UNITED STATES OF AMERICA

U.S. Congress.

Congressional Record

PROCEEDINGS AND DEBATES OF THE 93d CONGRESS
FIRST SESSION

VOLUME 119—PART 16

JUNE 15, 1973 TO JUNE 22, 1973

(PAGES 19757 TO 21050)

UNITED STATES GOVERNMENT PRINTING OFFICE, WASHINGTON, 1973

tion in a communitywide system which S. 504 requires and I ask unanimous consent, Mr. President, that it be printed in the RECORD for the information of other Senators.

There being no objection, the article was ordered to be printed in the RECORD, as follows:

COMMON PUBLIC MISCONCEPTION—NOT EVERY SOUTHLAND HOSPITAL WILL OR CAN TREAT EMERGENCIES

(By Harry Nelson)

Don,t think that every hospital can handle emergencies.

It's a common misconception that all hospitals have someone available to sew up cuts, set fractures and perform other emergency duties, say hospital authorities.

But a day does not pass that some unfortunate citizen is not confronted by the stark truth.

"The nearest hospital to my residence is located approximately two miles away," reads a letter from a Los Angeles resident who fell through a glass shower door and severed an artery in his arm. "My wife drove me to the hospital and as we drove up I observed I had lost a tremendous amount of blood. I felt faint and nausea was developing.

"As we approached the entrance to . . . Hospital a nurse unceremoniously told us that unless we had a doctor on staff I could not receive emergency treatment there—not even first aid to stop bleeding.

"My wife then proceeded to Daniel Freeman Hospital in Inglewood where I received immediate and efficient assistance."

Another complaining citizen, in a letter to the Hospital Council of Southern California, wrote:

"Wednesday evening my husband cut himself severely at home and was bleeding profusely. In view of the fact that the . . . Hospital is around the block from us, I rushed him there for treatment.

"Much to my dismay I was greeted by a frozen-faced secretary at the 'emergency' entrance who informed me that nothing could be done there because they were not equipped to handle emergencies.

"Whereupon I asked if there was a nurse available to stop the bleeding. Reluctantly she sent for one who appeared after 10 minutes, looking very professional, but said, 'We can't help you here—you'll probably have to go to . . . hospital.'

"My husband was so provoked he asked me to take him home. On the way I stopped at a drug store and the druggist told me how to stop the bleeding. I bought medication and proceeded to do the job that a hospital should be equipped to handle."

Both of these letter writers did what most people do when they have a medical emergency and decide to seek care on their own—they went to the nearest hospital, mistakenly assuming their needs would be met.

A far safer and more efficient approach, says Stephen Gamble, associate executive director of the Hospital Council of Southern California, is for every person to find out ahead of time the location of the nearest hospital that offers 24-hour basic emergency care.

In a densely populated area like metropolitan Los Angeles, it is not only impractical but undesirable for every hospital to equip itself to provide basic emergency care, according to Gamble.

Authorities agree that emergency services can be handled far more efficiently and with high quality if only certain well-staffed and well-equipped hospitals attempt to handle the problem.

Then, Gamble said in an interview, the job is to let the public know where adequately equipped and staffed emergency centers are located.

The hospital council has distributed 2 million pamphlets, printed in English or Spanish, explaining how to obtain emergency care. Individuals who want to learn the location of the nearest emergency center can call the council at 469–7311, or write to 6255 Sunset Blvd., Los Angeles 90028.

To avoid the problems which arise when persons go to a hospital which can't handle emergencies, the council has developed criteria for a true emergency center.

THREE CATEGORIES

All 240 member hospitals in Southern California have recently been classified in one of three categories with respect to their capability for handling emergencies.

Slightly more than half—129—meet the criteria making them eligible to be called basic 24-hour emergency centers, according to Gamble.

This means that they have a physician on the premises—not just on call—for emergency services 24 hours a day, that the emergency department has certain essential equipment and that certain facilities such as a blood bank, laboratory, X-ray, and similar things are available.

There are 39 hospitals in the second category, which is called the emergency standby service hospital. These hospitals are equipped to handle emergencies of most types, but ordinarily have a physician on call only.

The third group is called the emergency first aid and referral service hospital. These hospitals have no arrangement for providing outpatient emergency services but can give first aid under certain circumstances. There are 72 of them among council members.

The fact that a hospital is classified as standby or first aid and referral does not necessarily mean that it is a poor hospital, Gamble noted. Rather it means that in most cases the hospital has elected to offer other kinds of specialized services.

CHILD ABUSE

Mr. MONDALE. Mr. President, the Subcommittee on Children and Youth, of which I am chairman, has been conducting an intensive study of the problem of child abuse and its implications.

I am pleased to note that the spring issue of the magazine, "Mental Hygiene" contains a most informative article on this subject. The author, Jane C. Avery, discusses the potential of two approaches to dealing with child abuse which are of great interest to the subcommittee—multidisciplinary treatment programs and rehabilitation of the family unit. S. 1191, "The Child Abuse Prevention Act," which was reported by the subcommittee on June 18, would provide support for programs of this nature.

I ask unanimous consent that a copy of the article be printed in the RECORD.

There being no objection, the article was ordered to be printed in the RECORD, as follows:

THE BATTERED CHILD

(By Jane C. Avery)

Children have been abused as long as the family has existed. This is nothing new, but what is new is the rapidly expanding interest and concern by doctors, lawyers, social workers, and psychologists in what has come to be called *the battered child syndrome.**

The syndrome characterizes a clinical condition in young children who have received serious physical abuse and focuses on the large number of children who are permanently injured or die as a result of injuries inflicted by their parents or those legally responsible for their care.

What actually causes this phenomena still eludes us, chiefly because of the lack of statistics. The magnitude of the problem is only just beginning to surface.

Prior to 1962, the battered child syndrome was often referred to by doctors as *unexplained trauma* or *accident-proneness*. In fact, many physicians were emotionally unwilling to diagnose it and reluctant to initiate proceedings against the parents, even when they were sure of the diagnosis.

However from studies that have been done, one thing is clear—whatever form the abuse takes, the physical and emotional scars that remain are often permanently crippling.

The first problem that must be tackled in this area is to identify the battered child. Most often, this is the task of the doctor. He may become suspicious when the injury does not match the unconvincing, and often conflicting, stories the parents give about the child's "falling." Or the physical examination may reveal old scars that the parents are unable to explain.

All too often doctors have treated the injury and remained silent about the suspected cause. Among the reasons for this reluctance are: an emotional denial that parents could commit such acts on their own child, fear of legal reprisal from them, and fear of making an unjust accusation.

In response to the problem, almost every state has enacted some form of reporting statute. Generally, these statutes require that suspected child abuse cases be reported to some authority, usually the police or a child welfare agency. Statutes vary as to the class of people required to report, but most laws grant some form of immunity from civil liability for doing so.

Most authorities agree that the basic objective of any reporting statute is to identify the abused child. Yet, to think that improved reporting laws will end the child abuse problem is naive and unrealistic.

After a report is made, something has to happen. A multi-disciplinary network of protection needs to be developed in each community to implement the good intentions of the law. Legislatures that require reporting but do not provide the means for further protection not only delude themselves but neglect the children.

But who are the abusers? Families of battered children are often a study in deprivation; both physical and emotional. They are usually beset by marital and financial problems, alcoholism, and mental illness. In fact, studies have indicated that perhaps as many as 90 percent of the abusing parents were themselves battered children.

The battered child is usually the product of a parent who has never had adequate emotional development. In many cases, families of battered children tend to be lacking in group and community integration, and the recidivism rate among them is very high.

Our first inclination, perhaps, is to punish these parents, since the general attitude toward the problem is one of public shock and anger. There exists a natural desire to exact retribution, to punish the parents for their acts of cruelty. Criminal prosecution is simply not an adequate solution.

In the first place, criminal prosecution requires proof through evidence that establishes guilt beyond a reasonable doubt. This is often difficult to meet, for the abuse usually takes place in the privacy of the home. Parents become mutually protective, and the victim is too young to speak for himself. Also, the examining physician may be reluctant to appear as a witness.

Convictions in these cases average between 5 and 10 percent. Even where a conviction is obtained fines and/or imprisonment do

* Dr. Henry C. Kempe originally coined the term in 1961 at a meeting of the American Academy of Pediatrics. He is Director of the National Center for the Prevention and Treatment of Child Abuse and Neglect at the University of Colorado Medical School, Denver, Colo.

little to alleviate the problem. In fact, the criminal prosecution may impede the continuance of the family's life as a unit, since imprisonment separates parent and child, thereby making the latter's homelife even more insecure and unstable. Fines are little better, reducing the parents' financial resources for necessities and perpetuating one of the underlying causes of the initial behavior.

Moreover, conviction leads to further social ostracism and impairs the parents' community relations, which may have been precarious at best. Even in cases where the prosecution is unsuccessful, the parents' hostility during the proceedings may become channeled against the child when they return home. And lastly, the prosecutor feels an obligation to prosecute the parents but, in most instances, feels no corresponding obligation to keep the family intact.

Prosecution and punishment, when used alone, serve only to increase the child's time in psychological limbo, and do nothing to clarify his future status regarding adequate parental care. The worst secondary effect of prosecution is perhaps the fear this type of proceeding instills in the parents, making them often reluctant to bring a child to a doctor for treatment in the first place.

The second most common reaction on the part of the general public is a desire to see the abused child immediately removed from the custody of his parents.

The problem with this approach is the lack of legal guidelines afforded the courts which, in turn, has tended to perpetuate the antiquated presumption that parents, because they are the natural guardians of their children, should always have custody. Since the courts are extremely reluctant to sever these parental rights, juvenile court judges are often left with the impossible task of choosing between two equally undesirable alternatives.

They can bend with the *parental right* theory and leave the child in the potentially dangerous home environment, or they can remove the child from the parents' custody and place him in an institution, which cannot provide the emotional support needed.

Juvenile court acts that provide for removal from the home, or allow the court to assume *protective custody*, are often only supplying illusory solutions. In most cases, there is simply no place to put the child, once he has been removed from the parents. State institutions are often overcrowded, under-financed, and under-staffed and, in their present condition, can offer no viable alternative.

If treatment is to be effective, the family must be regarded as a unit, and the abusive cycle must be broken completely. Removal of the batered child does not guarantee that the parents will seek help for themselves—the ultimate goal in any program dedicated to curbing child abuse.

In this respect, the juvenile court judge has the difficult task of balancing the interests of the parents against the probability of continuing danger to the child. In order to ease this balancing process, the judge should have the means to order a coordinated, inter-disciplinary investigation of the family, with a view toward making a diagnosis of the family as an entity, and for providing recommendations.

Once we have progressed to the point of recognizing that abusing parents are mentally ill individuals, it is perhaps only normal to suggest that they receive psychiatric treatment. Yet this approach, while commendable and extremely important, is not without its own difficulties. For the patient must learn to look at the child as one who needs love and attention, rather than as a source of fulfilling his own needs—a task some parents will find impossible to accomplish.

The main difficulty with the types of legislative and social responses just mentioned is that they do not, in themselves, lead to the desired protection and alleviation of the problems of the abused child. They seek to solve only fragments of the problem and, by so doing, accomplish nothing.

The primary objective must be the rehabilitation of the family as a viable unit. The physical treatment of children by their parents should not, as a matter of social policy, fall into the realm of criminal law. For such law may provide an inappropriate frame of reference for evaluating parent-child relationships.

On the other hand, removal of all legal sanctions may not be feasible or desirable. Removing the influence and authority of the law from intra-familial relationships that are threatening the security, well-being, and very life of a child would be tantamount to removing the sole source of protection that child might have. What, then, is available to protect the child, help the parent, and reestablish the family as a functional entity?

One approach is that of *protective intervention*. It avoids placing any individual blame on the parent and attempts to help him or her provide optimal care for the child. Child care centers appear to offer the most promise in this respect.

These centers could provide for a degree of separation from the parents for 8- to 10-hour periods, 5 days a week, without actually terminating the parent-child relationship. The child would be safe, while the parents, hopefully, seek professional help and guidance. Yet, healing the wounds, correcting the malnutrition, and protecting the battered child is but a part of the solution. The most important objective must be the rehabilitation of the environment that permits the abuse.

Ultimately, the solution must be legal, in the form of legislation, judicial decisions, and the machinery of state and community protective services. Taking one step at a time, our first concern should be to improve the reporting statutes.

Reporting should be made mandatory for any group of people likely to come into contact with a child-abuse situation, or people with an on-going relationship with children. This group would include doctors and hospital personnel, teachers, social workers, policemen, and lawyers. Such reports should be required whenever the injury does not appear to be accidental.

To alleviate any hesitancy on the part of members within this group to report to police, reports should be allowed to be made to a social welfare agency first. This would avoid giving any premature criminal aura to the proceedings. But any social agency so notified must keep in close contact with the court at all times, or subsequent remedial legal efforts will be fruitless.

Reporting laws should also outline clearly what is to be contained in the report. Medical proof, such as x-rays, should be available, as well as any other documentation of the diagnosis made by the doctor. Parents should also be told as soon as possible afterwards that the doctor has reported his suspicions.

There should be no secrecy in the proceedings. This avoids hostility later on when the child may suddenly be removed from the home, and it allows for a slightly better prospect of gaining the parents' cooperation from the beginning.

The statute should also provide for at least some degree of abrogation of the doctor-patient and huband-wife evidentiary privileges. Some authorities have suggested that an attorney be appointed to represent the child in any abuse hearings. Moreover, there should be a provision for immunity from civil and criminal liability for good faith reporting, perhaps even establishing a penalty for knowing and willful failure to report. In any case, the overall object of the statute should be to promote reporting, and thereby case finding.

The major obstacle to any program to conquer child abuse has been the lack of effective coordination among social welfare agencies on the state and local levels, courts, and medical agencies. If the protective functions of reporting laws are to be carried through, responsible agencies must be provided with sufficient funds and qualified personnel.

There must be legal authority to permit removal of the child from the home and, when appropriate, the authority to implement prompt social investigation and responsible community action. Above all, legislation in this area should be protective, not punitive.

Since the basic cause of the battered child problem is found in the parents' behavior, and not the child's, it has also been suggested that psychiatric counseling be made a condition to replacement of the child in the home.

Another suggestion has been to place all suspected cases of child abuse under the supervision of one court. At the very outset of a case, this court would be responsible for formulating a definite plan that would set forth all long-range and short-range alternatives. The effectiveness of such a court presupposes the existence of a trained staff of family counselors.

These counselors should be specially trained in working with intrafamilial relationships. They would help the parents to decide if the marriage itself was stable enough to accept the intrusion of a child. If the parents do not want the child, the court should have the authority to terminate the relationship and provide immediately for permanent placement.

On the other hand, if the potential for improvement exists, the court would allow the child to return to the home under careful supervision, and with the requirement that the parents continue receiving psychiatric help. The follow-up supervision must be purposefully directed toward the improvement of the home environment in toto. The counselors would need to have the same authority as probation or police officers regarding emergency removal of the child when necessary, but they would also be expected to offer remedial help rather than penal sanctions or automatic removal.

The most obvious problem with any of these suggestions is having enough funds recommended to provide the legal and psychological services needed. This would necessarily increase the state's economic and social burdens, but somehow we must transcend the antiquated notion that the child is merely a chattel of its parents.

As Thomas J. Donovan once observed: "Not until society collectively decides that its children are to be valued as greatly as its highways and weapons, will any truly meaningful progress be made toward eradication of this shocking social problem."

TRIBUTE TO VICTOR A. VAUGHN ON HIS RETIREMENT FROM THE DEPARTMENT OF AGRICULTURE

Mr. ALLEN. Mr. President, Victor A. Vaughn has announced his retirement from the Department of Agriculture and the U.S. Federal service as of June 30.

We shall miss him for the efficient service he provided Members of the Senate as a senior officer of the Legislative Affairs Office in the Department of Agriculture. Equally, we will miss his friendly smile and cheerful cooperation in providing us with information not easily obtainable, or putting us in touch with the right people to respond to our constituents.

The job of being a Senator is easier be-