

# CULTURAL COMPETENCY IN MANDATED REPORTING AMONG HEALTHCARE PROFESSIONALS

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## I. INTRODUCTION

In the 1970s, a three-year-old Vietnamese boy with a persisting fever was brought into the emergency room, where doctors found his skin covered in long, red marks.<sup>1</sup> Believing the marks were the result of abuse, doctors called law enforcement to arrest the father, despite his attempts to explain that the marks were the result of coining, a benign folk medicine popular among various immigrant Asian populations.<sup>2</sup> The father subsequently committed suicide while in jail, “ostensibly because he was ashamed at having been arrested.”<sup>3</sup> In 2000, a different boy arrived at San Gabriel Valley hospital, where an emergency room doctor called law enforcement to arrest his parents for the bruise-like, red slashes across the boy’s chest and back.<sup>4</sup> The Chinese parents were handcuffed at the hospital, and a social worker was called to collect their son.<sup>5</sup> The parents denied the abuse, explaining that the marks were the result of coining.<sup>6</sup> Luckily, with the consultation of bilingual Chinese officers knowledgeable about the folk remedy, the arrest was called off and the boy was reunited with his parents.<sup>7</sup>

These stories are only some of many similar experiences for immigrant, ethnic minority parents mistakenly accused of child abuse. These incidents involve confusion and lack of knowledge not only of various folk remedies, but also of culturally-tied child rearing and discipline methods. A lack of cultural competency knowledge and training among healthcare professionals feeds into the rate of these occurrences and is further exacerbated by a lack of understanding in the legal obligations of a mandated reporter in the context of child abuse.

This Note will not analyze folk remedies or child-rearing methods that sit on either extreme of the spectrum: the extremes being those methods that are clearly not child abuse or egregious forms of abuse under the guise of a cultural defense. The focus instead will be on cases where cultural preservation is uneasily balanced with the desire to protect the health and well-being of children. An introduction of cultural competency provisions

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<sup>1</sup> Alison Dundes Renteln, *Corporal Punishment and the Cultural Defense*, 75 L. & CONTEMP. PROBS. 253, 259–60 (2010).

<sup>2</sup> *Id.* The technique involves “covering the body with mentholated oil and then rubbing it with a coin that has a serrated edge like a dime or quarter.”

<sup>3</sup> *Id.*

<sup>4</sup> Miles Corwin, *Cultural Sensitivity on the Beat*, L.A. TIMES (Jan. 10, 2000), <http://articles.latimes.com/print/2000/jan/10/news/mn-52555>.

<sup>5</sup> *Id.*

<sup>6</sup> *Id.*

<sup>7</sup> Corwin, *supra* note 4.

to legislation and statutes would alleviate the tensions; however, implementing medical-legal partnerships (“MLPs”) to assist with the issue will be a more timely and accessible solution.

This Note does not argue whether culture is a valid defense in the context of child abuse; instead, it focuses on how a lack of culturally competent knowledge among healthcare professionals can lead to increased incidences of mistaken child abuse reports due to the inherently foreign nature of folk remedies or child-rearing practices used by immigrant and ethnic minority parents. Additionally, this Note will only consider incidences and allegations of physical abuse, as it will provide the least debate over whether the alleged abuse actually occurred.

In Parts II and III, this Note will discuss the current structure and laws of mandated reporting of child abuse and neglect, with a specific focus on California state practices. Part II discusses the federal origin of child abuse statutes, which provides basic mandatory guidelines for the California civil and criminal statutes discussed in Part III. Part IV outlines the child welfare system generally and in California to give an overview of how a report is made and what steps follow. Part V examines mandated reporting specifically related to doctors and other healthcare professionals and the barriers that these professionals encounter in making mandated reports. Part VI discusses what cultural competency is and its goals, including examples of culturally-informed methods of discipline that have led to mistaken reports of child maltreatment. Part VII discusses the benefits of incorporating cultural competency into mandated reporting, and Part VIII considers the discussion of a cultural defense in criminal proceedings and compares it to discussions surrounding cultural competency in mandated reporting. Part IX discusses suggested solutions by advocating for different methods of implementing cultural competency in an official sense, specifically in the form of medical-legal partnerships. Finally, Part X concludes this paper by summarizing the beneficial effects of increasing and strengthening medical-legal partnerships and cultural competency when handling potential child abuse cases.

## II. THE LAWS OF MANDATED REPORTING & CHILD ABUSE: FEDERAL

The Child Abuse Prevention and Treatment Act (“CAPTA”) was enacted in 1974.<sup>8</sup> CAPTA provides federal funding and guidance to states

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<sup>8</sup> Child Welfare Information Gateway, *About CAPTA: A Legislative History*, CHILDREN’S BUREAU (Aug. 2017), <https://www.childwelfare.gov/pubs/factsheets/about/>.

in the “prevention, assessment . . . and treatment” of child abuse and neglect.<sup>9</sup> The act also established the Office on Child Abuse and Neglect, as well as a “national clearinghouse of information” on child maltreatment.<sup>10</sup> CAPTA sets forth the minimum definitions of child maltreatment, defining it as “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 present an imminent risk of serious harm.”<sup>11</sup> It is also specified in the definitions that “child abuse” does not include parental discipline, so long as it is “reasonabl[e] in manner and moderate in degree” and “does not constitute cruelty.”<sup>12</sup> These definitions set the minimum standards that states must follow to receive federal funding, but each state must then provide its own definitions within its civil and criminal statutes.<sup>13</sup> Professionals who are required under federal and most state laws to report suspected child maltreatment include physicians, nurses, and health care practitioners.<sup>14</sup> These mandated reporters have immunity from civil and criminal liability arising out of their reports if the reporter acted in “good faith,” which is presumed.<sup>15</sup>

### III. LAWS OF NONMANDATED REPORTING, MANDATED REPORTING, & CHILD ABUSE: CALIFORNIA

To further analyze the laws and culture surrounding mandated reporting, this Note will focus on California statutes related to healthcare professionals in the context of reporting child maltreatment. California has both civil and criminal statutes that address child abuse and neglect. The civil statutes provide the standards under which state child welfare agencies will intervene; criminal statutes provide guidance for prosecuting child abuse and neglect offenders, as well as mandated reporters who knowingly

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<sup>9</sup> *Id.*; see also 42 U.S.C. § 5106 (2018).

<sup>10</sup> *About CAPTA: A Legislative History*, *supra* note 8. The clearinghouse created is the Child Welfare Information Gateway, which is a service of the Children’s Bureau and the Department of Health and Human Services.

<sup>11</sup> 42 U.S.C. § 5106(g); CAL. PENAL CODE § 11165. A “child” refers generally to a person younger than 18 years old and is not an emancipated minor.

<sup>12</sup> 34 U.S.C. § 20341(c)(8) (2018).

<sup>13</sup> Child Welfare Information Gateway, *State Definitions of Child Abuse and Neglect*, CHILDREN’S BUREAU, <https://www.childwelfare.gov/pubPDFs/about.pdf>.

<sup>14</sup> 34 U.S.C. §§ 20341(a), (b)(1); 34 U.S.C. §20341(c); 34 U.S.C. §§ 20341(c)(8), (g) (2018).

<sup>15</sup> 34 U.S.C. § 20341(g) (2018).

falsify reports, make reports with “reckless disregard” of truth, or fail to make a report.<sup>16</sup>

#### A. CIVIL STATUTES

California recognizes four types of child abuse: physical abuse, neglect, sexual abuse, and emotional abuse.<sup>17</sup> Generally and across states, physical abuse is defined as “any nonaccidental physical injury to the child,” and a majority of state definitions for physical abuse also include acts or circumstances that create a substantial risk of harm to the child.<sup>18</sup> The Welfare and Institutions Code defines physical abuse as “a substantial risk” that the child has or will suffer “serious physical harm inflicted non-accidentally upon the child by the child’s parent or guardian.”<sup>19</sup> However, “serious physical harm” does not include “reasonable and age-appropriate spanking to the buttocks.”<sup>20</sup> The intent of that provision is to not unnecessarily intrude into family life or bar the use of “reasonable methods of parental discipline.”<sup>21</sup>

Interestingly, California makes a specific exception for cultural and religious child-raising practices.<sup>22</sup> The statute states that “cultural and religious child-rearing practices and beliefs which differ from general community standards shall not in themselves create a need for child welfare services unless the practices present a specific danger to the physical or emotional safety of the child.”<sup>23</sup> Although this provision is a promising step, it does not address cultural competency training, which would allow nonmandated and mandated reporters to take cultural and religious child-rearing practices into consideration. Without proper training or understanding of where to begin looking for information and guidance on cultural factors, reporters will not be able to identify situations in which this exception will apply—a topic that will be addressed in later sections.

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<sup>16</sup> Child Welfare Information Gateway, *Definitions of Child Abuse and Neglect*, CHILDREN’S BUREAU (Apr. 2016), <https://www.childwelfare.gov/topics/systemwide/laws-policies/statutes/define/>; CAL. PENAL CODE § 11172(a) (2018).

<sup>17</sup> Child Welfare Information Gateway, *supra* note 16.

<sup>18</sup> *Id.*

<sup>19</sup> CAL. WELF. & INST. CODE § 300(a) (2018).

<sup>20</sup> *Id.*

<sup>21</sup> WELF. & INST. § 300(j).

<sup>22</sup> WELF. & INST. § 16509.

<sup>23</sup> *Id.*

## B. CRIMINAL STATUTES: CANRA

The Child Abuse and Neglect Reporting Act (“CANRA”) is a California statute that requires certain people to report suspected child maltreatment.<sup>24</sup> Under CANRA, physicians, nurses, and other healthcare professionals are mandated by law to report observed or suspected child abuse or neglect.<sup>25</sup> As mandated reporters, healthcare professionals who “[know] or reasonably [suspect]” that a child is a victim of abuse or neglect must make a report to designated law enforcement departments or county welfare services.<sup>26</sup> In this statute, “reasonable suspicion” is defined as “objectively reasonable for a person to entertain a suspicion, based upon facts that could cause a reasonable person” to suspect child maltreatment.<sup>27</sup> The statute does not require certainty or specific medical indications of maltreatment.<sup>28</sup>

“Child abuse or neglect” includes “physical injury or death inflicted by other than accidental means upon a child by another person,” “the willful harming or injuring of a child or the endangering of the person or health of a child,” and “unlawful corporal punishment or injury.”<sup>29</sup> “Unlawful corporal punishment or injury” covers situations where “any person willfully inflicts upon any child any cruel or inhuman corporal punishment or injury resulting in a traumatic condition.”<sup>30</sup> However, in enacting the umbrella Article 2.5, the California legislature intended to carve out a safe harbor that does not require reporting physical punishment that is “reasonable parental discipline,” so long as it is not of a serious nature.<sup>31</sup> Parental privilege thus allows “a genuine disciplinary intention” to be a bar against a finding of child abuse under CANRA where it is “a reasonable occasion for discipline” that is imposed “reasonabl[y] in kind and measure.”<sup>32</sup>

Most states impose some form of penalties on mandatory reporters who knowingly or willfully fail to report incidents where they suspect child

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<sup>24</sup> CAL. PENAL CODE §§ 11164–11174.3 (2018).

<sup>25</sup> PENAL § 11164, § 11165.7(a)(21).

<sup>26</sup> PENAL § 11166.

<sup>27</sup> PENAL § 11166(a)(1).

<sup>28</sup> *Id.*

<sup>29</sup> PENAL §§ 11165.3, 11165.4, 11165.6.

<sup>30</sup> PENAL § 11165.4.

<sup>31</sup> PENAL § 11164.

<sup>32</sup> *Gonzales v. Santa Clara Cty Dep’t of Soc. Servs.*, 167 Cal. Rptr. 3d 148, 164 (Ct. App. 2014).

abuse or neglect.<sup>33</sup> In California, a mandated reporter who fails to report an incident of “known or reasonably suspected child abuse and neglect” is guilty of a misdemeanor punishable by up to six months in jail or a \$1,000 fine, or both.<sup>34</sup> Over half of all states also impose penalties for willfully or intentionally making false reports of child abuse and neglect.<sup>35</sup> A mandated reporter in California can incur civil or criminal liability for intentionally making a false report or making a report with “reckless disregard of the truth or falsity of the report” and is liable for any damages caused.<sup>36</sup>

#### IV. THE CHILD WELFARE SYSTEM

Most families enter the child welfare system when there has been a report of suspected child maltreatment, and most of these reports are made by mandatory reporters.<sup>37</sup> In California, initial reports are made to law enforcement or the social services department, where they will then be transferred to a child protective service (“CPS”).<sup>38</sup> Individuals unsure about making a report are able to contact their local child protective agency for advice.<sup>39</sup> During the initial report, an answering officer or CPS worker gathers information about the situation from the reporting individual.<sup>40</sup> The types of questions asked assess what type of abuse is being reported, who or what caused it, and whether the child is still in a dangerous situation.<sup>41</sup> There is an immediate response if the child is in danger, and an actual or attempted visit must occur within 24 hours of the report receipt date.<sup>42</sup> This can sometimes result in “emergency removals,” where law enforcement or CPS workers are authorized by statute to remove a child from the parents and/or home when these officials have reasonable cause to believe the child

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<sup>33</sup> CHILD WELFARE INFO. GATEWAY, U.S. DEP’T OF HEALTH AND HUMAN SERVS., PENALTIES FOR FAILURE TO REPORT AND FALSE REPORTING OF CHILD ABUSE AND NEGLECT 2 (2015), <https://www.childwelfare.gov/pubPDFs/report.pdf> [hereinafter REPORTING PENALTIES].

<sup>34</sup> PENAL § 11166(c).

<sup>35</sup> REPORTING PENALTIES, *supra* note 33, at 2.

<sup>36</sup> PENAL § 11172(a).

<sup>37</sup> CHILD WELFARE INFO. GATEWAY, U.S. DEP’T OF HEALTH AND HUMAN SERVS., HOW THE CHILD WELFARE SYSTEM WORKS 2 (2013), <https://www.childwelfare.gov/pubPDFs/cpswork.pdf> [hereinafter HOW THE CHILD WELFARE SYSTEM WORKS].

<sup>38</sup> OFFICE OF CHILD ABUSE PREVENTION, CAL. DEP’T OF SOC. SERVS., CHILD ABUSE REPORTING AND YOU 2 (2009), [http://file.lacounty.gov/SDSInter/lasd/145197\\_Child\\_Abuse\\_Reporting\\_CA\\_Doc.pdf](http://file.lacounty.gov/SDSInter/lasd/145197_Child_Abuse_Reporting_CA_Doc.pdf).

<sup>39</sup> *Id.* at 3.

<sup>40</sup> *Id.*

<sup>41</sup> *Id.*

<sup>42</sup> CHILDREN’S BUREAU, U.S. DEP’T OF HEALTH AND HUMAN SERVS., CHILD MALTREATMENT 2016 129 (2018), <https://www.acf.hhs.gov/sites/default/files/cb/cm2016.pdf>.

is in immediate danger otherwise.<sup>43</sup> The child is then “moved to a shelter, a foster home, or a relative’s home” during the investigation and court proceedings.<sup>44</sup> In lower risk situations, it can take three to ten days for action on the part of law enforcement or CPS, and the action may not even include an in-person response if the departments determine one is not necessary.<sup>45</sup> CPS workers determine if an investigation is appropriate, depending on the type of alleged abuse and severity, and conduct multiple interviews to gather further information.<sup>46</sup> The CPS worker may speak with the parents, relatives, teachers, other caretakers, and the child.<sup>47</sup> This will allow the CPS worker to make one of two findings: unsubstantiated or substantiated.<sup>48</sup> When a case is unsubstantiated, typically there is insufficient evidence to determine or declare that a child was abused or neglected.<sup>49</sup> When a case is substantiated, it is believed that maltreatment has occurred.<sup>50</sup> If deemed necessary, CPS will initiate a court action in juvenile court through a child protection or dependency proceeding, where the court can then order the child to be placed in shelter or temporary care or order services for the parents or family as a whole.<sup>51</sup> These services can include programs such as “parent education, child care, counseling, [and] safety planning.”<sup>52</sup>

For mandated reporters, there is a supposedly similar systemized method to reporting suspected child abuse or neglect. However, institutional policies and protocols also act as deterrents when healthcare professionals are considering whether to report suspected child maltreatment. Additionally, in California, reports made by mandated reporters must include the reporter’s name, business address, and telephone number, as well as “the capacity that makes the person a mandated reporter.”<sup>53</sup> However, their identity as a reporter remains confidential and is disclosed only in certain situations.<sup>54</sup> These factors, among others, contribute to the

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<sup>43</sup> CAL. WELF. & INST. CODE § 305 (2018); WELF. & INST. § 306; Paul Chill, *Burden of Proof Begone: The Pernicious Effect of Emergency Removal in Child Protective Proceedings*, 42 FAM. CT. REV. 540, 540 (2004).

<sup>44</sup> HOW THE CHILD WELFARE SYSTEM WORKS, *supra* note 37, at 4.

<sup>45</sup> OFFICE OF CHILD ABUSE PREVENTION, *supra* note 38, at 3.

<sup>46</sup> HOW THE CHILD WELFARE SYSTEM WORKS, *supra* note 37, at 4.

<sup>47</sup> *Id.*

<sup>48</sup> *Id.*

<sup>49</sup> *Id.*

<sup>50</sup> *Id.*

<sup>51</sup> *Id.*

<sup>52</sup> *Id.* at 5.

<sup>53</sup> CAL. PENAL CODE § 11167(a) (2018).

<sup>54</sup> PENAL § 11167(d).



under-reporting of suspected child maltreatment by healthcare professionals.

#### V. DOCTORS & MANDATED REPORTING

Current data indicates that physicians, nurses, and other healthcare professionals are underreporting incidents of potential child abuse. Two main barriers to mandated reporting are the lack of knowledge and recognition of child abuse and concerns about potential impacts on the family and healthcare professionals themselves. A lack of training for reporting procedures is cited as a major factor, such as not understanding when or how to make reports.<sup>55</sup> Additionally, in California, state statutes regarding mandated reporting only “strongly encourage” employers to provide relevant training to employees who are mandated reporters.<sup>56</sup> This is further frustrated by institutional protocols in situations where healthcare professionals are required by their employer’s procedures to send reports to their supervisors before making a report to Child Protective Services.<sup>57</sup> In these situations, healthcare professionals have indicated that they are unsure how to handle the situation when there is a disagreement with a supervisor over the decision to report.<sup>58</sup> Some have even complained that their administration is not supportive of decisions to report.<sup>59</sup> Healthcare professionals also indicated that concerns about reporting impacts on the family and on themselves bar them from reporting.<sup>60</sup> Many healthcare professionals do not want to lose the family as patients if their suspicions are unwarranted.<sup>61</sup> Further, healthcare professionals are deterred by the potential legal and career consequences that may result from making reports or actions claiming the healthcare professional knowingly made a false report.<sup>62</sup> As a result, healthcare professionals are underreporting, and

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<sup>55</sup> Krisann M. Alvarez et al., *Why Are Professionals Failing to Initiate Mandated Reports of Child Maltreatment, and Are There Any Empirically Based Training Programs to Assist Professionals in the Reporting Process?*, 9 *AGGRESSION & VIOLENT BEHAV.* 563, 565 (2004).

<sup>56</sup> PENAL § 11165.7(c).

<sup>57</sup> Alvarez et al., *supra* note 55, at 565.

<sup>58</sup> *Id.*

<sup>59</sup> *Id.*

<sup>60</sup> Anna Marie Pietrantonio et al., *Mandatory Reporting of Child Abuse and Neglect: Crafting a Positive Process for Health Professionals and Caregivers*, 37 *CHILD ABUSE & NEGLECT* 102, 105 (2013).

<sup>61</sup> *Id.*

<sup>62</sup> *Id.*

sometimes even turning to alternate approaches, such as working directly with the family on issues related to the suspected child abuse.<sup>63</sup>

In the United States, all medical schools must be accredited by one of two organizations in order to be eligible to receive federal loans, federal funding, and to comply with state licensing boards.<sup>64</sup> For M.D.-granting medical schools, the accreditation is done by the Liaison Committee on Medical Education (“LCME”).<sup>65</sup> Osteopathic schools, which produce a small percentage of the practicing physicians in the country, are accredited by the Commission on Osteopathic College Accreditation.<sup>66</sup> The LCME publishes accreditation standards required for accredited and applicant-schools to follow in structuring their medical education for students.<sup>67</sup> In the 2017 LCME publication for accreditation standards, the LCME states that the medical school faculty should ensure the medical curriculum “includes instruction in the diagnosis, appropriate reporting, and treatment of the medical consequences of common societal problems.”<sup>68</sup> However, further curriculum development beyond this broad standard is delegated to the medical school faculty, as it is not specifically dictated by the LCME.<sup>69</sup> As a result, curriculum related to child protection and mandated reporting varies from school to school based on “leadership, determination, and capacity.”<sup>70</sup> In a study surveying accredited medical schools and their curriculum in family violence, 95% of responding schools reported curriculum including child abuse and neglect with a median of two hours of required instruction across a four-year curriculum; 21% of responding schools reported no instruction on child abuse.<sup>71</sup> Unsurprisingly, pediatric

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<sup>63</sup> Pamela A. Herendeen et al., *Barriers to and Consequences of Mandated Reporting of Child Abuse by Nurse Practitioners*, 29 J. PEDIATRIC HEALTH CARE e1, e6 (2014).

<sup>64</sup> Liaison Committee on Medical Education, *Frequently Asked Questions*, <http://lcme.org/faqs/> (last visited Dec. 15, 2017).

<sup>65</sup> *Id.*

<sup>66</sup> Patrick Wu & Jonathan Siu, *A Brief Guide to Osteopathic Medicine: For Students, By Students*, AM. ASS'N OF COLL. OF OSTEOPATHIC MED. 1, 3 (2015), [https://www.aacom.org/docs/default-source/cib/bgom.pdf?sfvrsn=ebf55d97\\_6](https://www.aacom.org/docs/default-source/cib/bgom.pdf?sfvrsn=ebf55d97_6). Osteopathic doctors take a preventive, holistic approach that considers the patient’s body, lifestyle, and environment as an interrelated unit when developing treatment plans. They also utilize an osteopathic-specific treatment, which focuses on the “manual manipulation of the neuromusculoskeletal system.” *Id.*

<sup>67</sup> Liaison Committee on Medical Education, *supra* note 64.

<sup>68</sup> Liaison Committee on Medical Education, *Functions and Structure of a Medical School 2018–19*, <http://lcme.org/publications/> (follow Standards, Publications & Notification Forms hyperlink; then download the March 2017 publication; then go to Standard 7.5).

<sup>69</sup> Cindy W. Christian, *Professional Education in Child Abuse and Neglect*, 122 PEDIATRICS S13, S13 (2008).

<sup>70</sup> *Id.*

<sup>71</sup> *Id.* at S13–S14.

programs in graduate medicine provided far more training and resources for child abuse education than emergency medicine and family medicine; pediatric programs are more likely to have a medical provider specializing in child abuse pediatrics, faculty primarily responsible for child abuse training, written curriculum for child abuse training, and elective courses in child abuse.<sup>72</sup> However, this does not address the lack of mandatory uniform child abuse and reporting training across all medical schools.

Underreporting also stems from medical professionals' confusion as to legal obligations and cultures. Healthcare professionals and medical students report that they feel they have not received adequate training in identifying child abuse and are unfamiliar with the exact guidelines for mandatory reporting.<sup>73</sup> They also point to ambiguity in the statute surrounding terms such as "suspicion" and "'reasonable suspicion' of [abuse]" as reducing their confidence in identifying child abuse.<sup>74</sup> Studies have shown that healthcare professionals vary widely in interpreting the meaning of "reasonable suspicion."<sup>75</sup> When asked what it means to have a reasonable suspicion, a majority of healthcare professionals answered only with specific symptoms and indicators of abuse, such as an "overly protective parent," "non-typical wounds for age," or "multiple bruising in various stages of healing."<sup>76</sup> The rest of the healthcare professionals answered conceptually, but 34% of healthcare professionals indicated an unqualified threshold in their answers, such as "any suspicion is a reasonable suspicion."<sup>77</sup> The remaining 10% of healthcare professionals answered with a qualified threshold, such as "reasonable suspicion for me is when there is more than 10% chance of abuse."<sup>78</sup> No single interpretation is predominant, resulting in wide variations in setting a threshold for what would count as "reasonable suspicion."<sup>79</sup>

Existing curriculum in medical schools also proves inadequate in providing students cultural competency information. Traditionally, a

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<sup>72</sup> Kurt W. Heisler et al., *Child Abuse Training, Comfort, and Knowledge Among Emergency Medicine, Family Medicine, and Pediatric Residents*, 11 MED. EDUC. ONLINE 1, 5–6 (2006).

<sup>73</sup> Pietrantonio et al., *supra* note 60, at 104.

<sup>74</sup> *Id.*

<sup>75</sup> Robert Sege et. al., *To Report or Not to Report: Examination of the Initial Primary Care Management of Suspicious Childhood Injuries*, 11 ACAD. PEDIATRICS 460, 464 (2011); Benjamin H. Levi et al., *Reasonable Suspicions: A Pilot Study of Pediatric Residents*, 30 CHILD ABUSE & NEGLECT 345, 352 (2006).

<sup>76</sup> Levi et. al., *supra* note 75, at 348.

<sup>77</sup> *Id.* at 350.

<sup>78</sup> *Id.*

<sup>79</sup> *Id.* at 352.

medical school's four-year curriculum is divided into basic sciences and clinical sciences.<sup>80</sup> The first two years of the curriculum are focused on the biomedical sciences, which include courses such as anatomy, microbiology, pathology, and biochemistry.<sup>81</sup> The last two years are almost entirely clinical rotations.<sup>82</sup> Schools may offer an "introduction to the patient" course, which teaches students how to interact with patients through "physical examinations, history-taking and the behavioral sciences."<sup>83</sup> As discussed previously, integration of cultural competency courses and programs is merely a suggestion by the accreditation committees that is ultimately left to each school's discretion.<sup>84</sup> The current curriculum structure in medical schools allows for "territorial disputes about time allotted to the department's subject," which leaves little room for cultural competency education or any advocates.<sup>85</sup> To further exacerbate this issue, many students consider the behavioral sciences as "common-sense information" that is unimportant because it is not formally tested on the United States Medical Licensing Examination ("USMLE"), an examination that is required for medical students to become licensed physicians.<sup>86</sup>

## VI. CULTURAL COMPETENCY

Almost naturally, cultural competency revolves around ethnic minorities, immigrant parents and families, and first-generation children.<sup>87</sup> These families must balance cultural adaptation in the public sphere and cultural maintenance in the private sphere, prompting these parents to become "bicultural" in that they must determine which practices to keep

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<sup>80</sup> Gail Furman & M. Marie Dent, *Seamless Learning: Incorporating Cultural Competency into the Curriculum*, in CULTURAL COMPETENCY IN MEDICAL EDUCATION: A GUIDEBOOK FOR SCHOOLS 23, 24 (2004), <https://www.hrsa.gov/sites/default/files/culturalcompetence/cultcomp.pdf>.

<sup>81</sup> *Id.*

<sup>82</sup> *Id.*

<sup>83</sup> *Id.*

<sup>84</sup> See Christian, *supra* note 69, at S13 (discussing that while the LCME explicitly requires medical schools to provide education in "common societal problems," the medical school faculties ultimately have the final say in developing relevant curriculum and its details).

<sup>85</sup> Furman & Dent, *supra* note 80, at 24.

<sup>86</sup> *Id.*

<sup>87</sup> Theresa Hughes, *The Neglect of Children and Culture: Responding to Child Maltreatment with Cultural Competence and A Review of Child Abuse and Culture: Working with Diverse Families*, 44 FAM. CT. REV. 501, 503 (2006) (examining the cultural practices of racial and ethnic minorities, including the practices of Black, Native American, and Asian cultures, as well as other races and ethnicities other than White).

from their indigenous culture and which new ones to adopt.<sup>88</sup> As a result, immigrant parents are often misunderstood and judged by educational, health, and child welfare services for practices that do not conform to the cultural standards of their new home.<sup>89</sup> This becomes especially relevant when considered alongside the fact that ethnic minorities are overrepresented in the family court system.<sup>90</sup> Inevitably, there are culture clashes, as cultural child-rearing practices become the center of debate for what constitutes child abuse or neglect.<sup>91</sup>

Cultural competency has become a popular proposal as a solution to social inequalities of the U.S. healthcare and child welfare systems.<sup>92</sup> Although there are many working definitions for cultural competency, it generally encompasses the belief in creating a system that tailors its behaviors, attitudes, and policies to allowing professionals to work effectively in cross-cultural situations.<sup>93</sup> The basic purpose of cultural competency is to decrease discrimination and to promote social justice.<sup>94</sup> In the healthcare context, cultural competency comes into play when healthcare professionals are faced with cases of potential child maltreatment where different cultural customs and child-rearing practices can influence the perception of abuse.<sup>95</sup> One source of confusion is folk remedies.

Familiarity with a variety of folk remedies and sensitivity to cultural differences will assist healthcare professionals in differentiating these folk remedies from actual abuse.<sup>96</sup> Many medical practitioners agree that these practices do not constitute child abuse, labeling this group of practices that

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<sup>88</sup> MARC H. BORNSTEIN & YVONNE BOHR, IMMIGRATION, ACCULTURATION AND PARENTING 2 (2011), <http://www.child-encyclopedia.com/sites/default/files/textes-experts/en/664/immigration-acculturation-and-parenting.pdf>.

<sup>89</sup> *Id.*

<sup>90</sup> Hughes, *supra* note 87, at 501, 503 (explaining that minority children are 41% of U.S. children but make up 59% of maltreatment reports).

<sup>91</sup> *Id.* at 502.

<sup>92</sup> See Ana F. Diallo & Jacqueline M. McGrath, *A Glance at the Future of Cultural Competency in Healthcare*, 13 NEWBORN & INFANT NURSING REVS. 121, 122 (2013) (examining various organizations that promote cultural competency as a solution to social issues, as well as two main challenges facing its implementation).

<sup>93</sup> *Id.*

<sup>94</sup> *Id.*

<sup>95</sup> Karen Kirhofer Hansen, *Folk Remedies and Child Abuse: A Review with Emphasis on Caida de Mollera and Its Relationship to Shaken Baby Syndrome*, 22 CHILD ABUSE & NEGLECT 117, 117 (1997).

<sup>96</sup> *Id.*

mimic child abuse as “pseudobattering.”<sup>97</sup> Folk remedies include practices such as coining, moxibustion, and cupping.

Coining originates from Southeast Asia and is a remedy meant to relieve a wide range of symptoms.<sup>98</sup> The practice involves massaging medicated oil into targeted areas of the body then employing a coin or spoon rubbed in “a downward linear fashion” until skin discoloration forms.<sup>99</sup> The purpose is to expel “bad winds” from the body that cause “fever, seizure, chills, headaches, cough, vomiting, or other symptoms”; other users believe it encourages circulation, stimulates trigger points, and improves breathing.<sup>100</sup> The procedure is not painful or harmful and may even be enjoyable, but the resulting skin discoloration is readily confused with bruising from physical abuse.<sup>101</sup> The most well-cited case is described in the introduction of this Note, in which a Vietnamese father brought his sick son to the emergency room, where doctors observed coining marks on the child’s skin and believed they were the result of child abuse.<sup>102</sup> The father was arrested and died by suicide in jail from the humiliation.<sup>103</sup>

Moxibustion is used to treat fever, abdominal pains, and temper tantrums.<sup>104</sup> It involves placing a small ball of material, such as yarn, on a targeted body area where it is then lit on fire and allowed to burn “to the point of pain.”<sup>105</sup> Its purpose is based on traditional yin-yang classification, which is often an element found in naturalistic theory in Asian cultures.<sup>106</sup> The treatment results are “circular, target-like” burns that mimic intentional child abuse, such as cigarette burns.<sup>107</sup> This practice and similar ones are

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<sup>97</sup> Robert E. Primosch & Stephen Kent Young, *Pseudobattering of Vietnamese Children* (Cao Gio), 101 J. AM. DENTAL ASS’N 47, 48 (1980). See Hansen, *supra* note 95, at 120 (discussing specific folk remedies, such as moxibustion and burn therapy, that lead to burns and scarring that are easily confused with child abuse, such as cigarette burns).

<sup>98</sup> Hansen, *supra* note 95, at 117.

<sup>99</sup> *Id.* at 118.

<sup>100</sup> *Id.*

<sup>101</sup> Primosch & Young, *supra* note 97, at 48.

<sup>102</sup> Hansen, *supra* note 95, at 118.

<sup>103</sup> *Id.*

<sup>104</sup> *Id.* at 119–20.

<sup>105</sup> *Id.*

<sup>106</sup> Dedra Buchwald, Sanjiv Panwala & Thomas M. Hooton, *Use of Traditional Health Practices by Southeast Asian Refugees in a Primary Care Clinic*, 156 WEST J. MED. 507, 510 (1992) (describing naturalistic theory as the belief that diagnosis and treatment involves integrating physical and social factors, including metaphysical explanations for illnesses, which is what “hot and cold,” or yin-yang theory, falls under).

<sup>107</sup> Hansen, *supra* note 95, at 120.

used in multiple countries such as China, Japan, Cambodia, and Finland, and is also used among Asian refugees in the United States and Canada.<sup>108</sup>

Cupping is more often recognized and reported in American media, as it has been used with frequency by American celebrities such as Olympic athlete Michael Phelps in the 2016 Olympics.<sup>109</sup> This remedy is used in Asia, Eastern Europe, Africa, and Mexico to increase circulation and remove toxins from the body.<sup>110</sup> It involves “inducing a vacuum in a cup to create suction” and then placing the cup on the skin of the targeted area as the vacuum pulls the skin towards the cup.<sup>111</sup> This method results in circular skin discoloration, presenting similar pseudobattering bruises like those of coining and moxibustion.<sup>112</sup>

There are also situations of child rearing where a parents’ choice of discipline can become confused with child abuse. These culturally-tied discipline methods are often considered by mandated reporters, law enforcement departments, and child welfare agencies as bizarre and abusive, but they may not actually violate statutory definitions of child abuse and neglect, especially when the parental discipline doctrine is applied. In one instance, Mexican parents were reported by a social worker unfamiliar with Latino culture for “hincar”—they forced their child to kneel on uncooked rice as discipline.<sup>113</sup>

Another example is a form of discipline in the Latino community, “la chancla,” which has created almost its own subculture in Hispanic culture that may “even hold a degree of sentimental value.”<sup>114</sup> Although translated as “the flip flop” and typically characterized as such, la chancla can also include rulers, spatulas, or other items thrown or used to strike children upside the head to deter and punish bad behavior.<sup>115</sup> Although it does not typically result in bruises or marks, this form of discipline can still be relayed verbally by children to their doctors, teachers, and other mandated

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<sup>108</sup> *Id.* at 119–20.

<sup>109</sup> Josh Peter, *How Cupping Works and Why Olympic Athletes Use It*, USA TODAY (Aug. 8, 2016 3:39 PM), <https://www.usatoday.com/story/sports/olympics/rio-2016/2016/08/08/how-cupping-works-and-why-olympic-athletes-use/88410804/>.

<sup>110</sup> William Y. Chin, *Blue Spots, Coining, and Cupping: How Ethnic Minority Parents Can Be Misreported as Child Abusers*, 7 J. L. SOC’Y 88, 94 (2005).

<sup>111</sup> *Id.* at 93.

<sup>112</sup> *Id.* at 94.

<sup>113</sup> Renteln, *supra* note 1, at 262.

<sup>114</sup> Juan Vidal, *La Chancla: Flip Flops as a Tool of Discipline*, NPR (Nov. 4, 2014, 10:35 AM), <https://www.npr.org/sections/codeswitch/2014/11/04/361205792/la-chancla-flip-flops-as-a-tool-of-discipline>.

<sup>115</sup> *Id.*

reporters who then report to authorities, resulting in families being investigated by the child welfare system.<sup>116</sup> In one case, a juvenile court found a Mexican-immigrant mother had intentionally inflicted “serious physical harm” on her child by spanking him with her hand and a sandal because “hitting children with shoes” is “physical abuse” and “not a proper form of discipline.”<sup>117</sup> The California Court of Appeal rejected this reasoning and stated that parents spanking children on the buttocks with a bare hand or sandal does not constitute “serious physical harm;” instead, the correct legal standard to apply is the reasonable parental discipline doctrine.<sup>118</sup>

These examples of discipline methods arguably do not inflict serious physical harm even though they are intentionally inflicted by the child’s parents, and they do not cause permanent disfigurement or disability.<sup>119</sup> Federal child abuse reporting statutes define “child abuse” as the “physical” injury to the child, and California similarly defines child abuse as “physical injury” that is inflicted “by other than accidental means.”<sup>120</sup> In an analysis also applicable to the bruises and skin discoloration resulting from folk remedies, these discipline methods do not produce physical injuries and at most create slight bruising. Compared to cases in which nonculturally-tied parental discipline resulting in bruising did not constitute child abuse, a similar inference can be made that culturally-tied discipline methods which only cause bruising also do not constitute child abuse, and are only reported due to mandated reporters’ and healthcare professionals’ unfamiliarity with the cultural discipline method. For example, in *Gonzalez v. Santa Clara*, the California Court of Appeal rejected an automatic finding that a discipline method exceeded reasonable limits when a mother spanked her daughter with a wooden spoon on the buttocks, resulting in bruises.<sup>121</sup> The court found that while hitting the daughter was intentional, the resulting bruises were not (or, at most, were a result of carelessness) and found that the mother acted with “a genuine disciplinary motive” such that the circumstances equated to a reasonable exercise of discipline.<sup>122</sup>

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<sup>116</sup> See *In re D.M.*, 195 Cal. Rptr. 3d 402, 404 (Ct. App. 2015) (adjudicating a situation where the mother spanked the children with a sandal without leaving any marks, which the children’s primary doctor, grandmother, and teacher all denied observing, but the case was brought to the attention of authorities when the children recounted the spanking to social workers).

<sup>117</sup> *Id.* at 405.

<sup>118</sup> *Id.* at 408.

<sup>119</sup> CAL. WELF. & INST. CODE §§ 300(a), (b)(1), (e) (2018).

<sup>120</sup> 42 U.S.C. § 2034(c)(1); CAL. PENAL CODE § 11165.6 (2018).

<sup>121</sup> *Gonzalez v. Santa Clara Cty. Dep’t of Soc. Servs.*, 167 Cal. Rptr. 3d 148, 166 (Ct. App. 2014).

<sup>122</sup> *Id.* at 165.



## VII. BUILDING CULTURAL COMPETENCY INTO MANDATED REPORTING

This Note does not necessarily advocate accepting all forms of cultural child rearing that do not fall on either extreme end of the child maltreatment spectrum, but instead highlights the value of incorporating a culturally sensitive approach to identifying child abuse that can mitigate the effects of unsubstantiated child maltreatment reports on families and the child welfare system. Opponents to implementing cultural sensitivity into mandated reporting statutes may argue that failure to include such a requirement in statutes will keep reporting standards broad, which would reflect a “better safe than sorry” mentality in which it is better to have overreporting rather than underreporting so that the system can catch more incidents of child maltreatment. However, data and research report the concerning effects of false, mistaken, and unsubstantiated reports on families and their children because of mandated reporting, absent cultural competency.<sup>123</sup>

Emotional trauma is inflicted on families and children when they are brought into the welfare system, especially when children are removed from their families. Families endure psychological and financial harms, among others, that can lead to further instability in the family, such as divorce or job loss.<sup>124</sup> It causes children to feel “grief, terror, and feelings of abandonment,” and compromises the child’s “capacity to form secure attachments,” as well as other serious problems.<sup>125</sup> Although the law requires that removals be used sparingly, the number of emergency removals has increased steadily in the past twenty years.<sup>126</sup> Statistics show that in 2014, of the nearly 242,000 children who were removed, almost four in ten were later found not to have been maltreated.<sup>127</sup> This rate has

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<sup>123</sup> See David P. H. Jones, *Professional and Clinical Challenges to Protection of Children*, 15 CHILD ABUSE & NEGLECT 57, 59–62 (1991) (considering the harms that the professional system could inflict upon abused children, as well as children who have nothing to report).

<sup>124</sup> Chill, *supra* note 43, at 542.

<sup>125</sup> *Id.* at 541.

<sup>126</sup> *Id.*; STAFF OF HOUSE COMM. ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, 2016 GREEN BOOK: BACKGROUND MATERIAL AND DATA ON THE PROGRAMS WITHIN THE JURISDICTION OF THE COMMITTEE ON WAYS AND MEANS, Table 11-3 (23rd ed. 2016), <https://greenbook-waysandmeans.house.gov/2016-green-book/chapter-11-child-welfare>.

Although data shows a minor dip in numbers, the rate of foster care use increases again approaching 2015.

<sup>127</sup> CHILDREN’S BUREAU, U.S. DEP’T OF HEALTH AND HUMAN SERVS., CHILD MALTREATMENT 2014 84 (2016). Although the Children’s Bureau has released a 2016 report, the new 2016 data is qualified with an additional date specification that makes the 2014 and 2016 numbers incomparable.

increased from 2001.<sup>128</sup> Combined with very broad and low substantiation requirements of maltreatment definitions, it can be inferred that a number of children found to be maltreated could have been categorized as not maltreated by a different agency or state. The implication is that vulnerable families are potentially drawn into the child welfare system before having their cases closed as unsubstantiated, or they are found substantiated on unreliable standards and are then subject to child welfare services and penalties.

When children are in the child welfare system or their families are being investigated, they suffer repeated interviewing by separate professionals and repeated physical examinations.<sup>129</sup> Children also suffer psychological harm from having to attend court and may experience family breakup and decreased living standards.<sup>130</sup> Family breakup may be inevitable when a family enters the welfare system, but it also often intensifies the child's feelings of guilt and responsibility for splitting apart the family.<sup>131</sup> Furthermore, after a child has been removed, a wide variety of factors create a situation in which it is even more difficult for parents to reunite with their child because the court's focus is now on deciding whether the child should be returned to the parents.<sup>132</sup> This is further exacerbated by the psychological harm that a child will experience from removal and subsequent placements in multiple foster homes. A child may develop "post-traumatic stress disorder, reactive attachment disorder, or other major psychiatric illnesses," which then can contribute to longer or permanent separations.<sup>133</sup> Visitation between parents and the removed child are typically time-constrained and occur under supervision or in an unfamiliar place, and parents must navigate transportation that becomes more difficult when the child is placed in a home far away.<sup>134</sup> In this

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<sup>128</sup> CHILDREN'S BUREAU, U.S. DEP'T OF HEALTH AND HUMAN SERVS., CHILD MALTREATMENT 2001 68 (2001). The 2014 report, *supra* note 127, indicated that nonvictims made up around 39% of children removed from the home, and this report indicates that nonvictims made up around 37.5% of children removed from the home.

<sup>129</sup> Jones, *supra* note 123, at 60.

<sup>130</sup> *Id.* at 60–61.

<sup>131</sup> *Id.*

<sup>132</sup> Chill, *supra* note 43, at 542. These factors include biases, psychological influences such as "the sequentiality effect," "extremely brief" postremoval hearings, and the defensive attitudes of judges and caseworkers. *Id.* at 542–45.

<sup>133</sup> *Id.* at 545. Affected children rely on stability to recover, which can often mean maintaining their post-removal home placement. *Id.* Other times, parental rights are terminated even after family services because the parent is not capable of caring for a now "emotionally fragile" child. *Id.*

<sup>134</sup> *Id.*

situation, parents may not “fully pursue contact with the child” because of a “lack of services and a sense of hopelessness or rage,” and the child may feel that the parents have abandoned or rejected the child or feel angry at the parents for failing to prevent the situation entirely.<sup>135</sup>

Ultimately, implementing cultural competence into our mandated reporting laws would be beneficial. It can be used to help combat “defensive social work”—the tendency of Child Protective Services to base removal decisions on fear—which has been a key factor contributing to the rising rate of removals.<sup>136</sup> Additionally, the Due Process Clause of the Fourteenth Amendment provides a fundamental right to family integrity, which gives parents and children the right to be free from unwarranted government interference in child rearing.<sup>137</sup> Ultimately, the goal should be to prevent these families and cases from entering the system, and to prevent the cases from being substantiated if they do enter the system.

#### VIII. CULTURAL COMPETENCY VS. A CULTURAL DEFENSE

Although there is no official “cultural defense” policy built into the U.S. legal system, there have been various instances in which the court considered a defense that incorporated cultural differences.<sup>138</sup> Sometimes referred to as cultural evidence, the cultural defense works to exonerate immigrants or foreigners in the United States who find themselves accused of an illegal act that is acceptable in their culture or homeland.<sup>139</sup> The rationale behind this defense acknowledges “America’s commitment to the principle of individualized justice and cultural pluralism,”<sup>140</sup> and accepts that “certain ethnic values need to be preserved in order to maintain a culturally diverse society.”<sup>141</sup> Refusing to adopt a cultural defense can be seen as “evidence of disdain for an ethnic minority’s cultural values.”<sup>142</sup> This in turn can alienate that ethnic group from mainstream and majority society, and may fester into “hostility and intergroup conflict that disrupt[s]

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<sup>135</sup> *Id.*

<sup>136</sup> *Id.* at 542.

<sup>137</sup> U.S. Const. amend. XIV, § 1; *Troxel v. Granville*, 530 U.S. 57, 65 (2000).

<sup>138</sup> Malek-Mithra Sheybani, *Cultural Defense: One Person’s Culture is Another’s Crime*, 9 LOY. L.A. INT’L & COMP. L. REV. 751, 752 (1987).

<sup>139</sup> *Id.*

<sup>140</sup> The Harvard Law Review Association, *The Cultural Defense in the Criminal Law*, 99 HARV. L. REV. 1293, 1296 (1986).

<sup>141</sup> Sheybani, *supra* note 138, at 752 n.10.

<sup>142</sup> The Harvard Law Review Association, *supra* note 140, at 1305.

social order.”<sup>143</sup> The cultural differences become especially important during the charging and sentencing phases of the criminal process, where such differences can act as mitigating evidence.<sup>144</sup>

What distinguishes a consideration of cultural factors from a formal cultural defense? There is a distinct benefit in having a formal cultural defense over only allowing a consideration of cultural factors at the court’s discretion. Having a formal defense would accompany with it procedural safeguards and guidelines that would allow consistent application, rather than a case-by-case application that is strongly influenced by court and prosecutorial discretion.<sup>145</sup> Allowing such discretion in determining the impact of cultural factors without the protections of a formal defense makes these cultural factors vulnerable to prejudice and biases against minorities.<sup>146</sup>

One example of a case in which cultural evidence was used involved an Albanian Muslim father, Sam Krasniqi.<sup>147</sup> Krasniqi and his wife, Kathy, were immigrants from Yugoslavia and lived in Texas with their two children.<sup>148</sup> Krasniqi was arrested for inappropriately touching his four-year-old daughter in a public gymnasium.<sup>149</sup> The father denied that he had touched his daughter with sexual intent, claiming instead that Albanian culture is very physically expressive and the touching was a typical way to show pride and affection.<sup>150</sup> An expert witness testified to this, and Krasniqi was subsequently acquitted.<sup>151</sup> He was acquitted nearly a year after the couple had lost their final appeal of a verdict that had terminated their

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<sup>143</sup> *Id.*

<sup>144</sup> *Id.* at 1294.

<sup>145</sup> *Id.* at 1297.

<sup>146</sup> *See id.* at 1298 (citing B. Jackson, *LAW AND DISORDER* 160–62 (1984) (discussing data and studies that indicate prejudice exercised by officials as well as systematic discrimination against cultural minorities, specifically during the sentencing phase in a criminal proceeding).

<sup>147</sup> Ann Zimmerman, *A Mother and Child Reunion*, *DALLAS OBSERVER* (June 25, 1998, 4:00 AM), <http://www.dallasobserver.com/news/a-mother-and-child-reunion-6401785> [hereinafter Zimmerman, *A Mother and Child Reunion*]; Ann Zimmerman, *Tell Mama Why You Cry’ (Part I)*, *DALLAS OBSERVER* (Nov. 17, 1994, 4:00 AM), <http://www.dallasobserver.com/news/tell-mama-why-you-cry-part-i-6404797> [hereinafter Zimmerman, *Tell Mama Why You Cry’ (Part I)*].

<sup>148</sup> Zimmerman, *A Mother and Child Reunion*, *supra* note 147; Zimmerman, *Tell Mama Why You Cry’ (Part I)*, *supra* note 147.

<sup>149</sup> Alison Dundes Renteln, *The Use and Abuse of the Cultural Defense*, 20 *CANADIAN J. OF L. & SOC’Y* 47, 50–51 (2005); Zimmerman, *Tell Mama Why You Cry’ (Part I)*, *supra* note 147.

<sup>150</sup> Zimmerman, *A Mother and Child Reunion*, *supra* note 147; Zimmerman, *Tell Mama Why You Cry’ (Part I)*, *supra* note 147.

<sup>151</sup> Zimmerman, *A Mother and Child Reunion*, *supra* note 147; Zimmerman, *Tell Mama Why You Cry’ (Part I)*, *supra* note 147.

parental rights.<sup>152</sup> Unfortunately, this case was a years-long process, during which the children were removed from the family and placed into foster care homes that were not accommodating to their culture and religion.<sup>153</sup>

Another case that demonstrates the use of cultural evidence is *People v. Kimura*.<sup>154</sup> Fumiko Kimura was a Japanese-American woman who attempted to die by “oyako-shinju,” or parent-child suicide, by walking into the Pacific Ocean with her children after discovering her husband was having an affair.<sup>155</sup> While Kimura survived, her two children drowned.<sup>156</sup> In traditional Japanese culture, a mother who dies by suicide and leaves children behind is criticized far more harshly than one who takes her children with her.<sup>157</sup> Parent-child suicide has been “a common occurrence in Japan” for long enough that it is now part of Japanese culture.<sup>158</sup> It is interconnected with the Japanese belief that suicide “is considered an honorable way of dying,” and the Japanese would “prefer to die rather than live in humiliation.”<sup>159</sup> In fact, both the husband and mistress threatened suicide after Kimura’s failed attempt.<sup>160</sup> Although parent-child suicide is illegal in Japan,<sup>161</sup> perpetrators there are charged with involuntary manslaughter instead of murder and typically receive “a light suspended sentence, probation and supervised rehabilitation.”<sup>162</sup> The Japanese community in Los Angeles petitioned in support of Kimura, stating that her actions would not have constituted murder in Japan.<sup>163</sup> They further requested that the prosecutor apply Japanese law because Kimura’s actions were rooted in her culture.<sup>164</sup> The prosecutor allowed Kimura to plead guilty

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<sup>152</sup> Zimmerman, *A Mother and Child Reunion*, *supra* note 147; Zimmerman, ‘Tell Mama Why You Cry’ (Part I), *supra* note 147.

<sup>153</sup> Zimmerman, *A Mother and Child Reunion*, *supra* note 147; Zimmerman, ‘Tell Mama Why You Cry’ (Part I), *supra* note 147.

<sup>154</sup> The Harvard Law Review Association, *supra* note 140, at 1293 (citing *People v. Kimura*, No. A-091133 (L.A. Super. Ct. 1985)).

<sup>155</sup> Sheybani, *supra* note 138, at 751; The Harvard Law Review Association, *supra* note 140, at 1293.

<sup>156</sup> *Id.*

<sup>157</sup> Sheybani, *supra* note 138, at 760.

<sup>158</sup> *Id.* at 760–61.

<sup>159</sup> *Id.* at 761.

<sup>160</sup> *Id.* at 761 n.108 (citing Sherman, *Legal Clash of Cultures*, NAT’L L. J. (Aug. 5, 1985) at 26, col. 1).

<sup>161</sup> Sheybani, *supra* note 138, at 761.

<sup>162</sup> *Id.*

<sup>163</sup> *Id.*

<sup>164</sup> *Id.*

to voluntary manslaughter, even though the prosecutor had been confident that her actions could have made first-degree murder appropriate.<sup>165</sup>

These two cases, among many others like them,<sup>166</sup> show how cultural evidence can be used in a case to create a mitigating effect, albeit not a perfect procedure. Although the topics and charges may not immediately inspire empathy, this Note does not consider whether particular actions of these parents have any positive or redeeming qualities, no matter how rooted in culture they are. However, our justice system is tailored to individualized justice, meant to mold to the defendant's degree of personal culpability.<sup>167</sup> This is evident in criminal defenses that account for mitigating circumstances, such as a battered spouse defense.<sup>168</sup> As such, it would be in line with our justice system to adopt cultural considerations formally.

Much of the discussion for a formal cultural defense can be used in support of not only the formal incorporation of cultural competency into mandatory reporting laws but also of speaking towards the rationale and benefits of cultural competency as a whole. By incorporating cultural competency into mandatory reporting laws, the benefits will be introduced earlier in the process, rather than at the charging and sentencing stages of a court proceeding. The goal would be to employ a culturally competent and informed perspective in the early stages of an investigation through to a report of a suspected child maltreatment. Ideally, this would allow healthcare professionals to understand and employ cultural competency in their assessments of possible child maltreatment so as to reduce the number of families entering the child welfare system unnecessarily or having unsubstantiated cases opened with CPS.

As discussed earlier, California has an accommodation for cultural and religious practices,<sup>169</sup> which states that "cultural and religious child-rearing practices and beliefs which differ from general community standards shall not in themselves create a need for child welfare services unless the

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<sup>165</sup> The Harvard Law Review Association, *supra* note 140, at 1295 (presenting an interesting, more in-depth discussion of how the cultural evidence presented by defendant interacted with California criminal statutes and how it led to the reduced, voluntary manslaughter plea).

<sup>166</sup> *See State v. Kargar*, 679 A.2d 81 (Me. 1996) (vacating an action against an Afghani father for kissing his infant son's penis because it was a common method practiced in his culture to show love); *see also In re Jertrude O.*, 466 A.2d 885 (Md. Ct. Spec. App. 1983) (contemplating the cultural differences in parenting between parents from America and the Central African Republic to vacate child's removal, despite ultimately requiring parents to be educated in American parenting standards).

<sup>167</sup> The Harvard Law Review Association, *supra* note 140, at 1298–99.

<sup>168</sup> *Id.*

<sup>169</sup> *See supra* Part III(A).

practices present a specific danger to the physical or emotional safety of the child.”<sup>170</sup> While not a defense, this is a more formal acknowledgement of cultural competency. However, this provision presents additional issues. It does not consider that there is a lack of cultural competency training which would allow reporters to know when they are faced with a situation that may have mitigating cultural factors. Additionally, it is a near impossible task to create cultural competency training that encompasses every possible culture, as well as that culture’s child-rearing practices, much less one that creates the expectation of reporters to learn and remember all of this information as well.

However, the foregoing issues can be remedied in various ways. Making cultural competency an official component of mandatory reporting laws could smooth the path to further development of cultural competency training in other professional settings, such as in medical schools and hospitals. It would also encourage more funding for programs and research that gather and analyze cultural factors and child-rearing practices while creating and implementing guidelines by which to apply the data. In a more immediate sense, doctors and other healthcare professionals would benefit from being able to follow a consistent and readily understood process with which to assess situations of possible child abuse or neglect. Additionally, healthcare professionals should, and naturally will, follow up with questions for the child and family when they suspect that child abuse or neglect has occurred. In explanations from parents or the children themselves, the families may be forthcoming about how signs and symptoms in the child came about, such as in the cases described previously in this Note.<sup>171</sup> However, this assumes that parents and children are always forthcoming or answer fully and truthfully to questioning; in these situations, the healthcare professional would need to rely again on their own judgments. Considering the current major barriers that prevent healthcare professionals from reporting and making informed decisions in reporting, there is a need for improved mandatory training for mandated reporters on the laws of mandated reporting and their legal obligations.

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<sup>170</sup> CAL. WELF. & INST. CODE § 16509 (2018).

<sup>171</sup> See *In re D.M.*, 195 Cal. Rptr. 3d 402, 403 (Ct. App. 2015) (stating that the mother admitted to the use of corporal punishment on her children when she was visited by the Los Angeles County Department of Children and Family Services); see also *Gonzalez v. Santa Clara Cty. Dep’t of Soc. Servs.*, 167 Cal. Rptr. 3d 148, 155 (Ct. App. 2014) (detailing the mother’s admittance to the use of corporal punishment on her daughter to social workers and school personnel).

## IX. SUGGESTED SOLUTIONS

While statutory reform is a viable solution, it is also difficult to achieve due to the complexity of defining cultural competency when cultures are constantly changing and highly subjective. Existing definitions in federal and state statutes could be further expanded to eliminate confusion and establish uniformity across the nation, or at least within state agencies, such as a uniform standard for the application of “reasonable suspicion.” Alison Dundes Renteln, a professor of political science, anthropology, law, and public policy, outlined a cultural defense test that is intended to reduce misuse of the defense.<sup>172</sup> This test should be adopted in the effort to make determining culture in the context of cultural competency more consistent. The test asks three questions: (1) Are the parent(s) or family members of the ethnic group?; (2) Does the group have such a tradition?; and (3) Was/were the parent(s) influenced by the tradition when he/she/they acted?<sup>173</sup> Applying this test can be an informative guideline for healthcare professionals in determining what steps to take next.

Establishing uniformity and consistency across states would also include formatting better guidelines for diagnosing child abuse. Researchers and professors Lisa A. Fontes and Margarita R. O’Neill-Arana developed a list of factors that professionals can rely on when determining whether discipline constitutes abuse, which can also be incorporated into proposed amendments.<sup>174</sup> These factors include: (1) the age of the child, (2) frequency of the punishment, (3) apparent physical and emotional effects of the punishment, (4) duration of punishment, (5) severity, and (6) invasiveness of the punishment.<sup>175</sup> Statutory reform is also inhibited by the issue of lengthy amendment processes that could be stalled at the drafting stage or otherwise before the amendment is passed. However, this would not necessarily detract from the long-term viability and value of reform, which would include specified definitions and standards. It is important to have cultural competency standards added to the laws because then these standards will be legally required across the board, instead of remaining just recommendations. Statutory reform is also vital in clarifying and eliminating the widely variable interpretations of legal definitions within state agencies and across the nation.

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<sup>172</sup> Renteln, *supra* note 149, at 49–50.

<sup>173</sup> *Id.*

<sup>174</sup> Renteln, *supra* note 1, at 264.

<sup>175</sup> *Id.*



A more direct solution that could better adapt to the subjectivity of cultural competence and individual cases would involve expanding, funding, and implementing more medical-legal partnerships (“MLP”). An MLP integrates legal and healthcare teams to address the comprehensive needs of vulnerable populations by “providing legal assistance in the healthcare setting, transforming health and legal institutions and practices and influencing policy change.”<sup>176</sup> An overarching goal for medical-legal partnerships is to address needs with a multidisciplinary team and perspective, and to acknowledge that “many social and legal problems are involved with a patient’s illness and these problems need to be addressed . . . to achieve good and effective care.”<sup>177</sup> An MLP also focuses on “the social determinants of health,” which are described as the “conditions in which people are born, grow, live, work and age . . . [which] are shaped by the distribution of money, power and resources at global, national and local levels.”<sup>178</sup> MLPs also direct energy towards “the development and delivery of advocacy training curricula to medical faculty, residents, nurses, social workers, attorneys, and students.”<sup>179</sup> The basic setup of an MLP is comprised of a healthcare professional and a lawyer who collaborate to address patient needs.<sup>180</sup> In addition to this base partnership, most MLPs will also employ many other necessary and relevant professionals, including “social workers, paralegals, and/or networks of legal service or pro bono providers.”<sup>181</sup> One of MLP’s most important functions is in “educating physicians, social workers, and other professional staff about potential legal issues.”<sup>182</sup> In this context, MLPs are essential in informing healthcare and legal professionals of culturally-tied child-rearing practices and folk remedies.

Within the MLP, a feedback loop can be established between the attorneys and medical professionals. Partnership medical professionals would be able to inform attorneys on common forms of folk remedies and child-rearing practices that they observe in clients, and MLP attorneys

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<sup>176</sup> Ellen Lawton et al., *Medical-Legal Partnership: A New Standard of Care for Vulnerable Populations*, in *POVERTY, HEALTH AND LAW: READINGS AND CASES FOR MEDICAL-LEGAL PARTNERSHIP* 74 (Elizabeth Tobin Tyler et al. eds., 2011).

<sup>177</sup> Heather A. McCabe & Eleanor D. Kinney, *Medical Legal Partnerships: A Key Strategy for Addressing Social Determinants of Health*, 25 *J. GEN. INTERNAL MED.* S200, S200 (2010).

<sup>178</sup> *Id.* (citing World Health Organization, *Social Determinants of Health*, available at [http://www.who.int/social\\_determinants/en/](http://www.who.int/social_determinants/en/)).

<sup>179</sup> Lawton et al., *supra* note 176, at 75.

<sup>180</sup> McCabe & Kinney, *supra* note 177, at S200.

<sup>181</sup> *Id.*

<sup>182</sup> *Id.*

would be able to inform the physicians and nurses on the legal obligations of both professionals and clients in each situation. During this process, both the healthcare and legal professionals would be able to jointly consult with cultural experts to inform their assessment. This would improve a healthcare professional's ability to identify potential legal needs early on and help address them, since healthcare professionals are typically those with frontline access to vulnerable populations.<sup>183</sup> The healthcare professional would then have a better understanding of identifying child maltreatment and differentiating it from cultural child-rearing practices and folk remedies. Because of how varied and large an MLP can be in terms of involved professionals, this improved training can have farther reaching benefits beyond those to lawyers and healthcare professionals; it can affect related organizations and agencies—such as Child Protective Services and other family welfare agencies—and change their policies and procedures to reflect more culturally competent considerations in interacting with families.

This proposed solution would also require more research into cultures of a wide variety of ethnic minorities and data collection on child-rearing practices that are common and integral in each culture. Data collection on all relevant cultures and their child-rearing practices can be an endless task, potentially one that must constantly evolve over time. To that extent, it would be more logical to focus research on what types of discipline practices and folk remedies have high rates of being reported as child maltreatment but are later found unsubstantiated by child welfare agencies. Cultural experts and cultural training would therefore be beneficial additions to MLPs by structuring cultural competency into their teams and into their patient approaches.

In addition to cultural experts, in-house interpreters or outsourced interpretation services are critical in MLP clinics. MLPs should identify federal and state reimbursement options for interpretation services. To bridge the time gap created by waiting for data to provide useable results, creating a network or database of experts who could be consulted in the meantime would make a difference in informing healthcare professionals in their assessment of potential child maltreatment cases. This measure would conform to the timeliness requirement of the statute, as mandated reporters must report within thirty-six hours of their suspicion.<sup>184</sup>

MLPs can use their position to craft trainings and educational programs based on the needs of their current clients and issues that those

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<sup>183</sup> Lawton, *supra* note 176, at 75.

<sup>184</sup> CAL. PENAL CODE § 11166 (2018).

clients are experiencing relative to possible child abuse accusations. In designing these programs, MLPs should focus on basic information for the process of reporting while addressing relevant state legal definitions of “child abuse” and the vagueness of the definition. Creating workshops to encourage discussion and skills practice in reporting can help increase confidence in child abuse diagnoses and reporting knowledge. MLPs can also partner with medical and legal institutions and schools to educate current students on the value of cultural competency in assessing child abuse allegations, as well as to inform students of their legal obligations under mandatory reporting laws. To further distribute developed materials, MLPs can also work to create specific MLP structures that would best address cultural competency needs of clients and import these group setups into remote MLPs or areas lacking such partnerships. This could include an “ideal” MLP structure that lists the necessary professionals and roles needed to create a well-rounded and competent team in addressing cultural differences.

It would also be beneficial for MLPs and researchers to collaborate and develop guidelines to which physicians and healthcare professionals can refer when faced with potential child abuse and neglect. This can take the form of standard questions to ask or a set of steps that healthcare professionals can consult when making assessments as to whether to report a suspicion. The three-question test outlined by Renteln above would be a good model to use as a starting point.<sup>185</sup> Additional questions and procedures may provide a more readily digestible explanation of legal obligations. Factual hypotheticals or questions formatted for self-assessment could walk healthcare professionals through determining whether to report a situation and when and where to search for additional advice and information. This would have the additional benefit of encouraging consistency across organizations and addressing the concern that no one person can become completely knowledgeable as to all relevant cultures and their child-rearing methods. The MLP’s holistic approach also makes the partnership more conducive to healthcare professionals employing these new guidelines in their interactions with families and children, as MLP professionals have better access to more areas of their clients’ lives. MLPs can also stress to students the importance of pursuing further education in their abilities to diagnose child abuse with a culturally competent mindset and a full understanding of their reporting obligations.

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<sup>185</sup> See Renteln, *supra* note 149, at 49–50 (“(1) [are] the [parent(s) or family] members of the ethnic group?; (2) does the group have such a tradition?; and (3) [was/were] the [parent(s)] influenced by the tradition when [he/she/they] acted?”).

Converting cultural competency into more universal knowledge can be as straightforward as curriculum reform in medical schools across the United States. But as simple as this sounds, there are many considerations when overhauling a long-standing practice. It is necessary to have “departmental allies who are willing to devote time” and energy to incorporate cultural competency into their courses and advocate for this inclusion among their colleagues and superiors.<sup>186</sup> Additionally, offering cultural competency as a separate elective course, or as an afterthought in a basic course, encourages the view that it is less important than the “hard sciences.”<sup>187</sup> This view can best be avoided by incorporating cultural competency education into existing courses, which would provide the framework to change cultural competency into a “curriculum thread” and show that “providing good patient care is not separate from basic or clinical sciences courses.”<sup>188</sup> Opportunities for simulations and community participation can further bolster lessons learned in the classroom.<sup>189</sup> This includes role-play, clerkship activities, and volunteering at community clinics and health centers.<sup>190</sup> Interacting with a variety of individuals from diverse backgrounds “supports and reinforces the point of culturally competent medicine” while developing clinical skills.<sup>191</sup> It is also worthwhile to consider the value in advocating for changes in medical school accreditation standards to require curriculums that dedicate more mandatory time and units to the diagnosis and treatment of child abuse, as physicians and other healthcare professionals will come across incidents of child abuse regardless of their specialization. However, this proposal faces roadblocks similar to those of statutory amendment: the process will likely be expensive, lengthy, and complex, and may result in pushback from schools and agencies.

## X. CONCLUSION

Healthcare professionals such as doctors and nurses are often on the front line and make initial contact with children and families, as well as the initial assessment of potential child abuse. When these mandated reporters are mistakenly reporting innocent parents for child abuse, it can lead to

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<sup>186</sup> Furman & Dent, *supra* note 80, at 24.

<sup>187</sup> *Id.* at 23.

<sup>188</sup> *Id.* at 26–28 (describing various models of education that may be implemented to encourage and reinforce cultural competency learning).

<sup>189</sup> *Id.*

<sup>190</sup> *Id.*

<sup>191</sup> *Id.*

serious, negative effects on families and children. These mistakes in reporting occur when physicians and other healthcare professionals lack cultural competency training and knowledge, leading them to mistake folk remedies and culturally-tied child-rearing methods for child abuse. This problem can be alleviated by statutory reform, as well as by trainings held by medical-legal partnerships to bolster cultural competency and understanding of mandatory reporting obligations. MLPs can assist in the dissemination of crucial information to practicing healthcare professionals and attorneys, as well as improve the training and education of current students in those professions. With attorneys and medical professionals integrated into MLP teams, the sharing of information between professionals will assist in creating a more comprehensive and individualized approach to addressing situations of potential child abuse.