

Note: Legal Recognition of the Battered-Child Syndrome

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NOTES AND COMMENTS

NOTE: LEGAL RECOGNITION OF THE BATTERED-CHILD SYNDROME

Introduction

The "battered-child syndrome," a term used to characterize a clinical condition in young children who have received serious physical abuse, generally from a parent or foster-parent, is a significant cause of childhood disability and death. The problem of the battered child, common to every community, is a phenomenon which occurs regardless of the economic or educational background of parents. Cases of abuse are reported from the seemingly well-regulated home and from the obviously disorganized and broken home.

The fact of child abuse is an anomaly in our enlightened age. We live in a civilization which is essentially family oriented and child centered; in communities which speak of respecting the rights of children; and in a society which expresses dedication to the concept that the welfare of children is of primary importance. Yet we find that children are still victims of destructive parental behavior. What is more alarming is the fact that with all our vaunted progress, communities have, for the most part, failed to provide effective counter-measures to meet this profound problem. It is hoped that the present widespread concern for the plight of the battered child will be soon translated into social action to provide services calculated to meet the needs of children in grave

danger at the hands of parents and at the mercy of a well-meaning but misguided public.

National anxiety for the battered child can be traced to several positive occurrences. First is the new-found concern for these children by groups in the community not previously specifically identified with child protective services. No group has contributed more to the current understanding of the problem than have pediatricians and roentgenologists in hospitals and clinics. They have defined the battered-child syndrome as that constellation of symptoms which, when viewed together, unerringly point to a medical diagnosis of a physically abused child.¹ For the past several years medical literature has placed responsibility on the medical profession for proper identification and diagnosis of these conditions and for alertness to the signs and symptoms which indicate physical abuse of children. Great concern and frustration have been expressed in these writings. The concern results from the knowledge that the medical profession has failed to diagnose the battered child because doctors often accept the glib stories of parents who claim that the injuries resulted from accidental causes. The frustration relates to the fact that when such cases are identified, the community is ill-equipped to fully protect and safe-

¹ DeFrancis, CHILDREN'S DIVISION, THE AMERICAN HUMANE ASSOCIATION, CHILD ABUSE — PREVIEW OF A NATIONWIDE SURVEY 1 (1963).

guard the welfare of the abused child. Due to the increased efforts of the medical profession, the multi-faceted problem of the battered child has been given national recognition as a community problem of a high priority order.

The second occurrence is a wider acceptance of the stark reality of physical abuse of children. People everywhere are seeing evidence of parents who strike out blindly at their children. They read with horror newspaper accounts of children who are severely beaten; children who are locked in dark closets; children who are blistered and scarred by burns; children with broken bones, maimed limbs, and fractured skulls; and of children who are even killed by angry parents. These newspaper stories effect an emotional reaction and arouse furious indignation against parents who treat children so callously.

Much attention has been focused on the problem of the battered child by efforts to promote state legislation for the mandatory reporting of cases of suspected physical abuse. Physicians everywhere are urging the passage of legislation which:

- (1) will clearly compel the profession to report all cases where diagnosis leads them to believe the child is a victim of parental abuse; and
- (2) will free doctors from the ethical barriers arising out of the confidentiality of the doctor-patient relationship.²

The Advisory Committee to the Children's Division of the American Humane Association, on October 26, 1962, unanimously endorsed the concept of legislation

² DEFRANCIS, CHILDREN'S DIVISION, THE AMERICAN HUMANE ASSOCIATION, GUIDELINES FOR LEGISLATION: TO PROTECT THE BATTERED CHILD 6 (1962).

for the mandatory reporting of cases of suspected inflicted injuries on children. The Committee recognized and endorsed the following principles:

- (1) that such legislation be directed to medical practitioners and hospital personnel coming in contact with children for the purpose of examination and treatment of injuries sustained allegedly from accidental or other causes.
- (2) that doctors and hospital personnel have mandatory responsibility for reporting all cases of child injury where medical diagnosis and findings are incompatible with alleged history of how injuries were sustained and the syndrome leads to the inference of inflicted injuries.
- (3) that doctors and hospital staff members reporting cases of suspected inflicted injuries be made immune to possible civil or criminal action for the disclosure of matters which might be considered confidential because of the doctor-patient relationship.
- (4) that all reports of cases of suspected inflicted injuries be made to the public or voluntary child welfare service which carries the child protective function in the community.³

The need for such legislation is widely accepted. Doctors, probably more than any other group, are a prime source for "finding" abused children since such children are brought to them for treatment. Doctors are also best qualified to determine whether injuries are the probable result of accident or physical abuse. Therefore, it is necessary that they be legally freed to take responsible

³ *Id.* at 9.

action on behalf of abused children and to report such cases to an appropriate agency. That agency would then accept responsibility on behalf of the community to fully protect the child. In considering state legislation involving children, certain basic principles should always be kept in mind:

Parents have the primary responsibility for meeting the needs of their children; society has an obligation to help parents discharge this responsibility; and society must assume this responsibility when parents are unable to do so.⁴

When children are abused or mistreated by other persons, their parents or those responsible for their care and protection are expected to take whatever action may be indicated under the law. But when the family or home environment itself is unsafe for children, *i.e.*, when it has produced their injuries and threatens them with more, it is the duty of the state to provide protective services.

Recent Legislation: New York and California

As a result of the impetus received from medical associations and social service agencies, several states have passed legislation concerning the reporting of battered-child-syndrome cases. The legislation passed in New York and in California, while basically alike in requiring a report in suspected cases of child abuse, indicates different approaches utilized in following the suggested principles. It also delineates steps which state legislatures are willing to

take in order to effect a compromise between the medical and legal aspects of battered-child cases.

The New York "Battered-Child-Syndrome Act" amends the Penal Law by providing for reports of treatment of certain injuries sustained by children under sixteen years of age. This statute, which became effective July 1, 1964, is the result of several bills introduced in the New York State Assembly.⁵ The act provides that when a physician, surgeon, dentist, osteopath, resident or intern, who examines or treats a child, has reason to believe that the child has had serious injury inflicted upon him as a result of abuse or neglect, he, or the person in charge of the institution where the child is being treated, must immediately report the matter to a branch of the Society for the Prevention of Cruelty to Children, or another duly authorized child protective agency, or to a public welfare official. A person or institution submitting such a report in good faith is given immunity from any liability, civil or criminal, that might otherwise be incurred or imposed as a result of the report, *e.g.*, an unethical breach of confidence between doctor and patient.

By the enactment of chapter 811, New York becomes one of thirteen states which have laws whose general purposes are to provide sanctions and obligations for doctors who otherwise might be hesitant to report cases of abused children. Such legislation envisions methods for receiving these reports, dealing with them, investigating the situations they cover and, finally, attempting to provide help for both the parents and children involved.

The development of the act can be traced

⁴ WELFARE ADMINISTRATION, CHILDREN'S BUREAU, U.S. DEP'T OF HEALTH, EDUCATION, AND WELFARE, *THE ABUSED CHILD: PRINCIPLES AND SUGGESTED LANGUAGE FOR LEGISLATION ON REPORTING OF THE PHYSICALLY ABUSED CHILD* 5 (1963).

⁵ N.Y. Sess. Laws 1964, ch. 811, amending N.Y. PEN. LAW § 483-d.

through several bills introduced by various New York State Assemblymen. An examination reveals that the current act is but a synthesis of these preceding bills. The third provision of the Kelly-Conklin Bill⁶ proposed the addition of a new section to the Penal Law, requiring physicians and others treating abused children to report such incidents to the police; however, there is no mention of penal sanctions to be imposed upon the failure to make such a report. The imposition of such penal sanctions was attempted in the Savarese Bill⁷ which dealt only with the reporting to the police of cases of child abuse. Under this bill, the failure to make such a report was denominated an offense. The Curran Bill,⁸ which provided in part for the reporting of cases of child abuse, would have made the failure to report a misdemeanor. It also would have nullified the physician-patient and the husband-wife privilege in any judicial proceeding resulting from such reports.

The present law encompasses certain provisions of the Kelly-Conklin and Curran Bills. Similar to the Savarese Bill, the law as enacted fails to make any mention of criminal penalties imposed for failure to comply with the directive. The third part of the Curran Bill has been incorporated in the present law in that it provides that the physician-patient privilege shall not be the ground for excluding evidence in a child abuse case or in judicial proceedings which result from a report pursuant to this section.⁹ The current act does not regard the

husband-wife relationship, as the Curran Bill did, in a similar light. Unlike the latter, the present statute fails to give many particulars on the procedure for reporting suspected cases of child abuse. The Curran Bill, passed by both houses of the New York State Legislature, but vetoed by the Governor as "unnecessary,"¹⁰ provided that the report be made to the "appropriate *police* authority as soon as practicable by telephone to be followed by a report in writing within forty-eight hours thereafter. . . ."¹¹ It also imposed the duty upon the police authority to transmit a copy of the report to the public welfare official concerned with investigating complaints of neglect of children.¹²

Rather than placing the provision for the reporting of cases of child abuse under Penal Law Section 1915, which deals with physicians' reports of injuries received by firearms, the present enactment places the provision for the reporting of such cases under Penal Law Section 483, which deals with injuries inflicted upon children as the result of abuse or neglect. The only substantial result which arises from placing the provision in section 483 is the lack of imposition of a criminal sanction. While this absence of a penalty has been noted by one bar association report,¹³ the provision, however, has been considered a salutary one which enables the medical profession to aid the police in apprehending, and the district attorney in prosecuting, a "vicious type of crime that is all too prevalent."¹⁴

Although the legislation is not intended to prevent or discourage voluntary reporting by others, because of the seriousness of the

⁶ N.Y. Assembly Bill Int. No. 860, Print No. 4368 (1964); N.Y. Senate Bill Int. No. 308, Print No. 2731 (1964).

⁷ N.Y. Assembly Bill Int. No. 1486, Print No. 5009 (1964).

⁸ N.Y. Senate Bill Int. No. 2253, Print No. 4312 (1964) [hereinafter cited as the Curran Bill].

⁹ Curran Bill 3.

¹⁰ Governor's Memorandum, April 25, 1964.

¹¹ Curran Bill 2. (Emphasis added.)

¹² *Ibid.*

¹³ 1964 N.Y.C.B.A. LEG. BULL. 31.

¹⁴ *Ibid.*

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. When a physician has diagnosed a case as within the purview of the statute, neither he nor the institution has any discretion in the matter of notifying the appropriate authority. Without regard for considerations growing out of the physician-patient relationship or any other matter, he has the duty to make or cause to be made a prompt report.

The present enactment requires a report to be made when there is reasonable cause to suspect that physical injury was inflicted by a parent or other person responsible for the care of the child. The duty which would be imposed upon the reporter is necessarily a limited one. In its decision-making aspect, this duty is akin to that performed by a grand jury when it finds probable cause that a given individual committed a crime. Basically, the legislative language would require a judgment on the part of the reporter that the injuries are not reasonably explainable as having happened accidentally; that they were inflicted upon the child; and that they were inflicted in the family or home environment. It contemplates, furthermore, that the reporter will base his judgment on the facts readily available to him in the conduct of his professional services: he is not expected to make any outside, independent investigation. The reporter would be concerned only with what is disclosed to him by the nature and extent of the injuries and the case history. If from these he finds a reasonable likelihood both that the injuries were inflicted on the child by other than accidental means *and* that they were inflicted by a parent or other person responsible for the child's care, he would have to

make a report. If he is not able to draw this conclusion with respect to each of these, he is not required to report.

A physician, in making his diagnosis, would have to decide whether the case before him falls within the ambit of the statute. But, in so doing, his would be the preliminary act. His report would initiate investigatory machinery and might result in either law enforcement, social service or judicial action. It should be noted that in making his decision to report, he would not be functioning as judge or jury. He would merely be acting on a reasonable suspicion stemming from his professional experience and expert opinion. More than this would not be required of him.

Even with respect to physicians who serve on the staffs of hospitals or similar institutions, the responsibility for initiating a report is on them and not on hospital administrative officials, since the decision involved appears to be largely medical in nature. To the extent that nonmedical factors enter into the diagnosis, they, too, would have to be adduced by the physician. It would be anomalous to require another person, particularly one who has had no direct contact with the case, to have initial responsibility for this report. Moreover, when a staff physician notifies the appropriate administrative official, the making of a report is mandatory.

With respect to the contents of the report, the legislative language is self-explanatory. The physician is required to describe the nature of the child's injuries, and include other relevant data obtained in the course of his examination. He is not required to specify any individual as having inflicted the injury, nor is he burdened with obtaining additional information. However, the legislative language relates only to the reporting

of cases to the appropriate child welfare authority. It does not prescribe the duties of such authority upon the receipt of the report, nor does it include a provision for the protection, care, and treatment of the child. Similarly, it fails to provide a procedure for dealing with the parent or other person responsible for the child's well-being, whose failure, as such, has compelled the state to take action. The statute presupposes the existence of adequate, applicable legal and social machinery, *e.g.*, laws, social welfare agencies and courts, which will be set in motion by the filing of the required reports. This is based upon the further assumption that under the laws of New York, the report would allege facts sufficient to bring the child and the adults involved within the jurisdiction of the proper court.

California, through the enactment of Section 11161.5 of its Penal Code, has also recognized the problem of the battered child. Like New York, the California provision extends the requirement of reporting injuries which result from a violation of penal laws to include the reporting of injuries sustained by a minor if "it appears . . . that the minor *may* have been a victim of a violation"¹⁵ of the statute prohibiting willful cruelty or unjustifiable punishment of a child. The California legislation would seem to be of wider scope than the New York enactment since it provides for the reporting of suspect injuries in all minors, whereas the New York law confines the report to injuries in children under sixteen years of age.¹⁶ Like the Curran Bill, but unlike the enacted New York law, the California statute is specific as to the procedure

for reporting in that it requires: (1) that the report be made by telephone and in writing; (2) to the head of the police department, to the sheriff, or to the nearest child welfare agency; and (3) that the report state, if known, the name of the minor, his whereabouts, and the character and extent of the injuries.

The California law, besides establishing a definite procedure, differs from the New York law in three major respects: (1) it does not require a report if the physician thinks it "would not be consistent with the health, care, or treatment of the minor";¹⁷ (2) it makes no mention of any immunity granted to a physician or surgeon who makes such a report; and (3) it lists the police authority as one of the agencies to receive such reports. The inclusion of the first two factors would seem to greatly decrease the effectiveness of the statute since it fails to take into consideration the basic problem in cases of child abuse — the reluctance of the physician to report or testify in a case involving child abuse. By leaving the report subject to the doctor's discretion, the statute provides an available means for a physician, who does not wish to become involved in a case of child abuse, to "legally" avoid filing the report. If immunity were provided for by the statute, there would be less likelihood that the discretionary provision would be used as an escape clause.

While there is a general acceptance of the need for the type of legislation in question, there is a divergence of opinion with respect to what agency in the community should receive the reports on abused children. The California statute, while providing for reports to child welfare agencies, lists the police department as the preferred agency to receive such reports. Although the police

¹⁵ CAL. PEN. CODE § 11161.5. (Emphasis added.)

¹⁶ The New York age provision corresponds to the maximum juvenile age of family court jurisdiction in New York State.

¹⁷ CAL. PEN. CODE § 11161.5.

and other law enforcement agencies do have a definite role in community action against the parents, the needs of these children are the community's primary concern, and the emphasis should be centered upon fulfilling these needs, rather than upon punitive measures directed against adults by law enforcement officials. Of all the possible investigatory agencies in a community to which reports of child abuse cases might be made, the child protective agency is best qualified to focus on the problem of "what happens to children" in these circumstances.

The Psychology Behind the Problem

On January 1, 1962, the Children's Division of the American Humane Association initiated a project to obtain data on child abuse cases reported in the newspapers of the country.¹⁸ The project was carried out in two phases. The first phase was concerned with gathering statistics indicating the number of child abuse cases reported and collating this information with accounts contained in the news stories themselves. Of far greater importance was the second phase. This was designed to evaluate community awareness of the reality of child abuse. It studied community approaches toward the protection of abused children; assessed community action taken on behalf of abused children; and evaluated community attitudes toward the importance of social planning for the child as opposed to retributive action toward the parents.

The data compiled by Phase I of the project revealed unusual patterns regarding the frequency of child abuse cases.¹⁹ From January through December of 1962, a total of 662 cases of child abuse were reported in newspapers throughout the United States.

These children were found in 557 families and ranged in age from early infancy through 17 years. However, barely 10% of the cases involved children over 10 years of age. The preponderance of the cases fell into the 4-year age group or under, with more than half of the children, 55.5%, found to be under 4 years of age. Even more significant is the fact that of the 178 children who died, 81.35% were under 4 years of age and 53.98% were under 2 years of age. Both sets of figures indicate the importance of doctors' reporting instances of child abuse since the majority of injuries are sustained by those children incapable of communicating the abuse inflicted upon them.

In classifying the persons inflicting the injury, it was noted that fathers were responsible for 38.25% of injuries in the 662 cases reported and for 22.22% of the fatalities. Mothers inflicted injuries in 28.86% of the cases, but these injuries were of a more serious nature, as indicated by the fact that mothers were responsible for 48.54% of the fatalities. Both parents acting together caused injuries in 5.46% of the cases and were responsible for 5.85% of the fatalities.

The question of community attitudes and the amount of community planning and investment toward meeting the problem of the battered child was in part assessed and documented by the findings in Phase II of the project. Phase II dealt with an examination in depth of the family and environmental characteristics in the cases reported, with an exploration of community attitudes and approaches to the needs of these children and families. The study indicated that the type and degree of physical attack vary greatly. At one extreme, there is direct murder of the child. This is usually done by a

¹⁸ DEFRANCIS, *op. cit. supra* note 1, at 3.

¹⁹ *Id.* at 4-5.

parent or other close relative and, in these individuals, an acute psychosis is usually readily apparent. At the other extreme are those cases where no overt harm has occurred and one parent, usually the mother, comes to the psychiatrist for help, filled with anxiety and guilt related to fantasies of hurting the child. Occasionally the disorder has gone beyond the point of fantasy and has resulted in severe slapping or spanking. In such cases the adult is usually responsive to treatment and it is not known whether the disturbance in these adults would progress to the point where they would inflict significant trauma on the child.²⁰

Between these two extremes is a large number of children with mild to severe injuries which may heal completely or result in permanent damage or even death after repeated attack. In some of the reports of social workers' investigations of families in which children have been beaten, the parents, or at least the parent who inflicted the abuse, have been found to be of low intelligence. Often, they are described as being of psychopathic or sociopathic character. Alcoholism, sexual promiscuity, unstable marriages, and minor criminal activities are reportedly common among them. They are immature, impulsive, self-centered, hypersensitive, and quick to react with poorly controlled aggression. Data in some cases indicate that such attacking parents had themselves been subject to some degree of attack from their parents in their own childhood.

Beating of children, however, is not confined to people with a psychopathic personality or of borderline socio-economic status. It also occurs among people with higher education and stable financial and social

background. However, from the scant data 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. Not infrequently, the beaten infant is a product of an unwanted pregnancy, a pregnancy which began before marriage, too soon after marriage, or at some other time felt to be extremely inconvenient. Sometimes several children in one family have been beaten; at other times one child is singled out for attack while others are treated quite lovingly. There are also instances in which the sex of the abused child is related to very specific factors imbedded in the abusive parent's neurosis.²¹

In the vast majority of the cases in which the father was responsible, the abuse seemed to result from an emotional outburst on his part. Usually this was an instantaneous reaction to a particularly irritating occurrence or an attempt to discipline which got out of control. In both instances the outburst or loss of control was probably a result of pre-existing emotional instability in the parent.

While these factors apply equally to the abuse committed by mothers, another element seemed to enter into the mothers' immediate motivation. Their actions seemed to be influenced by deeper psychological pressures and more disturbed, imbalanced and irrational thinking. There were specific instances where the immediate causal factors for a mother's destructive behavior stemmed from feelings of hopelessness and despair — from acute despondency and depression. A situation typical of this syndrome took place in New York where a mother of 8, in her early forties, took 3 of her children on a ferry across New York

²⁰ Kempe, *The Battered Child Syndrome*, 181 A.M.A.J. 18 (1962).

²¹ *Id.* at 19.

Upper Bay. When about 100 yards from the ferry slip, she threw her 6-year-old daughter over the railing and then, holding her other 2 children in her arms, jumped into the water. She and 2 of the children were rescued but the third child drowned. Clinical reports described the mother as having been despondent and depressed over financial problems and as having considered this as the only solution for herself and her children.²² A Colorado case indicates the same pattern. In this instance the mother gave her 2 boys, ages 6 and 4, an overdose of barbiturates because she "wanted to get them out of this cruel world." Here again, the mother had been acutely depressed. She had a history of hospitalization for mental illness and was discharged from a mental hospital only weeks before this incident.²³

A somewhat different pattern was visible in a group of cases in which either children were suffering from severe handicaps or mothers feared that their children would become the victims of handicaps. These women rationalized their action in terms of doing what was best for the children. Without question, these mothers were deeply disturbed, if not psychotic. These deeper psychological and emotional conflicts were factors which contributed to the higher incidence of fatalities in cases where the mothers were the abusing parents.²⁴

It is often difficult to obtain evidence that a child has been attacked by its parents. Sometimes one spouse will indicate that the other was the attacking person; but, more often, there is a complete denial of any knowledge of injury to the child and the maintenance of an attitude of complete innocence on the part of both parents. Such

attitudes are maintained despite the fact that evidence of physical abuse is obvious and that any resultant trauma could not have been caused by other means. Denial by the parents of any involvement in the abuse may, at times, be a conscious protective device; but, in other instances, it may be a denial based upon psychological repression. An example of the latter was demonstrated when one mother had complete amnesia during the episodes in which her aggression burst forth causing injury to her baby.²⁵

In addition to the reluctance of parents to give information regarding the attacks on their children, there is another factor which is of great importance and extreme interest, for it relates to the difficulty in treating the problem of parental neglect and abuse. Physicians have great difficulty both in believing that parents could have attacked their children and in undertaking the essential questioning of parents on this subject.²⁶ Many physicians find it hard to believe that such an attack could have occurred, and they attempt to obliterate such suspicions from their minds, even in the face of obvious circumstantial evidence. The reason for this is not clearly understood. One possibility is that a physician's antipathy in response to such situations is so marked that it is easier for him to deny the possibility of a parental attack than to have to deal with the indignation he experiences when he finally realizes the truth of the situation. Furthermore, medical training and temperament usually make it quite difficult for the physician to assume the role of policeman or district attorney, and to start questioning patients, as if he were investigating a crime. The average physician finds it most

²² DeFrancis, *op. cit. supra* note 1, at 10.

²³ *Id.* at 10-11.

²⁴ *Id.* at 11.

²⁵ Kempe, *supra* note 20, at 19.

²⁶ For a further analysis of this problem and some suggested methods of procedure, see *id.* at 19-20.

difficult to proceed when he is met with protestations of innocence from the guilty parent, especially when the battered child was brought to him voluntarily.

Community Objective – Social Planning

The community faces a critical decision in determining where its major responsibility lies. Should the destructive behavior on the part of parents be viewed primarily in terms of the criminal nature of the act, so that arrest, prosecution and punishment are the principal objectives? Or, should community concern be centered in the need for social planning for the child victim of abuse? Should not the primary objective be, first, to remove children from hazardous situations and, second, to plan for their best care and supervision, preferably in their own homes? And, should not services be extended to their parents to help them resolve the problems leading to neglect and abuse, to help build in them the emotional maturity and stability so necessary and important to good parenthood?

Prosecution of parents is least likely to provide proper protection and safeguards for the child victim of parental abuse. Such prosecution requires evidence of the abusive act which establishes the culpability of the parent beyond a reasonable doubt. Because these acts usually occur in the privacy of the home without outside witnesses, lack of evidence all too often makes it impossible to sustain the burden of proof and the prosecution fails. What follows an unsuccessful prosecution may subject the child to increased hazards, for, unless other action is taken, he will remain in the care and custody of a parent who, in addition to his other problems, may now be embittered by his experience with the police authorities and the criminal courts. His "vindication"

by acquittal may be viewed by him as a license to continue or even increase the abuse.

There is another aspect to the problem when criminal prosecution is chosen by the community as the appropriate procedure. Child abuse cases normally come to public attention only after the child is taken to a doctor or hospital for treatment of his injuries. If seeking medical attention for the child exposes the parent to possible criminal prosecution (because such cases are reported to an appropriate authority), there is a real danger that some children will not get the necessary medical attention. In fact, many cases of the reported fatalities indicate that there was considerable delay between the time of injury and the first effort to obtain medical attention. One cannot help assuming that fear of legal consequences may have motivated the procrastination in requesting medical help at least until the situation had become desperate.

What is of greater moment is the fact that punishment of parents through criminal prosecution does not correct the fundamental cause of the abuse. If we recognize the mental, physical and emotional inadequacies of these people, then we must also recognize that prosecution and punishment do not alter their behavior. What these parents need is help and treatment. They require guidance and counselling in accepting their responsibilities as parents. They need services which will help mend their damaged personalities and which will provide them with the strength and stability to successfully assume parental roles.

With respect to the abused child, the community must determine whether the immediate provisions of social services for the parents will permit the child to remain at home without running a risk of continuing

abuse. If this risk seems too great, or if it is deemed unwarranted, the child welfare agency would file a petition in the proper court, seeking the removal of the child from parental custody. Such removal is concerned with social planning for the welfare of the child, and not with punishment of the parents by denying them the right of custody. After the court had made adequate provisions for the placement of the child, the agency would renew efforts to correct conditions in the home so that he may eventually be restored to his parents.

While concentrating on what is best for the child, however, we cannot overlook the community's right and responsibility to undertake retributive action against parents who commit heinous crimes against their children. In circumstances where the abusive act constitutes a felony, the protective service agency has an obligation to consult with the local law enforcement authorities in order to make known the facts it has gathered. It then becomes the duty of the prosecutor to determine whether criminal action should be taken against the parents. The important factor in this cooperative approach is that while potential criminal proceedings against parents are being considered by the prosecutor, the child's needs are provided for by the welfare agency.

A Proposed Solution

While we have established that the problem of the battered-child syndrome exists, and while we understand some of its causes, a complete solution of the problem is yet to evolve and it requires several diverse efforts. While doctors must be educated to recognize and acknowledge what they so often resist and evade, they cannot bear the responsibility without legal and social support. With this backing, the conscientious

physician would then be able to perform his professional duty to reveal his findings lucidly and emphatically. Psychiatrists should also consider themselves under an affirmative obligation so to act.

Most important and practical is public and legal recognition of this problem. Although only a minority of children require this special concern and protection of the law, in this area we are faced with a problem of *degree*. Every child psychiatrist meets children who are victims of hurtful, fearful, careless, or essentially unloving or unstable parents. On the other hand, some children are victims of obvious parental brutality, and these are the cases which demand special, vigorous and sometimes drastic action. Disturbed parents require psychiatric care, and that is one urgent national interest. But parents who repeatedly attack their children and who are in danger of killing them deserve quite another priority of attention.

Few would deny society the right to intervene where a child's life is at stake. Yet, as might be expected, opposition to laws which attempt to establish a basis for such intervention often centers about such rallying slogans as "individual rights," "parents' rights," or the right of the family to "privacy." Of course, in a complex society like ours, most "rights" are relative, and are consequently modified by various legal and social obligations. Most states, however, have not yet assumed the obligation to provide adequate protection to children whose parents are crazed enough, or so stunted in intelligence or psychological development, to threaten their very lives. The problem of the battered-child syndrome has finally begun to receive the recognition it must have before effective means can be determined for its solution. While the physician must

educate himself to better recognize the battered-child syndrome, the legal profession and society as a whole must seek the passage of laws similar to those enacted in New York and California. These laws must not

indicate a hasty repudiation of the senseless brutality of sad and frightful people, but rather a passionate interest and a determined attempt to shield both children and adults alike.

