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CHILD ABUSE & ETHICS: WORKING THROUGH DILEMMAS IN MANDATORY REPORTING

2.8 Contact Hours

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Objectives

The goal of this program is to educate nurses about ethical and legal issues related to mandatory reporting. Recognizing abuse can be difficult and can trigger ethical concerns. After reading this article you will:

- Understand mandatory reporting statutes.
- Understand the mandatory reporter's immunity from criminal and civil liability.
- Understand the penalties and consequences for failure to report suspected child abuse.
- Recognize warning signs of Munchausen Syndrome By Proxy (MSBP).
- Understand the ANA Code of Ethics, provisions 2 & 3 in relation to mandatory reporting.
- Understand the establishment and maintenance of central registries for child abuse.
- Understand how allegations of child abuse impact the nurse/ patient/ family relationship.

INTRODUCTION

Child abuse cases, especially those with horrific outcomes, are all too frequently covered in the media. The author will use real court cases of MSBP to illustrate dilemmas that nurses face when trying to decide when and what they are mandated to report. MSBP is highly controversial, difficult to diagnose, prosecute and prove. It can present nurses with ethical choices that elicit powerful feelings. This article will help you make choices that follow nursing standards of practice and help ensure your patient's safety when child abuse is suspected.

CONTENT OUTLINE

- I. Mandatory Reporting of Child Abuse Statutes.
- II. Standards for Making a Report.
- III. Penalty for False Reporting.
- IV. Immunity for Cases of "Good Faith" Reporting.
- V. Failure to Report Suspected Abuse.
- VI. MSBP: A Form of Child Abuse or Psychiatric Disorder?
- VII. What Are Some Warning Signs of MSBP?
- VIII. MSBP Controversy in Court and Child Protective Service (CPS) Systems.
- IX. The Kathy Bush Case.
 - A. The Nursing Process.
- X. Moral Distress in Nurses.
- XI. Code of Ethics for Nurses.
- XII. The Health Information Portability and Accountability Act (HIPAA).
- XIII. Confidentiality Issues Related to State Child Abuse Statutes.
- XIV. The Julie Patrick Case.
 - A. Deposition Statements Made by Nurse Linda
 - B. Medical Determiner's Examination.
- XV. Establishment and Maintenance of Central Registries for Child Abuse.
- XVI. How Allegations of Child Abuse Impact the Nurse/Patient/Family Relationship.
- XVII. Conclusion

MANDATORY REPORTING OF CHILD ABUSE STATUTES

The Child Abuse Prevention and Treatment Act (CAPTA) is a Federal law that mandates minimum definitions for child abuse and minimum requirements for mandatory reporting. It was most recently amended and reauthorized in 2010 as the Child Abuse & Treatment Act of 2010 (P.L. 111-320).

To comply with CAPTA and receive federal funding, states and U.S. territories have some form of regulation that requires health professionals, and usually social workers, teachers, daycare providers and law enforcement personnel, to report abuse and neglect to the appropriate agency. This article will provide general information applicable to most states. However, specifics vary from state to state. As a nurse, you must know and follow, the guidelines for the state in which you practice.

WHERE CAN I FIND MY STATE'S STATUTES?

The Child Welfare Information Gateway has an online summary of all state child abuse and neglect statutes and also contains links to state specific reporting numbers. The web address is www.childwelfare.gov, or you can call 800-394-3366 for answers to any questions you may have.

WHAT SHOULD I REVIEW WHEN I LOOK UP MY STATE'S STATUTES?

Specific things you should search for are:

- Definition of reportable events or situations
- Description of the level of suspicion, i.e., reasonable suspicion or knowledge
- Who to make the report to
- Consequences of failing to report
- Confidentiality guidelines

STANDARDS FOR MAKING A REPORT

In many states, the standard for mandatory reporting is any reasonable suspicion of abuse. Another standard frequently used is when the reporter has knowledge of, or observes a child being subjected to, conditions that would reasonably result in harm to the child. As a professional, you are expected to know what standards apply in your state and must report any abuse that falls within those standards.



PENALTY FOR FALSE REPORTING

A 1993 CAPTA amendment required states to enact legislation providing for prosecution in false reporting cases. A false report is one in which a person willfully or intentionally makes a report of child abuse or neglect that the reporter knows to be false. Most states classify false reporting as a misdemeanor, but some consider it a felony punishable by 30 days to 5 years in jail.

What happens if the person I report turns out to be innocent? Does that mean I'll be charged with making a false report?

IMMUNITY FOR CASES OF GOOD FAITH REPORTING

No, as long as you made the report in "good faith" you are immune from criminal and civil liability. The term "good faith" refers to the assumption that the reporter, to the best of his or her knowledge, had reason to believe that the child in question was being subjected to abuse or neglect. Many states also provide immunity for other actions you may need to take in connection with making a report, such as performing medical examinations and/or taking photographs, video recordings or x-rays.



FAILURE TO REPORT SUSPECTED ABUSE

On the other hand, if you fail to report suspected abuse you can face criminal or civil liability. The liability is typically a misdemeanor punishable by a fine, but it may also be a felony. Upon conviction, you could face a jail term ranging from 10 days to 5 years, or fines of \$100 to \$5000. You could also lose your nursing license.

As you can see, the laws are meant to encourage mandated reporters to make "good faith" reports, and discourage them from failing to report suspected abuse. This is because the well being of the child is of paramount importance. However, the system is imperfect and as we will see in our second case study (The Patrick Case), some families suffer when "good faith" allegations are, in reality, unfounded.

MSBP (MUNCHAUSEN SYNDROME BY PROXY): A FORM OF CHILD ABUSE OR PSYCHIATRIC DISORDER?

MSBP is a controversial diagnosis. Experts disagree whether it is a psychiatric disorder of the mother that should be diagnosed and treated by psychiatrists (who call it Factitious Disorder By Proxy) or a form of child abuse that should be diagnosed by medical doctors. Psychiatrists focus on the behavior and motives of the abuser when making the diagnosis. Medical doctors focus on the warning signs that may show up in the child or in the behaviors of the parent/caregiver that fit the MSBP profile.

In MSBP a caregiver, usually the mother induces or reports physical symptoms in a child and fabricates a corresponding history that results in unnecessary medical evaluation and treatment. As health care providers we are trained to give much credence to medical histories and it can take quite a while before we recognize that a mother might be intentionally lying to us. Unfortunately, this can make us unwitting accomplices to the abuse as doctors order, and we help carry out, batteries of unnecessary and painful medical procedures and tests.

WHAT ARE SOME WARNING SIGNS OF MSBP?

Warning signs may include the following, but it's important to remember that these signs can also be present in children with complex diseases. And the behaviors of good, conscientious parents can also match these signs:

- Illness that is multisystemic, prolonged, unusual, or rare
- Symptoms that are inappropriate or incongruent
- Multiple allergies
- Symptoms that disappear when caretaker is absent
- One parent, usually the father, absent during the child's hospitalization
- History of sudden infant death syndrome in siblings
- Parent who is overly attached to the patient
- Parent who has medical knowledge/background
- Child who has poor tolerance of treatment
- Parent who encourages medical staff to perform numerous tests and studies
- Parent who shows inordinate concern for feelings of the medical staff

(List taken from Mason and Poirier, 2007.)

MSBP CONTROVERSY IN COURT AND CHILD PROTECTIVE SERVICE (CPS) SYSTEMS

After a doctor or psychiatrist has made the diagnosis of MSBP and has reported suspicions of child abuse to CPS, the CPS workers may use the MSBP diagnosis as a reason to take temporary emergency custody of the child.

What if, aside from the MSBP diagnosis, there's no evidence of abuse? Will the courts return the child to the family?

It's possible. Some judges, fearing that the MSBP diagnosis taints jurors' ability to remain impartial, have ruled that prosecutors must present actual evidence of abuse when the case goes into court. That's why doctors and nurses must carefully document observations, lab tests and any other findings that show evidence of abuse. The importance of doing so can be seen in our first case study.

THE KATHY BUSH CASE

By the time she was 8 years old, Jennifer Bush had endured 200 hospitalizations and more than 40 surgeries. Doctors had removed her gallbladder, appendix and part of her intestines. She was often nourished through a feeding tube. Over time, some hospital nurses noticed that Jennifer seemed to get worse when her mother, Kathy visited. When Jennifer was 3 years old, nurse Donna thought she saw Kathy forcing something down her daughter's throat. Soon after, Jennifer vomited and tegretol was detected in the vomit. Jennifer had already been taken off tegretol but records show she continued to have toxic levels of it in her blood. The hospital staff confronted the Bushes with their concerns and the tegretol levels suddenly dropped.

Florida officials were notified but didn't think they had enough proof to intervene and take custody of Jennifer. Five years later, they received a complaint from a different nurse who suspected Kathy Bush had tampered with Jennifer's feeding machine, which had "mysteriously" sped up to 7 times the level it had been set on by the nurse. A year later CPS took custody of Jennifer and placed her in foster care where her health began to steadily improve. Kathy Bush was charged with aggravated child abuse and organized fraud stemming from the family's appeals for donations and free medical care for the sick child. She was convicted on both counts

THE NURSING PROCESS

At Kathy Bush's trial nurse Donna testified that she'd heard 3 year old Jennifer calling out, "No, Mommy, no." Donna peeked through the closed curtain and thought she saw Kathy Bush forcing "something" (she couldn't tell what) in Jennifer's mouth. On cross-examination she admitted it was possible Kathy Bush could have been brushing her daughter's teeth. At the time the incident occurred, nurse Donna had reported what she saw to Jennifer's doctor. Was it ethical for her to report something she wasn't sure of?

To answer that question, we'll apply the known facts to the nursing process and see if nurse Donna's actions reflect reasoning that's based on professional judgment, clinical knowledge and clinical observation:

- Assessment- She made an assessment that Kathy Bush might have been pushing something into Jennifer's mouth, which caused her to vomit.
- Nursing diagnosis- Based on her assessment she reasoned that the potential for child abuse exists and she must develop a plan to protect her patient.
- Outcome/planning- She set a short term goal of notifying the doctor of her concerns and observations, and a long term goal of gathering and documenting evidence that supports or disproves her suspicions of abuse.
- Implementation- She drew blood and sent vomit for toxicology testing.
- Evaluation - Her suspicions were confirmed when specimens came back positive for tegretol despite fact that MD had previously discontinued tegretol. The plan was then modified to include notification of CPS.

You can see that nurse Donna exercised the degree of care, skill and learning that any reasonable, prudent nurse would take in the same situation and followed the standard of care for nurses. Therefore, her actions, intended to protect her patient, were ethical.

MORAL DISTRESS IN NURSES

What if the doctor hadn't agreed with the nurse's suspicion of child abuse? Would it have been ethical and legal if she spoke to her supervisor and/or made a report to CPS?

Nurses perceive that they are subordinate to physicians and this hierarchical structure deters some of them from taking action in clinical situations where their own beliefs and assessments may differ from the doctor's. Patti Rager Zuzelo (Nursing Ethics 2007) did a qualitative study exploring the moral distress of nurses. One of the RN participants experienced moral distress when she took care of a child with questionable abuse. The child was discharged by the MD despite the fact that the doctor was aware of the nurse's feelings and suspicions of abuse. Two days later the child came into the ER dead on arrival. The nurse suffered terribly with the after effects of her perceived powerlessness. To avoid such moral distress nurses must do everything they can to protect patients from abuse.

CODE OF ETHICS FOR NURSES

Nurses can utilize the Code of Ethics for Nurses (The Code) (American Nurses Association 2005) when making ethical decisions that involve conflicts with doctors. The ANA periodically revises the code and the most recent revision is scheduled to be published in 2014. The Code provides guidance, not absolutes, for the legal and ethical responsibilities that nurses have to their patients. It requires that nurses base and justify their ethical decisions and the consequences of those decisions on universal moral principles. The principles most relevant to suspected child abuse are beneficence and non-maleficence, respectively defined as the nurse's moral obligation to do good and to avoid harm to the patient.

Provisions of The Code that are pertinent to the nurse's decision in our current example are:

- Provision 2.1 Primacy of the patient's interests. The nurse's primary commitment is to the patient. This means that the nurse must base her decision on what's best for the patient.
- Provision 2.2 Conflict of interest for nurses. Nurses must examine the conflicts arising between their own personal and professional values and those of others responsible for patient care. They must strive to resolve conflicts in ways that ensure patient safety. If the nurse suspects abuse, she must find the moral courage to report it, even if the doctor doesn't agree with her suspicions.
- Provision 3.2 Confidentiality. The rights, well-being, and safety of the individual patient should be the primary factors in arriving at any professional judgment concerning the disposition of confidential information. Only information pertinent to a patient's treatment and welfare is disclosed and only to those directly involved with the patient's care.

THE HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

The nurse must also follow HIPAA (Artmak & Benson, 2003) law. Like The Code, it's designed to provide guidance, not absolutes. In cases of mandatory reporting it provides for an exception to the obligation to maintain confidentiality. Thus, the nurse must balance the patient's right to privacy with protection of the patient from harm.

If nurse Donna shares her observations and suspicions with her supervisor or other health care providers directly involved with her patient's care, and does so in a private and professional manner, the information is being shared to protect the patient from harm and would not violate HIPAA law.

CONFIDENTIALITY ISSUES RELATED TO STATE CHILD ABUSE STATUTES

In regards to making a report directly to CPS, or complying with medical information requests from CPS, the nurse must understand and follow the confidentiality portion of her state's mandatory reporting statute. The statute will outline and specify the:

- Persons or entities that are allowed access to the records.
- Circumstances under which the medical records and information can be disclosed or shared with other agencies or providers.

Nurses must also be careful to follow their facility's policies and procedures regarding disclosure and mandatory reporting.



As you can see, you are responsible for making your own decisions about reporting child abuse and those decisions must be based on sound nursing practice. You don't need anyone's "permission" to make a report.

Our next case study will show that once a "good faith" report is made, nurses may continue to struggle with moral distress and dilemmas.

THE JULIE PATRICK CASE

Philip Patrick was born prematurely with multiple birth defects, including malrotation of the bowels and craniosynostosis. For the first ten months of his life he failed to thrive and endured repeated surgeries and hospitalizations in four different cities. Doctors at Vanderbilt Hospital treated him for multiple infections, then came to believe that his mother, Julie, might be responsible for Philip's illness. They suspected she was injecting fecal matter into Phillip's system to cause blood infections and were suspicious of her uncanny ability to predict his illnesses. A gastroenterologist diagnosed MSBP and called CPS. The state took custody of Philip and thereafter, Julie was only allowed infrequent, 15 minute supervised visitations. Despite separation from his mother, Philip got sicker, suffered from renal failure, had to be placed on a respirator and was given blood transfusions. He died alone, one month after the state took custody.

DEPOSITION STATEMENTS MADE BY NURSE LINDA

Excerpts from a deposition taken from Philip's nurse, Linda, will illustrate how hard it is for nurses to deal with their own ambivalent feelings when identifying, assessing and interacting with the victims of child abuse, their abusers, and other members of the health care team. Italicized words are exact quotations.

STRUGGLE TO REMAIN PROFESSIONAL

Nurse Linda is asked if she recalled any of the other nurses talking about Julie Patrick on the day the state took custody of Philip:

"Yeah. There was a lot of speculation in the unit. There were nurses who—and I don't remember the exact words, but they said typical gossip stuff like, "Well, I don't think she did it," and another one would say, "Well, you know, there was this particular time" or somebody would say, "Yeah, but she couldn't have meant to harm him." I mean, it was kind of like there was a split in the nurses about whether Julie was guilty or innocent."

You can see from Linda's words that all the nurses were having difficulty remaining professional and all were struggling over the issue of guilt/innocence. As nurses, we have an ethical duty to remain professional, despite our personal feelings toward the accused abuser and our patient. This is much easier said, than done. Bjorn Tinberg, et al, (2008) did a qualitative study to identify nurses' experiences in the clinical care of abused children. The objective was to assess how nurses remain professional especially when the suspected perpetrator is a parent. Participants expressed difficulties in maintaining a professional role in clinical encounters with the parents and in interactions with their co-workers. The authors of the study concluded that in order to remain professional the nurses had to devise strategies for their clinical encounters with the children and their parents. Doing so required education, counseling and experience.

(Please note that gossiping and making speculations about the alleged abuser are violations of HIPAA law, especially if it's being done in open areas where the remarks can be overheard by anyone within earshot.)

LOSS OF PROFESSIONAL BOUNDARY

The day that custody was taken away from Julie Patrick, nurse Linda used her lunch break to visit Julie at the Ronald McDonald house. When the nurse walked in, Julie was by herself, crying and sobbing. During her deposition Linda was asked to describe what happened on this visit:

"I went over to her and put my arms around her, and my feelings and thoughts at that particular moment were, right or wrong, she just needed a hug. So I put my arms around her and I just hugged her. We talked for a few moments and then I wrote my phone number down and said, "If you just want to talk, give me a call." I just felt really sorry for her."

In visiting the accused parent outside the hospital setting, Linda was allowing her personal feelings of empathy and sympathy to override her professional boundaries and judgment.

WITHHOLDING INFORMATION FROM THE PARENTS

The next day Linda and the other nurses were told that when Julie calls the unit, they are to give general information about Patrick's condition, such as saying his condition is stable, but they are not allowed to give specifics, such as what medication he's on or treatments he's getting. During her deposition nurse Linda says that this made her feel uncomfortable and the lawyer asks her to explain why:

"Because we always give reports to parents when they call and ask questions. As a nurse, I answer those questions to the best of my ability. I feel that every parent has the right to know what's going on with their child. And in the one conversation I had with Mrs. Patrick, I just remember feeling uncomfortable because my—it's like your loyalty's being torn, you know, I'm doing what I was told in my place of employment but yet the professional nurse in me said this is not right. This parent has a right to know what's going on with their child. Right or wrong, at that point, it was—she deserves to be given a legitimate report."

The lawyer asks her if she felt her ability to be honest with the parents was compromised by her instructions to answer the way she was told to answer:

"Yes, because I couldn't give the complete picture. I'd never been faced with that situation."

BREAKDOWN IN THE THERAPEUTIC RELATIONSHIP

You can see that nurse Linda felt caught in a moral dilemma between doing what her conscience and prior training told her to do, and what her employer was telling her to do. She was struggling with difficult ethical choices and powerful feelings about those choices. Interacting with alleged abusers, especially those with a diagnosis of MSBP challenges the way we think about our patient's family, our professional identity and the contract or "bargain" implicit within the therapeutic relationship, which is normally built on trust and truth. What starts out as lies by the abuser can end up ensnaring health care professionals in a web of deceit. To protect our patient, we may be asked, as Linda was, to withhold information from the parent or lie to them and that can cause moral distress, which we must acknowledge and deal with.

Linda and some of the other nurses spoke to their nurse manager about their feelings of not being able to give Julie a full report on Philip's condition. A few days later, they were told that all calls would be taken by the unit clerk who would direct them to one of the doctors. This allowed the doctors to maintain control over what information was given to Julie and relieved the nurses from being direct participants in the evasive lying.

MEDICAL EXAMINER'S DETERMINATION

Julie Patrick was never charged with a crime involving her son's illness. The medical examiner felt Philip's death was the result of multiple birth defects, most notably those related to his gastrointestinal illness. In his report the examiner wrote that Julie Patrick's behavior fit the profile of a Munchausen perpetrator in some ways. She was clearly pushy to the point of being obnoxious. She frequently questioned the medical staff, their conclusions and treatment options and took Philip to a succession of hospitals. However, Philip's condition did not improve in the absence of the mother, as would be expected if she was making him ill and there was an adequate medical explanation for Philip's medical course and death so the examiner concluded that there was no evidence that Julie Patrick had Munchausen Syndrome By Proxy.

When the medical examiner's report was made public a representative from the hospital issued the following statement, "There was evidence to suggest that Munchausen's could have been the diagnosis here. We've got a legal responsibility, when we have any reason to suspect child abuse, to report it." His statement is correct and because they acted in "good faith" the hospital and staff should be protected from lawsuits related to allegations of abuse.

However, Julie Patrick and her husband filed a federal lawsuit against Vanderbilt Hospital, accusing doctors there of malpractice for failing to control a serious infection that Philip had.

Doctors and nurses must be particularly diligent in cases of MSBP not to attribute all symptoms the child exhibits to possible abuse. Any acts of malpractice, such as failure to diagnose and treat an existing medical condition that's separate from the abuse are not immune from malpractice lawsuits.



ESTABLISHMENT AND MAINTENANCE OF CENTRAL REGISTRIES FOR CHILD ABUSE

CAPTA mandates the establishment and maintenance of central registries for child abuse reports. The registry and internal information system is meant to be used to determine whether previous reports have been made regarding actual or suspected abuse or neglect of the subject child, and/or their siblings, and to provide such information as may be contained in previous reports. Each state legislates specifics regarding what files are kept and for how long.

Here is a fictional case that shows how registries can be useful in detecting abusers:

Three year old Matthew is admitted to St. Joseph's Hospital for severe diarrhea. Mom reports that this is his fourth hospitalization in the past 10 months, though this is his first time at St. Joseph's. He has a history of mitochondrial disease, intestinal failure, recurrent sepsis and recurrent diarrhea. He is on TPN feedings and narcotics for visceral pain. Over the next three days his mother is continually by his side during the day and evening shifts. She's an epidemiologist and frequently questions staff about lab test results, discussing in detail different infectious organisms. Her neighbor, who's a retired nurse, stays with Matthew at night. Dr. Goodman, the attending pediatric gastroenterologist, is familiar with MSBP and contacts the Central Registry for Child Abuse. He finds out that one of Matthew's doctors from City Hospital filed a report alleging MSBP six months ago, but it was deemed unsubstantiated. His suspicions heightened, Dr. Goodman assembles a multidisciplinary team and the team, working with the local police, decides to have a video recorder installed in Matthew's room. The results surprise everyone when Mom's friend, the retired nurse, is captured on video injecting something into the TPN line. Forensic testing later determines it was feces.

This fictional case illustrates the importance of not using just the warning signs of MSBP as proof of child abuse. As previously said, many loving, conscientious parents of children with complex diseases exhibit some of the warning signs of MSBP. Obtaining physical evidence in these complicated cases is vitally important and may yield surprising results.

HOW ALLEGATIONS OF CHILD ABUSE IMPACT THE NURSE/PATIENT/FAMILY RELATIONSHIP

As we have seen from our case studies, all of the relationships that an accused abuser has, including those with health professionals, are impacted by the allegations of child abuse. Even if the accused is innocent, he/she may be reluctant to seek or accept emotional and physical support from relatives, friends and health professionals for fear that anything they say or do may be misconstrued and used against them. Or nurses might distance themselves from the accused abuser because, as in the Patrick case, they are told to do so or the state has taken custody and the parent is no longer allowed normal visits with the child.

If the alleged abuser is guilty, they may rightfully fear the possibility that their child may be taken away from them and that they may face criminal charges. Parents may panic, remove the child from the hospital or move to another state to make it more difficult for police or CPS workers to keep track of them. Family tensions may increase, perhaps putting the child at even greater risk of abuse until CPS determines there's enough evidence to take custody of the child.

Parents like Julie Patrick, who have had children taken away from them by CPS on the basis of allegations of MSBP, feel they were treated as guilty until proven innocent, and that their civil rights have been violated. They must deal with emotional trauma that will most likely last a lifetime.

The spouses of the alleged or convicted abusers also suffer from a heavy emotional burden, as do any other children in the family. After his wife's conviction, Craig Bush spoke poignantly about how his daughter, Jennifer's, removal from the family had affected him, and his two older sons, then 20, and 17.

“In the 3 ½ years since Jennifer was swept away by the state, we’ve missed her at every family event, big or small. She wasn’t there for her brother’s high school graduation, his prom or when he became a Marine. And when my sons make new friends they wonder if they should tell them or not tell them or if they already know. I feel like I’m living in a balloon of pressure that gets tighter every day” (Sun-Sentinel interview 1999).

Another pressure on families is the burden of paying legal fees for the defense of the parent who’s been charged with child abuse. Regardless of whether the parent is guilty or innocent, the legal defense can cost thousands of dollars and lead to severe financial hardship, even bankruptcy, stressing families to the breaking point.

CONCLUSION

All nurses are mandated reporters who must follow the mandatory reporting of child abuse statutes for the state(s) in which they practice. They must know the standards for making a “good faith” report as well as the confidentiality specifications written in the statutes. When sharing medical information with other agencies and providers they must also follow HIPAA law, and the policies and procedures of their employer.

When making difficult ethical decisions regarding mandatory reporting, nurses practice under, and are bound by, The Code of Ethics for Nurses. They also have an ethical duty to remain professional, despite their personal feelings and beliefs about the accused abuser. They must devise strategies for their clinical encounters with abused children and their parents and seek out education, counseling and experiences that help them develop strategies and coping skills.

Even if they are the only health care provider to suspect child abuse, they must make a report to CPS. The nursing process should guide their actions and they must exercise the degree of care, skill and learning that a reasonable, prudent nurse would take in the same situation.

The diagnosis of MSBP does not prove that a parent or caregiver is guilty of abuse. Good documentation of nursing observations, lab tests and the collection of forensic evidence including video recordings, are invaluable in helping prosecutors obtain convictions that will ultimately protect the child victim from further abuse.

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CE Exam

Child Abuse & Ethics

COURSE TEST**Directions: Circle the best answer.**

- 1) What is the federal law that mandates minimum definitions and requirements for mandatory reporting?
 - a) HIPAA
 - b) CAPTA
 - c) FTCA
 - d) JCAHO

- 2) Each state has child abuse and neglect statutes which define reportable events or situations that a nurse practicing in that state must follow.
 - a) True
 - b) False

- 3) If a nurse willfully and intentionally makes a report of child abuse or neglect that she knows to be false, she is immune from criminal and civil liability.
 - a) True
 - b) False

- 4) Immunity from criminal and civil liability in mandatory reporting of child abuse cases protects a nurse from being sued for malpractice.
 - a) True
 - b) False

- 5) A nurse who fails to report suspected abuse and is subsequently convicted of failure to report abuse can:
 - a) Lose her nursing license.
 - b) Be given a jail term ranging from 10 days to 5 years.
 - c) Be fined \$100 to \$5000.
 - d) All of the above.

- 6) A nurse is not required to report abuse unless she has proof that substantiates her suspicions.
- a) True
 - b) False
- 7) Which statement about the American Nurses Association Code of Ethics is not true?
- a) It requires that nurses base and justify their ethical decisions and the consequences of those decisions on universal moral principles.
 - b) It provides guidance, not absolutes, for the legal and ethical responsibilities that nurses have to their patients.
 - c) Provision 2.1 says that the nurse's primary commitment is to follow doctor's orders.
 - d) Provision 3.2 addresses the issue of confidentiality.
- 8) Nurses can utilize the Code of Ethics for Nurses when making ethical decisions that involve conflicts with other health care providers, such as when the doctor disagrees with the nurse's assessment that a child's at risk for abuse.
- a) True
 - b) False
- 9) The Child Abuse Prevention and Treatment Act mandates the establishment and maintenance of central registries for child abuse reports and legislates specifics regarding what files are kept and for how long.
- a) True
 - b) False
- 10) Central Registries for Child Abuse only keep the names and files of convicted child abusers.
- a) True
 - b) False
- 11) If a parent or caregiver exhibits several of the warning signs of MSBP it means they are abusing their child and must immediately be reported to CPS.
- a) True
 - b) False
- 12) The warning signs of MSBP can be present in children diagnosed with complex diseases whose parents are conscientious about seeking medical care for their child.
- a) True
 - b) False

- 13) Which of the following are impacted by allegations of MSBP?
- a) The child's relationship and interactions with the alleged abuser.
 - b) The child's relationship and interactions with siblings.
 - c) The nurse's interactions with the alleged abuser.
 - d) All of the above.
- 14) The Bjorn Tinberg qualitative study to identify nurses' experiences in the clinical care of abused children, concluded that nurses are always professional in their interactions with the parent who is suspected of child abuse.
- a) True
 - b) False

Your opinion is important to us. Please answer the following questions by circling the response that best represents your experience.		Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
COURSE OBJECTIVES & CONTENT						
1.	The activity was valuable in helping me achieve the stated learning objectives.	5	4	3	2	1
2.	The content was up to date.	5	4	3	2	1
2.	The number of credit hours was appropriate for the content.	5	4	3	2	1
TEACHING/LEARNING METHODS						
4.	The teaching/learning methods, strategies, and slides were effective in helping me learn.	5	4	3	2	1
5.	The material was clearly explained.	5	4	3	2	1
6.	The answers to the post-test questions were appropriately covered in the activity.	5	4	3	2	1
OVERALL ACTIVITY						
7.	The online course/download supported the achievement of the stated learning objectives.	5	4	3	2	1
8.	The material was relevant to my professional development.	5	4	3	2	1
9.	Overall, I am pleased with this activity and would recommend it to others.	Yes	No			
10.	The content was presented free of commercial bias. *	Yes	No			
11.	Did the material presented increase your knowledge and/or understanding of this topic? *	Yes	No	NA		

Continued on Next Page

* If you responded "No" to question 10, please explain why:

* If you answered "Yes" to question 11, what change do you intend to make?

What barrier, if any, may prevent you from implementing what you learned?

Cite one new piece of information you learned from this activity:

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With my signature I confirm that I am the person who completed this independent educational activity by reading the material and completing this self evaluation.

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