

PROVING MEDICAL CHILD ABUSE: THE TIME IS NOW FOR OHIO TO FOCUS ON THE VICTIM AND NOT THE ABUSER

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I. INTRODUCTION

“Medical child abuse” is a term unfamiliar to most lay people and many individuals in the medical community. In fact, the term evokes an erroneous image

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of medical professionals abusing their minor patients.¹ Medical child abuse, however, is not a new phenomenon. It is merely a new term for the better-known phenomenon of “Munchausen’s Syndrome by Proxy.”² This Note discusses the differences between medical child abuse and Munchausen’s Syndrome by Proxy and why professionals in the medical community are pushing for the use of a broader term, such as medical child abuse,³ or simply, child abuse that occurs in a medical setting.⁴ “Medical child abuse occurs when a child receives unnecessary and harmful or potentially harmful medical care at the instigation of a caretaker,”⁵ wherein the caregiver is most likely the mother of the child.⁶

To understand the medical child abuse phenomenon, the following case study illustrates the typical interaction between the abusive caregiver and the medical provider and the insufficient, yet predictable, outcome produced by our current legal framework. In Ellis County, Texas, Susan Hyde medically abused her three daughters by subjecting them to more than one hundred-fifty emergency room visits

¹ See generally *MOTHERS AGAINST MUNCHAUSEN’S SYNDROME BY PROXY ALLEGATIONS*, <http://www.msbp.com/> (This group was created to address the false allegations of Munchausen’s Syndrome by Proxy.).

² THOMAS A. ROESLER & CAROLE JENNY, *MEDICAL CHILD ABUSE: BEYOND MUNCHAUSEN’S SYNDROME BY PROXY* 43 (Diane E. Beausoleil ed. 2009). Co-author Carole Jenny, M.D., MBA, FAAP, is the director of the Child Protection Program at Hasbro Children’s Hospital in Rhode Island. *Hasbro Children’s Hospital Online Newsroom: Carole Jenny M.D.*, LIFESPAN, <http://www.lifespan.org/hch/news/expert/jenny.htm> (last visited Feb. 13, 2011). Dr. Jenny is “nationally known for her work in child protection and lectures around the globe.” *Id.* She has developed the ChildSafe program which provides services for children who are suspected victims of sexual abuse, failure to thrive, neglect, medical neglect, or factitious illness. *Id.* Co-author Thomas A. Roesler, M.D., is the co-director of the Hasbro Children’s Partial Hospital Program and an Associate Professor at the Warren Alpert Medical School of Brown University. *Bradley Hasbro Children’s Research Center: Thomas A. Roesler, M.D.*, LIFESPAN, <http://www.lifespan.org/services/childhealth/research/team/roesler.htm> (last visited Feb. 13, 2011). His research interests include the “psychological effects of childhood sexual abuse, medical child abuse, and the delivery of medical and psychiatric services in a collaborative day hospital environment.” *Id.*

³ ROESLER, *supra* note 2, at 2.

⁴ John Stirling, Jr., *Beyond Munchausen Syndrome by Proxy: Identification and Treatment of Child Abuse in a Medical Setting*, 119 J. AM. ACAD. PEDIATRICS 1026, 1027 (2007).

⁵ ROESLER, *supra* note 2, at 1. The consequences of medical child abuse can be minor or fatal. *Id.* The similarity between caregivers exaggerating symptoms, falsifying symptoms, or inducing symptoms is that the caregiver insists that something is wrong with the child, no medical explanation as to the symptoms can be described, and the child suffers consequences. Stirling, *supra* note 4, at 1027. Examples of possible medical child abuse include: (1) caregivers lying about medical symptoms; (2) caregivers treating their children as if they were handicapped; (3) caregivers “putting spit and feces” in a child’s IV; (4) a caregiver smothering a child during a hospital visit when medical staff were not present, causing a child to vomit. ROESLER, *supra* note 2, at 135-37.

⁶ *Diseases & Conditions, Munchausen Syndrome by Proxy*, CLEVELAND CLINIC FOUND., http://my.clevelandclinic.org/disorders/Factitious_Disorders/hic_Munchausen_Syndrome_by_Proxy.aspx (last visited Jan. 12, 2011).

over the course of four years.⁷ The girls were treated for “cerebral palsy, cystic fibrosis, headaches and seizures.”⁸ Hyde used her knowledge as a paramedic to deceive doctors into believing that one of her daughters needed a feeding tube and another needed a wheelchair, leg braces, and a safety helmet.⁹ Hyde “doctor shopped” by seeking out medical professionals in Texas, Nebraska, and Iowa.¹⁰ Hyde would then change medical professionals before anyone detected a pattern of abuse.¹¹ After the investigation began, Hyde’s paramedic certification was revoked.¹²

The Assistant District Attorney for the Crimes Against Children Unit of Tarrant County, Texas, stated that “[o]ur laws are not written to prosecute cases such as these.”¹³ The Assistant District Attorney also felt that the inability of the criminal justice system to prosecute parents for medical child abuse “is a problem, and there should be some way to incorporate these cases in our laws to be able to protect children from situations such as this.”¹⁴ Unfortunately, it is usually difficult to catch medical child abuse perpetrators because their “doctor shopping” habits may span several different states.¹⁵

Some generalizations can be made regarding the typical medical child abuse perpetrator. For example, the perpetrating caregiver is generally the minor patient’s mother.¹⁶ Additionally, the caregivers know what they are doing and often have a medical background.¹⁷ Further, these perpetrators are generally excessively attentive, concerned with the medical staff and crave the attention they receive from medical

⁷ Jon Nielsen, *Doctors Believe Mother Has Munchausen Syndrome by Proxy, Has Medically Abused Her Children*, THE DALLAS MORNING NEWS (Aug. 15, 2009, 4:45 PM), <http://www.wfaa.com/news/local/64507072.html>.

⁸ *Id.* Hyde medically abused her three daughters, aged 4, 6, and 8. *Id.*

⁹ *Id.* During the proceedings, a pediatrician testified that the girls did not need any of the treatment they received. *Id.*

¹⁰ *Id.*

¹¹ *Id.* At each new medical location the physicians would accept Hyde’s version of the story that her children suffered from a variety of diseases. *Id.*

¹² *Id.* Hyde’s middle daughter was fortunate in that her father was given custody. Barb Ickes, *Little Girl Who Suffered Years of Abuse at Hands of Mother Reunited with Father*, QUAD-CITY TIMES (Sept. 28, 2008, 12:00 a.m.), http://qctimes.com/news/local/article_3d235c36-fa5c-5a5e-8dd8-bd1e1679b496.html. Hyde vanished with her daughter shortly after giving birth. *Id.* The three girls were taken away from her once before, in Iowa, only to be returned three days later. *Id.* Hyde convinced the proper authorities that the allegations made by Iowa physicians were incorrect. *Id.* In March 2007, Hyde’s daughters were removed from her custody again, but this time by the Texas Child Protective Services. *Id.* Within two weeks of this removal, almost all of the children’s illnesses and symptoms were gone. *Id.*

¹³ Nielsen, *supra* note 7.

¹⁴ *Id.* As a result of the physical and emotional abuse suffered by Hyde’s daughters, they would bandage their dolls as a recreation of their abuse. *Id.*

¹⁵ *Id.*

¹⁶ *Diseases & Conditions, Munchausen Syndrome by Proxy, supra* note 6.

¹⁷ *Id.*; see also ROESLER, *supra* note 2, at 121 (“[P]eople who abuse their children medically often have a history of over-involvement in the medical community.”).

professionals when they bring their children in to be treated.¹⁸ Perpetrators may seek “care, warmth, affection, and attention” because her needs were ignored or neglected.¹⁹ Medical child abuse may also be a way for a woman to fulfill a void for attention from a spouse.²⁰ A child becomes a “representative of [a woman’s] needy self” for the mother to satisfy her emotional needs.²¹

According to a clinical professor of psychiatry at the University of Alabama at Tuscaloosa, medical child abuse is “child maltreatment, undeniabl[y]. It may be the single most lethal form of child abuse there is.”²² Prosecutors, however, face difficulties when attempting to prosecute abusive caregivers because it is difficult to gather the medical records from each medical institution that treated the child.²³ Despite the challenges faced by prosecutors, there have been some successful cases in which the abused child was removed from the custody of the perpetrating caregiver. For example, Susan Hyde, the Texas mother discussed above, was successfully prosecuted.²⁴ As a result of Hyde subjecting her children to medical child abuse, one daughter now lives with her biological father and the other two, who have a different father, are in foster care.²⁵

Ohio must amend its legislation to make it clear that medical child abuse is a type of abuse that necessitates a shift away from a focus on the caregiver’s mental state and intentions. Focusing on the caregiver produces uncertainty as to whether an individual suffers from Munchausen’s Syndrome by Proxy; therefore, the proposed legislation needs to focus on the best interest and safety of the abused child. Furthermore, the country needs to depart from the term Munchausen’s Syndrome by Proxy and refer to this scenario as medical child abuse to better ensure the safety of our children. The legislation changes must include a specific definition of medical child abuse. A specific definition will make it easier to prosecute perpetrating caregivers and will prevent children from remaining in the harmful parent’s custody solely because the caregiver’s mental state could not be proven.

Part I of this Note will discuss the history of Munchausen’s Syndrome by Proxy and how the medical community is trying to make the general public aware of medical child abuse. Part II provides a history of Munchausen’s Syndrome by Proxy and medical child abuse. It also highlights the differences in how litigation was previously handled under the nomenclature of Munchausen’s Syndrome by Proxy

¹⁸ Nielsen, *supra* note 7. Caregivers often plan out their conduct and are deceptive in “carrying out the ruses.” *Id.*; *see infra* note 138 (a mother received thousands of dollars from her church, as well as a free trip to Disney World from the Make-A-Wish Foundation).

¹⁹ ROESLER, *supra* note 2, at 115 (citing Lesnik-Oberstein M., *Munchausen Syndrome by Proxy*, 10 CHILD ABUSE NEGL. 133 (1986)).

²⁰ ROESLER, *supra* note 2, at 115 (citing Lesnik-Oberstein M., *Munchausen Syndrome by Proxy*, 10 CHILD ABUSE NEGL. 133 (1986)).

²¹ ROESLER, *supra* note 2, at 115 (citing Lesnik-Oberstein M., *Munchausen Syndrome by Proxy*, 10 CHILD ABUSE NEGL. 133 (1986)).

²² *Id.* There is significant planning and deception in many cases, proving that the perpetrator is not psychotic. *Id.*

²³ *Id.*

²⁴ Nielsen, *supra* note 7.

²⁵ *Id.*

and how litigation should be handled in the future under the nomenclature of medical child abuse. Part III identifies Ohio's current statutes and federal legislation that have an effect on child abuse. Part III also identifies individuals with a duty to report child abuse, analyzes other states' laws, and discusses the efforts that have been taken to successfully prosecute medical child abuse. Part III also proposes Ohio legislation that includes a specific definition for medical child abuse. Finally, Part IV analyzes how the proposed Ohio legislation will affect physicians, the medical community, hospital programs, and children that need to be removed from the custody of harmful caregivers.

II. THE SHIFT FROM MUNCHAUSEN'S SYNDROME BY PROXY TO MEDICAL CHILD ABUSE

A. *What Is Munchausen's Syndrome by Proxy?*

The term "Munchausen's Syndrome" was first used by Dr. Richard Asher in 1951 as a way to describe self-induced illnesses²⁶ caused by providing eccentric, but

²⁶ Jessica Feurtado, *Munchausen by Proxy Syndrome: A Deadly Disorder*, ALLPSYCH JOURNAL (May 15, 2005), <http://allpsych.com/journal/munchausen.html>. An individual who suffers from Munchausen's Syndrome induces or falsifies information about him or herself. Richard Asher, *Munchausen's Syndrome*, 257 LANCET 339, 339 (1951).

The patient showing the syndrome is admitted to [a] hospital with apparent acute illness supported by a plausible and dramatic history. Usually his story is largely made up of falsehoods; he is found to have attended, and deceived, an astounding number of other hospitals; and he nearly always discharges himself against advice, after quarreling violently with both doctors and nurses.

Id. The possible motives behind an individual suffering from Munchausen's Syndrome can include:

1. A desire to be the centre of interest and attention. They may be suffering in fact from the Walter Mitty syndrome, but instead of playing the dramatic part of the surgeon, they submit to the equally dramatic role of the patient.
2. A grudge against doctors and hospitals, which is satisfied by frustrating and deceiving them.
3. A desire for drugs.
4. A desire to escape from the police. (These patients often swallow foreign bodies, interfere with their wounds, or manipulate their thermometers.)
5. A desire to get free board and lodgings for the night, despite the risk of investigations and treatment.

Id. "The additional term *by proxy*, therefore extends the diagnosis beyond the *individual* to fabricate illness in another through whom this dynamic is acted out." *Id.* (emphasis in original). Although "it is conceptually possible that a factitious disorder by proxy would involve another adult, the literature to date suggests that the proxy is a child, which becomes crucial when this diagnosis jumps the boundary from the consultation room to the courtroom." Michael R. Butz et al., *A Practitioner's Complaint and Proposed Direction: Munchausen Syndrome by Proxy, Factitious Disorder by Proxy, and Fabricated and/or Induced Illness in Children*, 40 PROF. PSYCHOL. RES. & PRAC. 31, 32 (2009).

incorrect, medical histories and symptoms in a dire attempt to seek medical care.²⁷ Munchausen's Syndrome by Proxy (hereinafter "MSBP") was first coined in 1977 by Roy Meadows,²⁸ when he reported that MSBP occurred in situations where adults fabricated illnesses or deliberately produced life-threatening symptoms *in children*.²⁹ MSBP is "a type of factitious disorder, [or] a mental illness in which a person acts as if an individual he or she is caring for has a physical or mental illness when the person is not really sick."³⁰ The term was first "introduced early in the history of child abuse as a pediatric entity. It came into use when most child abuse was still referred to as battered child syndrome."³¹

Mothers are the most common group of people to suffer from MSBP.³² When MSBP was a newly minted disorder, the primary role of women was to care for their children. Because mothers were home with their children all day, and because most of the children were under the age of six, mothers had ample opportunities to induce symptoms in their children that seemed to require medical attention and treatment.³³

²⁷ Christine Klebes & Susan Fay, *Munchausen Syndrome by Proxy: A Review, Case Study, and Nursing Implications*, 10 J. PEDIATRIC NURSING 93, 93 (1995) (citing J. Malatack et al., *Munchausen Syndrome by Proxy: A New Complication of Central Venous Catherization*, 75 PED. 523 (1985)).

²⁸ Richard Meadow, *Munchausen Syndrome by Proxy: The Hinterland of Child Abuse*, 310 LANCET 343, 343 (1977). Munchausen's Syndrome by Proxy may also be called pediatric condition falsification. See Loren Pankratz, *Persistent Problems With the Munchausen Syndrome by Proxy Label*, 34 J. AM. ACAD. PSYCHIATRY 90, 91 (2006), available at <http://www.jaapl.org/cgi/reprint/34/1/90>.

²⁹ Klebes, *supra* note 27, at 93 (citing L. Turk et al., *Munchausen Syndrome by Proxy: A Nursing Overview*, 13 ISSUES IN COMPREHENSIVE PED. NURSING 279 (1990)).

³⁰ *Diseases & Conditions, Munchausen Syndrome by Proxy*, *supra* note 6. Other terms for Munchausen's Syndrome by Proxy include: factitious disorder by proxy, ROESLER, *supra* note 2, at 1; pediatric condition by falsification, *Id.*; pediatric condition fabrication, see Myers v. Myers, 940 N.E.2d 591, 594-95 (Ohio 2010); and parental alienation syndrome, see Rice v. Lewis, No. 08CA3238, 2009 Ohio App. LEXIS 1532, at **2 (Ohio Ct. App. Apr. 10, 2009).

³¹ ROESLER, *supra* note 2, at 17; see also Mary Eminson & Jon Jureidini, *Concerns About Research and Prevention Strategies in Munchausen Syndrome by Proxy (MSBP) Abuse*, 27 CHILD ABUSE & NEGLECT 413, 414, 416 (2003) (stating that "Munchausen Syndrome by Proxy abuse occurs in a medical arena" and that "[t]he use of a label like MSBP establishes that child abuse is an issue and that the medical system is involved"); Lynne Wrennall, *Munchausen Syndrome by Proxy/Fabricated and Induced Illness: Does the Diagnosis Serve Economic Vested Interest, Rather Than the Interests of Children?*, 68 MED. HYPOTHESES 960, 960 (2007) (providing that "Munchausen Syndrome by Proxy, Fabricated or Induced Illness (MSBP/FII), is a conceptual construction alleging medical or education child abuse by parents or carers").

³² *Diseases & Conditions, Munchausen Syndrome by Proxy*, *supra* note 6.

³³ Feurtado, *supra* note 26. Commonly, the fathers of MSBP children are typically not involved in the treatment of the children and can seem distant. Klebes, *supra* note 27, at 95 (citing Richard Meadow, *Management of Munchausen Syndrome by Proxy*, 60 ARCHIVES OF DISEASE IN CHILDHOOD 385 (1982)). Most fathers do not visit the child during the hospital visits and claim to not have knowledge of the mother's actions when questioned. Klebes, *supra* note 27, at 95 (citing Richard Meadow, *Neurological and Developmental Variants of Munchausen Syndrome by Proxy*, 33 DEVELOPMENTAL MED. AND CHILD NEUROLOGY 270 (1991)). "[W]ith MSBP the fathers are often perceived as passive or absent." Ludwig von

Caregivers who suffer from MSBP may: falsify medical records; lie about the symptoms a child is actually experiencing; put a child's life in jeopardy; induce symptoms; and, withhold medical treatment.³⁴

The causes of MSBP vary widely. A person might suffer from MSBP because he or she: wants to become closer to a spouse; craves attention; was a victim of abuse as a child; or feels a strong need to develop relationships with others.³⁵ Because those who suffer from MSBP are often dishonest, however, the psychiatric disorder is difficult to detect and treat.³⁶ Once the disorder is diagnosed, however, the first concern is to separate the individual from any potential victims.³⁷ From there, treatment can be challenging because individuals with MSBP may deny there is a problem.³⁸ These individuals often have difficulty separating reality from fiction.³⁹ Psychotherapy is the main treatment used for MSBP, and it involves changing the thoughts and behaviors of the affected individual to determine the causes and contributing factors of the illness.⁴⁰

Hahn et al., *A Case of Factitious Disorder by Proxy: The Role of the Health-Care System, Diagnostic Dilemmas, and Family Dynamics*, 9 HARV. REV. PSYCHIATRY 124, 129 (2001).

³⁴ Feurtado, *supra* note 26. One article analyzed 451 cases of Munchausen's Syndrome from 154 medical and psychological journals. Mary S. Sheridan, *The Deceit Continues: An Updated Literature Review of Munchausen Syndrome by Proxy*, 27 CHILD ABUSE & NEGLECT 431 (2003). "In 258 (57.2%) of the cases, it was judged that the perpetrator actively produced symptoms" in the child." *Id.* at 438. "In 126 cases (48.8% of cases in which there was production), symptoms were produced while the victim was hospitalized." *Id.* at 439. Suffocating, giving drugs, and poisoning are the most common methods of symptom production. *Id.* The most common symptoms that caregivers lie about children experiencing include: apnea, anorexia or feeding problems, diarrhea, seizures, cyanosis, behavior, asthma, allergies, fevers, and pain. *Id.* at 443; *see also* R.J. Postlethwaite, *Caustic Ingestion as a Manifestation of Fabricated and Induced Illness (Munchausen Syndrome by Proxy)*, 34 CHILD ABUSE & NEGLECT 471 (2010) (discussing examples of mothers inducing symptoms in their children with lye); Hudaverdi Kucuker et al., *Pediatric Condition Falsification (Munchausen Syndrome by Proxy) as a Continuum of Maternal Factitious Disorder (Munchausen Syndrome)*, 11 PEDIATRIC DIABETES 572, 576 (2010) (describing how a mother of seven was diagnosed with adult factitious disorder and at least three of her children were diagnosed with pediatric condition falsification resulting in the death of two children and one with mental retardation due to the mother injecting herself and her children with insulin); Eric Su et al., *Severe Hyponatremia in a Hospitalized Child: Munchausen by Proxy*, 43 PEDIATRIC NEUROLOGY 270, 270 (2010) (discussing a case of a mother giving her child an excess amount of sodium).

³⁵ Feurtado, *supra* note 26. The mother's actions may be an attempt to keep her family together or to divert her attention from marital or other family problems. Klebes, *supra* note 27, at 95 (citing S. Weber, *Munchausen Syndrome by Proxy*, 2 J. PEDIATRIC NURSING 50 (1987)).

³⁶ *Diseases & Conditions, Munchausen Syndrome by Proxy, supra* note 6.

³⁷ *Id.*

³⁸ *Id.*

³⁹ *Id.*

⁴⁰ *Id.*

There are several warning signs when recognizing and diagnosing an individual with MSBP. Some of these signs include: (1) the abuser is often a parent, a mother in most circumstances; (2) the individual may now be, or was previously, employed in the healthcare field; (3) the individual is friendly and cooperates with the health care staff and providers; and (4) the individual appears to be concerned about the patient, and at times may seem overly concerned.⁴¹ Additionally, there are warning signs to look for in the at-risk child. These signs include: (1) multiple hospitalizations for an individual child, sometimes presented with strange symptoms; (2) the child's symptoms often seem worse when described by the caregiver, but the symptoms are not observed by the health care staff; (3) the symptoms and conditions reported by the caregiver do not correlate with test results; (4) the child's symptoms actually improve while in the hospital but seem to recur when the child is discharged; (5) the blood tested in lab samples is not the same blood type of the child; and, (6) the child's blood, urine, or stool test positive for chemicals.⁴²

Children clearly endure the gravest consequences due to the conduct of the perpetrators suffering from MSBP. Most victims are infants and children under the age of six years old⁴³ because as children get older, they may begin to question the actions of the perpetrator; as they grow older, children may also tell others.⁴⁴ A literature review and case study revealed that the frequency of abuse does not correlate with gender.⁴⁵ Gender does not appear to play a role in demographically

⁴¹ *Id.* "Women with MBPS are often colleagues (nurses) or are at least medically knowledgeable and combine firmness with adulatory support for the physician." Herbert A. Schreier et al., *Munchausen by Proxy Syndrome: A Modern Pediatric Challenge*, 125 J. OF PEDIATRICS S110, S114 (1994).

⁴² *Diseases & Conditions, Munchausen Syndrome by Proxy*, *supra* note 6. "As a medically focused variant of child abuse, MSBP also should be considered specifically when a child's symptoms are not verifiable and do not make biomedical sense, and when parents are resistant to reassurance about the health of their child." Hahn, *supra* note 33, at 126; see also *Ohio v. Irving*, No. C-060311, 2007 Ohio App. LEXIS 1360, at **7 (Ohio Ct. App. Mar. 30, 2007) (describing how a mother's actions did not amount to criminal liability). In *Ohio v. Irving*, an expert testified that the mother suffered from Munchausen's Syndrome by Proxy. *Id.* The expert further testified that Munchausen's Syndrome by Proxy does not involve a situation where the "caregiver is unable to stop the abusive activity." *Id.* at **6-7. Further, the expert stated that the mother "was able to stop the abuse, but she didn't," the mother's "actions were intricately plotted," and the mother had mental problems, "but not to a degree negating criminal liability." *Id.* at **7.

⁴³ Klebes, *supra* note 27, at 94 (citing K. Crouse, *Munchausen Syndrome by Proxy: Recognizing the Victim*, 18 PEDIATRIC NURSING 249 (1992)). "The average age of these children at diagnosis was 48.6 months." Sheridan, *supra* note 34, at 433. "Rosenberg found an average diagnosis at 39.8 months . . . to indicate that MBP is more frequent in young children but may occur through the teens." *Id.* at 433. *But cf.* Nida Awadallah et al., *Munchausen by Proxy: A Case, Chart Series, and Literature Review of Older Victims*, 29 CHILD ABUSE & NEGLECT 931 (2005) (discussing a chart review of children seen at the Cleveland Clinic over the age of six years old thought to be victims of Munchausen's Syndrome by Proxy).

⁴⁴ Klebes, *supra* note 27, at 94 (citing K. Crouse, *supra* note 43).

⁴⁵ Klebes, *supra* note 27, at 94. A study of 415 children indicated that "214 (52%) were males and 201(48%) were females." Sheridan, *supra* note 34, at 433. "[T]here is no strong overall gender preponderance in MBP cases. However, in the specific case of the father as the perpetrator . . . targets of abuse are more commonly boys than girls." *Id.*

identifying children that are more likely to suffer the consequences of MSBP. Additionally, no one socioeconomic class seems to be represented more than any other when identifying the victims of MSBP.⁴⁶ “[M]any siblings (39%) had also been the victims of fabricated illnesses, failure to thrive, nonaccidental injury, neglect, and inappropriate[] medicat[ion].”⁴⁷ It is possible, in some circumstances, that one child will be the focus of the perpetrator’s actions until another sibling arrives, then transference occurs and the new sibling becomes the new victim.⁴⁸

Victims of MSBP may suffer consequences that vary from minor to life-threatening. There is a nine percent (9%) mortality rate and an eight percent (8%) morbidity rate for child victims.⁴⁹ This may be due, in part, to the fact that MSBP can go undetected for months or years,⁵⁰ which allows perpetrators to further injure the child.⁵¹ Additionally, a child may also suffer from severe psychological damage.⁵² After being a victim of abuse, a child may begin to feel and think that he

⁴⁶ Klebes, *supra* note 27, at 94.

⁴⁷ “Out of 43 MSBP children with siblings studied, 13 had siblings who had died, 11 from medically inconclusive causes.” Klebes, *supra* note 27, at 94 (citing C. Booles, B. Neale & S. Meadows, *Co-Morbidity Associated with Fabricated Illness (Munchausen Syndrome by Proxy)*, 67 ARCHIVES OF DISEASE IN CHILDHOOD 77 (1992)). “The 451 victims had 210 known siblings. Fifty-three of these siblings (53%) are known to be dead. One-hundred-thirty (61.3%) siblings either had symptoms that were similar to those of the victims, or symptoms that could be of suspicious origin.” Sheridan, *supra* note 34, at 436.

In *Williamson*, the Fifth District Court of Appeals of Texas found that the medical records of a suspected medically abused child’s siblings were “permissible to provide context to the offenses” of medical child abuse. *Williamson v. State*, Nos. 01-08-00365-CR, 01-08-00366-CR, 2010 Tex. App. LEXIS 3432, at *53 (Tex. Ct. App. Apr. 6, 2010), petition for discretionary review refused by *In Re Williamson*, No. PD-0676-10, 2010 Tex. Crim. App. LEXIS 1214 (Tex. Crim. App. Sept. 29, 2010). Furthermore, the medical records of siblings were relevant to prove a perpetrator’s motive. *Id.*

⁴⁸ Klebes, *supra* note 27, at 94 (citing Lori J. Turk et al., *Munchausen Syndrome by Proxy: A Nursing Overview*, 13 ISSUES IN COMPREHENSIVE PED. NURSING 279 (1990)).

⁴⁹ *Id.* at 93 (citing Turk, *supra* note 48; see also Barbara Ostfeld & Marc Feldman, *Factitious Disorder by Proxy Awareness Among Mental Health Practitioners*, 18 GEN. HOSP. PSYCHIATRY 113, 113 (1996)).

⁵⁰ Klebes, *supra* note 27, at 93; see also Schreier, *supra* note 41, at S111.

⁵¹ See Sheridan, *supra* note 34, at 435. This particular review suggests “that all victims suffered at least short-term harm for their maltreatment.” *Id.* Moreover, “[t]hirty-three (7.3%) were judged to have suffered long-term or permanent disability from their maltreatment.” *Id.* In the twenty-seven (6.0%) cases where the child died, the average “age of death of 18.83 months (range 1.5-96 months).” *Id.* In twenty-one of the cases where death resulted, illness was produced. *Id.*

⁵² *Munchausen Syndrome by Proxy*, KIDSHEALTH.ORG, http://kidshealth.org/parent/geral/sick/munchausen.html#a_What_Happens_to_the_Child (last visited Feb. 5, 2011); see also Lawrence J. Braunstein & Pamela Walitt, *Medical Child Abuse: Munchausen Syndrome by Proxy and Pediatric Condition Falsification*, Law Journal Newsletters, at 1 (2008), available at <http://www.lawrencejaybraunstein.com/articles/Medical%20Child%20Abuse.pdf> (stating that “[s]adly some children unknowingly cooperate with a parent’s efforts to make them sick”).

or she will only receive love when sick.⁵³ Thus, child victims may help the caregiver deceive physicians, “using self-abuse to avoid being abandoned.”⁵⁴ Unfortunately, in some instances, child victims of MSBP may later become perpetrators themselves.⁵⁵

B. Elements of Proof for Munchausen’s Syndrome by Proxy

There are legal implications when MSBP is suspected, and it is difficult to prosecute MSBP cases due to a “lack of clarity about the diagnosis or its certainty [that] may be transported [in]to the legal arena.”⁵⁶ This may lead to misdirected legal choices, judgments, and detrimental consequences for the children involved.⁵⁷ Courts want to know what risks the child victim of MSBP may face in the future when the perpetrator has already inflicted some type of harm on the child.⁵⁸ In court, the question seems to be: “Does this woman suffer from MSBP?”⁵⁹ The court’s decision then rests on the answer to that question.⁶⁰

“The DSM-IV [Diagnostic and Statistical Manual of Mental Disorders] diagnostic criteria for factitious disorder by proxy require that the mother intentionally produce an illness, or the appearance of an illness, motivated by a desire to assume the sick role by proxy.”⁶¹ An examination of the perpetrator’s motivations and intentions are necessary to confirm a diagnosis.⁶² The DSM-IV assessment criteria, however, is rarely utilized.⁶³ In court proceedings, judges are expected to rely on an expert who testifies and informs the fact finder to trust his or her personal judgment regarding whether an individual suffers from MSBP.⁶⁴ The expert has knowledge that was acquired through experience, training, and education, and the expert’s testimony is admissible and relevant to assist the trier of fact.⁶⁵ “[T]estimony by persons holding ‘specialized knowledge’ concerning the condition,

⁵³ KIDSHEALTH.ORG, *supra* note 52.

⁵⁴ *Id.*

⁵⁵ *Id.* “Another severe consequence of PCF is that it may lead to the victim of PCF to grow up to develop AFD themselves.” Kucuker, *supra* note 34, at 576.

⁵⁶ Donna Rosenberg, *Munchausen Syndrome by Proxy: Medical Diagnostic Criteria*, 27 CHILD ABUSE & NEGLECT 421, 421 (2003).

⁵⁷ *Id.* at 422.

⁵⁸ Eminson, *supra* note 31, at 415.

⁵⁹ *Id.*

⁶⁰ *Id.*

⁶¹ Pankratz, *supra* note 28, at 91.

⁶² *Id.*

⁶³ *Id.* at 92.

⁶⁴ *Id.*

⁶⁵ *State v. Weaver*, 898 N.E.2d 1023, 1035 (Ohio 2008) (citing *State v. Boston*, 545 N.E.2d 1220 (Ohio 1989)). Individuals are permitted to testify as long as they are a qualified expert pursuant to Evidence Rule 702. *Weaver*, 898 N.E.2d at 1035. The experts were not permitted, however, to testify as to their opinion regarding whether the mother, or any other family member, poisoned the child. *Id.* at 1038.

of an opinion that the child has been a victim of such child abuse, [is] relevant and admissible.”⁶⁶

When confronted about MSBP, however, some MSBP experts “have admitted that they are not qualified to make a psychiatric diagnosis of the mother.”⁶⁷ This obstacle can be avoided “by proclaiming that MSBP is really a diagnosis of the child or by calling the problem ‘pediatric condition falsification’ and then declaring it an equivalent of MSBP.”⁶⁸ Simply eliminating the term “Munchausen’s Syndrome by Proxy” might appear to resolve some of the confusion and difficulty. Even if the term is not used, MSBP will still be considered synonymous to whatever term replaces it. In the end, eradicating verbiage does not solve any of the problems that are generated by using the term “Munchausen’s Syndrome by Proxy.” Such a step only creates more confusion. By focusing on the caregiver, the key question becomes whether an individual suffers from MSBP. This question creates uncertainty; thus, the focus should more appropriately rest on whether the child is the victim of abuse by a caregiver.

C. History of Medical Child Abuse

The history of medical child abuse is neither extensive nor elaborate. Even though medical child abuse has always been thought of as a form of child abuse,⁶⁹

⁶⁶ *Id.* at 1036; *see also* Braunstein, *supra* note 52 (discussing how to represent both the spouse or former spouse that suffered from Pediatric Disorder by Proxy or Pediatric Condition Falsification and a parent who has been accused of having Pediatric Disorder by Proxy or Pediatric Condition Falsification).

⁶⁷ Pankratz, *supra* note 28, at 92. A forensic psychologist questioned, “How can somebody have something when we don’t know what it is?” Nielsen, *supra* note 7. Moreover, another psychologist stated that “[r]egardless of the [MSBP] debate, it doesn’t lessen a mother’s culpability.” *Id.*

⁶⁸ *Id.*; *see also* Ruth Kannai, *Medical Family Therapy Casebook Munchausen by Mommy*, 27 FAMILIES, SYS., & HEALTH 105, 111 (2009) (stating that Munchausen’s syndrome is difficult to “prove, confront, litigate, and treat”).

⁶⁹ ROESLER, *supra* note 2, at 1; *see also* Meadow, *supra* note 28, at 343. Because medical child abuse is not nationally known and accepted yet, the annual statistics involving deaths of children from child abuse does not include a number specific to medical child abuse. *See Frequently Asked Questions*, PREVENTCHILDABUSE.ORG, http://www.preventchildabuse.org/about_us/faqs.shtml (last visited Feb. 3, 2011). The forms of maltreatment that are recognized include neglect, physical abuse, sexual abuse and emotional abuse. *Id.* Each year there are over 3.5 million children reported to state and local Child Protective Services agencies as victims of abuse and neglect. *Id.*; *see also* *National Child Abuse Statistics*, CHILDHHELP.ORG, <http://www.childhelp.org/pages/statistics> (last visited Feb. 3, 2011) (stating that “[o]ver 3 million reports of child abuse are made every year in the United States.”). In 2007, there was an estimated 3,535,501 children who were victims of child maltreatment and an estimated 1,760 children died from abuse or neglect. *Frequently Asked Questions*, PREVENTCHILDABUSE.ORG, http://www.preventchildabuse.org/about_us/faqs.shtml (last visited Feb. 3, 2011); *see also* *National Child Abuse Statistics*, CHILDHHELP.ORG, <http://www.childhelp.org/pages/statistics> (last visited Feb. 3, 2011) (“In 2007, approximately 5.8 million children were involved in an estimated 3.2 million child abuse reports and allegations.”); *Frequently Asked Questions*, PREVENTCHILDABUSE.ORG 2, http://www.preventchildabuse.org/about_us/faqs.shtml (last visited Feb. 3, 2011) (noting that “[t]he National Child Abuse and Neglect Data System (NCANDS) reported an estimated 1,740 child fatalities in 2008 . . . [and t]he number and rate of fatalities have been increasing during the past few

members of the medical community are only recently trying to adopt the term “medical child abuse” and rid their vocabulary of MSBP.⁷⁰

As previously mentioned, “medical child abuse occurs when a child receives unnecessary and harmful, or potentially harmful, medical care at the instigation of the caregiver.”⁷¹ The main concern of medical child abuse, and the primary reason for moving away from MSBP, is to make the child’s experience the key focus, as opposed to what the caregiver is thinking or feeling.⁷² Medical child abuse is like any other form of abuse, including sexual, physical, psychological, and emotional; thus, it should be criminalized the same way.⁷³ Criminalizing medical child abuse is the first step in placing the main focus on the abused child’s best interest because prosecution will result in the removal of the child from the perpetrating caregiver’s custody.⁷⁴ The difference between medical child abuse and other forms of child abuse is that the perpetrator of medical child abuse uses the “medical community as the instrument of abuse.”⁷⁵ Therefore, the medical community must play a significant role in identifying medical child abuse to ensure it does not continue or recur.⁷⁶

Medical child abuse should not be confused with medical malpractice. While it may initially seem as though doctors and the medical community are abusing minor patients with tests, procedures, and hospitalization, this is certainly not the case. In situations of medical negligence or malpractice, “doctors provide bad medical care,

years.”). Each day, CPS agencies receive approximately 9,686 reports of suspected child abuse and neglect. *Frequently Asked Questions*, PREVENTCHILDABUSE.ORG, http://www.preventchildabuse.org/about_us/faqs.shtml (last visited Feb. 3, 2011). The majority of the cases reported are not investigated and assessed. *Id.* Instead, only the substantiated cases, those that contain sufficient evidence to confirm child abuse or neglect did occur, are investigated. *Id.*

⁷⁰ See *In re Anesia E.*, No. NA 3877/02, 2004 N.Y. Misc. LEXIS 1343, at *4 (N.Y. Fam. Ct. July 9, 2004).

⁷¹ ROESLER, *supra* note 2, at 1. If a medical treatment or procedure is intrusive or potentially harmful for a child, the child then becomes a victim of medical child abuse and the caregiver that subjects the child to such treatment is the perpetrator. *Id.*; see also Stirling, *supra* note 4, at 1027 (stating that “[w]hether it is called Munchausen Syndrome by proxy, pediatric symptom falsification, or simply child abuse, what remains as the central issue of importance is that a caregiver causes injury to a child that involves unnecessary and harmful or potentially harmful medical care.”).

⁷² ROESLER, *supra* note 2, at 1. “[A] proposal by a task force of the American Professional Society on the Abuse of Children advocates terminology that distinguishes two separate elements: the child abuse and a psychiatric disorder affecting the perpetrator.” Hahn, *supra* note 33, at 129.

⁷³ See ROESLER, *supra* note 2, at 20. “[C]hild abuse can exist whether the parent has been diagnosed with MSBP, depression, substance abuse, a personality disorder, or with no diagnosis at all.” *Id.* at 20. Some have said that subjecting a child to multiple sexual abuse evaluations can be considered Munchausen’s Syndrome by Proxy. *Id.* at 25.

⁷⁴ See ROESLER, *supra* note 2, at 7. “Child abuse is a pediatric diagnosis, one that describes what is happening to the child. Motivation of the perpetrator often becomes an issue when society considers incarceration, treatment, or reunification, but not when the physician makes the medical diagnosis of child abuse.” Stirling, *supra* note 4, at 1028.

⁷⁵ ROESLER, *supra* note 2, at 13.

⁷⁶ *Id.*

care that does not meet the standards of treatment usually offered by other physicians in the community. With medical child abuse, the physician administers usual and customary, appropriate, well-intentioned treatment based on the information available to him or her provided by the caretaker.”⁷⁷

Dr. Carole Jenny,⁷⁸ a nationally known expert for her work in child protection and medical child abuse, identifies five factors to consider when protecting a child from harm, including medical child abuse.⁷⁹ First, the child who is being harmed or is at risk of harm needs to be identified.⁸⁰ Second, the harm to the child needs to be stopped.⁸¹ Third, someone must ensure that the child will no longer be put at harm or at risk of harm.⁸² Fourth, the child at harm or at risk needs to be treated for the consequences of the abuse.⁸³ And, finally, the first four steps of the protection should be done in such a way as to maintain, as best as possible, “the integrity of the family unit.”⁸⁴

Similar to victims of MSBP, children who are subjected to medical child abuse do not fit exclusively into any particular demographic. Medical child abuse victims are diverse and the families involved do not share any particular criteria.⁸⁵ Also, it is practically impossible to categorize caregivers who desire to subject their children to unnecessary medical treatment in order to seek attention.⁸⁶

Fact finders should not primarily focus on whether the perpetrator or caregiver suffers from MSBP to find that a child is being harmed. Instead, fact finders should only look to whether the caregiver subjected a child to unnecessary and invasive medical treatment, falsified information, or induced symptoms in a child.⁸⁷ Thus, the important question to ask is what can be done⁸⁸ that is in the best interest of the child to keep the child safe.

⁷⁷ *Id.* at 7.

⁷⁸ *See* Hasbro Children’s Hospital, *supra* note 2.

⁷⁹ ROESLER, *supra* note 2, at 10.

⁸⁰ *Id.*

⁸¹ *Id.* “For the abuse to come to a halt the medical team needs to arrive at a consensus that harmful medical care is indeed taking place.” *Id.* at 203. All members of the medical team must act in concert to end the abusive medical care. *Id.*

⁸² *Id.* at 10.

⁸³ *Id.*

⁸⁴ *Id.*

⁸⁵ *Id.* at 14-15; *see also id.* at 147, Table 3 (comparing children who were found to be victims or medical child abuse to those were not victims—the chart notes differences between gender, minorities, whether a suspect perpetrator worked in the healthcare profession, and the history of the child as an infant).

⁸⁶ *Id.*

⁸⁷ *See* ROESLER, *supra* note 2, at 120 (“[T]he determination of whether behavior constitutes medical child abuse resides in the harm experienced by the child and not in the motivation of the parent.”).

⁸⁸ ROESLER, *supra* note 2, at 9.

D. Cases Involving Medical Child Abuse

Examining some of the case law that uses the term “medical child abuse” helps to provide a more complete understanding of medical child abuse. In *In re Joseph*, the Superior Court of Connecticut held that Michael, a three-year-old child, was a victim of MSBP, or medical child abuse.⁸⁹ The court defined MSBP as a “rare disorder in which a parent, usually a mother, fabricates or even induces illness in her child in order to become involved in the medical system.”⁹⁰ The hospital had the mother on videotape administering a substance, via a syringe, to Michael, through a gastrostomy or “G” tube.⁹¹ The syringe contained “Valium, a tranquilizer that can depress respiration, and Valproic Acid, an anti-seizure medication.”⁹² The mother tried to convince hospital staff that she was administering tea and water because her son was dehydrated.⁹³ Michael’s father told medical staff that Michael’s mother had over-medicated Michael at home with Valium.⁹⁴

The *Joseph* court also considered evidence regarding the mother’s past conduct regarding his health care.⁹⁵ First, the mother refused to take Michael to behavioral therapy while simultaneously informing the hospital staff that the behavioral therapy was not working.⁹⁶ Michael’s mother requested that the doctors insert a “G tube,” which is a “highly intrusive procedure” for a young child.⁹⁷ Second, Michael’s father stated that “the mother made Michael out to be worse than he was,” and that he never saw the frequent seizures that Michael’s mother claims she witnessed.⁹⁸ Lastly, and most importantly, health care providers saw that “Michael’s medical condition improved dramatically after his mother[.]” was removed from his care.⁹⁹ Four days after Michael’s mother was removed from his care, he was running down the

⁸⁹ *In Re Joseph P.*, 2000 Conn. Super. LEXIS 984, at *6 (Conn. Super. Ct. Apr. 14, 2000).

⁹⁰ *Id.* at *2.

⁹¹ *Id.* The Department of Children and Families alleged that “the hospital staff had clearly ordered the mother not to administer any medication or other substance to Michael through his G tube, which she previously had permission to do.” *Id.* The video clearly depicts Michael’s mother “leaning over Michael, withdrawing a hand containing a syringe, and going over to the bedside table.” *Id.* at *3.

⁹² *Id.*

⁹³ *Id.* The court relied on the fact that approximately thirty minutes prior to this incident, a “nurse discovered a syringe under a towel on Michael’s bedside table.” *Id.* The mother explained to medical staff that the syringe was in her purse and spilled and that she was simply “cleaning it out.” *Id.*

⁹⁴ *In Re Joseph*, 2000 Conn. Super. LEXIS 984, at *3. This evidence supported the claim that Michael’s mother most likely injected Michael with Valium at the hospital. *Id.*

⁹⁵ *Id.* at *3-4.

⁹⁶ *Id.*

⁹⁷ *Id.* at *4.

⁹⁸ *Id.*

⁹⁹ *Id.* at *5. Michael’s father informed the Department of Children and Families that he would rather see Michael not in his mother’s care. *Id.* at *4. After being removed from his mother’s care, Michael was able to feed himself and “ate vicariously.” *Id.* at *5.

hospital hallways, and upon his release, “was bright, oriented, very verbal, playful and interactive.”¹⁰⁰

Dr. Carole Jenny¹⁰¹ provided testimony regarding the relationship between Michael and his mother.¹⁰² Although Dr. Jenny was not completely familiar with Michael’s case, she was able to state that the facts and circumstances surrounding this particular situation “fit the profile of a Munchausen case.”¹⁰³ Dr. Jenny also testified that “when a Munchausen victim is removed from the home, the parent will often turn her attention to a remaining child.”¹⁰⁴

In another case, the Family Court of New York found that Anesia, a minor child, was abused, and thus, the court did not need to determine the mother’s psychological state.¹⁰⁵ Anesia’s mother had her admitted to the hospital at eighteen months of age after allegedly suffering from two seizures in one week.¹⁰⁶ Doctors were informed by Anesia’s mother that Anesia had been hospitalized fourteen times due to seizures.¹⁰⁷ Additionally, Anesia’s mother claimed that she had several other children who died from seizures, and as a result, she had multiple abortions in fear that her newborns would have seizures too.¹⁰⁸ Upon learning this information, the doctor contacted “a well-known child abuse expert” who subsequently spoke with Anesia’s mother.¹⁰⁹ After that conversation, the child abuse expert opined that Anesia was a victim of MSBP, “now called ‘medical child abuse,’” and that if Anesia were to be left in the care of her mother, she would be at a “substantial risk” of harm.¹¹⁰ “No medical personnel ever witnessed any seizures, and all tests performed . . . produced normal results.”¹¹¹ Anesia’s mother’s fabrications led to

¹⁰⁰ *Id.*

¹⁰¹ ROESLER, *supra* note 2.

¹⁰² *In Re Joseph*, 2000 Conn. Super. LEXIS 984, at *6.

¹⁰³ *Id.* The events that lead to a conclusion of MSBP case included the mother’s “medical expertise as a licensed professional nurse, her desire to debate medicine with Michael’s doctors, Michael’s status as being chronically ill, and the fact that the father, as a long-distance truck, was not in the home on a daily basis.” *Id.*

¹⁰⁴ *Id.* at *7.

¹⁰⁵ *In re Anesia E.*, 2004 N.Y. Misc. LEXIS 1343, at *1.

¹⁰⁶ *Id.* at *2. Anesia’s mother also alleged that as a result of the seizures, Anesia would foam at the mouth, roll her eyes and jerk her extremities. *Id.* at *3. When ambulances responded, however, Anesia was “routinely alert and happy.” *Id.*

¹⁰⁷ *Id.* at *2. Anesia’s mother also misinformed medical personnel in order for Anesia to have an imminent liver transplant. *Id.* at *4.

¹⁰⁸ *Id.* at *3. “MSP patients may make extraordinary false statements, such as Anesia’s mother claiming Anesia need[ed] a liver transplant and that four to six of her other children ha[d] died from seizures. None of which [was] true.” *Id.* at *5.

¹⁰⁹ *Id.* at *2.

¹¹⁰ *Id.* at *3. “The morbidity rate for children diagnosed with MSBP is 9% to 33%, with many deaths, and permanent disfigurement or disabilities up to 8%.” *Id.* at *4. Because MSBP is so difficult to diagnosis, nearly 9% of the victims of this abuse die. Feurtado, *supra* note 26.

¹¹¹ *In re Anesia E.*, 2004 N.Y. Misc. LEXIS 1343, at *3.

multiple hospitalizations, tests, procedures, and the administration of powerful anticonvulsants, all of which carried a substantial risk of injury.¹¹²

Anesia's mother became angry upon hearing from multiple doctors that her daughter was healthy and threatened to take Anesia to another hospital.¹¹³ As a result, Anesia was removed from her mother's care and discharged to her grandmother as a healthy child.¹¹⁴ At trial, the child abuse expert noted that:

[T]he pediatric community is changing the victim's diagnosis from MSP to medical child abuse in order to shift the emphasis away from the perpetrator and place it on the abused child, disregarding the psychological motivation or emotional state of the parent. The less stringent diagnostic criteria used by the pediatric community in making the diagnosis of medical child abuse differs from, and thus, warrants using a different name from, the psychiatric community's diagnostic criteria for MSP, known as factitious disorder by proxy in the Diagnostic and Statistical Manual "DSM" (4th edition).¹¹⁵

In a similar 2010 case from the Fifth District of Texas, the court held that C.W.¹¹⁶ was the victim of medical child abuse.¹¹⁷ A jury found the defendant, Laurie Williamson, guilty of two first-degree felony offenses, and guilty of using a scalpel, an instrument characterized as a "deadly weapon."¹¹⁸ Williamson had two sons, C.W. and D.W., and one daughter, L.W.¹¹⁹ Her son, C.W., began to have various medical problems by the age of five, and was reported by some to be over medicated or "doped up."¹²⁰ Similar to the case described above, Williamson reported seeing

¹¹² *Id.*

¹¹³ *Id.* "When confronted by health care providers, MSP patients typically become angry, as in this mother's response to [the child abuse expert] when she was informed Anesia was healthy." *Id.* at *5.

¹¹⁴ *Id.* at *3.

¹¹⁵ *Id.* at *4. The child abuse expert stated the factors that are commonly found in case histories of parents, usually mothers, who are diagnosed with MSP, which include:

(1) the child's prolonged illness, presenting confusing symptoms defying diagnosis and unresponsive to medical treatment; (2) the child's recurring hospitalizations, surgeries, and other invasive procedures; (3) the child's dramatic improvement after removal from parent's access and care; (4) the mother's training in nursing or related medical fields; (5) the mother's unusually supportive and cooperative attitude toward medical personnel; and (7) the mother's symbiotic relationship to the child.

Id.

¹¹⁶ Initials are used to reference each of the defendant's three minor children.

¹¹⁷ Williamson, 2010 Tex. App. LEXIS 3432.

¹¹⁸ *Id.*

¹¹⁹ *Id.* at *2.

¹²⁰ *Id.* at *3. C.W. appeared to be "drowsy and unsteady on his feet." *Id.* A blood test revealed that C.W. had twice the recommended level of an anti-seizure medication. *Id.*

C.W. have seizures, but no seizures were ever recorded on the EEG.¹²¹ A device was implanted in C.W. to control the seizures, but according to Williamson, the seizures did not stop.¹²² One month later, when C.W. was hospitalized for “failure to thrive,” the medical team had a meeting regarding whether C.W. was a victim of MSBP.¹²³ The medical team, however, did not believe they had enough information to make a proper MSBP diagnosis for Williamson.¹²⁴ Before being discharged, C.W. had a nasal gastric feeding tube inserted to feed him liquid formula.¹²⁵

Others began to have concerns for C.W.’s health and welfare.¹²⁶ As a result of C.W.’s mood and demeanor, C.W.’s teachers confronted Williamson with their concerns.¹²⁷ Williamson quickly withdrew C.W. from public school, and began homeschooling him.¹²⁸ C.W.’s babysitters then began having concerns regarding his lethargic mood and how he begged for food.¹²⁹

Subsequently, C.W. had a gastrostomy tube inserted through his abdomen into his stomach due to Williamson’s allegations that C.W. suffered from a “feeding disorder.”¹³⁰ Williamson also contended that C.W. had mitochondrial disease; muscle sample testing indicated, however, that C.W. tested negative for mitochondrial disease.¹³¹ Regardless of this negative finding, Williamson continued

¹²¹ *Id.* at *3-4. Despite the fact that C.W. was taking maximum dosages for anti-seizure medications, his mother still claimed that C.W. had up to eleven seizures a day. *Id.* at *4. Doctors deactivated the device after six weeks and it was never reactivated. *Id.* at *5.

¹²² *Id.* at *4-5. A vagal nerve simulator was implanted and can decrease seizure activity by administering shocks at different times and strengths. *Id.* The device is inserted just under the skin and a wire runs from the device to the nerve. *Id.* at *4.

¹²³ *Id.* at *5-6. A central line was placed in C.W. to provide nutrition. *Id.* at *5. During C.W.’s hospital stay, he saw many specialists, including neurology, endocrinology, hematology, oncology, and genetics. *Id.*

¹²⁴ *Id.*

¹²⁵ *Id.* at *6.

¹²⁶ *Id.* at *7.

¹²⁷ *Id.* at *6-7. C.W.’s mother informed his teacher that C.W. was on a special diet. *Id.* at *6. His teachers noticed that he was “very thin and losing weight” and that he was “just skin and bones.” *Id.* Moreover, it seemed like C.W. was always craving food, but his teachers did not give him food due to his restricted diet. *Id.* C.W.’s teachers became concerned that he was overmedicated. *Id.* A letter was drafted regarding the school’s suspicion that C.W. was being abused at home. *Id.* at *7.

¹²⁸ *Id.*

¹²⁹ *Id.* at *7. Again, C.W.’s mother told the neighbors and babysitters that C.W. was on a restricted diet. *Id.* C.W. would beg for food from the time his mother dropped him off until she returned to pick him up. *Id.*

¹³⁰ *Id.* at *8. C.W.’s mother also claimed that he suffered from “hypotonia, which is decreased muscle tone,” and that C.W. could not “hold himself up or walk comfortably.” *Id.* at *7-8.

¹³¹ *Id.* Mitochondrial diseases are a group of disorders that result from the mitochondria failing to create the energy necessary to grow and sustain life. *Mitochondrial Disease Information for Teachers*, UNITED MITOCHONDRIAL DISEASE FOUND., <http://www.umdf.org/atf/cf/%7B858acd34-ecc3-472a-8794-39b92e103561%7D/MITOCHONDRIAL%20DISEAS>

to represent that C.W. had mitochondrial disease, and C.W. began using a wheelchair.¹³² When Williamson became sick, and unable to care for her children, the community came to the Williamson home to help care for her children.¹³³ It was at this time that the community started to realize that the “children’s health dramatically improved.”¹³⁴ Upon seeing the children’s drastic improvement, one of the community members assisting with the child care made a report of child abuse.¹³⁵ The children were subsequently removed from Williamson’s care.¹³⁶

At trial, the State alleged that C.W. was a victim of medical child abuse.¹³⁷ Dr. Jane Shook, one of the State’s experts, testified that “[m]edical child abuse is when the caretaker of a child or children falsifies information, visits harm upon a child, does other things in order that a child ends up seeking and receiving medical care, often for the secondary gain of the adult, the supervising adult.”¹³⁸ The court noted that “[e]vidence that [Williamson] profited financially from her children’s claimed afflictions also is probative of her intent to fabricate or exaggerate C.W.’s symptoms

E%20INFORMATION%20FOR%20TEACHERS.PDF (last visited Sept. 29, 2011). Mitochondrial diseases mostly affect children and have no set pattern or one identifying feature. *Id.* Patients may be diagnosed with another disorder before being diagnosed with a mitochondrial disease. *Id.* Children that have “fewer affected mitochondria may be mislabeled as lazy, uncooperative, or underachievers.” *Id.* Currently, there is no cure for mitochondrial diseases and “no truly effective treatments.” *Id.* Because each patient’s symptoms are individual, it is difficult for physicians to “predict a prognosis.” *Id.*

¹³² Williamson, 2010 LEXIS 3432, at *8. Furthermore, even though C.W. was potty trained, he became “incontinent of bowel and bladder.” *Id.* “[Williamson’s] other two children also had numerous medical problems diagnosed over the years.” *Id.* at *9. “[Williamson’s] middle child, D.W., had fewer medical diagnoses than C.W. and L.W. But, similar to C.W. and L.W. [Williamson] maintained that D.W. had mitochondrial disorder.” *Id.* at *11.

¹³³ *Id.* at *13. Home health nurses, volunteers, members of the church and friends assisted in caring for the children. *Id.* Eventually, C.W.’s mother required a wheelchair. *Id.*

¹³⁴ *Id.* The children were growing, gaining weight, wearing larger clothing sizes, walking, and generally seemed happier. *Id.*

¹³⁵ *Id.* at *14.

¹³⁶ *Id.* After being evaluated at the Texas Children’s Hospitals for evaluation, “C.W. was discharged three days after being admitted. At that time, he had no gastrostomy feeding tube, no glasses, no wheelchair, and fewer medications.” *Id.* at *15.

¹³⁷ *Id.* at *18.

¹³⁸ *Id.* at *19. The community member who reported the child abuse calculated that Williamson had received approximately \$150,000 from her church. *Id.* at *20. Williamson also received a trip for her and her family to Disney World through the Make-A-Wish Foundation. *Id.* Additionally, Williamson was on public assistance. *Id.* The court allowed the admission of evidence of Williamson’s other children to demonstrate a pattern of conduct of medical abuse and to show the defendant’s degree of motive. *Id.* at *53. The state’s medical experts testified that the motivating force behind Munchausen Syndrome by Proxy or medical child abuse is some form of secondary gain to the perpetrator, such as financial gain. *Id.* at *58. “[T]angible gains such as church donations, special trips from the ‘terminally ill’ child, or entitlement monies may result from the deceptions, but the principal goal is the satisfaction of emotional needs.” Hahn, *supra* note 33, at 130.

to subject C.W. to unnecessary medical procedures.”¹³⁹ The preferred term at trial was “medical child abuse” even though it was used interchangeably with MSBP.¹⁴⁰

E. New Elements of Proof for Medical Child Abuse

Medical child abuse should be treated like any other form of child abuse, including physical, sexual, emotional, and psychological. The motivation of the perpetrator is often at issue when society is considering treatment, reuniting a parent with a child, or incarceration.¹⁴¹

Children can be placed in a safer environment sooner by ridding the equation of determining whether the caregiver suffers from MSBP. This is particularly true because much ambiguity and uncertainty related to the diagnosis and treatment of MSBP still exists.¹⁴² By amending Ohio’s legislation that relates to child abuse, and by adding specific language concerning medical child abuse, future medical child abuse cases can be prosecuted like any other form of child abuse.

Like all other criminal cases, beyond a reasonable doubt should be the burden of proof¹⁴³ used to convict an individual of providing misinformation, inducing symptoms, or falsifying symptoms to subject a child to unnecessary and invasive medical treatment. Beyond a reasonable doubt means “proof of such character that an ordinary person would be willing to rely and act upon it in the most important of the person’s own affairs.”¹⁴⁴ Specific language of medical child abuse should be included in the sections of the Ohio Revised Code (R.C.) that relate to the definition and crime of child abuse.¹⁴⁵ This would allow abusive caregivers to be found guilty of a felony.¹⁴⁶

*F. Key Differences Between Munchausen’s Syndrome
by Proxy and Medical Child Abuse*

While medical child abuse and MSBP both involve the child’s caregiver, there is one key distinction that differentiates the two characterizations of the phenomenon. Medical child abuse focuses solely on the treatment and experience of the child,¹⁴⁷ whereas, MSBP focuses on what the caregivers thought, believed, or

¹³⁹ Williamson, 2010 LEXIS 3432, at *40.

¹⁴⁰ *Id.* at *50 n.4. The medical records of Williamson’s other children were admissible at trial as it was “relevant to understand[] the magnitude of the motivational force, which the average person would have difficulty comprehending,” to “prove motive” and to “provide context to the offenses.” *Id.* at *53-54.

¹⁴¹ “In no other forms of child abuse do we include the perpetrator’s motives as a diagnostic criterion.” Stirling, *supra* note 4, at 1028.

¹⁴² See Pankratz, *supra* note 28, at 92.

¹⁴³ Burden and Degree of Proof, OHIO REV. CODE ANN. § 2901.05(A) (LexisNexis 2011).

¹⁴⁴ § 2901.05(E).

¹⁴⁵ See Permitting Child Abuse, OHIO REV. CODE ANN. § 2903.15 (LexisNexis 2011); Child Abuse Defined, OHIO REV. CODE ANN. § 2151.031 (LexisNexis 2011).

¹⁴⁶ § 2903.15(C).

¹⁴⁷ ROESLER, *supra* note 2, at 56.

wanted out of their conduct.¹⁴⁸ In all cases of medical child abuse, the caregiver is knowingly subjecting a child to unnecessary and excessive medical treatment by falsifying information, deceiving health care providers, or inducing symptoms.¹⁴⁹ Thus, the focus of the attention should be on the child and the unnecessary treatment that is being provided. Although the caregiver likely has psychiatric issues to be dealt with, the focus needs to be on the child and ensuring the child's safety once the medical child abuse is detected. Once the child is separated from the caregiver (and in most circumstances this may be necessary) and the child is safe, then medical assistance can be provided to the caregiver.

III. LEGISLATION

A. *Ohio's Current Legislation That Effects Medical Child Abuse*

R.C. section 2151.031 defines "abused children," and states in pertinent part:

As used in this chapter, an "abused child" includes any child who:

Is the victim of "sexual activity";

Is endangered as defined in R.C. § 2919.22 of the Revised Code;

(C) Exhibits evidence of any physical or mental injury or death, inflicted other than by accidental means, or an injury or death which is at variance with the history given of it;

(D) Because of the acts of his parents, guardian, or custodian, suffers physical or mental injury that harms or threatens to harm the child's health or welfare.

(E) Is subjected to out-of-home care child abuse.¹⁵⁰

¹⁴⁸ Pankratz, *supra* note 28, at 91.

¹⁴⁹ See ROESLER, *supra* note 2, at 1.

¹⁵⁰ § 2151.031. Section 2151.03 defines a "neglected child" and states in pertinent part:

(A) As used in this chapter, "neglected child" includes any child:

(1) Who is abandoned by the child's parents, guardian, or custodian;

(2) Who lacks adequate parental care because of the faults or habits of the child's parents, guardian, or custodian;

(3) Whose parents, guardian, or custodian neglects the child or refuses to provide proper or necessary subsistence, education, medical or surgical care or treatment, or other care necessary for the child's health, morals, or wellbeing;

(4) Whose parents, guardian, or custodian neglects the child or refuses to provide special care made necessary by the child's mental condition;

This statute came into effect over two decades ago,¹⁵¹ and it should be amended to reflect and incorporate changes in human behavior.

Section 2151.421 is a critical section of the Ohio Revised Code that was recently amended, regarding the duty to report child abuse and neglect.¹⁵² More specifically, section 2151.421(A)(1)(a) sets forth a duty to immediately report abuse or neglect if a reasonable person would suspect abuse based on the facts and circumstances.¹⁵³ This duty applies to any “physician, including a hospital intern or

(5) Who, because of the omission of the child’s parents, guardian, or custodian, suffers physical or mental injury that harms or threatens to harm the child’s health or welfare.

¹⁵¹ Section 2151.031 became effective on August 3, 1989.

¹⁵² Duty to Report Child Abuse or Neglect, OHIO REV. CODE ANN. § 2151.421 (LexisNexis 2011) (amended Oct. 6, 2009). Pursuant to § 2151.421(A)(1)(b), the duty to report of § 2151.421(A)(1)(a) applies to the following:

[a]ttorney; physician, including a hospital intern of resident; dentist; podiatrist; practitioner of a limited branch of medicine as specified in section 4731.15 of the Revised code; registered nurse; licensed practical nurse; visiting nurse; other health care professional; licensed psychologist; licensed school psychologist; . . . coroner; administrator or employee of a child day-care center; administrator or employee of a residential camp or child day camp; administrator or employee of a certified child care agency or other public or private child services agency; school teacher; school employee; school authority; person engaged in social work or the practice of professional counseling; agent of a county humane society; . . . ; employee of a county department job and family services who is a professional and works with children and families; superintendent, board member, or employee of a county board of developmental disabilities; employee of the department of developmental disabilities; employee of a facility or home that provides respite care in accordance with section 5123.171 of the Revised Code; employee of a home health agency; employee of an entity that provides homemaker services; . . . or third party employed by a public children services agency to assist in providing family or family related services.

See § 2151.421(H)(1) (amended 2009). Reports made under this section, are confidential. § 2151.421(H)(1). The section further states:

Nothing in this division shall preclude the use of reports of other incidents of known or suspected abuse or neglect in a civil action or proceeding brought pursuant to division (M) of this section against a person who is alleged to have violated division (A)(1) of this section, provided that any information in a report that would identify the child who is the subject of the report or the marker of the report, if the maker of the report is not the defendant or an agent or employer of the defendant, has been redacted.

§ 2151.421(H)(1).

¹⁵³ OHIO REV. CODE ANN. § 2151.421(A)(1)(a) (amended 2005); see § 2151.421(C)(1)-(3) (amended 2006) (setting forth the requirements of the written report to be submitted via telephone or in person of the suspected child abuse or neglect); see also Complaint Involving Child, OHIO REV. CODE ANN. § 2151.27 (LexisNexis 2011) (amended 2005) (explaining the requirements of a sworn complaint to be filed in the Juvenile Court in the jurisdiction of where the child resides or where the violation occurred).

resident; dentist; podiatrist; practitioner of a limited branch of medicine as specified in section 4731.15 of the Revised Code; registered nurse; licensed practical nurse; visiting nurse; [or] other health care professional.”¹⁵⁴

More specifically, section 2151.421(A)(3)(b) places a duty on physicians who know or “ha[ve] reasonable cause to suspect[.]” based upon the facts and circumstances, that the child “suffered or faces a threat of suffering any physical or mental wound, injury . . . or condition of a nature that reasonably indicates abuse.”¹⁵⁵ Pursuant to R.C. section 2151.421(H)(1), however, if a person that has a duty to report “knowingly makes or causes another to make a false report under division (B),” and alleges that someone has committed conduct that constitutes child abuse, the reporting person is guilty of violating section 2921.14.¹⁵⁶

Section 2151.421(M) was recently added to the Ohio Revised Code and raises a problem for physicians.¹⁵⁷ This section states, in pertinent part, that a person who violates section 2151.421(A), not reporting when there is a reason to suspect abuse, is “liable for compensatory and exemplary damages *to the child* who would have been the subject of the report that was not made.”¹⁵⁸ A child who brings suit against an individual with a duty to report can introduce evidence in the civil action, or

¹⁵⁴ See § 2151.421(A)(1)(b) (amended 2006).

¹⁵⁵ See § 2151.421(A)(3)(b).

¹⁵⁶ Making or Causing False Report of Child Abuse or Neglect, OHIO REV. CODE ANN. § 2921.14 (LexisNexis 2011) (governing the compounding of crimes and prohibiting individuals from “knowingly demand, accept, or agree to accept anything of value in consideration of abandoning or agreeing to abandon a pending criminal prosecution”). In *Nash v. Cleveland Clinic Foundation*, the plaintiffs attempted to subpoena from the defendants during discovery “all records or notes concerning any communications made with the Cuyahoga County Department of Family Services.” No. 92564, 2010 Ohio App. 5, at **5-6 (Ohio Ct. App. Jan. 7, 2010). The court ruled that “[o]nly reports of child abuse, the identity of persons making such reports, and the information contained in such reports, are confidential under R.C. § 2151.421(H)(1).” *Id.* at **2-3. The court further stated that “R.C. § 4121.421(H) does not preclude discovery of all discussions about injuries or conditions that may have resulted from abuse.” *Id.* at **11-12. However, R.C. § 2151.423 authorizes public child services agencies to “disclose confidential information discovered during an investigation conducted pursuant to *section 2151.421 [2151.42.1] or 2151.422 [2151.42.2] of the Revised Code* to any federal, state, or local government entity that needs the information to carry out its responsibilities to protect children from abuse or neglect.” Disclosure of Confidential Information to Agencies Responsible for Protecting Children from Abuse or Neglect, OHIO REV. CODE ANN. § 2151.423 (LexisNexis 2011) (emphasis in original).

¹⁵⁷ OHIO REV. CODE ANN. § 2151.421(M) (amended 2009). In *Bucey v. Carlisle*, the First Appellate District of Ohio held that R.C. § 2151.421(M) was substantive and thus applying the statute retroactively would be unconstitutional. No. C-090252, 2010 Ohio App. LEXIS 1858, at **16 (Ohio Ct. App. May 21, 2010). The court applied a two part test to determine whether the statute could be applied retroactively. *Id.* at **15. The First District found that the amendment was substantive “because it would impose a new liability on the [defendants] with respect to a past transaction, when the [defendants] would otherwise be immune.” *Id.* at **16. “Thus, at the time of [the plaintiff’s] injuries, R.C. § 2151.421 did not expressly impose any civil liability for a failure to report; it imposed only criminal liability.” *Id.* at **14; *see also* *Roe v. Planned Parenthood*, 912 N.E.2d 61 (Ohio 2009) (addressing the issue of constitutionality in applying R.C. § 2151.421(M) retroactively).

¹⁵⁸ OHIO REV. CODE ANN. § 2151.421(M) (emphasis added).

proceeding, of “reports of other incidents of known or suspected abuse.”¹⁵⁹ Pursuant to these sections, physicians and other listed medical practitioners are under a duty to report suspected child abuse, or neglect, by filing a report immediately; if they fail to do so, then section 2151.421(M) can take effect.¹⁶⁰

It is important to note that individuals listed under section 2151.421(A)(1)(a) are immune from any civil or criminal liability “for injury, death, or loss to person or property that otherwise might be incurred” if the report was made in good faith.¹⁶¹ However, if a physician or any other individual with a duty to report fails to do so pursuant to section 2151.421(A)(1), criminal charges can also be brought against him/her for that failure to report.¹⁶² The individual that failed to report will be guilty of a fourth-degree misdemeanor.¹⁶³ If the child that is the subject of the report “suffers or faces the threat of suffering the physical or mental wound, injury, disability, or condition that would be the basis of the required report,” however, then the individual will be guilty of a first-degree misdemeanor.¹⁶⁴

¹⁵⁹ See § 2151.421(M). The information that is used as evidence identifies the child, the subject of the report, if the person making the report is not the defendant or defendant’s employee, has already been redacted. *Id.*

¹⁶⁰ *Id.*

¹⁶¹ § 2151.421(G)(1)(a). In 2002, the Court of Appeals of Washington dismissed the parent plaintiff’s complaint because the hospital and physician were entitled to the good faith immunity for health care providers who had a duty to report suspicions of child abuse pursuant to Washington Revised Code section 26.44.060(1)(a). *Yuille v. State*, 45 P.3d 1107, 1110 (Wash. 2002). The court stated that the physician and hospital were entitled to immunity as there was an “inadequate showing that the report was *not* made in good faith.” *Id.* at 1110. The physicians and hospital were suspicious of abuse when the mother’s two adopted, non-related children presented with similar symptoms. *Id.* at 1109. Washington Revised Code section 26.44.060, governing immunity from civil or criminal liability, states in pertinent part:

(1) (a) [a]ny person participating in good faith in the making of a report . . . or testifying as to alleged child abuse or neglect in a judicial proceeding shall . . . be immune from any liability arising out of such reporting or testifying under any law this state or its political subdivisions.

(b) A person convicted of a violation of subsection (4) of this section shall not be immune from liability under (a) of this section

. . .

(4) A person who, intentionally and in bad faith, knowingly makes a false report of alleged abuse or neglect shall be guilty of a misdemeanor punishable in accordance with RCW 9A.20.021.

Immunity from Civil or Criminal Liability—Confidential Communications Not Violated—Actions Against State Not Affected—False Report, Penalty, REV. CODE WASH § 26.44.060 (LexisNexis 2011).

¹⁶² Penalty, OHIO REV. CODE ANN. § 2151.99 (amended 2007).

¹⁶³ § 2151.99(C)(1) (amended 2007).

¹⁶⁴ § 2151.99(C)(2). Section 2151.99 states in pertinent part:

If those individuals with a duty to report do so and the caregiver is found not guilty of child abuse, then notwithstanding the statutory immunity for reporting in good faith, the caregiver may bring an action against the individual who filed the report.¹⁶⁵ Between the options of over-reporting versus under-reporting, the safer option for physicians and others with a duty to report is to report so they may not be found liable for the serious harm or death of a child.¹⁶⁶ If those with a duty to report are sued by the caregiver, the physicians and other health care practitioners can present evidence that they had reasonable cause to suspect abuse, and, consequently, reported in good faith so as to invoke the immunity provisions of section 2151.421(G)(1)(a).¹⁶⁷ It is much more difficult for a physician or other health care practitioner to present evidence substantiating an alleged failure to report if a suit is brought by a child for the alleged failure to report.

The only mention of child abuse as a criminal offense is found in section 2903.15 of the Ohio Revised Code.¹⁶⁸ This section states that no individual, as the parent or guardian of a minor child, “shall cause serious physical harm to the child, or the death of the child, as the proximate result of permitting the child to be abused [or] to be tortured.”¹⁶⁹ If an individual’s violation of this section causes serious physical harm, the child abuse is classified as a third-degree felony; if the death of a child results, however, the child abuse is classified as a first-degree felony.¹⁷⁰ Additionally, section 2903.13 governs assault and states that a person shall not knowingly or recklessly “cause or attempt to cause physical harm to another.”¹⁷¹ Furthermore, section 2919.22(B) sets forth six actions that an individual shall not do

(C) Whoever violates division (A)(1) of section 2151.421 of the Revised Code shall be punished as follows:

(1) Except as otherwise provided in (C)(2) of this section, the offender is guilty of a misdemeanor of the fourth degree.

(2) The offender is guilty of a misdemeanor of the first degree if the child who is the subject of the required report that the offender fails to make suffers or faces the threat of suffering the physical or mental wound, injury, disability, or condition that would be the basis of the required report when the child is under the direct care or supervision of the offender who is then acting in the offender’s official or professional capacity or when the child is under the direct care or supervision of another person over whom the offender while acting in the offender’s official or professional capacity has supervisory control.

Id.

¹⁶⁵ § 2151.421(M).

¹⁶⁶ *See Id.* § 2151.421.

¹⁶⁷ *See* §§ 2151.421(G), 2151.421(M).

¹⁶⁸ § 2903.15

¹⁶⁹ § 2903.15(A).

¹⁷⁰ § 2903.15(C).

¹⁷¹ OHIO REV. CODE ANN. § 2903.13(A) (LexisNexis 2011).

to a child under the age of eighteen years old, including “[a]buse the child” or “[t]orture or cruelly abuse the child.”¹⁷²

B. Federal Legislation Regarding Child Abuse

States look to the Federal Child Abuse Prevention and Treatment Act (“CAPTA”) that sets forth the minimum standards that states must integrate into their statutory definitions regarding child abuse.¹⁷³ On December 20, 2010, President Barack Obama signed the reauthorization of CAPTA to amend the statute, which now only provides the definition for sexual abuse, ridding the statute of the definition of child abuse.¹⁷⁴

For states to be eligible to receive federal grants under CAPTA, “[s]tates are required to establish provisions for immunity from liability for individuals making good faith reports of suspected or known instances of child abuse or neglect.”¹⁷⁵ The immunity statutes can potentially “protect reporters from [future] civil or criminal liability,” and from participating in judicial proceedings.¹⁷⁶ In many states, however, civil or criminal liability immunity is not provided in circumstances where the reporter makes a report in “bad faith” or acts with malice.¹⁷⁷

The Child Welfare Information Gateway is another place that states look for guidance and information regarding child abuse.¹⁷⁸ The Child Welfare Information Gateway “promotes the safety, permanency, and well-being of children, youth, and families by connecting child welfare, adoption, and related professionals,” and also

¹⁷² Endangering Children, OHIO REV. CODE ANN. § 2919.22(B)(1)-(2) (LexisNexis 2011).

¹⁷³ See Child Abuse Prevention and Treatment Act, ch. 67, 124 Stat. 3459 (2010) (codified as amended at 42 U.S.C.S. § 5101 (LexisNexis 2011)).

¹⁷⁴ 42 U.S.C.S. § 5106(g)(4) (LexisNexis 2011). Before the statute was amended, the following was the definition for child abuse and neglect stated in 42 U.S.C.S. § 5106(g):

the term “child abuse and neglect” means, at a minimum, any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of serious harm.

This definition, however, still remains in 42 U.S.C.S. § 13925(a)(2) (LexisNexis 2011).

¹⁷⁵ *Immunity for Reporters of Child Abuse and Neglect: Summary of State Laws*, CHILD WELFARE INFO. GATEWAY, 1 (2008), http://www.childwelfare.gov/systemwide/laws_policies/statutes/immunityall.pdf (last visited Sept. 30, 2011); see also 42 U.S.C. § 5105(b)(2)(B)(vii).

¹⁷⁶ *Immunity for Reporters of Child Abuse and Neglect: Summary of State Laws*, *supra* note 175, at 2.

¹⁷⁷ *Id.* at 3. “Immunity is denied for acting with malice or in bad faith in 10 states: Arizona, Colorado, Idaho, Indiana, Missouri, Montana, New Mexico, Ohio, Texas and Virginia.” *Id.* at 3 n.11. Furthermore, “[i]mmunity is denied for knowingly making a false report in 10 states: California, Louisiana, Maine, Missouri, Montana, Nebraska, North Dakota, Ohio, Utah and Washington.” *Id.*

¹⁷⁸ *About Child Welfare Information Gateway*, CHILD WELFARE INFO. GATEWAY, <http://www.childwelfare.gov/aboutus.cfm> (last visited Sept. 30, 2011). The Child Welfare Information Gateway provides services to multiple governmental agencies including Children’s Bureau, Administration for Children and Families, and U.S. Department of Health and Human Services. *Id.*

provides information and resources regarding child abuse.¹⁷⁹ The Child Welfare Information Gateway analyzes the following types of abuse: physical, neglect, sexual abuse/exploitation, emotional, parental substance abuse, and abandonment.¹⁸⁰ All fifty states have statutes that set forth the specific procedures that certain state agencies must follow when reports of suspected child abuse are made to that agency.¹⁸¹ In many states, the “procedures include requirements for cross-system reporting and/or information sharing among professional entities.”¹⁸² Ohio is one of nine states that require child protection and law enforcement agencies to coordinate efforts and conduct investigations to minimize the number of times children are interviewed.¹⁸³

Additionally, all fifty states identify those persons with a duty to report child maltreatment.¹⁸⁴ Forty-eight states identify professionals, many of whom have frequent contact with children, who must report.¹⁸⁵ These people may include: social workers, teachers, physicians and health care professionals, mental health professionals, child care providers, medical examiners, and law enforcement officers.¹⁸⁶

C. *The Law in Other States: A Statutory Review*

1. Rhode Island

Rhode Island statutes define an abused or neglected child as a “child whose physical or mental health or welfare is harmed or threatened when his or her parents or other person responsible for his or her welfare” do any of the following: (1) “[i]nflicts or allows to be inflicted upon the child physical or mental injury, including excessive corporal punishment”; (2) “[c]reates or allows to be created a substantial risk of physical or mental injury to the child, including excessive corporal punishment”; or, (3) “[c]ommits or allows to be committed any sexual offense against the child.”¹⁸⁷ Rhode Island’s public policy is:

¹⁷⁹ *Id.*

¹⁸⁰ *Definitions of Child Abuse and Neglect: Summary of State Laws*, CHILD WELFARE INFO. GATEWAY 2-4 (2009), http://www.childwelfare.gov/systemwide/laws_policies/statutes/define.pdf (last visited Sept. 30, 2011).

¹⁸¹ *Cross-Reporting Among Responders to Child Abuse and Neglect: Summary of State Laws*, CHILD WELFARE INFO. GATEWAY 1 (2010), http://www.childwelfare.gov/systemwide/laws_policies/statutes/xreportingall.pdf.

¹⁸² *Id.*

¹⁸³ *Id.* at 2; see *Interagency Agreement Regarding Reports of Alleged Child Abuse*, OHIO REV. CODE ANN. § 2151.421(F) (LexisNexis 2011); *Obligations of Public Official or Agency Unaffected*, OHIO REV. CODE ANN. § 2151.428(A) (LexisNexis 2011).

¹⁸⁴ *Mandatory Reporters of Child Abuse and Neglect: Summary of State Laws*, CHILD WELFARE INFO. GATEWAY 1 (2010), http://www.childwelfare.gov/systemwide/laws_policies/statutes/manda.pdf.

¹⁸⁵ *Id.* at 1-2.

¹⁸⁶ *Id.*; see § 2151.421.

¹⁸⁷ *Definitions*, R.I. GEN. LAWS ANN. § 40-11-2(1)(i)-(ii), (ix) (LexisNexis 2011).

[T]o protect children whose health and welfare may be adversely affected through injury and neglect; to strengthen the family and to make the home safe for children by enhancing the parental capacity for good child care; to provide a temporary or permanent nurturing and safe environment for children when necessary; and, for these purposes, to require the mandatory reporting of known or suspected child abuse and neglect, investigation of those reports by a social agency, and provision of services, where needed, to the child and family.¹⁸⁸

Physicians and duly registered nurse practitioners in Rhode Island have a duty to report when a child is presented for an examination, care, or treatment, and the medical professional has cause to suspect that the child has been abused.¹⁸⁹ The report shall be made immediately, orally by telephone or otherwise, to both the law enforcement agency and department, and must be followed by a written report explaining the “extent and nature of the abuse . . . the child is alleged to have suffered.”¹⁹⁰ An individual who has a duty to report and knowingly fails to do so, or an individual who prevents another from reporting, will be guilty of a misdemeanor and subject to a fine not to exceed \$500, or imprisonment not to exceed one year.¹⁹¹ Furthermore, the individual who knowingly failed to report “shall be civilly liable for the damages proximately caused by that failure.”¹⁹² The child abuse records, including reports made to the department, are confidential and any violation will result in finding an individual guilty of a misdemeanor.¹⁹³ Individuals that report in good faith, however, are immune from any “liability, civil or criminal, that might otherwise be incurred or imposed.”¹⁹⁴ Rhode Island physicians and law enforcement officers have the right to keep a child in custody, or take a child into temporary custody, if they have reasonable cause to believe that the child or children are subject

¹⁸⁸ Policy, R.I. GEN. LAWS ANN. § 40-11-1 (LexisNexis 2011).

¹⁸⁹ Report by Physicians of Abuse or Neglect, R.I. GEN. LAWS ANN. § 40-11-6(a) (LexisNexis 2011).

¹⁹⁰ § 40-11-6(b) (amended 1997). Upon the department’s receipt of a report by an individual other than a physician or duly certified registered nurse practitioner, the report shall be investigated and if the investigation uncovers physical or sexual abuse, the department must have the child examined immediately. *Id.* A child protection investigator has the authority to remove the child, with or without the parent’s consent, to conduct an examination. *Id.* After said examination, the physician or nurse must write a mandatory report of the findings. *Id.*

¹⁹¹ Penalty for Failure to Report or Perform Required Act, R.I. GEN. LAWS § 40-11-6.1 (LexisNexis 2011).

¹⁹² *Id.*

¹⁹³ Confidentiality of Reports and Records—Penalty for Disclosure, R.I. GEN. LAWS ANN. § 40-11-13(a) (LexisNexis 2011) (amended 1999). An individual may be fined an amount not to exceed \$200.00 or shall be imprisoned for a period not to exceed six months, or both. *Id.*

¹⁹⁴ Immunity from Liability, R.I. GEN. LAWS ANN. § 40-11-4 (LexisNexis 2011). This immunity also applies to “judicial proceeding[s] resulting from the report.” *Id.*

to abuse, or are at a substantial risk of harm by staying in their current environment.¹⁹⁵

Rhode Island has enacted Brendan's Law, which states that an individual is guilty of first-degree child abuse when he or she knowingly or intentionally inflicts upon a child "serious bodily harm."¹⁹⁶ An individual is guilty of second-degree child abuse when he or she knowingly or intentionally inflicts upon a child "any other serious physical injury."¹⁹⁷ Brendan's Law further defines "serious bodily injury" as any physical injury that: (1) "[c]reates a substantial risk of death"; (2) "[c]auses protracted loss or impairment of the function of any bodily parts, member or organ, including any fractures of any bones"; (3) "[c]auses serious disfigurement"; or (4) "[e]vidences subdural hematoma, intercranial hemorrhage and/or retinal hemorrhages as signs of 'shaken baby syndrome' and/or 'abusive head trauma.'"¹⁹⁸

Recently, Rhode Island has collaborated with the Rhode Island Department of Children, Youth, and Families to insert the following definition into its guidelines:

Medical Abuse

Definition: Acts by a caretaker resulting in unnecessary and harmful or potentially harmful medical care to a child. The unnecessary medical care can be the result of either a pattern of persistent misinformation provided by the caretaker to the medical care provider(s), or by falsification of symptoms, or by actual induction of illness in the child by the caretaker.

Usage: The abuse must be attributable to a pattern of behavior by the caretaker. Direct harm to a child resulting from the induction of illness, such as non-accidental poisoning or suffocation, shall be considered assault.

Caveat: The harmful or potentially harmful medical care cannot be solely the result of medical provider error.¹⁹⁹

¹⁹⁵ Protective Custody by Physician or Law Enforcement Officer, R.I. GEN. LAWS ANN. § 40-11-5 (LexisNexis 2011). Physicians who are treating children whom they believe to suffer from physical injury may keep the child in custody, with or without a parent's consent, for no longer than seventy-two hours, pending the filing of an ex-parte petition in the family court. § 40-11-5(a). The expenses incurred while the child is in temporary custody are paid by the parents or guardian of the child, or by the department if they are unable to pay. *Id.* An officer also has the right to take a child into custody if they reasonably believe the child is in imminent danger; the child may not be in custody for longer than forty-eight hours. § 40-11-5(c). Finally, a child protection investigator has the power to take a child into custody, with or without the consent of the parents, if she reasonably believes the child or the child's siblings have been abused and the children are at risk of imminent harm. § 40-11-5(d).

¹⁹⁶ Child Abuse—Brendan's Law, R.I. GEN. LAWS § 11-9-5.3(a)-(b)(2) (LexisNexis 2011).

¹⁹⁷ *Id.*

¹⁹⁸ § 11-9-5.3(c)(1)-(4); *see also* §§ 11-9-5, 11-9-5.1 (discussing cruelty to or neglect of child).

¹⁹⁹ ROESLER, *supra* note 2, at 304 (emphasis in original).

Children in the state of Rhode Island are now protected against medical child abuse, to the same extent they are protected from other forms of child abuse.²⁰⁰

2. Texas

The Children's Hospital Association of Texas (CHAT) "is an organization of regional not for profit children's hospitals in Texas."²⁰¹ The primary mission of CHAT is to "advance pediatric health care services for the benefit of children in Texas."²⁰² This organization was created when Texas realized its "size and diversity" and also recognized the need for a state-wide approach "to provide access to medical child abuse specialists."²⁰³ Texas lawmakers have acknowledged that child abuse is a "very real public health threat with concrete health consequences for its victims, making the roles of hospitals and medical professionals in child abuse cases crucial from the moment the abuse is suspected until the legal case has been closed."²⁰⁴

On September 1, 2009, Texas enacted Senate Bill 2080, section 1001.151 of the Texas Health and Safety Code. Senate Bill 2080 established Texas's Medical Child Abuse Resources and Education Systems (MEDCARES) to "improve the assessment, diagnosis, and treatment of child abuse and neglect."²⁰⁵ The MEDCARES grant program will award grants:

for the purpose of developing and supporting regional programs to improve the assessment, diagnosis, and treatment of child abuse and neglect as described by the report submitted to the 80th Legislature by the committee on pediatric centers for excellence

²⁰⁰ "On a case-by-case basis concerns can be raised and a report can be filed with the state. This results in an investigation to determine if the allegations can be substantiated and whether a child requires protection." *Id.*

²⁰¹ Erin Daley, *Medical Child Abuse Services: An Investment in the Future of Texas* ii (May 2008), <http://www.childhealthtx.org/pdfs/Medical%20Child%20Abuse%20Services-An%20Investment%20in%20the%20Future%20of%20TX.pdf>.

²⁰² *Id.*

²⁰³ *Id.* at vi.

²⁰⁴ *Id.* at 2. The American Academy of Pediatrics has noted that the role of the physician is essential in detecting child physical abuse. The American Academy of Pediatric states:

Child physical abuse is a common problem of childhood. The physician must be able to recognize suspicious injuries, conduct a comprehensive and careful examination with appropriate auxiliary tests, critically assess the explanation provided for the injury or injuries, and establish the probability that the explanation does or does not correlate with the pattern, severity, and/or age of the injury or injuries.

Id. Medical professionals should be suspicious of "repeated visits to the hospitals for cases of injuries, ingestions, or fractures." *Id.* at 3 (citing Michelle A. Lyn, *Child Abuse: Overview and Ethical Dilemmas*, (2006) <http://www.texaschildrens.org/professionals/telehealth/PDFs/October06.pdf>).

²⁰⁵ Texas Medical Child Abuse Resources and Education System Grant Program, TEX. HEALTH & SAFETY CODE ANN. § 1001.151(a) (LexisNexis 2011).

relating to abuse and neglect in accordance with section 266.0031, Family Code.²⁰⁶

The executive commissioner establishes an advisory committee to “advise the department and the executive commissioner in establishing rules and priorities for the use of grant funds awarded through the program.”²⁰⁷ The advisory committee is to be comprised of: the Texas Medicaid director; the Department of Family and Protective Services’ medical director; two pediatricians; one nurse with expertise in child abuse or neglect; a representative of a pediatric residency training program; a representative of a children’s hospital; a children’s advocacy center representative; and a member of the Governor’s EMS and Trauma Advisory Council.²⁰⁸

Under Texas law, “[a] physician who has reason to believe that a minor has been, or may be, physically or sexually abused by a person responsible for the minor’s care, custody or welfare” has a duty to “immediately report the suspected abuse to the Department of Protective and Regulatory Services and shall refer the minor to the department for services or intervention that may be in the best interest of the minor.”²⁰⁹ The report “should reflect the reporter’s belief that a child has been or may be abused or neglected or has died of abuse or neglect.”²¹⁰ In Texas, “[a] person commits an offense if the person has cause to believe that a child’s physical or mental health or welfare has been or may be adversely affected by the abuse or

²⁰⁶ *Id.*

²⁰⁷ MEDCARES Advisory Committee, TEX. HEALTH & SAFETY CODE ANN. § 1001.153 (LexisNexis 2011).

²⁰⁸ § 1001.153(1)-(3)(f).

²⁰⁹ Physician’s Duty to Report Abuse of a Minor; Investigation and Assistance, TEX. FAM. CODE ANN. § 33.008(a)-(b) (LexisNexis 2011). Texas Family Code section 261.101 sets forth individuals that have a duty to report. Persons Required to Report; Time to Report, TEX. FAM. CODE ANN. § 261.101(a)-(b) (LexisNexis 2011). It states that “[a] person having cause to believe that a child’s physical or mental health or welfare has been adversely affected by abuse or neglect by any person shall immediately make a report provided by this subchapter.” § 261.101(a). Further, section 261.101(b) states that a professional who has reason to believe a child is a victim of abuse or neglect must report no later than forty-eight hours from when “the professional first suspects that the child has been or may be abused or neglected.” § 261.101(b). Those individuals considered to be a “professional” include:

[a]n individual who is licensed or certified by the state or who is an employee of a facility licensed, certified, or operated by the state and who, in the normal course of official duties or duties for which a license or certification is required, has direct contact with children. The term includes teachers, nurses, doctors, day-care employees, employee of a clinic or health care facility that provides reproductive services, juvenile probation officers, and juvenile detention or correctional officers.

§ 261.101(a)-(b). Additionally, Texas Human Resources Code section 40.0522(b) states that “[t]he department shall assure that training concerning child abuse or neglect is available to professionals who are required by law to report, investigate, or litigate those cases.” Community Education and Training Relating to Child Abuse or Neglect, TEX. HUM. RES. CODE ANN. § 40.0522(b) (LexisNexis 2011).

²¹⁰ Matters to Be Reported, TEX. FAM. CODE ANN. § 261.102 (LexisNexis 2011).

neglect and knowingly fails to report.”²¹¹ Texas Family Code section 261.106 provides immunity from civil or criminal liability when a person acts in good faith to report or assist in investigating a report of alleged child abuse or neglect.²¹² Conversely, the same statute does not provide immunity for those who make reports of suspected child abuse or neglect in bad faith.²¹³ Similarly, Texas Family Code section 261.107 states that a person commits an offense if he or she knowingly files a false report.²¹⁴ Furthermore, courts have the authority to order the convicted person to pay reasonable attorneys’ fees incurred by the falsely accused as a result of the false report and may also be liable for a civil penalty of \$1,000.00.²¹⁵ Under the Texas Penal Code, a person can be found to have committed an offense if the individual intentionally, knowingly, or recklessly by omission causes “serious bodily injury;” “serious mental deficiency, impairment, or injury;” or “bodily injury.”²¹⁶

D. *The Future of Ohio Legislation*

Ohio must amend its legislation to include specific language regarding medical child abuse in order for medical child abuse to be prosecuted like all other forms of child abuse. The focus needs to shift from the motivation and intent of the perpetrator to the unnecessary and invasive medical treatment the child is receiving. The guidelines adopted in Rhode Island provide a sound framework for changes to Ohio legislation.

R.C. sections 2151.031 and 2903.031 should adopt or incorporate specific language that directly pertains to medical child abuse. Specifically, section 2151.031, which defines an “abused child,” should add the following italicized language:

As used in this chapter, an “abused child” includes any child who:

...

²¹¹ Failure to Report; Penalty, TEX. FAM. CODE. ANN. § 261.109(a) (LexisNexis 2011). Further, section 261.109(b) states the following in part:

An offense under this section is a Class A misdemeanor, except that the offense is a state jail felony if it is shown on the trial of the offense that the child was a person with mental retardation who resided in a state supported living center . . . or a facility licensed under Chapter 252, Health and Safety Code, and the actor knew that the child suffered serious bodily injury as a result of the abuse or neglect.

§ 261.109(b).

²¹² Immunities, TEX. FAM. CODE. ANN. § 261.106(a) (LexisNexis 2011).

²¹³ § 261.106(c).

²¹⁴ False Report; Criminal Penalty; Civil Penalty, TEX. FAM. CODE. ANN. § 261.107(a) (LexisNexis 2011).

²¹⁵ § 261.107(d)-(e); *see also* False Report of Child Abuse, TEX. FAM. CODE. ANN. § 153.013 (LexisNexis 2011) (stating that a court may impose a civil penalty of not more than \$500.00 if a party to a pending lawsuit involving the parent-child relationship knowingly makes a false report that alleges abuse by another party to the suit).

²¹⁶ Injury to a Child, Elderly Individual, or Disabled Individual, TEX. PENAL CODE ANN. § 22.04(a)(1)-(3) (LexisNexis 2011).

(F) Is the victim of “medical child abuse,” if the acts by a parent, guardian, custodian, or person having custody or control of a child, subject a child to unnecessary and harmful or potentially harmful medical care by falsifying the symptoms the child is experiencing, providing persistent misinformation regarding the child’s medical condition, or by actually inducing an illness in the child.

Additionally, R.C. section 2903.15, which governs the crime of child abuse, should be amended to include the following italicized language:

(A) No parent, guardian, custodian, or person having custody of a child under eighteen years of age or of a mentally or physically handicapped child under twenty-one years of age shall cause serious physical harm to the child, or the death of the child, as a proximate result of permitting the child to be abused, to be tortured, to be administered corporal punishment or other physical disciplinary measure, to be physically restrained in a cruel manner or for a prolonged period, or to be subjected to unnecessary and harmful or potentially harmful medical care.

A central reason for embracing the term “medical child abuse” and rejecting the term “Munchausen’s Syndrome by Proxy” is the latter term’s inherent uncertainty, ambiguity, and complications that arise in many situations.²¹⁷ Actually “identifying, understanding and defining [MSBP] as ‘child abuse’ has been problematic from the identification of the disorder.”²¹⁸ Utilizing the term “Munchausen’s Syndrome by Proxy” only creates more obstacles in the courtroom. It can take months or even years for a physician to diagnose an individual with the disorder.²¹⁹ This may simply prolong the time that a child is with a possible abusive caregiver, only to result in more harm to the child. Additionally, for decades MSBP has been viewed as a form of child abuse and it is now time to call it what it is: child abuse.²²⁰ Medical child abuse is a more appropriate term for the harmful treatment the child is receiving.

Furthermore, advocating for the term “medical child abuse” to be included in Ohio legislation will clarify any misconceptions surrounding the term’s definition. Some operate under the impression that medical child abuse is when caregivers “fail[] to ensure that the child receives the medical treatment that is necessary to

²¹⁷ See Michael T. Flannery, *Munchausen Syndrome by Proxy: Broadening the Scope of Child Abuse*, 28 U. RICH. L. REV. 1175, 1178 (1994). Another problem arises when mothers and other individuals believe they were misdiagnosed with MSBP causing their children to be removed from their care. Carol Smith, *Persecuted Parents or Protected Children?*, SEATTLE, Aug. 7, 2002, at P-1, http://www.seattlepi.com/local/81574_munchausen07.shtml. The cost of litigation for individuals to get their children back can take a substantial toll. *Id.*

²¹⁸ Flannery, *supra* note 217, at 1188.

²¹⁹ *Id.* at 1210.

²²⁰ ROESLER, *supra* note 2, at 43. A physician who has testified on many MSBP cases has stated that MSBP is “not considered a psychological disorder.” Rather, it is “just child abuse.” Nielsen, *supra* note 7.

ensure [his/her] health.”²²¹ This seems more like medical neglect rather than medical child abuse, which the proposed legislation is intended to address. Additionally, some individuals mistakenly believe that medical child abuse occurs when physicians prescribe medication to a child that has not been proven to be safe or effective.²²² Amending Ohio legislation will clarify that medical child abuse occurs when the caregiver is subjecting a child to unnecessary and harmful or potentially harmful medical treatment.²²³

If Ohio incorporates the proposed legislation, medical child abuse can, and should be, prosecuted like all other forms of child abuse. Thus, fact finders must find, beyond a reasonable doubt,²²⁴ that the caregiver, or defendant, “caused serious harm”²²⁵ to a child. Depending on whether the defendant caregiver is found to have caused serious harm or death, the defendant will be found guilty of a felony of either the first or third-degree.²²⁶ Including specific language about medical child abuse in Ohio legislation ensures that children are safe by eliminating the need for an expert to testify and determine whether the caregiver suffers from MSBP. Accordingly, the testimony provided in judicial proceedings can rightfully focus solely on the child.

IV. THE EFFECT AND IMPACT OF OHIO’S NEW LAWS

A. *The Effect on Physicians and Other Health Care Practitioners*

Physicians and other health care practitioners are part of the problem, but also part of the solution to medical child abuse. Physicians play a critical role in medical child abuse situations because they are the instrument through which caregivers subject their child to unnecessary and invasive medical treatment.²²⁷ Physicians, nurses, and other health care practitioners, however, are in the best position to witness and observe the occurrence of medical child abuse and to determine whether medical treatment is actually necessary.²²⁸

Because doctors are in the hospital setting day in and day out, they should be cognizant of the possibility that caregivers falsify symptoms, induce symptoms, or

²²¹ *Signs of Child Abuse*, MORE4KIDS CHILD SAFETY AND WELFARE, <http://safety.more4kids.info/177/signs-of-child-abuse/> (last visited Feb. 13, 2011).

²²² Dana Ullman, *The Epidemic of ‘Medical Child Abuse’ and What Can Be Done*, HUFFINGTON POST (Nov. 1, 2010), http://www.huffingtonpost.com/dana-ullman/the-epidemic-of-medical-c_b_338645.html.

²²³ See ROESLER, *supra* note 2, at 1, 43.

²²⁴ OHIO REV. CODE ANN. § 2901.05(A).

²²⁵ § 2903.15(A).

²²⁶ § 2903.15(C).

²²⁷ ROESLER, *supra* note 2, at 13. “[W]ithout doctors there would be no medical child abuse.” *Id.* at 279. “Because MSP is so hard to prove, confront, litigate, and treat, a health care professional must be careful not to participate in the cycle of abuse when they suspect the caregiver is manufacturing symptoms.” Kannai, *supra* note 68, at 111.

²²⁸ ROESLER, *supra* note 2, at 289; see also Klebes, *supra* note 27, at 93 (“If educated about this syndrome, nurses can be instrumental in the early detection, identification, and treatment of cases. . . . Nurses can initiate the referrals necessary to begin” the treatment and protection process.).

tell fictitious tales that defy medical logic. When doctors become aware of the widespread concept of medical child abuse, it will be easier to detect and report and thereby, keep children safe. "Medical child abuse should be reported in the same way as physical and sexual child abuse."²²⁹ When doctors are dealing with caregivers and their children, they need to be conscious of two circumstances that converge to create medical child abuse: "harm or potential harm to the child involving medical care and a caregiver who is causing it to happen."²³⁰

If medical child abuse is embodied in Ohio statutes, it may place a heavier burden on the shoulders of physicians and other individuals charged with a duty to report pursuant to R.C. section 2151.421(A)(1)(a).²³¹ Adding medical child abuse as another form of abuse means that health care practitioners will need to be more familiar with medical child abuse, so they may recognize it and report it when there is reasonable suspicion.²³²

There are two suggestions for physicians and other health care practitioners when medical child abuse is suspected. First, physicians may utilize covert video surveillance in recognizing and diagnosing medical child abuse if there are false stories or if symptoms are alleged by the caregiver that are simply not present.²³³ While video surveillance can be critical in finding that a caregiver is abusing a child, this method should only be used when physicians reasonably suspect child abuse, so as to not subject the child to more invasive treatment or cause any issues with the caregiver.²³⁴ Discussing the possibility of covert video surveillance with a multi-disciplinary team may assist physicians in determining whether to employ such a method.²³⁵ Second, the medical records prepared by the medical staff must be detailed and objective because the records will be used in court as vital evidence to prosecute caregivers and/or may be used to decide whether to remove a child from the home.²³⁶

B. Programs Implemented by Hospitals

As the medical community adopts the term "medical child abuse" as opposed to MSBP, hospitals are creating and implementing programs to assist in medical child abuse cases.²³⁷ Without the use of a multi-disciplinary team, it is virtually impossible

²²⁹ Stirling, *supra* note 4, at 1029.

²³⁰ *Id.* at 1027-28.

²³¹ See OHIO REV. CODE ANN. § 2151.421(A)(1)(a).

²³² *Id.*

²³³ Stirling, *supra* note 4, at 1028; see *United States v. Martinez*, 274 F.3d 897, 901 (5th Cir. 2001) (explaining that an FBI video camera placed in a child's room caught on tape five separate incidences of abuse by the child's mother).

²³⁴ Flannery, *supra* note 217, at 1211.

²³⁵ See Cleveland Clinic Foundation, *supra* note 6; Klebes, *supra* note 27, at 96 ("A multidisciplinary team approach is required for the assessment and management of MSBP."); Pankratz, *supra* note 28, at 92 ("The purpose of a multi-disciplinary team, of course, is to assess different domains of function and, one hopes, to avoid viewing the patient through a diagnostic peephole.").

²³⁶ Klebes, *supra* note 27, at 97.

²³⁷ See *infra* notes 243, 248.

for medical child abuse to be detected, evaluated, and handled in the most professional way possible.²³⁸ Based on observations and knowledge, physicians are usually the individuals who determine that medical child abuse is present and that the treatment being offered may be unnecessary.²³⁹ Nurses also play a critical role in the recognition of possible medical child abuse by assisting in the diagnosis in the early stages²⁴⁰ and by being a part of the multi-disciplinary team.²⁴¹ Additionally, nurses should explicitly note the timing of a child's symptoms in relation to whether the caregiver was present, the information provided by the caregiver, and any observations made by the hospital staff.²⁴²

In the past few years, the Cleveland Clinic Foundation, in Cleveland, Ohio, has created and implemented a Child Advocacy Committee.²⁴³ The Committee's purpose is to provide "guidance and support for the evaluation of children who are possible victims of medical child abuse."²⁴⁴ The Committee meets monthly, and as necessary.²⁴⁵ The standing members include: the medical director; social work administration; social workers; nurse reviewers; legal counsel from the law department of the Cleveland Clinic Foundation; psychologists and/or psychiatrists; pediatricians; and bioethicists.²⁴⁶ The Committee serves as a peer review committee, and thus, all proceedings and documents are privileged pursuant to R.C. sections 2305.24 through 2305.253.²⁴⁷

²³⁸ ROESLER, *supra* note 2, at 11. "Reevaluating a child's care usually starts with one person on the medical team raising concerns." *Id.* at 199. "If the team has been practicing primary prevention and including the possibility of a broken medical contract in the differential diagnosis, much harmful care can be avoided." *Id.* at 200.

²³⁹ *Id.*

²⁴⁰ Klebes, *supra* note 27, at 96.

²⁴¹ *See id.*; Pankratz, *supra* note 28, at 92.

²⁴² Pankratz, *supra* note 28, at 97.

²⁴³ CHILD ADVOCACY COMMITTEE OF THE CLEVELAND CLINIC FOUNDATION, INVESTIGATION OF MEDICAL CHILD ABUSE (PEDIATRIC DISEASE FALSIFICATION) (2008) (on file with author).

²⁴⁴ *Id.* "Prior to accepting a child for evaluation of by committee, the clinician [must] notif[y] a Social Work[er] or member of the committee to facilitate the development of a plan for evaluation." *Id.* It is recommended that all outside medical records are obtained as soon as possible. *Id.* "It is important to differentiate what is actually observed from what the parent reported." *Id.*

²⁴⁵ *Id.* "The review and discussion in committee leads to" both a timely report to the Department of Children and Family Service and the "creation/implementation of [a] safety plan to substantiate possible abuse." *Id.*

²⁴⁶ *Id.*

²⁴⁷ *Id.*; Information Furnished to Quality Assurance or Utilization Committee to Be Confidential, OHIO REV. CODE ANN. § 2305.24 (LexisNexis 2011); Incident or Risk Management Report Not Admissible or Discoverable, OHIO REV. CODE ANN. § 2305.253 (LexisNexis 2011).

Similarly, the Cincinnati Children's Hospital Medical Center in Cincinnati, Ohio, has implemented the Mayerson Center for Safe and Healthy Children.²⁴⁸ This program started with a Child Abuse Team at Cincinnati Children's Hospital in 1975 comprised of doctors, nurses, social workers, and public and private child-protection representatives.²⁴⁹ Each year, the Child Abuse Team assesses over 2,000 cases of physical and sexual abuse, as well as neglect.²⁵⁰ The Child Abuse Team reaches out to children in the surrounding counties and communities with a mission "to be the national leader and resource in the development and validation of best practices for the evaluation, treatment and prevention of child maltreatment."²⁵¹ The hospital's 2010 Annual Research Report noted that a significant accomplishment of the Mayerson Center for Safe and Healthy Children was "continu[ing] to intervene in cases of medical child abuse to prevent unnecessary medical care."²⁵²

Conversely, MetroHealth Medical Systems (MetroHealth) in Cleveland, Ohio, has not implemented a program that is as specific as the Cleveland Clinic in handling suspected medical child abuse cases.²⁵³ MetroHealth has a Child Advocacy Committee that has met for many years that reviews child abuse cases and systems issues with the county child protective services.²⁵⁴ One of the main reasons MetroHealth does not have a specific program for medical child abuse is because it does not see as many cases of medical child abuse as the Cleveland Clinic, due to the Clinic's size, specialties, and referrals.²⁵⁵ MetroHealth, however, currently has two potential medical child abuse cases that involve a mother exaggerating or causing symptoms, as well as a mother abusing the medical system.²⁵⁶ MetroHealth handles these cases like any other child abuse case through its Child Advocacy Committee.²⁵⁷ It is also trying to use the term "medical child abuse" as opposed to MSBP.²⁵⁸ If a caregiver is suspected of medical child abuse, a flag will be put on the child's records to ensure that the next time the caregiver attempts to seek medical treatment

²⁴⁸ *Mayerson Center for Safe and Healthy Children Significant Accomplishments*, CINCINNATI CHILDREN'S HOSPITAL, <http://www.cincinnatichildrens.org/research/about/ann-report/2010/MayersonCenterforSafeandHealthyChildren/default.htm> (last visited Jan. 30, 2011).

²⁴⁹ Child Abuse Team/Mayerson Center, CINCINNATI CHILDREN'S HOSPITAL, <http://www.cincinnatichildrens.org/svc/alpha/c/child-abuse/history.htm> (last visited Jan. 5, 2012).

²⁵⁰ *Id.*

²⁵¹ Mayerson Center Overview, CINCINNATI CHILDREN'S HOSPITAL, <http://www.cincinnatichildrens.org/service/m/mayerson-center/about/> (last visited Jan. 5, 2012).

²⁵² *Mayerson Center for Safe and Healthy Children, 2010 Annual Research Report*, CINCINNATI CHILDREN'S HOSPITAL, <http://www.cincinnatichildrens.org/research/about/ann-report/2010/MayersonCenterforSafeandHealthyChildren/default.htm> (last visited Jan. 5, 2012).

²⁵³ Telephone Interview with Diane Roberts LISW-S, Social Work Supervisor, MetroHealth Medical Systems (Mar. 5, 2011).

²⁵⁴ *Id.*

²⁵⁵ *Id.*

²⁵⁶ *Id.*

²⁵⁷ *Id.*

²⁵⁸ *Id.*

at MetroHealth, a social worker will be involved.²⁵⁹ MetroHealth also put limits on which doctors' caregivers can see, how often caregivers can speak with doctors, and the contact that caregivers can have with the medical staff.²⁶⁰ If caregivers do not return to MetroHealth for treatment, MetroHealth hopes that Child and Family Services will monitor the activity of treatment sought by caregivers.²⁶¹ While MetroHealth has not implemented a program as specific as that of the Cleveland Clinic, MetroHealth has implemented precautionary measures in handling cases of medical child abuse.²⁶²

A hospital that is not as large, or as well funded, as the Cleveland Clinic may not have implemented programs similar to the Cleveland Clinic's Child Advocacy Committee. The absence of such programs, however, does not mean that the victim of medical child abuse will not walk through the door. If Ohio legislation changes as proposed here, all hospitals in Ohio will hopefully implement programs that focus on how to handle suspected medical child abuse situations.

C. *Best Interest of the Child*

When courts are determining the best interest of the child and deciding who shall have permanent custody over the child or children, courts look to R.C. section 2151.414(D). The court must find by clear and convincing evidence that it "is in the best interest of the child to grant permanent custody of the child to the agency that filed the motion for permanent custody."²⁶³ This section provides a non-exhaustive list of relevant factors for courts to consider in making this determination: the child's relationship with her family and anyone who may have an impact on the child; the child's wishes; the child's custodial history; the child's "need for a legally secure permanent placement"; and, the parent's criminal record.²⁶⁴

Additionally, R.C. section 3109.04 governs the court's authority "to allocate the parental rights and responsibilities for the care of [a] minor child."²⁶⁵ More specifically, section 3109.04(E)(1)(a) grants courts the authority to modify the allocation of "parental rights and responsibilities" and designation of the residential parent if the court finds that there has been a change in circumstances and a modification is necessary to serve the best interest of the child.²⁶⁶ Further, the statute provides in pertinent part:

In applying these standards, the court shall retain the residential parents designated by the prior decree . . . unless a modification is in the best interest of the child and one of the following applies:

²⁵⁹ *Id.*

²⁶⁰ *Id.*

²⁶¹ *Id.*

²⁶² *Id.*

²⁶³ Hearing on a Motion for Permanent Custody; Notice; Determinations Necessary for Granting Motions, OHIO REV. CODE ANN. § 2151.414(B)(1) (LexisNexis 2011).

²⁶⁴ §§ 2151.414(D)(1)(a)-(e), (E)(7).

²⁶⁵ Allocation of Parental Rights and Responsibilities for Care of Children; Shared Parenting, OHIO REV. CODE ANN. § 3109.04(A) (LexisNexis 2011).

²⁶⁶ § 3109.04(E)(1)(a).

- i. The residential parent agrees to a change in the residential parent or both parents under a shared parenting decree agree to a change in the designation of residential parent.
- ii. The child, with the consent of the residential parent or of both parents under a shared parenting decree, has been integrated into the family of the person seeking to become the residential parent.
- iii. The harm likely to be caused by a change of environment is outweighed by the advantages of the change of environment to the child.²⁶⁷

When determining the best interest of the child, or with which parent the child should primarily reside, R.C. section 3109.04(F)(1) sets forth a non-exhaustive list of relevant factors including: (1) “[t]he wishes of the child’s parents regarding the child’s care”; (2) “[i]f the court has interviewed the child in chambers . . . regarding the child’s wishes and concerns as to the allocation of parental rights and responsibilities concerning the child, the wishes and concerns of the child, as expressed to the court”; (3) “[t]he child’s interaction and interrelationship with the child’s parents, siblings, and any other person who may significantly affect the child’s best interest”; (4) “[t]he child’s adjustment to the child’s home, school, and community”; (5) “[t]he mental and physical health of all persons involved in the situation”; (6) “[t]he parent more likely to honor and facilitate court-approved parenting time rights or visitation and companionship rights”; (7) “[w]hether either parent has failed to make all child support payments, including all arrearages, that are required of that parent pursuant to a child support order under which that parent is an obligor”; (8) “[w]hether either parent or any member of the household of either parent previously has been convicted of or pleaded guilty to any criminal offense involving any act that resulted in a child being [abuse or neglected]”; (9) “[w]hether the residential parent or one of the parents subject to a shared parenting decree has continuously and willfully denied the other parent’s right to parenting time in accordance with a[court] order”; and, (10) “[w]hether either parent has established a residence, or is planning to establish a residence, outside this state.”²⁶⁸ A court also has the authority to order parents and their children to take a medical, psychological, or psychiatric examination.²⁶⁹

In *Myers v. Myers*, the Ninth District Court of Appeals of Ohio was faced with determining whether the minor child’s mother or father should be awarded custody.²⁷⁰ The court considered: the child’s adjustment to home, school, and the community; the mental and physical health of all persons involved; which of the parents were more likely to honor and facilitate court-approved parenting time; and, whether any parent had been convicted of an offense resulting in a child being

²⁶⁷ *Id.*

²⁶⁸ § 3109.04(F)(1)(a).

²⁶⁹ § 3109.04(C).

²⁷⁰ *Myers*, 940 N.E.2d at 593.

abused or neglected.²⁷¹ After the couple's oldest daughter passed away from mitochondrial disease, the parents were concerned that their youngest daughter might also suffer from the disease.²⁷² The mother, who had primary custody of the daughter,²⁷³ subjected the child to extensive medical treatment.²⁷⁴ Eventually, the physicians contacted the Summit County Children's Services Board to help with the withdrawal of medical treatment.²⁷⁵ The guardian ad litem filed an emergency transfer of custody to the father, and the trial court immediately issued an order that granted the father custody and prohibited the mother from any contact.²⁷⁶ The mother did not have any contact with her daughter for months and after an evidentiary custody hearing, the trial court ultimately decided that parental rights were to remain with the father.²⁷⁷

In determining the best interest of the child, the trial court heard testimony from the father that the atmosphere in the mother's home was "unhealthy and dominated by illness and death."²⁷⁸ Additionally, the father felt that the mother "needed the children to be sick because she needed and wanted pity and sorrow."²⁷⁹ The father testified that at times the mother would not allow him to be involved in his

²⁷¹ *Id.* at 598-602.

²⁷² *Id.* at 593-94. The doctors informed the parents that their youngest daughter also suffered from mitochondrial disease and a "mitochondrial cocktail" was recommended. *Id.* at 594. The "mitochondrial cocktail" was simply an assortment of vitamins to help those who suffer from mitochondrial disease. *Id.* at 594.

²⁷³ *Id.* at 593. The mother was a nurse and kept very detailed records of her daughter's symptoms to report to the physicians. *Id.* at 594. The daughter's "treatment became progressively more invasive and involved." *Id.*

²⁷⁴ *Id.*

²⁷⁵ *Id.* at 595. During one hospital visit, the daughter's physicians met regarding whether she actually suffered from mitochondrial disease, and the physicians discussed the possibility that she was a victim of Pediatric Condition Fabrication or Munchausen Syndrome by Proxy. *Id.* All of the daughter's medical treatment was withdrawn, and the mother was surprised when she was told by the physicians that they did not believe her daughter was suffering from mitochondrial disease. *Id.*

²⁷⁶ *Id.*

²⁷⁷ Myers, 940 N.E.2d at 591. "The record reflects that the Father did not substantiate the original allegation that Mother was afflicted with PCF as none of the witnesses offered testimony that Mother was diagnosed with the disorder or that [the daughter] was a victim of child abuse." *Id.* at 596. An expert for the mother believed that the daughter was over treated and that there was insufficient communication between all of the daughter's physicians. *Id.* One of the daughter's physicians could not recall a specific instance where the mother falsified the daughter's symptoms. *Id.* That same physician also acknowledged that many of the characteristics of PCF were not present. *Id.* "There was also acknowledgement that once the medical devices were moved, Mother did not pose a threat to [the daughter]." *Id.*

²⁷⁸ *Id.* at 598. This speaks to the element of the child's adjustment to home, school, and community. *Id.*

²⁷⁹ *Id.* at 600. "The guardian ad litem expressed concern that after the death of [the youngest daughter's sister], Mother was so overcome with grief that she had refocused her energies on [her youngest daughter], which resulted in 'overmedicalizing' her." *Id.*

daughter's care if the mother felt the father was not doing things exactly as she told him.²⁸⁰

Once she began living with her father, a "night and day difference" was noticed by the father in his daughter's attitude, confidence, and ability to cope with her older sister's death.²⁸¹ Other positive changes in the daughter included changes in her physical and mental well-being, her ability to engage in extracurricular activities, and the ability to enjoy school and friends.²⁸² Additionally, since the daughter began living in her father's care, she was weaned from all medical drugs and devices.²⁸³ Finally, although the mother was not charged or convicted of any crime in connection to the care of her daughter, the court found the physicians' decision to involve the Summit County Children's Services Board relevant to the custody proceedings.²⁸⁴

V. CONCLUSION

Even though medical professionals around the country have, for decades, recognized Munchausen's Syndrome by Proxy as a form of child abuse, no action has ever been taken to actually incorporate medical child abuse into laws concerning other forms of child abuse. Many websites, national programs, and state programs do not recognize "medical child abuse" as a type of abuse.²⁸⁵ It is time to make the distinction clear and bring medical child abuse to the forefront of child abuse to highlight the importance of protecting children and vigilantly reporting the signs of abuse.

Ohio, along with other states and the federal government, must amend its legislation to include language that relates to medical child abuse as another form of child abuse. By including specific language in its statutes, states and the federal government will make it perfectly clear that medical child abuse is like all other forms of abuse. The statute should provide the definition and the setting in which

²⁸⁰ *Id.* According to the father, "when he stepped out of line in [the mother's mind], [he] wouldn't see [his] kids for a week or two." *Id.* There was one instance where the mother criticized the father for sending information directly to a doctor, as opposed to first informing the mother, as she had previously demanded. *Id.*

²⁸¹ *Id.* at 599.

²⁸² *Id.*

²⁸³ *Id.* This speaks to the element of mental and physical health of all persons involved. *Id.*

²⁸⁴ *Id.* at 594. In *Rice v. Lewis*, the Fourth Appellate District Court held that the trial court erred in considering Munchausen Syndrome by Proxy or Parental Alienation Syndrome when considering the best interest of the child pursuant to R.C. section 3109.04(F)(1)(e) because it was against the manifest weight of the evidence. 2009 Ohio App. LEXIS 1532, *rev'd*, No. 09CA3307, 2010 Ohio App. LEXIS 887, at **1-2 (Ohio Ct. App. Mar. 11, 2010). There was no credible or competent evidence that the mother exhibited signs of Munchausen Syndrome by Proxy. *Id.* at **23-24. There was no evidence in the record to suggest that the mother falsified records, induced symptoms in the child, or acted consistent with the characteristics of Munchausen's Syndrome by Proxy. *Id.*

²⁸⁵ See generally 42 U.S.C.S. § 13925(a)(2); OHIO REV. CODE § 2903.031; *supra* Parts III(A) and (B) (discussing Ohio and Federal Statutes that have an effect on child abuse); PREVENTCHILDABUSE.ORG, *supra* note 69; CHILD WELFARE INFO. GATEWAY, *supra* note 180; Meadow, *supra* note 28, at 343.

medical child abuse may occur. This ensures that once the statute is amended, and put into effect, medical child abuse will be prosecuted like any other type of abuse. This also focuses the medical community and judicial system solely on the child, the victim of the abuse, and not on the perpetrator's motivation or intentions. Under the theory of Munchausen's Syndrome by Proxy, if health care practitioners or the judicial system were unable to affirmatively state that the caregiver suffered from Munchausen's Syndrome by Proxy, there was no assurance that the child would be taken from the home and be safe.

Adversaries strongly oppose diagnosing individuals with Munchausen's Syndrome by Proxy because they believe that doctors make false allegations and accusations regarding those individuals.²⁸⁶ They claim it destroys individuals and their families.²⁸⁷ Additionally, the adversaries claim that diagnosing individuals with Munchausen's Syndrome by Proxy is a simple way for doctors to avoid medical malpractice litigation.²⁸⁸ This is not the case.

Doctors are under a statutory duty to report when they have a reasonable belief that a child is in danger or is being subjected to abuse.²⁸⁹ Consequently, due to recently amended statutes, doctors now may face civil liability for not reporting if there was "reasonable cause to suspect based on facts that would cause a reasonable person in a similar position to suspect" abuse.²⁹⁰ Most doctors are only trying to provide necessary medical treatment to children based upon the information alleged by the caregiver;²⁹¹ doctors have to take the information provided as true, until it can be reasonably determined to be untrue.²⁹²

There is at least one particularly large hurdle in moving the medical community and child protection agencies away from Munchausen's Syndrome by Proxy and towards medical child abuse: some critical entities are not even aware of Munchausen's Syndrome by Proxy.²⁹³ If Ohio legislation were amended to include the term "medical child abuse," extensive training must be provided for the medical community and child protection agencies to ensure that all individuals with a duty to

²⁸⁶ Mothers Against Munchausen's Syndrome by Proxy Allegations, *supra* note 1.

²⁸⁷ *Id.*

²⁸⁸ *Id.*

²⁸⁹ OHIO REV. CODE ANN. § 2151.421(A)(1)(a).

²⁹⁰ §§ 2151.421(M), 2151.521(A).

²⁹¹ See ROESLER, *supra* note 2, at 119, 121. "Giving accurate information to the physician is part of the sick person using all efforts to get well." ROESLER, *supra* note 2, at 119. "Medical decisions made based on false information are almost invariably bad decisions. And as a result children receive unnecessary and harmful or potentially harmful medical care." *Id.* at 121.

²⁹² *Id.* "In fact, people lie so regularly about some things that physicians have routinely taken certain falsehoods into account." *Id.* at 121.

²⁹³ Telephone Interview with Dr. Farah Wadia-Brink, M.D., Fellow, Cincinnati Children's Hospital Medical Center (Feb. 2, 2011) (on file with the author). "There are some smaller counties in Ohio that had never even heard of Munchausen's Syndrome by Proxy when we called to report abuse." *Id.*

report are operating and conducting business under the same theory.²⁹⁴ “Correct, skills-based education is the foundation of working appropriately with suspected and confirmed cases.”²⁹⁵ It is time to educate those with a decision-making power because determining Munchausen’s Syndrome by Proxy is too uncertain and problematic.²⁹⁶ Thus, medical child abuse must be included in Ohio statutes as another form of abuse to rid the medical community and judicial system of Munchausen’s Syndrome by Proxy.²⁹⁷

The term “Munchausen’s Syndrome by Proxy” that the world has come to know may be better suited in the medical and judicial setting to be called, reviewed and assessed as “medical child abuse,” or simply, child abuse that occurs in a medical environment. Just because federal legislation, such as CAPTA, is removing crucial definitions from statutes, such as “child abuse and neglect,” this does not mean that states can be as relaxed in their statutes. These federal amendments give states more power to create their own statutes and definitions. Regardless, this can be seen as an opportunity for states to take the initiative and create legislation that will benefit the citizens of their state, mainly children. By amending state and federal legislation to specifically include “medical child abuse” as one of the main forms of child abuse we can better protect those who are severely at risk—children.²⁹⁸ Children are the victims of medical child abuse and the focus must be on them.

²⁹⁴ Educating medical professionals and child protection agency staff members is outside the scope of this Note, but it should not be overlooked. Ohio’s inclusion of this Note’s proposed language would serve no purpose if all physicians and other health care practitioners remain unaware of its existence or how it functions.

²⁹⁵ See Louisa J. Lasher, *Munchausen by Proxy (MSP) Maltreatment: An International Educational Challenge*, 27 CHILD ABUSE & NEGLECT 409, 410 (2003) (discussing the possibility of including MSBP in state statutes); see generally Louisa J. Lasher, *Abuse or Neglect Through Deliberate Problem Falsification/Deception* (2011), available at <http://www.mbpexpert.com/>.

²⁹⁶ *Id.* at 410-11.

²⁹⁷ *Id.*

²⁹⁸ As the scope of this Note does not include the process of removing a child from the home, once medical child abuse is recognized as another type of child abuse, the removal will follow the same statutory provisions. See OHIO REV. CODE ANN. §§ 2151.31, 2151.312, 2151.331.