Preparation for Child Abuse Litigation: Perspectives of the Prosecutor and the Pediatrician

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In child abuse litigation, the prosecutor and the pediatrician must work jointly to achieve the successful prosecution of a perpetrator and to preserve the child’s health. The experience testifying on the child’s behalf can be a gut-wrenching experience for the physician, whereas having an ill-prepared physician–witness can be a nightmare for the district attorney. Experience and reason, as well as an understanding of the law and medicine specific to this area, will enable the ultimate soul-lifting experience, a child who is physically, socially, and psychologically well.

The authors have worked together extensively in the area of child abuse and neglect and present some insights, experiences, and perspectives to benefit practitioners as they prepare to go to deposition or trial.

EDUCATIONAL OBJECTIVES
1. Understand the legal systems involved in the prosecution of child abuse cases.
2. Prepare the physician to properly document diagnosed child abuse in anticipation of litigation.
3. Underscore the need for a cooperative approach in the legal and medical community to adequately protect the abused child.

THE PROSECUTOR’S PERSPECTIVE
Throughout history, society’s track record for protecting children from abuse has been abysmal. For centuries, social and legal standards failed to protect children from the hands of abusive parents in the interest of maintaining a curtain of privacy in the family home. In 1886, the Supreme Court of North Carolina reversed an assault and battery conviction of a father who had severely beaten his 16-year-old daughter. In so ruling, the court reasoned

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While acts of indiscriminate severity are not criminally punishable ... their check for the good and welfare of society must be found in the prompting of parental affection and wholesome public opinion, and if these are insufficient, they must be tolerated as an incident to the relation, which human laws cannot wholly remove or redress.

The North Carolina decision reflected the prevailing opinion of society at that time: spare the rod, spoil the child. Corporal punishment of children was tolerated without question.

Progress toward the protection of children finally began in 1962 with the publication of "The Battered Child Syndrome" in the Journal of the American Medical Association. The article recognized the battered child syndrome as a constellation of particular injuries in children that suggested abuse as the etiology. The authors called for the removal of children in such abusive settings and suggested the physician report the abuse to authorities. At that time, the physician would have been bound to confidentiality by reason of the doctor-patient privilege. Reporting to authorities without civil liability exposure was, therefore, virtually impossible at the time of the publication.

In response to the paradox, Congress enacted legislation in the 1970s that propelled all 50 states to enact mandatory child abuse reporting laws. All states require physicians to report to local or state human service agencies suspected cases of child abuse or neglect. These statutes also afford the pediatrician a cloak of immunity from criminal and civil liability for the reporting of suspected child abuse when done in compliance with the statute and in good faith. These laws underscore the affirmative duty of the physician to protect the abused child and subjects the physician to criminal liability for failure to report suspected child abuse.

As a result of the mandatory child abuse reporting laws, it is not surprising that the number of reported cases of child abuse and neglect have skyrocketed. In response to the influx of mandatory reports, it necessarily follows that the litigation of these reports would increase correspondingly.

Before Dr. Kempe's 1962 article, the medical literature was virtually void of articles or research in child abuse. Since 1962, there have been a myriad of publications now devoted to the research, diagnosis, and treatment of child abuse and neglect. Medical science has witnessed the advent of numerous diagnoses such as "the whiplash shaken infant syndrome" and "child sexual abuse accommodation syndrome." These are now recognized terms of medical diagnosis for child abuse, and bridge the gap between the law and medicine.

Unlike the physician of 30 years ago, today's pediatrician will undoubtedly have occasion to evaluate, report, and treat numerous victims of child abuse. Most of these reports will result in referrals to the criminal or juvenile justice system. Litigation must therefore be anticipated and expected in today's clinical practice of pediatrics. The thought of going to court to testify causes most practitioners to suffer immediate anxiety. This article is written to alleviate these fears and to provide knowledge about what to expect and guidelines for effective management of child abuse cases.

Understanding the Legal Process

There are several legal forums for child abuse litigation. Each has different standards and rules. It is imperative to understand the differences and to appreciate what may be expected of the physician witness. There are three primary jurisdictions: civil, criminal, and juvenile court. This article will discuss primarily criminal and juvenile court because child abuse litigation typically falls into one of these two forums.

Civil cases are matters in which one person or representative sues another generally for monetary damages. Criminal penalties are never available in civil litigation. Criminal cases originate from the filing of criminal charges by the State or Federal government with jurisdiction. The government is represented by a prosecutor. Private individuals may not sue each other directly for violating criminal law. The purpose of criminal prosecution is to punish the defendant with monetary fines or, more commonly, incarceration. Juvenile court actions are separate and distinct. Juvenile court petitions are filed through the juvenile division of the district attorney's office, the juvenile court, or the local human services agency responsible for investigating reports of child abuse. Juvenile court has the authority to remove children from the custody of their parents, place them in foster care, and require the children and/or parents to undergo treatment or therapy. Criminal sanctions and monetary damages are not available in juvenile court.

In each judicial forum, the prosecutor has a different burden of proof. Burden of proof is a legal term that describes the level of proof that is required for the plaintiff or prosecutor to win on the merits of the case. In civil court, the plaintiff is required to prove his allegation by a "preponderance of the evidence." Juvenile court typically requires the prosecutor to establish that abuse has occurred by "clear and convincing evidence." Criminal court has the highest burden of proof. The prosecutor must prove that the criminal conduct or abuse has occurred "beyond a reasonable doubt." In other words, criminal prosecution requires the most evidence for a successful outcome.

After the litigation is initiated by the prosecutor, pretrial discovery may be available to the defense attorney. Discovery is the mechanism where the defense is afforded the opportunity to review or "discover" the evidence that the prosecution has against his or her client. This includes production of documents,
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such as medical records of the physician and hospital and depositions of each party’s witnesses. This allows the defense to be better prepared to meet the charges at trial. Not all jurisdictions permit pretrial discovery so this depends on the rules in the jurisdiction of the litigation.

Depositions are sworn statements of witnesses taken by a court reporter, which can be used in court as sworn testimony. Depositions of the state’s witnesses are usually taken by the defense attorney, who propounds a series of questions to elicit information about the case. Depositions are more common in criminal litigation and very rare in juvenile court litigation.

Usually, the physician is served with a subpoena to appear at a particular time and place for the deposition. Generally, the parties are cooperative about scheduling depositions for a mutually agreeable time. Typically, criminal court depositions are conducted at the courthouse or the prosecutor’s office because the criminal defendant has the constitutional right to be present at all stages of the litigation to confront his or her accusers. Because frequently the criminal defendant is incarcerated pending trial, he or she will not be allowed outside of the courthouse or the district attorney’s office for security reasons.

Oftentimes, a physician will receive a “subpoena duces tecum,” which requires not only appearance for deposition, but the production of all records concerning the case. This would require production of those documents within the control of the physician.

Whether the physician is subpoenaed for deposition or trial, the subpoena is a court order and the appearance of the physician is mandatory unless cancelled. If any witness who is subpoenaed fails to comply with the subpoena, it could result in sanctions by the court. Therefore, it is imperative that, if the pediatrician receives a subpoena with either inadequate notice or where there is a schedule conflict, he or she contact the party who has subpoenaed the witness to reschedule. If all else fails, the attorney for the physician or hospital may file a Motion to Quash a subpoena that is otherwise unduly oppressive.

The treating physician of a child who is the victim of abuse is technically a factual witness. However, if the prosecutor utilizes the pediatrician beyond the factual observations to reach conclusions that are in the nature of an expert witness, expert witness fees may be available. Some states have statutes that allow the court to award expert witness fees in criminal and juvenile cases. The allowances are often woefully inadequate for the time that is committed. For example, the State of Iowa allows $150 per day for an expert witness. However, the district attorney’s office may compensate the physician for the difference, if necessary. Many experts, however, including pediatricians, pediatric radiologists, and pediatric pathologists, keep their expert fees to a minimum or waive them entirely. The court may determine, however, that the treating physician is a factual witness and expert witness fees will not be permitted. In this event, the uncompensated time, preparation, and testimony will just be a part of contemporary pediatric practice.

After completion of the discovery process, the matter is ready to proceed to trial. In juvenile court, the trial is before a judge. There may be several parties present, including a prosecutor, an attorney representing one or both parents, a guardian ad litem representing the child, a court-appointed special advocate (CASA) for the child, a representative from the social services agency, and a foster care worker if the child has been removed from the home. Juvenile court proceeds less formally than a criminal or civil court. Often, medical reports may be submitted in lieu of the physician testifying in person. The Rules of Evidence are not adhered to as stringently, and hearsay is commonly admissible. Criminal court is the other extreme. The Rules of Evidence are rigidly adhered to and the matter proceeds formally before a jury of 12 persons. On rare occasions, the defendant may waive his or her right to a jury and proceed with the judge as the fact-finder.

In criminal court, it is imperative that the physician appear in person for testimony. Deposition testimony may be admissible by the court under certain unusual circumstances. However, it is almost never advisable for a successful outcome of the case. This is due to the burden of proof required by the state in a criminal matter and the general formality of the proceedings. Additionally, an individual’s liberty is at stake and the proceedings should be taken seriously by all parties. This almost mandates that the physician testify in person for the best possible outcome.

Clinical Management of Child Abuse Cases in Anticipation of Criminal or Juvenile Court Litigation

Information relevant to the litigation begins the instant the physician sees the victim of abuse in his or her office. Knowing that the attorneys will ultimately see all records, photographs, charts, and radiographs, it is imperative that the observations be documented as precisely as possible. Visual observations should be documented with a detailed description. Body dia-
grams to document location of injuries and bruises are beneficial for the court or jury to understand the exact nature and location of injuries. Children heal quickly and memories dim. Therefore, take the time to reflect and thoroughly document observations as soon as possible after viewing the child. The use of descriptive terms need to be accurate, e.g., the distinction between abrasions, lacerations, and bruises. All injuries, no matter how large or small, should be recorded (e.g., circular bruising on the chest may later be relevant if a posterior rib fracture is discovered).

If the patient is old enough to communicate, it is important to take a medical history statement. Any statements that the child would make to the physician are admissible in court because medical history statements have an indicia of reliability, which most courts recognize as an exception to hearsay. It is therefore important to document verbatim everything the child says that is relevant to the diagnosis. Questions should not be asked in a leading manner that would put words in a child's mouth. Allow the child to provide narrative answers. An example of a leading question would be “Did daddy put his peep in your mouth?” The better question or series of questions would be “Did someone touch you in your mouth?” “Who touched you in your mouth?” “What part of their body did they touch you with?” “How did it hurt?” “How did you feel?” “How did it feel?” Questions eliciting the sensory perceptions of the children frequently provide a narrative description of remarkable detail. When a child describes the events of sexual abuse with a sophistication beyond their years, it is extremely persuasive to a jury.

It is important to take a relevant history from the caretaker of the child for a medical diagnosis. When a child presents with suspicious injuries, a physician may not have any notion about who the perpetrator is and, in some instances, it may be the caretaker who presents the child. A medical history obtained immediately from the caretaker may elicit a history of injury inconsistent with the medical findings and therefore assist in identifying the perpetrator. These statements are subsequently admissible in a criminal proceeding as an exception to hearsay. It is never advisable, however, for the physician to put on the hat of an investigator or police officer. The physician should not search for inconsistencies nor interrogate potential witnesses. Simply obtaining relevant information that would otherwise be required to make a sound medical diagnosis is appropriate.

Finally, it is important that a medical diagnosis be made and documented whenever possible. If it is the physician's conclusion that a child suffers from battered child syndrome, that should be documented in the file as it will later assist the prosecutor in proving the case. The physician should not be reluctant to use terms such as shaken baby syndrome or battered child syndrome if that is the diagnosis.

One of the most important measures that can be taken to ensure effective trial testimony is to schedule a pretrial meeting with the prosecutor. This assures the physician that he or she will know exactly what the prosecutor will be expecting and what questions will be asked.

Testifying at Depositions

In preparing for depositions, it is important to review the chart and medical file of the child before testifying. Depositions can be used later for impeachment if a different answer is given at trial. Therefore, preparation is imperative so consistency can be assured throughout the litigation.

At depositions, the physician will be sworn in before the court reporter who will record all questions and answers. The opposing counsel, generally the defense attorney, will ask the questions. The defense attorney will not only be trying to understand what the extent of the physician's testimony will be at trial, but will be searching for any weaknesses in the State's case. The rules at depositions are very broad about what may be asked. Many questions that would be irrelevant at trial will be permitted at deposition.

Rarely are there objections during the deposition, and if there are, the witness should not answer until the objection is resolved between the attorneys. Sometimes, it is necessary to contact a judge to resolve a dispute.

After the defense attorney has asked deposition questions, the prosecutor will often choose not to follow up with any additional questions. Do not be alarmed or surprised by this tactical move. Frequently, there is no useful purpose in following up with questions other than being argumentative with opposing counsel. Cases are not tried, won, or lost in deposition. They are tried before the judge or jury and, therefore, arguments should be saved for that time.

Testifying at Trial Need Not Be a “Weight Loss” Experience

One measure to ensure effective trial testimony is a pretrial meeting with the prosecutor. The physician will then know exactly what the prosecutor will be expecting and what questions will be asked. It is also an opportunity to review physical exhibits or photographs that may be introduced at trial. It is also helpful to discuss the use of any exhibits, such as enlarged body diagrams or human models. This pre-
trial briefing can go a long way in alleviating physician anxiety about the courtroom setting. This pretrial meeting can include a tour of the courthouse and courtroom where the witness will testify. If the prosecutor does not contact the witness within 1 week of the trial, the physician should make contact and schedule a meeting.

Preparation for trial consists of reviewing the child's chart and all relevant medical records. It is imperative that the physician review his or her deposition before the trial to avoid inconsistent testimony. Additionally, it is helpful to review recent literature or research that may be relevant to the child's diagnosis. It is permissible to bring medical records to court and the witness stand, but they will be subject to inspection by the defense attorney.

Witnesses in criminal cases are usually sequestered before testimony. They must wait in a witness lounge or outside the courtroom until they are called to testify. Witnesses should not speak with each other about their anticipated testimony. Although attorneys try to schedule witnesses with the hope of not making them wait, this is sometimes out of the hands of the lawyers. There are often mid-trial objections or legal issues that must be taken up with the judge and cause minor delays. If this occurs, patience from the witness is required. If the delay is substantial, it is appropriate for the witness to consult with either the attorneys or the judge about rescheduling his or her testimony.

Dress appropriately for the courtroom decorum. The male attorneys are certainly expected to wear jackets and ties and women attorneys should wear skirts or dresses. Other professionals should adhere to the same standards. If the physician is coming from practice or the hospital, lab coats over appropriate attire are acceptable. Hospital scrubs are never appropriate.

The prosecutor will have the opportunity for direct examination initially. This is followed by cross examination by the defense attorney, which is usually less time-consuming than the direct examination. Cross examination may be followed by redirect and re-cross, and so on, until each party has concluded asking questions.

The prosecutor will initially lay a foundation for the physician's testimony by reviewing the witness' qualifications, experience, and background. Providing the prosecutor with a copy of the physician's curriculum vitae or resume will expedite this. It is important that the physician be modest when providing testimony about his or her background. The jury has little time to get to know each witness and will make credibility decisions within that timeframe. Provide the jury with as much information as possible to lend credibility to your testimony.

On direct examination, the prosecutor is trying to construct a story for the jury. The witness should assist by describing the observations and the conclusions. Above all, do not assume a pseudo-personality for the trial. Relax and simply be yourself. The following is a list of suggested "do's" and "don't's" for the direct and cross examination.

- Do listen to the entire question that is being asked before answering.
- Do ask for clarification if a question is confusing. It is always wise to remain quiet until you are certain you understand the question.
- Do answer just what is asked; do not ramble in a narrative fashion.
- Do be informative and educational so the jury will learn from your testimony.
- Do use terms and illustrations that the jury of lay people will understand.
- Don't use complex medical terms, i.e., cerebral edema versus brain swelling.
- Do smile, when appropriate, and be yourself.
- Do remember that this is a search for the truth, so simply tell the jury what you know based on your observations, your knowledge, and your experience.
- Do bring literature to support your opinion, but tell the prosecutor about it first.
- Don't guess or speculate about an answer. If you are not sure, it is best to simply preface it with "To the best of my recollection."
- Don't worry if you cannot remember a fact and do not be afraid to say so.
- Don't believe that everything has to have an answer because sometimes the answer is "I don't know."
- Don't talk at the same time as the attorney because the court reporter must write down everything that is said.
- Do look at the jury or judge when testifying. They are the fact-finders, not the lawyers.
- Don't continue to testify when an objection is made. When the objection is made, stop and listen to the parties and wait for the judge to rule or tell you to proceed with another question or answer.
- Don't violate any pretrial agreements not to talk about particular things, i.e., polygraph examinations.

On cross examination:
- Don't ever get mad.
- Don't interrupt.
- Do answer questions that call for a yes or no answer with simply a yes or no.
- Don't worry if the question sounds bad for the prosecutor or elicits an answer that you perceive as bad for the State's case. The prosecution always has the opportunity to come back and repair any damage that is done by redirect examination.
- Don't let the defense attorney put words in your mouth that are not correct. If this is attempted, then simply rephrase or restate the proposition correctly.
- Don't be afraid to say that you do not understand
the question or are confused by it.

- Do answer only what is asked and do not volunteer anything else.
- Don't let the jury see you sweat. If they see that you are agitated, it may detract from their ability to listen to the substance of your answer. If you are nervous and cannot conceal it, do not be afraid to say so.

THE PEDIATRICIAN'S PERSPECTIVE

The first time I sat in the witness chair was the last time I was insecure as a witness whether for the prosecution or the defense. I remember it involved a 6-month-old white female who had presented to the emergency room with contusions of the lips and gums and the story of being hit in the mouth while looking up at a bottle precariously balanced on top of an infant swing.

Although I felt quite prepared as to the diagnosis of bruises and their association with child abuse, I was unprepared for the barrage of questions from the opposing attorney. These were intended to anger me to the point of a shouting match, leaving my testimony argumentative hogwash (or so I thought, because the attorney had carefully not asked many questions about child abuse at all). Unfortunately, the attorney for our case at the time did not know much about child abuse (maybe less than the opposing attorney) and was unable to fully refute the jury to the cause of the child's injuries. The case ended in a hung jury. It was then in 1985 that I realized it takes more than knowledge in your field to make a good witness.

In child abuse, specifically, the ability to take a case of a suspected criminal act to its completion, namely, the preservation of a child's physical, sexual, and emotional health, and bring a perpetrator to justice, relies heavily on a dedicated team of experts that combine the medical and legal professions. I have found that when I involve all members of our Child Abuse Trauma Team in a timely manner, the outcome is almost always positive. Since that time, I have been involved in no less than 50 serious child abuse cases in several states. I have also made child abuse a personal study topic and have lectured to various groups from the general public to medical, legal, and clergy representatives. At the same time, I have seen members of the Department of Human Services, Social Services, the police department, the county attorney's office, and other members of the medical profession become "experts" in child abuse. These individuals have become our Child Abuse Trauma Team.

Many physicians appear in court with minimal knowledge of child abuse and less of the judicial system. Their testimony may be the only thing that may help the real victim—the child. The prosecuting attorney who has limited knowledge of the physician—witness' expertise and child abuse may be unable to direct the witness toward the accurate testimony. Of course, any time the defense can create an atmosphere of uncertainty on the part of the witness, the jury will be less able to assess valuable information necessary for the case. However, a well-directed team, including a prepared physician and attorney as well as other members of the investigative arm of the child protection system, will make all the difference.

Every healthcare provider who cares for children needs significant knowledge in the diagnosis and management of child abuse and neglect. It is helpful to have a library of the basics, like textbooks, slides, articles, including landmark articles, and even a canned lecture. I have found lecturing in the subject to be very helpful in gaining confidence and in understanding nonprofessionals' views (potential jurors). Included in this library should be identifying characteristics of normal and abnormal findings. Knowledge of basic growth and development can make a difference. In a small town in Iowa, information about the inability of a 4 month old to pull him- or herself out of a walker and fall from a standing position to sustain a severe brain injury led to a conviction of first-degree murder.

When asked, one should be knowledgeable about dating bruises and fractures, and identifying risks from injury and neglect. Several times a year, I am asked to look at pictures or radiographs that have been identified as suspicious, to find a normal variant or cultural demarcation, such as bruises from "coining" in Asian medical treatments. In these cases, knowledge of what is normal preserves the family and maintains advocacy for the child.

Having an in-depth understanding of "hot" areas, such as Munchausen's syndrome by proxy, the shaken baby syndrome, and failure to thrive will enable identification and successful testimony. A little knowledge in these areas can be dangerous. Recently, I was challenged by an attorney on the validity of retinal hemorrhages. I recited a list of various causes of retinal hemorrhages and asked the attorney if any of these nonabuse causes included an association of macular fold and retinal schisis. The attorney asked what that had to do with the diagnosis to find that the child in question had these entities, which are only found with shaken baby syndrome. The deposition quickly ended. My Zantac dose had been appropriate that day.

The most important word to keep in mind is documentation. Take statements in quotations instead of paraphrasing what was said. It is more powerful to read in testimony "Mrs. Smith said "The baby was well when I left her with the sitter this morning," than "the baby was apparently well when the mother left the baby with the sitter this morning." Remember that a picture is worth a thousand words, and photographs or slides of a bruise when it is at its earliest stage will demonstrate the seriousness of the injury and assist in dating the age of the bruise. A single lens reflex-type camera is much better than a
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Polaroid. Good quality photographs are more reliable at trial than a witness’ description from memory. Often, the ophthalmologist who reviews a retinal hemorrhage will draw a picture of what she sees because retinal hemorrhage photography is cost prohibitive. If photography is unavailable, the physician should also draw a diagram of the injury immediately. This is also the optimum time for taking a complete history and performing a physical examination. Everyone in the emergency room involved in the care of a suspected victim should provide documentation immediately before the chart disappears to the ward. Take the time to write or draw legibly.

Remember, any notation in the medical record is discoverable by the defense attorney and should absolutely never be altered without notation of the time and date the alteration is made.

Child protective services, social services, and law enforcement should be involved immediately on examination of a child who may have suffered abuse or neglect. They are the principal investigators, not the healthcare provider. If a child is admitted on Friday with a severe brain injury and child protective services is not notified until Monday, the case will be jeopardized by a loss of scene evidence, “fresh” history, uncoached stories, and injury healing time. So get all investigative members of the team involved in a timely manner.

It is important for the physician to know who the experts are in specific areas of child abuse. The doctor can give testimony in areas specific to his or her field of pediatrics. However, do not allow yourself to be called on to testify in areas beyond your expertise. Let the radiologists, neuroradiologists, retinal specialists, and others give their highly specialized testimony. For example, use other local more knowledgeable pediatricians, the medical examiner, or national experts as witnesses. I have found that the more experts we can enlist, the better the case presentation.

Although one does not need to know everything there is to know in this field, knowledge is indeed power, and we have the power to maximize our advocacy for the children and families we serve. If we do not know all of the answers, we need to let the investigating and prosecuting teams know this for the same reason. The saddest part of a child abuse investigation is initially identifying abuse and neglect in the first place. The hardest part of a child abuse investigation is obtaining an appropriate conviction. When the medical and legal professions work together, the outcome is much improved. A team of individuals in these areas can be established to regularly evaluate suspected child abuse and enable a higher level of consistency in prosecution. Knowledge of state mandatory reporting laws is essential.

At the end of a trial or deposition, I will often ask the attorney for a mini-critique of my testimony. I always learn from this. The attorney will usually also ask for more information on a given subject. She always learns from this. After 10 years, we have a well-blended knowledge of each other’s fields in this area.

In the end, surviving deposition and court testimony depends on individual knowledge, confidence, and attitude. Being prepared, recognizing yourself as a healthcare provider and not as an investigator, and the attorney as a legal expert, not a medical expert, will lead to a safe end and possibly the desire to participate again.

Anyone doing any kind of court work in the area of child abuse should recognize the adversarial nature of the opposing attorney. This person is an expert at law not medicine. Generally, lawyers are not experts in the area of child abuse. However, never assume anything except your own abilities and limitations. Any attempt at conversation about any case with a potential defense attorney must be avoided. I once apparently discussed a case of an infant death with a friend who is an attorney, only to find, 1 year later, the case went to trial for alleged child abuse. The attorney tried to enter our conversation, now lost to memory, into the trial. Any discussion regarding this case should be done at the advice and with the permission of counsel. This also includes interviews with the media. During a trial, the physician may be asked to respond or comment by members of the press both on and off the record. There is no such thing as off the record in dealing with the opposing legal team or the press. Remember, no matter how sensational a case may become, the healthcare provider is still responsible for the victim, for whom he or she is testifying. This is applicable whether the victim is alive or dead.

Finally, there are several deadly sins in child abuse litigations. Here are a few of the most serious:

• Failure to know “the game.” Knowledge is power. Keep up.
• Failure to prepare for the individual case.
• Failure to know your own expertise and limitations.
• Failure to know your “child abuse team.”
• Failure to be quiet, listen, and learn.
• Failure to represent 100% all of the needs of the child victim.

It is important to remember that, at the end of the
trial, we all go home to our families. It may be up to us what happens to the abused child.

CONCLUSION

Networking within the community of professionals who deal with child abuse can be very effective in litigation coordination. Mutual support between the medical and legal communities can create a brain trust of information that may additionally be useful for staffing difficult cases. Most importantly, it is a community effort to respond to child abuse and afford protection to the innocent victim. By asking for assistance from the legal community, the medical professional will become more integrated into the judicial process. Finally, it is imperative to remember that it is the fundamental belief of our judicial system that the truth will emerge from the adversarial process. In the end, the prosecutor and the pediatrician seek the same goal—to reveal the truth and protect the child.

REFERENCES
6. U.S. Constitution, amendment VI.

SUGGESTED READING