article.[24]

Liability for Reporting and Statutory Immunity

The good news first: The possibility of liability is near nonexistent where a practitioner discloses information pursuant to the mandatory reporting statute. Every state has a statute that provides some type of immunity for reporters of abuse, and the immunity is recognized even when the report turns out to be incorrect. The form of these statutes varies. The majority provide immunity from liability if the report is made in "good faith," while others protect the professional unless he acted "maliciously," in "bad faith," or knew the report was false. These types of immunity are called *qualified* immunity, as opposed to *absolute* immunity.

Examples of immunity provisions include: Alaska Stat. 47.24.120(a), which states, "A person who in good faith makes a report under [the reporting statute], regardless of whether the person is required to do so, is immune from civil or criminal liability that might otherwise be incurred or imposed for making the report;" and the Georgia Code Ann. 30-5-4, which states, "[A]nyone who makes a report . . . shall be immune from any civil or criminal liability . . . unless such person acted in bad faith or with malicious purpose."

Case Examples – Qualified Immunity

Hazlett v. Evans.[25] In this case, a 1-month-old baby was taken to an ED after she developed a fever and demonstrated symptoms consistent with seizures. The baby was treated and transported to the defendant hospital. The defendant physician treated the baby. Computed tomography (CT) scan results showed that the baby had a diffuse subarachnoid hemorrhage, and the report noted that "on the basis of this examination alone, the possibility of Battered Child Syndrome cannot be excluded." Upon this finding, Dr. Evans noted that he was "obligated to pursue follow-up since diagnosis could be 'Shaken Baby Syndrome.'" He then reported the baby's injury to social services authorities, in order for them to investigate the possibility that she was an abused child. Social services agents ultimately removed the baby from her parents and the father was charged with child abuse. The father subsequently sued the doctor and the hospital for negligence in misdiagnosing shaken baby syndrome.

The court noted the applicable law, which required a doctor to report any possible child abuse when he has reasonable cause to believe or suspect such child abuse has occurred. If the doctor fails to report such suspected abuse, he is subject to a misdemeanor charge. Realizing the onerous burden placed upon the doctor and others who fall under the reporting provision, the legislature provided such persons with immunity, civilly and criminally, when the person acted "in good faith."[26]

The plaintiff claimed that the doctor did not have the reasonable cause to trigger a mandatory report. The court noted as a preliminary matter, "Being that the injuries were consistent with 'shaken baby syndrome,' the doctor certainly had 'reasonable cause' to suspect and report [the baby's] injury to the authorities." The court then rejected the plaintiff's argument, stating: "To say that because a doctor did not have reasonable cause, and therefore is not immune from liability, because he misdiagnosed a child who had injuries that were consistent with child abuse, is to fly in the face of the whole purpose of these statutes." Therefore, the court found, "[u]nless the plaintiffs can show that [the doctor] had bad intent when he reported the suspected child abuse. . . to social services, [he] is afforded the immunity granted by the statute." There was no evidence that the doctor acted in bad faith, and the suit was dismissed.

The problem for practitioners with suits like the one described here lies less in the potential for liability, than in the time, effort, and money that often are required to resolve them. Numerous cases are filed even though every state affords health care professionals threshold immunity from liability if they report in good faith. Plaintiffs lose numerous cases, but the qualified nature of the immunity in many statutes does not relieve the practitioner of all fear of defending a suit

arising out of a report. Qualified immunity does leave the door open, slightly, to liability for making a report that turns out to be untrue.

Liability for Failure to Report

Practitioners may face criminal or civil liability, or both, for failing to comply with mandatory reporting statutes. Some statutes provide for criminal liability, though usually at the misdemeanor level. The use of criminal penalties obviously is designed to provide a deterrent to, and punishment for, noncompliance. Often, though, to produce criminal liability the failure to report must be willful or knowing, or rise to another, similarly elevated standard. Commentators agree that prosecutors rarely prosecute those who are required by law to report but who fail to do so.[27] Prosecutors rarely are aware of the failure to report; therefore, lack of criminal enforcement is not surprising. Even when they are aware, prosecutors sometimes are reluctant to prosecute white-collar professionals. Moreover, difficulties in securing evidence for these cases (e.g., the victim is reluctant to testify, or a disability renders testifying difficult) likewise may make criminal prosecution unlikely.[28] Nonetheless, the very dangerous possibility exists.

Civil Liability for Failure to Report

Use of the reporting statutes to impose civil liability on physicians has been neither widespread nor common. Nonetheless, it has happened.[29] Moreover, other mandated reporters have been held civilly liable for failure to report, and a court could decide to extend this liability to health care practitioners. Liability for negligence can arise through two legal mechanisms, illustrated in the landmark *Landeros v. Flood* case. *(See following section.)* To prove common law negligence (though technically these actions are codified in most states), the plaintiff must prove that the practitioner: 1) owed a duty to the patient/plaintiff to provide care consistent with the professional standard; 2) failed to provide such care (i.e. did not meet the standard of care, or, on more general terms, the practitioner breached his or her duty); and 3) proximately and actually caused harm to the plaintiff/patient. Statutory negligence (or negligence per se) is different in that if a plaintiff can prove that a practitioner failed to comply with a statutory provision, the practitioner will be presumed to have breached his or her duty. Courts have specific rules for applying the statutory negligence doctrine, and it is applied much less frequently than "regular" negligence is.

Practitioners also should remember that the reporting statute specifically may provide for civil liability. Several jurisdictions have laws that mandate civil liability against those who do not fulfill their statutory duty to report child abuse. The Montana statute is typical: "Any person, official, or institution required by law to report known or suspected child abuse or neglect who fails to do so or who prevents another person from reasonably doing so is civilly liable for the damages proximately caused by such failure of prevention."[30] In these jurisdictions, the failure to report is automatically a breach of the reporter's duty — the plaintiff must simply (though this is not so simple) prove that the practitioner's breach caused harm.

Tort Liability For Failure To Report Child Abuse

Landeros v. Flood.[31]

A landmark instance of liability imposed on a professional for failure to meet statutorily required reporting is the California Supreme Court's 1976 decision in *Landeros v. Flood*. A child was brought to a hospital with a spiral fracture of the tibia and fibula, apparently caused by a twisting force for which there was no natural explanation. The child also had bruises and abrasions over her entire body, and exhibited other symptoms of battered child syndrome. The physician failed to diagnose mistreatment and failed to report the case to the proper authorities. The child was returned to her parents and severely beaten again, suffering permanent, physical injury. Subsequently, the child's guardian *ad litem* sued the original physician and hospital for common law and statutory negligence for the injuries the child suffered after she was discharged into her mother's care. The California Supreme Court upheld the two causes of action, holding that the physician could be liable for the child's subsequent injuries. The court first considered common law negligence and used the reporting statutes to establish the standard of care, stating that the statutes "evidence a determination by the Legislature that in the event a physician does diagnose a battered child . . . due care includes a duty to report that . . . to the authorities."

The court also considered the statutory negligence claim, and upheld the use of statutory negligence as a means of holding civilly liable a physician who did not report child abuse to the authorities pursuant to the requirements of a reporting statute.

Progeny of *Landeros*

Numerous courts have looked to *Landeros* for guidance in ruling on liability for failure to comply with a mandatory reporting statute, both in the child abuse context and the elder abuse context – and, at some point, in the domestic violence/spousal abuse context.

Some courts have agreed with *Landeros* that there can be a common law tort duty to report child abuse.[32] Other courts have been more protective of the reporter. A number of courts have indicated there is no common law duty to report possible child abuse.[33] For example, the court in *Vance v. T.R.C.*,[34] considered a physician who diagnosed a 13-year-old girl with genital herpes and failed to file a report that she was a victim of child abuse, as directed by statute. The court found that the mandatory reporting statute did not create a civil cause of action. "Even if Vance violated this statute . . . this statute does not create a civil cause of action in favor of the abused child." Moreover, the court held, even if the statute did create a private cause of action in tort, no viable claim would exist. It noted that statute requires that notice be given only by those physicians "having reasonable cause to believe that a child has been abused" and it penalizes only those physicians "who knowingly and willfully" fail to do so. It does not require that notice be given by those physicians "who should have had reasonable cause" to suspect child abuse and it does not penalize those physicians "who fail to discover and report" suspected instances of child abuse.

Statutory negligence-based cases have met mixed responses from courts as well. Tribunals in states like New York, Michigan, and Tennessee have agreed with California's *Landeros* decision that statutory negligence applies to physicians and other mandatory abuse reporters who do not report. For example, *Ham v. Hospital of Morristown* was a federal case that applied Tennessee law to conclude that a private, civil cause of action could be stated under that state's reporting law.[35] Tennessee's reporting statute does not expressly create a civil action for failing to report, but makes failure to report a misdemeanor. The grandmother of the child sued the doctor and hospital who failed to recognize and report the following symptoms as abuse: nausea, vomiting, blisters on the hands, and an abrasion on the forehead. The mother claimed that the child may have been bitten by a mouse. After treating the child for acute gastroenteritis, the doctor returned the child to her mother. Two days later, the mother took the child to a different hospital, where she was diagnosed as having been abused and suffering brain damage. The grandmother alleged these injuries were inflicted by the mother or her boyfriend after the child was released from the defendant hospital.

The court, deciding whether to grant the doctor's motion for summary judgment (basically, to dismiss the case because the plaintiff couldn't make a case), reasoned that violation of the Tennessee reporting law is not a criminal statute unless someone "knowingly" fails to make a report. Therefore, since the doctor and the hospital did not have reason to know the child was abused, they could not be subjected to punishment. They could, however, be exposed to civil liability for not reporting. Thus, the court allowed the case to go forward, because there was a "genuine issue of material fact as to whether the defendant doctors should have been put on *notice* that the child was the victim of child abuse."

Note that this "notice" standard is a much lower threshold than "knowledge." According to the *Ham* court, knowledge is required by the reporter to be subjected to criminal liability, whereas notice may be enough for civil liability to attach. Since the defendants did not know the child was abused, they could not be punished. Since they did not know the child was abused but may have been put on notice, they might have been subjected to monetary damages which could far exceed the amount of criminal fines imposed.

A number of other jurisdictions, however, have refused to extend statutory negligence to violations of child abuse reporting statutes.[36] For example, in *Borne v. Northwest Allen County School Corp,*[37] the Indiana Court of Appeals concluded that the legislative purpose in enacting Indiana's child abuse statutory scheme was not to create a private right of action against non-reporters of abuse. Since the legislature did not intend for a private right of action, statutory negligence, in turn, would not apply. In similar cases, courts have held that the reporting laws are intended to protect the general public rather than a specific class of individuals.[38]

Elder Abuse Failure to Report[39]

A civil cause of action for failing to report suspected elder abuse or neglect as required by law has been created by statute in four states.[40] However, few reported cases have tested the scope of these requirements. In *Wall v. Fairview Hosp. & Healthcare Serv.*,[41] the court dismissed a claim by psychiatric patients against a psychiatric nurse for failure to report abuse by a psychiatrist. This court considered what knowledge is sufficient to

trigger the reporting statute. The court stated that the knowledge that gives rise to the reporting duty must be particularized or specific to each individual, rather than mere suspicion or foreseeability. Because the nurse, who was the psychiatrist's assistant, did not have particularized knowledge of the psychiatrist's drunkenness, sexual advances, and other inappropriate behavior with patients, her duty to report was not triggered.

The statutes differ on this point in particular — each statute requires a somewhat different (or differently described) mental state to trigger the reporting requirement. One noted professor suspects that litigation in these four states could provide the catalyst for more civil liability for failure to report suspected elder abuse.[42]

Professional Discipline for Failure to Report

All members of licensed professions are subject to disciplinary control by a legislatively designated agency or board in the state of license. Thus, potential professional disciplinary action is yet another possible outgrowth of a failure to report. For example, the District of Columbia Code explicitly provides: "Any health-care administrator or health professional licensed in the District who willfully fails to make a report required by [mandatory reporting statute regarding elder abuse or neglect], or willfully makes a report under [the reporting statute] containing information that he or she knows to be false, shall be guilty of unprofessional conduct and subject to any sanction available to the governmental board, commission, or other authority responsible for his or her licensure."[43]

Moreover, many state professional licensure statutes generally provide for revocation of licenses if the professional violates rules, laws, regulations, etc. For example, some jurisdictions make the failure to file "any report required by law" grounds for revocation of a doctor's professional license.[44] Similarly, a state examining board may be given the power to sanction physicians who violate a law that relates to the practice of medicine.[45] This is but another reason practitioners should refresh their knowledge of state reporting laws.

Conclusion

The ED practitioner has little choice but to be involved in the legal process. If the practitioner can learn the issues and discern his role, he can add considerable value to the legal process by aiding, rather than obscuring, truths which always seem at peril once subsumed by the legal process. Knowledge of the law will protect the practitioner from the risks of either civil or criminal liability, and even discipline through state licensing agencies. Reporting laws have been developed to protect patients, not penalize physicians. Ultimately, proper practice of forensic emergency medicine can save lives.

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14. *See supra* note 7 at section 7.
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Protect Physician Reporters, *Hous J Health L Pol* 2001:133:140 and footnote 37; Jones J, Battered Spouses' Damage Actions Against Non-Reporting Physicians, 45 DePAUL L. REV. 191, 198; Moskowitz at 114.

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CE/CME Questions

1. Among the steps that should be taken with a patient who has suffered a gunshot wound is/are:
   A. to separately package clothing in paper bags.
   B. to cover the patient's hands with paper bags if gunshot residue or soot is noticed.
   C. to avoid use of povidone-iodine on skin that might be tested for gunshot residue.
   D. to handle bullets with gloves.
   E. All of the above

2. If possible, in order to determine if a bite pattern can be used to identify a suspect, a bite wound should be examined by a/an:
   A. dentist.
   B. police officer.
   C. orthodontist.
   D. odontologist.

3. An excited utterance:
   A. must have been made while responding to the event that prompts the utterance in order to be admitted as an exception to the hearsay rule.
   B. may be admitted even if the victim is unwilling to testify.
   C. Both A and B are correct.

4. Acceptable inclusions in a patient's medical record include:
   A. wording which casts doubts upon a patient's reliability.
   B. comments written in shorthand.
   C. photographs or body maps indicating location of injury.
   D. terms that draw legal conclusions, such as "domestic violence."

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