A H R M N Y

RISK MANAGEMENT JOURNAL

JOURNAL OF THE NEW YORK RISK MANAGEMENT CHAPTER OF ASHRM

AHRMNY
The Association for Healthcare Risk Management of New York, Inc.

www.ahrmny.com

Making a Federal Case Out of It: The Perils, Pitfalls & Protections for Mandated Reporters of Suspected Child Abuse

By Christopher Simone and Jason R. Corrado

Introduction

While the possibility to someday being sued for medical malpractice looms for any physician, the same probably cannot be said for accusations of a constitutional dimension – literally. But for clinical providers who are mandated by law to report suspected child abuse, the potential is real. How such practitioners approach their assessment of potential child abuse, lodge their mandated report and cooperate with the investigative authorities can make a world of difference towards determining whether their conduct rises to the level of state action and/or affords them statutory immunity under state and federal law.

The Interplay Between Mandated Reporters of Suspected Child Abuse & Civil Rights Violation

The source of potential constitutional claims against the medical practitioner starts with the obligations under Title 6 of New York's Social Services Law. In particular, § 413(a) anoints physicians and nurses, among others, as "mandated" reporters who are *required* to alert authorities – the police or appropriate child protection agency - "when they have reasonable cause to suspect that a child coming before them in their professional or official capacity is an abused or maltreated child". Furthermore, since protecting children from harm is the statute's overarching goal, the range of potential abuse or maltreatment that triggers reporting can span injuries as simple as a bruise to as significant as brain trauma, whether unexplained or even with an explanation. While pediatric child abuse specialists would naturally stand at the forefront of the inquiry, any healthcare clinician could face such injuries at some point. If these duties are not clear enough, § 420 slaps mandated reporters with a Class A Misdemeanor for willfully failing to report. At the same time, however, the statute *protects* mandated reporters when they report in good faith by shielding them with immunity from civil or criminal suit.

But this immunity does not prevent disgruntled or offended parents subjected to the report from commencing suit for garden variety medical malpractice and other state law claims as a means to bootstrap constitutional civil rights violations under 42 USC § 1983. (Nor are they discouraged from doing so by their attorneys who stand to collect statutorily prescribed attorney's fees for their efforts.)

By way of background of the constitutional claims, 42 USC § 1983 provides for an action at law against a "person who, under color of any statute, ordinance, regulation, custom, orusage of any State . . . subjects or causes to be subjected, any citizen of the Unites States . . . to the deprivation of any rights, privileges, or immunities secured by the Constitution and law." Examples of these deprived rights those arising under the 4th Amendment (violations of search and seizure) and the 14th Amendment (denial due process), along with malicious prosecution or false imprisonment. (Traditional § 1983 litigation arises from actual government conduct, such as police misconduct and the like.)

Private citizens and entities (such as physicians and hospitals) are not generally subject to § 1983 liability. A plaintiff can sue physicians or hospitals, however, by alleging that they were de facto "state actors," requiring proof that they "acted under color of state law." Depending on the conduct at issue, this may be shown in any of three ways, namely the (1) joint action test, (2) compulsion test or (3) public function test. Joint action requires an agreement between the state and a private entity (not merely cooperation with the state) to act in concert to inflict an unconstitutional injury and an overt act done in furtherance of that goal causing damages -- essentially a conspiracy. Alternately, under the compulsion test the entity must act pursuant to the coercive power of, or be controlled by, the state. Lastly, the public function test is satisfied where the private citizen performs a function that is traditionally the exclusive prerogative of the state.

Even if deemed state actors, however, the private citizen and entity enjoy qualified immunity under § 1983 for performing a discretionary task if (a) their action did not violate clearly established law or (b) it was objectively reasonable for them to believe that their action did not violate such law. Clearly, where NY State law *mandates* reporting of suspected child abuse, a physician or hospital would not be violating any law by making the required report. They would thus be immune from federal suit as well, provided the report was reasonable. Reporting suspected child abuse itself is not state action.

Furthermore, when a private hospital admits and performs tests on a child for medical reasons, the hospital is not subject to liability under § 1983, even if concerns of abuse partially inform the decision. Once a child is no longer being held for any medical treatment, but a hospital continues to detain and test the child for purely investigatory reasons, however, the hospital itself becomes a part of the "reporting and enforcement machinery" of the investigating agency and may be subject to § 1983 liability.

Overall, federal courts recognize the potential Hobson's Choice facing clinicians: failure to report is a misdemeanor, but reporting where a subsequent entity determines the report was

"unfounded" may prompt civil liability against the clinician. As such, even where courts have found "state action," to date they have uniformly applied a deferential standard to protect clinicians from civil liability, as well as finding them immune from liability. After all, qualified immunity is only necessary when the clinician's suspicions of abuse were wrong.

Minimizing the Risks to Mandated Reports

Determining state action and/or immunity in the context of private citizens and entities is a fact-sensitive endeavor. Thus, practitioners suspecting child abuse must be careful when assessing children, reporting and making recommendations to the state agency and the court system. Otherwise, they may be viewed as entangled with part of the enforcement mechanism (i.e. state actors) or as acting unreasonably (i.e. not entitled to immunity). Furthermore, the caution must continue throughout the process as the role of the mandated reporter rarely ends at the report itself. It can extend into the state's investigation and reach the inside of a courtroom. That is, the reporter or clinician involved must remain objective, report what is observed or – with good faith, suspected – but allow the *actual* state actors to conduct an appropriate investigation (e.g. – police department, child protective agencies, etc.).

So, how can clinicians minimize the legal risks in reporting suspected child abuse and avoid the perils and pitfalls attending to the reporting duty? This can generally be accomplished by maintaining their objectivity and circumscribing their role in the reporting process to no more than expected or needed.

The first step is proper documentation. Specifically, clinicians must accurately document their observations and, if relevant, discussions with family. Drawing *medical* conclusions, or diagnosing the patient's medical condition is appropriate, but drawing conclusions regarding *causation* of the condition should be left to investigators or police – unless a caretaker, parent or other individual with custody of the child identifies the cause, which should be documented and reported.

Next, clinicians should seek appropriate medical consultations as needed, including, for example, orthopedics, neurology, neurosurgery or radiology, to obtain objective assessments *where medically indicated*. (While photographs *absent* medical need is permitted under the Social Services Law[1], radiological examinations require medical necessity.) If available, the clinician also should seek a consultation with a staff pediatric child abuse specialist.

When to report, or how such report is viewed thereafter, is truly an objective standard. Governing New York State law repeatedly uses the phrase "reasonable cause to suspect" as the reporting trigger. For example, when defining mandated reporters, the law refers to persons with "reasonable cause to suspect that a child coming before them in their professional or official capacity is an abused or maltreated child." Moreover, § 419's immunity provision requires the report be made in "good faith," which will be presumed "provided such person, official or institution was acting in discharge of their duties and within the scope of their employment," and that reporting did not result "from the willful misconduct or gross negligence of such person, official or institution." In practice, examples of willful misconduct or gross negligence include circumstances where the report itself was not warranted under *any* objective criteria, was made maliciously to negatively affect the parent or guardian, or was completely unsupported by the information available to the clinician at the time.

Reasonable vs. Unreasonable Suspicion of Abuse

"Reasonableness" lies at the heart of the report as well as the clinician's subsequent conduct. In New York, the "reasonable basis to suspect" abuse or neglect carries a rather low threshold. Confronted with any unexplained injury, or illogical etiology or cause provided by the child's caretaker, the obligation to report is clear and eminently reasonable. Situations will arise which are not so obvious; it is there that a clinician's "good faith" will be presumed unless the report is *objectively* unreasonable.

It is demonstrably challenging - if not impossible - to list each and every circumstance where a report is mandated, or what circumstances would be considered "reasonable" to the average person, clinician or court. But, identifying such situations that leave the clinician in peril are somewhat easier.

First, failing to take an adequate history can lead clinicians down the wrong path, towards potential liability. But, a thorough, well-documented history, including the specific source of the information, coupled with appropriate assessments and testing can readily demonstrate the reasonableness of the subsequent report.

Next, neglecting to adequately document the observations, objectives and assessments, diagnostic or test results, or conversations that informed the decision to report, can lead to liability. So, too, can failing to adequately communicate with colleagues, or seek consultations from appropriate specialists to more thoroughly investigate a child's condition. Clinicians are strongly cautioned against making assumptions as to the cause of a condition, but strongly encouraged to obtain as much objective information as is medically necessary, and seeking appropriate consultations to better understand the potential causes of any given condition or presentation.

Another manner in which clinicians place themselves at risk is is by striving for the conclusion by (1) forcing a diagnosis, (2) rendering an unsupported opinion on causation,

(3) overzealous advocacy or (4) ignoring equivocal clinical or historical data. It may be the natural inclination of medical providers to treat and cure. But, when a clinician seeks to protect a child "at all costs" by chasing the conclusion of abuse or neglect despite insufficient data, the clinician can lose their entitlement to immunity. In practice, this often presents when the clinician suspecting abuse or neglect pressures or enlists – overtly or subtlety – other physicians to support their deductions or conclusions.

For example, approaching another provider and merely saying "I think this child was abused; do you think that could be the cause of her condition", already plants the seed of an intended conclusion and may affect the other provider's judgment, discretion or decision-making. If *consistent* with trauma, the provider may respond "it could be," possibly foreclosing further medical evaluation and arriving at the conclusion without considering the equivocal response.

Also, reporters can lean toward overzealous advocacy on behalf of the child they believe was abused or neglected due to the desire to protect the child. Advocating for the *conclusion*, however, is *not* the province of medical providers and places them at risk of liability. Clinicians can and should report about the objective findings, and if qualified, can render opinions regarding potential causes. But unless direct information as to such cause is actually *known*, the clinician should not play detective and opine as to the cause.

Approach the Report Clinically

In making a mandated report, clinicians should remain objective and conduct a reasonable assessment of a child given the circumstances presented. The most reasonable approach is to see what is present, observe, document and consult, without overreaching or prejudging. As always, treating the patient is paramount, and all appropriate and medically necessary tests should be ordered and performed. If circumstances warrant a reasonable suspicion of abuse or neglect, a report should be made with a clinical approach: describe what was observed, the results of lab or diagnostic tests, and if such information was learned by obtaining the data and history, the medical conclusions reached.

Reporters should remain clinical in their approach. For example, they should avoid concluding that injuries were caused by "child abuse" in favor of a more objection description as "consistent with non-accidental trauma". The difference is obvious: "child abuse" is a legal conclusion while the latter is akin to a medical assessment. Noting that injuries or a condition are consistent with trauma" or that "non-accidental trauma cannot be excluded" are equally appropriate for clinicians.

After the Report: Family Court Proceedings & Potential Litigation

The above-discussed clinical approach to making a report applies equally to post-report proceedings in which the practitioner likely will be involved in some way. Even after officially lodging their suspicion, mandated reporters must cooperate with the agency conducting an investigation and/or prosecuting a case against the alleged abuser. Moreover, proceedings may be criminal in nature, or civil actions involving removal of the child (and possibly siblings as well) from the custody of the parents. Whatever the circumstances, objectivity is in order.

The scope of a clinician's cooperation is far more nuanced, though, and depends greatly on their role (e.g., a neurosurgeon performing surgery will have a vastly different role than a pediatric child abuse specialist), their involvement with the child's care or treatment, and even subsequent contact with the child or the child's family. In Family Court removal proceedings, the prosecuting "state" attorneys often seek the clinicians involved to testify in court, and regularly seek "expert opinions."

An entire article could be dedicated to this one topic, but for sake of brevity, clinicians should speak with their risk management department and request the assistance of counsel familiar with these proceedings. At a minimum, the attorney will act as a guide through the process and help reduce the risks of potential litigation or liability concerns which may result *from* the process.

Of course, practitioners served with legal papers such as a subpoena, summons and/or complaint should immediately report it to their risk management department. If required to testify, either at a deposition or in court, they should request the assistance of counsel to protect both their and their employer's interests.

References on page 38

About the Authors

Christopher Simone, a Senior Partner/Co-Chair of the Litigation/ Appellate Strategy & Advocacy Group and Jason R. Corrado, Sr., a Trial Partner in the Medical Malpractice Litigation Group at Shaub, Ahmuty, Citrin & Spratt, LLP, have successfully defended mandated reporters against allegations of civil rights violations in both Federal and New York State court systems.