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Child Abuse in the Netherlands: The Medical Referee

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The phenomenon of child abuse has received special attention in the Netherlands since the early seventies when the Association against Child Abuse began its work in September 1970. On January 1, 1972, four medical referees or “confidential doctors” were appointed to deal with child abuse. These doctors play a decisive role in the Netherlands in preventing and treating such cases.

People from various countries of Western Europe1 and the United States have shown particular interest in this approach both through correspondence and by visiting the Netherlands. The idea of the confidential doctor appeals to the imagination. Nonetheless, interest abroad has not so far led to any concrete action.2 In the Netherlands, we now have six years’ experience of working with confidential doctors. This article will describe something of that experience and the way the institution of the confidential doctor has developed since 1972.

The discussion will begin by describing opportunities and problems in the Netherlands as they stood in 1972. For a proper understanding of the position of the confidential doctor and his importance in dealing with child abuse, it is necessary to say something about the background (organizational and legal) against which he commenced his work. Knowledge of this background is also necessary to determine whether this lead can be followed elsewhere.

The article will then deal with the introduction of the confidential doctor in the Netherlands, the original intentions, and developments since 1972. This section will end with a few conclusions (provisional) on the advantages and disadvantages of this method of locating, treat-
ing and, where possible, preventing child abuse. Finally, the discussion will deal further with the question of whether confidential doctors are also practicable in other countries and in the United States in particular, and with what points deserve special attention in the light of Dutch experience.

**The Situation in the Netherlands in 1972**

**Child Abuse: An Unknown Problem?**

Until the early seventies, little specific attention was paid to the phenomenon of child abuse in the Netherlands, in the sense of a separate and systematic approach. This does not mean, however, that child abuse was unheard of before 1970.

The oldest and most concrete legal basis is to be found in our Criminal Code. Since the present Criminal Code became effective in 1886, the Netherlands criminal law has had a specific provision mentioning child abuse by parents. The provision appears in a section in which various forms of abuse are made criminal. Child abuse is a special form of abuse for which the Criminal Code provides especially heavy penalties. The practice of the courts in applying these articles can help to define what child abuse must now be taken to mean, at least in the criminal sense. Before 1970, such cases of child abuse that came to our knowledge did so within the framework of criminal law. Child abuse was initially a concept determined chiefly by criminal law, and long remained so. It was also so at the time the first confidential doctors were appointed. Therefore, one should first deal with the criminal law aspect.

The fact that “child abuse” was long a concept mainly of criminal law did not, however, mean that the only action taken when parents abused their child fell entirely into the area of criminal law. Child neglect and juvenile crime flowing from it reached such serious proportions at the end of the last century that the government made legislative proposals not only to combat but also, where possible, to prevent neglect and crime of this nature.

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3. Child abuse, as used in this article, chiefly means the causing of bodily harm to children by parents or guardians. However, in the seventies, the term “child abuse” has acquired wider connotations in the Netherlands.

4. Between 1811, when the previous Dutch state was incorporated into France, and 1886, the French Penal Code applied in the Netherlands. This was a result of the French domination which began in 1795 and lasted until 1813. The Penal Code also made separate mention of child abuse and made it a criminal offense. (Penal Code art. 317). Fairly little can be said about the period before 1795 since there was no unity. No Dutch Criminal Code existed until 1886.

5. **CRIM. CODE** art. 304 (Neth.).

6. *Id.*
In 1901, the Dutch Parliament enacted three bills intended to protect young people who had been neglected and had turned to crime.\(^7\) An important fact in this connection is that, since then, a neglected child—and an abused one—may be removed from his parents' authority. In other words, the "ordinary" means of protecting children which the law provides can be applied in cases of child abuse. This was regularly done from December 1, 1905 onwards—the date on which the 1901 children's legislation became effective—and still is the case today.\(^8\)

The existence of special measures to protect the child and of a separate provision of criminal law demonstrates that the abuse of children is not an unknown phenomenon. However, it has not always been differentiated from other problems of raising children. It has not always been regarded as a separate problem. Hence, the "traditional" means of combating child abuse—the criminal law and the special measures to protect children—are worthy of consideration.

**Child Abuse and Criminal Law**

The Netherlands Criminal Code devotes a special section to abuses.\(^9\) The section distinguishes between simple abuse,\(^10\) abuse with premeditation,\(^11\) grave abuse,\(^12\) and grave premeditated abuse.\(^13\)

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7. The following Dutch statutes are concerned: Children's Act (Feb. 6, 1901), 62 Stat. (Civ. Law), (Neth.); Children's Act (Feb. 12, 1901), 63 Stat. (Crim. Law) (Neth.); Outline Child Care and Protection Act (Feb. 12, 1901), 64 Stat. (Neth.). The first two of these Acts form part of the Netherlands Civil Code and Criminal Code respectively. Although they have been repeatedly amended and supplemented since 1901, they continue to determine the system and largely, too, the substance of legal protection for children in the Netherlands (under civil and criminal law).

An extensive description of existing Dutch law on the protection of children may be found in (in Dutch):

a. "De Bie's Child Law," civil law section, fully revised 5th edition, by G. Delfos and J.E. Doek (1974); and,


8. We do not in fact know what protective measures were applied and in how many cases before 1972. This is a result of the fact that until then no special attention was paid to the phenomenon of child abuse.

9. Specific forms of aggressive conduct by parents toward their children, particularly infanticide (by the mother shortly after birth for fear of the birth being discovered), are also subject to penal sanctions. (CRIM. CODE art. 290, 291 (Neth.). This form of abuse was already punishable in the seventeenth and eighteenth centuries. Penal sanctions against sexual abuse of a child by his parents are governed by CRIM. CODE art. 249 (Neth.).

10. CRIM. CODE art. 300 (Neth.).

11. Id. art. 301.

12. Id. art. 302.

13. Id. art. 303. Serious abuse is the willful causing of grievous bodily harm. According to article 81 of the Criminal Code, the latter includes illness that leaves no prospect for full recovery and the disturbance of mental capacity lasting for more than four weeks. The terms used here indicate that maltreatment may also relate to non-physical injury. (See also CRIM. CODE art. 300(4) (Neth.).)
Article 304 of the Criminal Code provides that the maximum penalties under articles 300 to 303 can be increased by one-third in certain cases. One of these cases is the abuse of a child by his parent. It is clear that Parliament considers this form of abuse as so serious that the courts are enabled to increase the sentence normally applicable. This reaction is understandable. A child is greatly dependent precisely on his parents and particularly vulnerable for that reason. A parent who abuses his position by maltreating his child is considered culpable to an enlarged degree in existing criminal law.

No similar increased culpability attaches to a person who maltreats the child of another. Therefore, there is a difference between a parent and an arbitrary third party. Apart from this, however, both fall within the scope of articles 300 to 303 of the Code if they abuse a child. This means determining under which form of abuse described in these articles the action of a parent or third party must be classified.

The first question, however, is when must an action be regarded as "abuse of a child" within the meaning of the criminal law. To answer this question, one must consult case law. Abuse, as defined by the Supreme Court of the Netherlands, is the intentional infliction of pain or hurt. Such pain may be inflicted on a person's body or to his health. Article 300(4) of the Criminal Code in fact states that abuse is equated with intentional injury to health. This rule is not an unimportant one. Because of it, one can assume that under existing criminal law the mental maltreatment of children is a criminal act in the same degree as physical maltreatment.

However, is the infliction of physical or mental hurt/pain a criminal act, under all circumstances? This question arises, and sometimes makes us hold back, when we consider that every parent gives his child a smack or slap now and again. The Netherlands Supreme Court has said of this that the chastisement of a child by his parents or teachers

14. This may be important in connection with the provisions of article 305 of the Criminal Code. A conviction for premeditated (serious) abuse (articles 302 and 303) may lead, as an additional punishment, to the deprivation of certain rights, such as the holding of (certain) offices, the right to elect or be elected (active and passive voting rights). See CRIM. CODE, art. 28 (1) to (4) (Neth.).
15. This discussion will be limited to the parent-child relationship because the abuse of children by their parents forms the large majority of cases of child abuse reported (an average of approximately eighty per cent in the Netherlands between 1972-1975).
17. See II NOYON-LANGEMEIJER 330 (6th ed.); II SIMONS, LEERBOEK NEDERLANDS STRAFRECHT 18. On the question of whether the mental abuse of children should become a specific crime, see B.L.F. CLEMENS SCHRONER, PSYCHISCHE KINDERMISHANDELING (1957).
within the limits of necessity is not abuse. The infliction of physical pain in this case is a means towards a justified end.\textsuperscript{18} This invites two comments. First, the justified limits of disciplinary rights vested in a parent may not be exceeded during chastisement. No recent judicial decisions have been published; therefore, it is not possible to indicate where the courts now draw the line. It is reasonable to suppose that the limits to parental discipline will not be so widely drawn as some twenty-five years ago. The infliction of physical hurt to a child can only to a limited extent be regarded as a justified means of bringing up children. Second, the Netherlands Supreme Court has further found that the mere fact that an action has been taken to a justified end does not mean that some abuse may not have occurred.\textsuperscript{19} In the case of child abuse, this means that discipline may be improper even if the intention of the parents is good (\emph{i.e.}, bringing up the child). The end does not justify the means.

The conclusion will have to be that, on the one hand, not all physical pain inflicted by a parent on a child is abuse in the criminal sense but that, on the other hand, the arbitrary infliction of physical or mental dolor is not a parental right. One gains the impression that the limits within which the first group of acts do not as yet amount to child abuse are tightly drawn, partly as a result of changed attitudes towards bringing up children. In other words, hitting or chastising children as a means of correction will be less rapidly accepted in criminal law than it was ten to fifteen years ago.

Theoretically, it could be postulated on the above conclusion that increasingly more parents have in the course of the years been prosecuted and sentenced for abusing their children (even though, in fact, child abuse has remained at the same level overall). Practice shows us differently, however.

For example, the number of criminal convictions hardly increased in the period between 1960 and 1972. The total number of convictions for child abuse during that time varied from about ten to fifteen.\textsuperscript{20}


\textsuperscript{20} The statistics are from the Central Bureau of Statistics in the Netherlands. Statistics from this source will hereinafter be referred to as CBS Statistics.
This phenomenon cannot be precisely explained on the basis of scientific research. However, a first possible cause is the fact that the public prosecutor was not aware of a case of child abuse. This can be explained by the low anticipation of successful prosecution and sentencing in cases of child abuse.  

A second cause may be the public prosecutor's policy towards prosecution. Cases will undoubtedly arise where the public prosecutor—possibly after laying down certain conditions—decides not to institute proceedings. Between 1964 and 1972 this happened in about ten to twenty-five cases each year. In order to avoid any misunderstanding on this point, it is certainly not the case that involving the public prosecutor necessarily means that the parent is put into prison. The public prosecutor has wide means at his disposal to bring in assistance should he consider this necessary: conditional suspension of proceedings, involvement of the probation service and possibly other bodies are remedies he can call upon. Nonetheless, it is seldom that the public prosecutor is involved, particularly because criminal proceedings are not regarded as constructive. Those involved wish to aid and support the parent(s) and child and do this by recourse to a suitable welfare organization. Thus, the public prosecutor is not the first to come to mind when child abuse is discovered. It should not be inferred from this, however, that the prevalent view in the Netherlands in 1972 was that the abuse of children by their parents should not be punishable. The fact is that a criminal investigation did take place, particularly in serious cases, and was not necessarily pointless.

As regards the penalties to be imposed, an unconditional spell in prison must be regarded as the last resort. Investigation has shown that criminal sentencing of the parent—particularly where this means spending a period in prison—often has the opposite effect to the possibility of maintaining or reinstating family unity. The parent returns embittered from prison and the child (or children) is exposed to yet greater risk than before. Hence, serious account must be taken of the fact that such a sentence may finally break up family unity. A suspended sentence allowing additional conditions to be placed on the parent’s conduct can be imposed. It should be done in a manner that will make it possible to ask agencies other than the probation services to offer the parent help and assistance in observing the conditions. As

22. CBS Statistics. See note 20 supra.
23. CRIM. CODE art. 14a, 14c (Neth.).
This is a continuation of the previous text:

regards the steps to be taken, a means should certainly be found for imposing measures on the parent more aligned to the problem of child abuse.

Child Abuse and Child Care

The term "child care" in this case means action by the judiciary imposing child care measures and everything connected therewith (preparation and execution). There is insufficient room to deal in any detail with the legal and organizational aspects of child care in this form. It relates to cases where parents seriously neglect their duty to look after and bring up a child. This may mean leaving him to look after himself, failure to provide necessary medical care, physical neglect (under-nourishment), abuse of parental powers, maltreatment, affective neglect, and the like. In short, it covers all those various situations where the development, growth and personal evolution of the child are so seriously threatened and/or damaged that the authorities feel they must take action. In the Netherlands, work preparatory to a child care measure being instituted is left to a state institution, the Child Care and Protection Board. This Board not only undertakes the necessary investigation but also submits the official application to the court for measures to be taken.

It can generally be said—but for a few infrequent exceptions—that, under the Dutch system, the Child Care and Protection Board in fact decides (1) whether steps should be taken and, if so, (2) what action will be most appropriate. We do not know in how many child abuse cases child care measures have been initiated by these Boards up to 1972 and confirmed by the courts. Until then child abuse was not differentiated from other situations where children's development was seriously damaged or threatened.

In these cases, prosecution will not be the immediate consequence. An attempt will first be made—as long as there is reason for doing

24. See the literature cited in note 7, supra. A succinct introduction to child protection in the Netherlands by J.E. Doek and S. Slagter (published, in Dutch, by the Children's Foundation, 38 Emmastraat, Amsterdam) will appear shortly in German, French, and English translations. The English title is CHILD PROTECTION IN THE NETHERLANDS.

25. There are 19 Child Care and Protection Boards in the Netherlands in all (one Board for the legal district of each court). These Boards play an important part in other fields as well, e.g., as advisers; this applies for example to adoption and the criminal prosecution of minors. Owing to the multiplicity of these Boards' tasks and the actual weight of their opinion (the courts nearly always follow the Boards' advice), they play a central role throughout Dutch child care and protection work and their actual power is very great. They come in for a good deal of sharp criticism in dailies and weeklies and on the radio and television. As regards the origin, development and future of these Boards, see Doek, "Which is the good Board for the future?" (in Dutch, Samson, Alphen on Rhine 1978).
so—to help the parents and child on a voluntary basis, *i.e.*, without involving the courts, using existing opportunities of rendering assistance. Only if this has no adequate effect will a child care measure be adopted. However, this is often not a direct progression. Aid services who come to the conclusion that their assistance has no adequate effect unfortunately will generally not inform the Board, which all too often learns the facts only via other channels (*e.g.*, the police, neighbors, etc.) and, regrettably, is frequently apprised of the problems affecting the child and parents only much later. Court action is clearly the last resort and is often taken relatively late, and sometimes too late.

Certain actions to stop and/or prevent child abuse can also be taken under the Civil Code. These measures are provisional taking into care by the Child Care and Protection Board; supervision (possibly provisional); suspension of parental authority (possibly enforced); and, removal from parental custody.

What these measures have in common is that to a greater or lesser degree they impinge on the exercise of parental authority. This is understandable when we consider that the situation in each case is one where the parents fail to meet their statutory duty to care for and bring up the child. Depending on the circumstances, they are entirely deprived of the exercise of parental rights. For the sake of completeness, it should be mentioned that detailed proposals have been made to streamline and improve the existing system of child care measures.\(^{26}\)

The first measure, provisional taking into care, can be recommended by the public prosecutor, *i.e.*, no decision by the court is required for this. Its consequence is that the child is removed from the authority of the parent(s). Provisional taking into care means that the Council largely acquires rights over the child. In particular, the Council is entitled to take the child from his home should this prove necessary. The measure is—as the name implies—provisional in nature; it may lead to a more far-reaching (more final) measure. It is also possible for the measure to be suspended after a period of time because the contemplated effect has been achieved. It is a means much adopted in critical situations in particular; it can be very quickly implemented as the Board immediately has wide powers, and it can be terminated simply and at any time.

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\(^{26}\) See De Cie-Wiarda, *Report on the Law Relating to Child Care and Protection* (State Publishers, The Hague 1971). To avoid any misunderstanding, these proposals were not made with a view to combating child abuse. The Dutch Government is preparing bills based on the proposals.
The second measure, supervision (provisional), can be ordered by the juvenile judge if a child is growing up in such a way that his moral or physical future is endangered. The courts may make a provisional supervision order while an investigation in connection with an application for supervision is in progress. This decision can quickly be taken; there is no need to hear the parents and no appeal is possible. Provisional supervision continues until a final decision is taken on the application for supervision.

A supervision order implies the appointment of a family guardian by the judge. In most cases, this will be a staff member (professional employee) of a family guardianship organization. In nearly all other cases it will be a member (volunteer) of such an organization. Before making an appointment, the family court will generally consult the organization involved. While a supervision order applies, the child may be taken from home for observation or for care or bringing up at an observation home, a private or state institution, or elsewhere (e.g., a foster family). The juvenile judge will seek the assistance of the guardianship organization to implement the measure, for which it (still) bears the formal responsibility. However, the practical aspects of implementing the measure lie with the organization which regularly consults the juvenile judge since it is under the latter's guidance that the guardian supervises the child and the judge can make all kinds of decisions while the order applies (including termination/extension, replacement of the guardian, removal from home).

A supervision order is normally made for one year and can be renewed for a further year in each case. Removal from home while an order applies is tied to set periods: the maximum period for observation is five months (including extensions), for removal for care and bringing up, the maximum period is two years; however, further extension is possible in certain cases.

This measure constitutes a restriction on the parents' authority. The latter must in fact follow the directions of the family guardian. But before a guardian gives mandatory instructions, he will have to advise the parents as much as possible on care and bringing up and try

27. CIV. CODE art. 257 (Neth.).
28. CODE OF CIV. PRO. art. 940 (Neth.).
29. CIV. CODE art. 257 (Neth.).
30. Id. art. 255.
31. Id. art. 262.
32. Id. art. 263.
33. Id. art. 262.
34. Id. art. 263.
35. Id. art. 260.
to persuade them to do what may be necessary.36 Within this framework, persuasion and motivation is the rule and enforcement is only a last resort.

The third measure, mandatory suspension of parental authority, may be taken if the parent is incapable of or unsuitable for fulfilling his duty to care for and bring up the child and if, moreover, it is not against the interests of the latter.37 The consequence of this measure is that the parent loses his authority over the child. This almost always means that the child is placed under the authority of a guardianship organization and must be lodged away from home. The guardianship organization decides whether the new place of stay will be a foster family or an institution and where this will be.

The measure can be imposed only if the parent does not object. Nonetheless, suspension of parental authority is possible in certain cases.38 This applies particularly to the situation following an unsuccessful supervision order—an exception which has given rise to discussion and continues to do so.

The fourth measure, removal from parental custody, may occur on various grounds.39 The best known, and also the most common, are abuse of parental authority, gross neglect of care and attention, and a detrimental life style on the part of the parents. If one of the grounds for removal is present, the imposition of this measure is still subject to the court considering it necessary in the child’s interests. The direct consequence of removal is generally the transfer of parental authority to a guardianship organization and removal of the child. Other consequences of removal from custody affecting the parents are the loss of active and passive voting rights40 and loss of usufruct of the child’s assets.41 The latter consequences and the fact that in most cases culpable misconduct by the parents must be proven mean that removal from custody is seldom resorted to. On the list of various measures open to the court, removal from custody is well to the bottom; it is contemplated only in extreme situations offering little prospects.

Both of the latter measures—suspension of authority and removal from custody—appear to have much in common with termination of parental rights in the United States. However, there are important differences. The Dutch measures do not mean that the child is free for

36. Id. art. 259.
37. Id. art. 266.
38. Id. art. 268 (mandatory suspension).
39. Id. art. 269.
40. NETH. CONST. art. 90.
41. CIV. CODE art. 251 (Neth.).
adoption. In other words the parents, despite their loss of parental authority, retain the right to refuse consent to their child being adopted (e.g., by the foster parents).\textsuperscript{42} Further, loss is not final. If the mutual relationship has improved adequately, they can apply for reinstatement of parental authority. The court can approve this request if it is convinced that the child can again be entrusted to his parents.

\textit{Child Abuse: Growing Concern in the Netherlands}

The abuse of children is as old as mankind. This section is concerned with a brief sketch of recent developments in the Netherlands in the concern regarding child abuse.

The first public evidence of concern following the Second World War dates to 1957. In that year, Mrs. B.L. F. Clemens Schröner published her paper on the "Mental Maltreatment of Children."\textsuperscript{43} For the Netherlands, it is still a unique study, not only because it brought child abuse to the attention of Dutch lawyers and doctors long before this happened in America but, chiefly, because it systematically dealt with the highly complex subject of mental maltreatment (the first, and unfortunately, so far the last to do so). Regrettably, this publication was far ahead of its time. At least, it did not lead to discernible social and/or political activity. It was only in the sixties that—undoubtedly partly under the influence of growing concern in America—a number of articles again appeared in professional journals (chiefly medical).\textsuperscript{44}

However, interest remained limited to professional journals. The articles did not lead directly to concrete action. They did, however, instigate attention on a wider front. In 1969 particularly, child abuse was brought to the attention of the wider public through many newspaper reports, comment in weeklies, etc. Members of Parliament asked questions and the policy makers involved became active. The Minister

\textsuperscript{42} We must remember that no final refusal is concerned in this case. The foster parents may re-apply for adoption two years after such a refusal. If the child's parents again withhold consent to adoption, the courts are then—unlike on the first occasion—no longer obliged to refuse the foster parents' request. \textsc{Civ. Code} art. 228 (Neth.).

\textsuperscript{43} The study is based on 100 cases which Clemens Schröner collected from the police at Groningen and Rotterdam over a ten-year period. Partly inspired by German writing on the subject, it puts a detailed proposal for making the mental maltreatment of children a criminal offense under a separate article of law.

\textsuperscript{44} The main articles were: Abbenhuis, \textit{The Maltreatment of Children}, 21 \textsc{De Koepe} 110 (1967) (in Dutch) (in which it was estimated that 12,000 Dutch children were being abused each year in the Netherlands, with approximately 120 deaths and 160 children suffering permanent injury); Kuipers and van Crevel, \textit{The Maltreatment of Children}, 108 \textsc{Dutch Med. Rev.} 2399 (1964) (in Dutch) (in which Dutch doctors first described child abuse cases treated in Amsterdam hospitals). See also Kuipers, \textit{The Maltreatment of Children and Professional Secrecy}, \textsc{76 Nursing J.} 640 (1966) (in Dutch); Beemer, \textit{Professional Secrecy and Child Abuse}, 44 \textsc{Kath. Artsenblad} 256 (1965) (in Dutch).
of State for Social Affairs and Public Health, in a letter, asked the Royal Dutch Society for the Promotion of Medicine to give attention to the phenomenon of child abuse. The Society’s response was favorable. It is clear from this correspondence that the professional secrecy of physicians is an important obstacle to rapid reporting and treatment of child abuse.

In his letter, the Minister of State wrote:

[N]ot only neighbors and members of the family can sometimes suspect abuse, but it is usually doctors . . . that can confirm abuse of this kind with an at least reliable degree of certainty. However, in practice they make virtually no use of their knowledge regarding the child, i.e., where these factors come to light, they hardly ever involve the persons and organizations concerned with the problem . . . . The argument is often put that if they do otherwise, the public will in the future no longer wish or dare to approach a doctor. In addition, considerations of a medical ethical nature also play an important role. I have in mind the interpretation by a great many doctors of medical professional secrecy.

In its reply, the Society stated that it felt that the doctor will have to refrain from notifying the court on initial suspicion—probably a certainty for him personally—of an as yet slight abuse of a child by his parents:

However, it is a function of the physician, and this cannot be too greatly stressed, to attempt at this first stage to seek a solution by other means . . . . When it is clear that attempts by these other means to avoid further abuse of the child by his parents remain unsuccessful, the medical attendant will have to ask himself whether maintaining secrecy of his findings may not be detrimental to the child . . . . This may mean that, after consulting his conscience, he will consider himself relieved of his professional secrecy and will lay an information.

In essence, the Minister of State suggested that thought be given to a procedure that could be followed by a doctor if he wished to contact non-medical organizations in connection with a case of child abuse. For this purpose, a working party was set up at the beginning of 1970 including officers from three departments, i.e., Social Affairs and Public Health; Culture, Recreation and Social Work; and Justice; and rep-

45. All physicians in the Netherlands belong to this organization, which is generally referred to as the KNMG.
46. This correspondence was published in 21 MEDISCH CONTACT 1047 (1969).
47. This should not be surprising. Doctors’ professional secrecy was (and perhaps still is) a major problem in the United States, too; the “reporting laws” are partly a result of this. Medical professional secrecy is also an obstacle to dealing effectively with child abuse in other European countries.
49. Id.
resentatives of the Society and a number of specialist associations (pediatricians, psychiatrists). It was known as the "Inter-departmental Working Party on Child Abuse" and submitted its report in October 1970. In it, the working party suggested that, as an experiment, four confidential doctors be appointed in certain large cities in different parts of the country (Amsterdam, Arnhem, Groningen, and Rotterdam). The confidential doctors would be available for consultation and advice, particularly to physicians, but also to others whenever child abuse was suspected or confirmed. In the meantime, in September 1970, the "Association against Child Abuse" was set up by a number of private persons.

Before dealing with the effects of these two activities and especially with the introduction and development of the confidential doctor in connection with child abuse, a look should first be taken at the legal aspects of medical professional secrecy in the Netherlands.

**Child Abuse and Medical Professional Secrecy**

The preceding discussion of increasing interest shown in the phenomenon of child abuse indicates that the approach eventually proposed (the appointment of four confidential doctors) was to a large extent determined by the problems surrounding medical confidentiality. For that reason, a closer examination of the legal aspects of professional secrecy—which, in fact, was also a substantial obstacle to the effective combating of child abuse elsewhere—appears at least pertinent.

This section will be limited to the professional secrecy of the physician. However, others who are professionally concerned with the rendering of assistance may find themselves faced with the problem of confidentiality.

On completing his examinations, each physician takes an oath or affirms that "he shall reveal to no one what has been entrusted to him or what has come to his knowledge in secret in the pursuit of medicine unless he is required in legal proceedings to make a statement as witness or expert or he is obliged by law to provide information." The legal significance of this oath is substantial. It is a condition that must

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51. For example, social workers must deal with problems of confidentiality. The courts have viewed this matter variously and social workers do not (as yet) fall under a discipline governed by law. This does not conceal the fact that the social worker may have particular problems with secrecy because of his professional code.

be met in order to be admitted as a physician. The doctor must undertake to keep secret the knowledge that he obtains as medical attendant. This obligation is also protection for the patient. Breach of this oath is not penalized specially.

In criminal law, the duty of secrecy is laid down in article 272 of the Criminal Code and the refusal to give testimony in article 218 of the Code of Criminal Procedure. These provisions must be regarded on their merits; they are not a direct consequence of or based on the oath or affirmation given. Finally, it may be mentioned that the final part of the oath or affirmation may give rise to misunderstanding. The position is not that the doctor must speak out if he is heard before the courts as a witness or expert. On the contrary, he may remain silent throughout by virtue of the right granted him to withhold testimony.53

The secrecy that the physician undertakes to observe by oath or affirmation is not of an absolute nature. The law may oblige him to provide information, according to the final clause of the oath. Confirmation of this may be found in the statutory obligation, inter alia: (1) to make notification of an infectious disease;54 (2) to make notification of certain occupational diseases;55 and (3) to supply a death certificate. Failure to supply such a certificate means that the doctor considers that in his opinion the deceased did not die a natural death.56

The doctor's obligation of secrecy, confirmed by the oath or affirmation made by him, has three legal aspects, i.e., disciplinary, criminal and civil. Each of these aspects will be examined separately.

Medical Professional Secrecy and Disciplinary Liability

Although the law relating to medical discipline offers no special sanctions for breach of professional secrecy, this aspect of law ensures that professional confidences are properly kept. Section 1 of the Medical Practice (Discipline) Act provides inter alia "that a physician who is guilty of actions that undermine confidence in the physician's standing may, without prejudice to his liability pursuant to other statutory provisions, be exposed to the disciplinary measures . . . ."57

Precisely the fact that a doctor may be expected to keep his knowledge concerning a patient secret forms an important pillar of the confidence that medical people enjoy in society. Failure to honor this

53. Code of Crim. Pro. art. 218 (Neth.).
54. Infectious Diseases Act of 1928, 265 Stat. (1928) (Neth.).
57. Act of July 2, 1928, § 1, 222 Stat. (Neth.).
expectation may mean that this confidence is undermined. It is not therefore unusual for a medical disciplinary committee to find in connection with a complaint that a doctor has undermined confidence in the physician’s standing by passing certain information on to third parties. The disciplinary measures that can be instituted are a warning, a reprimand, a cash fine not exceeding 10,000 Dutch guilders, suspension from the pursuit of medicine, and withdrawal of his authority to pursue medicine.58

If a doctor, despite suspension or withdrawal of his authority, continues to practice medicine he may become criminally liable.59 The fine imposed is paid to the state and not to the complainant.

With regard to child abuse, an important point was, and is, of course, whether a doctor who brings child abuse, or a suspicion thereof, to the knowledge of the competent authorities (e.g., the courts) undermines confidence in the physician’s standing, in other words, whether he becomes subject to disciplinary proceedings. Save for a few exceptions,60 doctors in the Netherlands are quite generally of the opinion that a doctor is free to discuss a case of child abuse with non-physicians, including the court authorities.61 This is already clear from the letter referred to above from the Royal Society for the Promotion of Medicine. The view of this organization—that the doctor may, should he consider it necessary, bring a case of child abuse to the notice of a social agency (e.g., the Child Care and Protection Board)—is confirmed by the result of an inquiry among doctors published in December 1970.62

To avoid misunderstanding, the question is whether the duty of confidentiality is absolute or relative in nature. Relative nature is defended in the older sources, too,63 i.e., the general interest or the interest of the patient himself may mean that the doctor is relieved of his

58. Id. § 5.
59. CODE OF CRIM. PRO. art. 195 (Neth.).
62. The inquiry was commissioned by the Dutch Broadcasting Organization carried out by Intomat on Nov. 27, 1970. The project was carried out with a representative sample covering 200 of the 4,600 family doctors in the Netherlands. Of the family doctors questioned, 67% replied that they, where necessary, would not hesitate to breach professional secrecy in the case of child abuse. A good 31% said they preferred the Child Care and Protection Board as the body to notify about child abuse (should a duty of disclosure be introduced).
duty to remain silent. This does not mean that nothing can happen to a doctor who breaches his professional secrecy in such a case. On the contrary, he must take account of the possibility of a complaint being brought against him before the disciplinary court. If this happens, he will have to justify his action before the court; in other words, he remains professionally liable (and also criminally and in civil law). The chance of a finding against him is perhaps small, but this freedom (i.e., to breach professional secrecy) will not be resorted to so quickly because of the (detrimental) chance of legal proceedings.

**Medical Professional Secrecy and Criminal Liability**

Professional secrecy that may be expected of a doctor is also acknowledged in criminal law. On the one hand, there is the duty to remain silent under the Criminal Code: “Any person who deliberately betrays any secret which he knows or can reasonably be expected to know that he is obliged to keep by virtue of his office, his profession, or a statutory regulation, or by virtue of his former office or profession, commits an offence.” On the other hand, there is the right to remain silent under the Code of Criminal Procedure: “Any person may refuse to give testimony or to reply to certain questions if by virtue of his position, his profession or his office he is bound to secrecy, but only concerning matters knowledge of which has been entrusted to him as such.”

As regards the duty of silence, not only disciplinary but also criminal action is possible against a doctor who breaches his duty of secrecy. There need not be any great doubts as to a doctor’s knowledge that he must honor a confidence as described above. The oath or affirmation given by him is an adequate indication of this.

The duty of secrecy recognized by criminal law is based on the peculiar requirements of the profession exercised. The requirements of the medical profession imply that anyone who places himself or a member of his family under a doctor’s care may be certain that the

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64. For a discussion of who is the doctor’s patient in child abuse cases, see text accompanying notes 78-80 infra.


66. CRIM. CODE art. 272 (Neth.).

67. CODE OF CRIM. PRO. art. 218 (Neth.).

68. A prosecution can be brought in respect of the offense only on a complaint lodged by the specific person against whom the offense has been committed. CRIM. CODE art. 272 (2) (Neth.). (If the offense is committed against a person who has not yet reached age 16, the complaint must be submitted by his legal representative. Three months are allowed for submitting the complaint.).
doctor will not reveal any information about the patient without his consent. The duty of secrecy stated here is not based directly on the oath or affirmation made; rather, it is based on statutory\(^69\) and case law.\(^70\)

It cannot be inferred from published decisions that the duty of secrecy under the Criminal Code is often applied to doctors. It must be remembered that a doctor who reveals information obtained through the doctor-patient relationship in a case of child abuse may be faced with a complaint from the parents which can lead to criminal proceedings.

However, a complaint does not automatically lead to a prosecution. The public prosecutor may use his discretion in deciding whether to bring proceedings. The principle of expediency in the Netherlands criminal law means that the public prosecutor may withhold proceedings if this is in the common interest. He may withdraw a case right up to the point when the court begins to sit.\(^71\) If the public prosecutor sees a reason for desisting from criminal proceedings in the common interest the interested party may bring his case to the Appeal Court, which may still authorize institution of proceedings.\(^72\)

This applies in a quite different context when considering the right to remain silent. Under the Criminal Code, the doctor must remain silent\(^73\) while under the Code of Criminal Procedure he may remain silent when asked to testify.\(^74\) This faculty is remarkable when compared with other provisions. If during legal proceedings a doctor decides to reply to the questions put, it may lead to a complaint (\textit{e.g.}, by the parents of the child where child abuse is concerned) that the doctor has been guilty of a criminal offense under the Criminal Code. Further, a right to remain silent before the court (implying a choice on the doctor’s part) is difficult to square with the oath or affirmation (implying no choice) made by the doctor. The right to remain silent under the Code of Criminal Procedure is derived from the duty of confidentiality based on the particular requirements of the medical profession. What is of interest with regard to child abuse cases is that a doctor who is in breach of his duty to remain silent by involving third parties is still not thereby compelled in court proceedings to provide all information in his possession or to answer all questions. The right to remain silent

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\(^69\). See text accompanying note 66 supra.
\(^70\). Judgment of April 21, 1913, Hoge Raad der Nederlanden, [1913] N.J. 958.
\(^71\). CODE OF CRIM. PRO. art. 167(2), 242(2) (Neth.).
\(^72\). Id. art. 12.
\(^73\). CRIM. CODE art. 272 (Neth.).
\(^74\). CODE OF CRIM. PRO. art. 218 (Neth.).
is not suspended if the suspect gives the doctor permission to speak in court.  

Breach of secrecy in order to set effective assistance in motion to help a maltreated child and the parents does not therefore mean that the doctor could be legally compelled to make statements which could lead to the parents being sentenced. Proper use of the right to remain silent can in that respect benefit confidence in the physician's standing. It must be understood, however, that this point applies, by virtue of the Code of Criminal Procedure, only in criminal matters. However, the same applies under the Civil Code to civil matters as well. In such cases, too, a doctor may refuse to give evidence. Because the question of civil liability for a doctor's errors is important in both the Netherlands and the United States, a more detailed examination of it is warranted.

**Medical Professional Secrecy and Civil Liability**

In the Netherlands, when a person applies to a doctor, asking him for treatment, and the doctor accepts the patient, a contract is concluded in private law. On the whole, this contract is regarded as one for the rendering of certain services. The contract requires the doctor to make "every effort." This means that the doctor will, in the correct way and to a sufficient degree, use the knowledge and skills which he possesses as a doctor; he does not undertake to achieve a certain result. Failure to achieve the anticipated result is not in itself a breach of contract. This may be the case if the doctor applies his knowledge and skills in an incorrect way or in insufficient measure.

The patient is, in principle, obliged to give the necessary cooperation. But this does not mean that he is an arbitrary object of medical treatment. The patient has exclusive authority over his own body; in other words, he is entitled to refuse his cooperation with treatment or with part of it. The contract applies only to the examination or the treatment in respect of which it was concluded. If in the course of examination other complaints come to light, the doctor will require separate consent to treat them.

76. **CIV. CODE** art. 1946(2) 3.e (Neth.).
77. The ease with which very high damages can be claimed in civil proceedings in the United States in the case of errors by a doctor is a "bogeyman" to the Dutch physician. The comment that the author heard on this question during his visit to the United States (Fall 1977) was not entirely positive. His impression is that the doctor's civil liability in the United States has an almost inhibiting effect on his activities, particularly in crisis situations (e.g., traffic accidents).
78. **CIV. CODE** art. 1637 (Neth.).
However, what is the position in private law when a parent comes to the doctor with his child for medical treatment? The parents are acting as the legal representatives of the child, who is being treated by the doctor as a patient. But does this relationship mean that the doctor may not proceed further in his treatment than the parents wish? Must he dutifully follow the parents' directions irrespective of the consequence it may have for the child?

A commentator has referred to a "contract of treatment" in connection with the above relationship. Parents, as legal representatives, conclude a contract of treatment with the doctor in respect of their children. Under this contract, the doctor is responsible to the parents for the welfare of the child to be treated, in other words the doctor is here bound by the parents' judgment. Consequently, the physician would be in breach of contract if he notified others of his suspicion of child abuse. In fact, he would already be in breach of his contract if he allowed the interests of the "child" to prevail over the interests of the "family" or, of the parent(s). This breach of contract may lead to an action in damages being brought against the doctor.

This view of the rights of the child and the function of the doctor must be categorically rejected. It relegates the child to an object of the parents' free disposal and degrades the doctor to a puppet in the hands of the same parents. The consequence would be that a doctor who suspected that serious maltreatment of the child was the cause of the injury being treated by him and who strongly feared that the child might be further abused would be acting properly (in the legal sense) if he did not report his suspicions and fears to suitable persons or agencies. This would apply even if the child suffered permanent brain damage as a result of further maltreatment or even lost his life. A doctor who breached professional secrecy in an attempt to avoid further abuse could have damages awarded against him for breach of contract in private law.

This narrow, legalistic view is to overlook the fact that every minor (even a young child) has rights and that the doctor has his own professional responsibility particularly in connection with the minor's interests. It must be recognized that in the doctor-parents-child relationship we are dealing with a legal situation of a quite peculiar nature sui generis. The basic premise is that the child is the doctor's patient who, according to universal principles, must enjoy special protection and must be given the opportunity and facilities to develop physically and mentally in a sound and normal manner. Further, he is a patient who is entitled to protection against all forms of neglect, cru-
As regards the child, the parents have certain powers by law. However, these powers are not for the parents' benefit but are given for the purpose of serving the child's interest. They are directly connected with the parental duty of care and upbringing. The doctor's position has two aspects: (1) that of providing treatment by practicing physical medicine; and, (2) that of locating the causes of the symptoms, which often requires the application of social medicine. For example, if a parent comes to a doctor with his child and the doctor accepts a request to provide treatment, the latter is obliged to use his knowledge and skills to best effect. If necessary, he must search out the more deeply rooted causes of a particular symptom. The parents may expect this if they take the child to a doctor for treatment. This also follows from a development of the role of the physician (and of the family doctor in particular), which is to pay more attention to psychosomatic symptoms and the aspect of social medicine in the work of the family doctor. Further, it includes the child's right to such facilities that he can develop physically and mentally in a sound and normal manner. The doctor's responsibility for the patient brought to him is next in line to the parents' primary responsibility for their child.

What, then, if a parent comes to the family doctor with a maltreated child? Let us assume that most parents in such cases will not indicate as the cause of the injury that they have struck or abused the child. Our knowledge of the phenomenon of child abuse has increased and spread in such a way that the doctor is generally capable of recognizing the stated cause as incorrect (e.g., it does not tally with the child's age or with the nature of the wounds). Having regard to the parents' primary responsibility, the doctor will have to put his suspicion of maltreatment to them. In the first instance, the cause will lie with one or with both of them and/or with the family situation as a whole. He will have to try to deal with this cause in consultation with the parents and by involving suitable bodies or persons. This is, of course, an extremely delicate operation. However, his duty as a doctor and the interests of his young patient oblige him to go further than to deal with the symptoms by trying to tackle the causes, partly for the sake of prevention in his patient's interest. However, the parents will usually deny abuse or bluntly refuse to cooperate in the approach proposed by the doctor.

The doctor's own responsibility for his patient—in this case a minor—means that he must help the latter as much as possible in the abusive situation in which he finds himself. The doctor derives this responsibility from his position as a provider of aid and from the confidence that even a minor may place in him, a confidence that the doctor will, wherever possible, do more than merely combat the symptoms. Finally, his responsibility as a citizen to protect minors also plays a part. Thus, because of this important responsibility to the child, if the doctor involves third parties in such a case against the express wish of the parents, any action in damages brought by the parents would, probably, have no chance of success.

An Interim Balance Sheet: Why a Confidential Doctor?

If, looking back to the start of the seventies, we were to draw up a balance sheet for that period and ask why a confidential doctor was introduced to deal with child abuse in the Netherlands, we would have to consider the following:

(1) Various opportunities exist for rendering aid and for legal intervention. Criminal law, alone, is quite directly concerned with the abuse of children by their parents by application of article 304 of the Criminal Code; the number of reported criminal cases of child abuse in this way is negligibly small.

(2) When applying measures under civil law, no distinction is made between child abuse and other problem situations. The welfare organizations, too, have no separate approach to the phenomenon of child abuse.

(3) It may, therefore, be concluded that in the early seventies little or nothing was known about child abuse, with interest being limited to a few articles in professional journals. The breakthrough came chiefly as a consequence of publicity in dailies and weeklies in 1969 and 1970, and through political activity.

(4) When seeking ways for effectively combating child abuse, the doctor can and must play a central role. However, his duty of secrecy is also the chief obstacle to an effective approach of that kind.

80. Any person who willfully leaves a person whom he is obliged to maintain, nurse, or care for by virtue of an agreement in a helpless position commits an offense. Crim. Code art. 255 (Neth.).
(5) The appointment of confidential doctors was intended to allow this hurdle to be taken more easily by being available to doctors for consultation. The confidential doctor would have to advise on how to act, and possibly he would have to mediate, e.g., through contact between the family doctor and the courts and, if necessary, be able to take initiative on his own in connection with cases of child abuse submitted to him.

(6) The introduction of the confidential doctor changed nothing in the opportunities for applying criminal law nor any more so in that of applying child care measures. They have had some influence, however.

(7) The introduction of the confidential doctor made no official change, either, in the statutory arrangements for the doctor's disciplinary, criminal and civil liability; the confidential doctor must enable a physician to tackle cases of child abuse effectively while adopting a responsible attitude towards his duty of secrecy. Precisely for that reason, a doctor and not a lawyer, social worker or psychologist was appointed as a confidential adviser.

THE CONFIDENTIAL DOCTOR AND CHILD ABUSE

Plans: Objectives, Tasks and Organization

The problems relating to the doctor's professional secrecy were the direct cause for the appointment of confidential doctors. However, maintaining the physician's professional secrecy, i.e., making it possible for him to treat child abuse without infringing confidentiality, certainly was and is not the sole object of the confidential doctor. According to the report of the Inter-Departmental Working Party on Child Abuse,81 two objectives are aimed at with the appointment of confidential doctors: (1) improved (and earlier) identification and treatment of child abuse; and, (2) widening knowledge about the nature and extent of the phenomenon of child abuse in the Netherlands. To achieve these two objectives, the confidential doctors were given a threefold task: to give advice; to collect data; and, to offer "organizational" after-care.

The advisory task means that the confidential doctor is available for consultation and to advise doctors and also other persons and bodies who come into contact with cases of child abuse. After such consultation, the attendant (family doctor, specialist, and also others) would

81. See text accompanying note 50 supra.
have to take the necessary steps in order to give or procure child and parents the help most suitable to them. This might mean treating them oneself and/or referring them to others, such as the social work service, the Child Care and Protection Board, and the like. In short, the task means that the confidential doctor essentially plays a passive role (he gives advice and is a sounding board for consultation) and does not take on the case from the notifier (doctor, etc.).

The task of collecting data may be done by gathering the relevant data on each case submitted to the confidential doctor (for advice and consultation). The notifier would have to be prepared to supply this information. Not only would actual knowledge of child abuse in the Netherlands thereby be widened but material could also be collected for scientific research. Last but not least, the recording of data could make it possible to locate recidivism immediately. Precisely because of this early indication of repetition, it is considered desirable that any person dealing with cases of child abuse should bring the matter to the confidential doctor's knowledge. In order to make it possible to locate repetition on a national basis, the setting up of a central register should be facilitated. Use of data collected in this way would be left to the discretion of the confidential doctor. In other words he decides, without involving any others, whether, and if so, to what extent, such information should be brought to the knowledge of third parties.

The task of organizational after-care means that the confidential doctor must make sure a case of child abuse submitted to him does not end up between ship and shore. In other words, after some time has passed, the confidential doctor will have to ask the notifier whether the aid plan discussed in the course of advice or consultation was in fact implemented. If necessary, he can then give further advice, particularly if implementation of the plan has encountered problems.

Organizational shaping is kept as simple as possible because it was not possible in 1970 to forecast how great the need for advice and consultation on child abuse might be. The person appointed as a confidential doctor would be a doctor (preferably a family doctor or pediatrician) with his own full-time practice. The function of confidential doctor would be fulfilled in addition to an ordinary day's work. He could have an assistant available for administration—recording data, dealing with correspondence and the like. This would be provided by the Child Care and Protection Board insofar as he might need it. Partly for that reason, the confidential doctor would come under the Board organizationally, albeit as a quite independent and self-contained unit; i.e., the confidential doctor is not employed by the Board.
To stress this independence, he would have his own telephone number and his own postal address, despite the fact that his office is in the same building as that housing the Board. Another reason for "latching on" to the Board is that the confidential doctor in this way obtains easy and rapid access to the data in the Board's possession. After all, the Board is the Government body concerned with preparing and submitting (to the court) applications for the institution of child care measures. The Board, therefore, has a great deal of information available on problem families that can be of particular use to the confidential doctor when giving advice. The confidential doctor is appointed by the Ministers of Justice and Public Health and is required to report to them. This duty would at least comprise a joint report annually by the confidential doctors.

Implementation of the Plans

Four confidential doctors were appointed on January 1, 1972 experimentally. The Ministers responsible wished to keep the experimental character particularly to make it possible to retract the appointments one or two years later should it appear that the (anticipated) needs had not been met. This section will discuss the state of affairs after six full years, ending with a listing of the advantages and disadvantages of the Dutch approach to child abuse through the institution of the confidential doctor. By way of a general comment and for better insight into developments in recent years, it should be noted that the work of the confidential doctors did not have any statutory base; the approach was and is based on the willingness of all kinds of persons and organizations to cooperate in the cases that arose. Notification to the confidential doctor is made voluntarily and the notifier is free either to follow up or to disregard the advice given. Moreover, he is not obliged to make available the information requested by the confidential doctor.

Preference for an approach on a voluntary basis flows from various considerations. In the long run, compulsory notification will not be more effective than a system of notification on a voluntary basis. A "duty" could make doctors (and others) shy off and, in any event, lead to all kinds of legal problems. For example, what should be reported (what is child abuse and how can this be defined in a legal form)? How can the failure of notification be discovered? What sanctions should be applied for failure to make notification? Further,
mandatory notification demands time-consuming legislation and the problem requires a rapid and pragmatic approach.

The Work of the Confidential Doctor82

Recording, Advice and Initiative

Since January 1, 1972, anyone may apply to a confidential doctor with a case of child abuse. These "notifications" reach the confidential doctor sometimes in writing but mostly by telephone. In the latter case, the notification will be received by the confidential doctor's administrative help. There are no fixed arrangements for the way in which notification is made, i.e., no forms have to be completed by the notifier. The confidential doctor's administrative help fills in a form with the chief particulars (this is the base document of any future file).

Of major importance is the rule that the name of the notifier remains known only to the confidential doctor. His name will not be made known by him to any others (parents, child, organizations possibly involved). This rule can be departed from only if the notifier agrees to disclosure; however, this is limited to cases where it is strictly necessary. In order to obtain a proper picture of what the confidential doctor actually does, notifications can be subdivided into notifications for registration purposes; notifications for advice and consultation; and, notifications with a request for referral.83

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>only for registration purposes</td>
<td>*</td>
<td>122(19.4%)</td>
<td>173(21%)</td>
<td>104(12.8%)</td>
</tr>
<tr>
<td>with request for advice</td>
<td>*</td>
<td>179(28.5%)</td>
<td>145(17.6%)</td>
<td>67(8.2%)</td>
</tr>
<tr>
<td>with referral (further treatment left to medical referee)</td>
<td>*</td>
<td>319(50.8%)</td>
<td>505(61.4%)</td>
<td>637(78.1%)</td>
</tr>
<tr>
<td>unknown</td>
<td>*</td>
<td>8(1.3%)</td>
<td>-</td>
<td>7(0.9%)</td>
</tr>
</tbody>
</table>

* No figures available

82. See generally Pieterse, 29 MENTAL HEALTH MONTHLY 129 (1974); van Ruller, 10 PROCES 199 (1973). (Pieterse and van Ruller are confidential doctors.)

83. The following table shows the extent of these three categories of notifications:
Notifications for registration purposes come from organizations or persons who have themselves dealt with the matter or have referred it. All the confidential doctor does is register the information provided. From this data, he can identify whether and when repetition occurs.

Although such reporting "for registration purposes" is of particular importance (widening knowledge, prevention of recidivism), one gains the impression that the confidential doctor receives much less in this category than might be possible. Further, the information he does receive is very limited; often little is reported regarding the nature of the abuse, the help offered and the organizations involved. Thus, knowledge is not greatly expanded by these summary reports for registration purposes. The voluntary nature of the notification to a confidential doctor is apparently the cause of these shortcomings. In this case, the confidential doctor's role is a clearly passive, recording one.

Notification with a request for advice and/or consultation dovetails fully with the confidential doctor's primary task. We are concerned here with reports from persons or bodies who themselves have facilities for offering or providing (by referral) treatment or assistance but require consultation or want advice as to the most effective approach, the involvement of certain organizations, or the consequences of certain actions (e.g., involving the police). The confidential doctor's work in this case is as an active advisor. What this advice amounts to in actual fact cannot be explained in as many words. It depends on the queries put by the applicant and the nature of the case reported and it may vary from confirming that a method already adopted is correct (with the advice being, "continue"), to urgent advice to refer the matter to others, or even to leaving the case with the confidential doctor himself. It will be clear that "collecting data" has more of a chance here than with notifications purely for recording purposes, even if it is only because the confidential doctor must have as much information as possible in order to give effective advice. In such cases, "after care," i.e., information as to whether or not the advice was carried out, is of importance.

Notification with a request for referral comes from the group of notification-makers who, while bringing cases of child abuse to the confidential doctor's notice, wish to take it no further than that. The reason for this may be that they have no means of contributing toward
further action or that they do not wish to harm an existing relationship with the family or the parents. The group includes, in particular, members of the family, neighbors, friends and also doctors and professional or voluntary workers who have contact with the family.

When notification is made, the confidential doctor will himself have to set a treatment plan in motion. In many cases, the data will be too summary or too vague in order to undertake anything concrete. It is a firm rule with all bureaus that the family doctor and/or the school doctor is the first to be approached. If necessary, the identity of the family doctor is established. In this way, a check is made whether the report should give rise to certain steps and, if so, whether the family doctor or school doctor may be prepared to help. In other words, it is not merely a matter of checking the notification (i.e., is there any real likelihood or a serious suspicion of child abuse as the neighbor or family member alleges) but also of finding a starting point for treatment. It is, in fact, sometimes possible to refer the parents via the family or school doctor to a suitable welfare organization. This "medical" referral is the least threatening and the least stigmatizing (who is not at one time or another referred by his family doctor to an expert or a specialist?).

For further treatment, the confidential doctor may, if necessary, involve other organizations himself. Preference will then be given to those who have already had contact with the family or parents. In order to obtain this information, much detective work is sometimes necessary. The activities of the confidential doctor following a notification with a request for referral clearly go further than foreseen in the working party's report. 84 It is certainly more than the relatively passive advisory function. The confidential doctor is forced to instigate treatment himself because the notifier drops out. He must make and maintain contact himself with the treating organizations. Direct contact with the family itself may sometimes be necessary in such cases. It could be said that the confidential doctor takes the initiative and becomes the attendant on the case, i.e., he takes the first steps, makes the first contacts but then passes further treatment to others as quickly as possible.

In order to be able to play this initiating role, the confidential doctor will have to gather much information from an agency such as the Child Care and Protection Board. An ad hoc team is also usually

84. See text accompanying note 81 supra.
formed, consisting of the confidential doctor and his staff and staff of organizations involved with the case or who should be so involved.

All of these activities generally take place without the parents being aware of them. They begin to notice something of these efforts only when a social worker or another welfare worker contacts them. There are some differences in practice on this point. Some confidential doctors spend little time searching for welfare organizations whose members might well be prepared to contact the family. Rather, the confidential doctors themselves approach the family fairly rapidly in order to assess the situation at first hand and in order to motivate the parents to accept help from others. However, most confidential doctors prefer to avoid this direct contact. They believe that this accords with the original scheme, in which the confidential doctor was to act only as adviser to the person reporting.

Organizational After-Care

The confidential doctor is appointed not only in order to mount the most suitable assistance in cases of child abuse (by giving advice or on his own initiative) but he must also make sure that the assistance given is maintained and not withdrawn prematurely. For this, the confidential doctor takes up contact, by telephone or letter, after a certain period which varies according to the nature of the problems from three to six months. The chief purpose of such contact is:

85. This is known as "maturing" the family for assistance.
86. An investigation by K. Blankman carried out at the confidential doctor's office at Amsterdam indicated that from 1972 to 1976 a member of the office's staff had had direct contact with the family in 32.6% of the cases. With other offices this varies from two to fifteen per cent.
87. In order to give some idea of the extent of these three aspects of the confidential doctor's daily work, the following review is based on the confidential doctors' annual reports:

<table>
<thead>
<tr>
<th>Confidential doctors' work</th>
<th>1972</th>
<th>1973</th>
<th>1974</th>
<th>1975</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advisory</td>
<td>117(19.3%)</td>
<td>103(12.5%)</td>
<td>82(10.1%)</td>
<td></td>
</tr>
<tr>
<td>On own initiative</td>
<td>320(52.8%)</td>
<td>498(60.5%)</td>
<td>589(72.2%)</td>
<td></td>
</tr>
<tr>
<td>Both</td>
<td>23(3.8%)</td>
<td>63(7.7%)</td>
<td>35(4.3%)</td>
<td></td>
</tr>
<tr>
<td>Exclusively registration</td>
<td>146(24.1%)</td>
<td>159(19.3%)</td>
<td>109(13.4%)</td>
<td></td>
</tr>
</tbody>
</table>

* No figures available

It will be inferred from this table that the confidential doctor's unforeseen and unplanned initiative-taking work is the greatest. The doctor is not so much asked for advice but is left to deal with the matter further. This does not mean, however, that the confidential doctor will treat the family himself. His task is and remains to set existing welfare facilities in motion—if necessary after having done the initial work himself—to help and advise the child and the parents.
(1) to make certain that treatment is not becoming bogged down;
(2) to advise on any interim adjustment to the treatment plan;
(3) if necessary, to ensure that treatment is duly transferred to another body;
(4) to advise on whether assistance should be ended or not; and,
(5) to keep the situation of other children in the family under scrutiny.

Such after-care is already planned when a welfare worker is involved. The information requested is generally readily supplied. On the other hand, it is extremely summary and often limited to a statement that the family is still receiving treatment or that the case is closed. Sometimes, when problems arise, the welfare worker will himself contact the confidential doctor. Some confidential doctors take such after-care very seriously and translate it in practice to personal responsibility for the progress of the case. In actual fact, if a welfare worker involved by the doctor ceases his work because he considers it no longer necessary, some confidential doctors like to check that this decision is correct and will initiate further assistance if necessary. The welfare worker is, of course, likely to see this as a motion of no confidence. Other confidential doctors stop at less far-reaching after-care, taking the view that the welfare worker has his own responsibilities. These differences apart, "organizational after-care" has remained an under-developed aspect of the confidential doctor's task. This is probably due largely to its open-ended character. The welfare worker involved by the doctor is not obliged to provide any information at all. He is free to react as he wishes to an amicable request from the doctor to keep him informed on the state of affairs. The confidential doctor apparently feels uncomfortable if asked to monitor something without having explicit powers to do so—i.e., those that are statutorily based.

The Gathering of Data

The outcome of this task of the confidential doctor is centered in an annual report containing a great deal of information on such things
as the age of child and perpetrator, their sex, the position of the child in the family, parents’ occupation and social class, the nature of the abuse, and so on. This data cannot be dealt with extensively here. The reports up to and including 1975 have now been published.\(^8\) Unfortunately, there is no indication that they have so far given any impetus to incisive scientific research. In brief, one could say that we now know a great deal on the phenomenon of child abuse as such but still little about the effects of the treatment applied. For the sake of completeness, it might be mentioned that a committee was set up at the end of 1977 to promote scientific research in the field of child abuse. The committee receives powerful support from the Association against Child Abuse.

### Organizational after-care

A. Contact within the framework of organizational after-care*

<table>
<thead>
<tr>
<th></th>
<th>1973</th>
<th>1974</th>
<th>1975</th>
</tr>
</thead>
<tbody>
<tr>
<td>contact made</td>
<td>318</td>
<td>541</td>
<td>625</td>
</tr>
<tr>
<td>no contact</td>
<td>193</td>
<td>149</td>
<td>56</td>
</tr>
<tr>
<td>not applicable**</td>
<td>95</td>
<td>133</td>
<td>134</td>
</tr>
</tbody>
</table>

This group chiefly covered so-called administrative reports notifications for registration only.

B. Nature of contacts within the framework of organizational after-care*

<table>
<thead>
<tr>
<th></th>
<th>1973</th>
<th>1974</th>
<th>1975</th>
</tr>
</thead>
<tbody>
<tr>
<td>purely for information (once)</td>
<td>82  25.8%</td>
<td>194 35.6%</td>
<td>73  11.7%</td>
</tr>
<tr>
<td>purely for information (repeated)</td>
<td>89 28.0%</td>
<td>173 32.1%</td>
<td>299 47.8%</td>
</tr>
<tr>
<td>consultation on further treatment (once)</td>
<td>16 5.0%</td>
<td>33 6.1%</td>
<td>25 4.0%</td>
</tr>
<tr>
<td>consultation on further treatment (repeated)</td>
<td>129 40.6%</td>
<td>132 24.5%</td>
<td>195 31.2%</td>
</tr>
<tr>
<td>advice to involve other body</td>
<td>1  0.3%</td>
<td>7 1.3%</td>
<td>27  4.3%</td>
</tr>
<tr>
<td>advice to transfer to other body</td>
<td>1  0.3%</td>
<td>2 0.4%</td>
<td>6   1.0%</td>
</tr>
</tbody>
</table>

No data are available for 1972.

It may in any event be inferred from these figures that the number of cases in which contact is maintained between the confidential doctor's office and the treating organization after notification is clearly increasing. Furthermore, contact is increasingly repeated and more than for information purposes.

Organizational Development—From the Lone Ranger to Teamwork

It became clear quite soon after January 1, 1972 that the humble beginnings—a part-time officer with a modicum of administrative support—were insufficient to deal adequately with the reports coming in. The confidential doctor clearly needed more than a secretary. Reports received by telephone not only had to be correctly recorded but often required first aid. This meant that the office staff had to meet high standards. It was also obvious that the nature of the notifications required much more than advice. The large and increasing number of reports in which the confidential doctor was expected to act on his own initiative made it necessary to appoint a staff member able to mount an investigation and to make and maintain contact with the various welfare organizations, i.e., someone with experience of rendering direct assistance.

The flexible organizational form allowed this unforeseen development to be handled quickly. The Child Care and Protection Board not only provided a high-quality full time clerical assistant where necessary but also one of its social workers on a part-time basis (or full time where necessary). In this way, the lone adviser quite quickly developed into a team consisting of a confidential doctor (spending an average of one day a week on his part-time advisory work), a highly qualified clerical assistant (a kind of co-ordinator), and a social worker; the latter two were provided on a full-time or part-time basis, depending on the extent of the reports, by the Child Care and Protection Board. It is common now to speak of the confidential doctor's office. The experimental consultant for cases of child abuse has grown into an institution. This development is further confirmed by the expansion in the number of confidential doctors from four to ten, so that these officers and their staff are now available throughout the Netherlands for consultation, advice and mediation.

This development has further led to the institution of the confidential doctor acquiring a special identity in that the office is becoming steadily more independent from the Board. The first signs of this were the removal of the team to its own quarters, i.e., they were no longer housed in the same building as the Board. This independence also gives rise to problems, particularly for the confidential doctor's staff. These people are on the Board's payroll and, as such, are appointed by the Minister of Justice but work for the confidential doctor. In their latter

90. See text accompanying note 82 supra.
91. See text accompanying note 81 supra.
capacity, they are considered bound to secrecy and not required to give any account to their director.

The chief problem is the fact that this development into a team has come about quite spontaneously, i.e., it is not based on a clear policy. As a result, the differences that have arisen between the various confidential doctors’ offices, particularly as to the role of the social worker, are not inappreciable. Should the social worker have direct contact with the family or precisely the opposite? This is one of the chief queries as to method which, like several others, including organizational questions, is still awaiting a clear answer. The chief reason for this tardiness in policy-making is that there is no definite co-ordinating body for today’s ten confidential doctors and offices. Responsibility for the development of the institution of confidential doctor is in fact rather vaguely divided between three departments, namely Justice (which pays the confidential doctor’s staff via the Board), Public Health and Environmental Hygiene (which pays for the confidential doctors’ reports) and Culture, Recreation and Social Work (which makes no financial contribution). This interdepartmental responsibility does not make for rapid decisions and policy-making.

Results and New Problems

It is not easy to indicate precisely the results and effects of the confidential doctors’ action. No fundamental scientific research on this has as yet been carried out. However, after six years’ experience something can be said both on the positive results of the institution of confidential doctor and on the new problems that this institution has engendered.

The positive results have been related to the central goal of confidential doctors’ activities: to promote improved detection and treatment. The aim has been a more responsible approach to professional secrecy. The confidential doctor was devised precisely for doctors. One can consider the results from these two aspects and then examine a residual group of other results.

Improved Detection and Treatment

Since 1972, some 5,000 cases of child abuse have been brought to the attention of confidential doctors. Thanks to the activity of the confidential doctor, these maltreated children have received the help

92. See note 86 supra.

93. The precise figures are as follows (the number of confidential doctors operating during that year is in parentheses): 1972—438 (4); 1973—628 (4); 1974—823 (6); 1975—815 (6). The
and treatment they required where it was needed (before 1972, they did not receive this additional attention without the confidential doctor). This is the most important of the positive results of action by the confidential doctor. Precisely because of the intervention of the confidential doctor and his staff, account was taken of the treatment of abused children as a fact, and of the associated risks to the child (the danger of repetition, for example). The organizational after-care by the confidential doctor meant that treatment continued in the most suitable way as long as it was necessary (premature termination was countered; the risk of recidivism was pointed out, etc.). In short, it has been a clearly beneficial outcome for the maltreated child.

Another important result relates to existing provisions for assistance and treatment. Through the work of the confidential doctor, existing organizations, who, before 1972, did not or did not wish to recognize child abuse, were confronted with this phenomenon. The confidential doctor's simple questions, “would you help a maltreated child and his parents reported to me?” forced them to think about child abuse as such (denial was no longer possible), about the methods of giving help adopted hitherto, and about their prejudices and emotions toward abusive parents. In this way, various organizations concerned with social work and health care generally have begun to assist maltreated children on a more conscious and expeditious basis. Their skill in the early detection of child abuse has also been improved. They have come to pay more attention to the possibility of child abuse being present and to know how to bring suitable assistance to bear via the confidential doctor. Certain organizations have begun to take very special notice of the maltreated child and his parents;94 others are in the course of doing so.95 The effects outlined above have been further strengthened by the advice that the confidential doctors regularly give to the organizations with which they work in their areas.

In sum, it may be said that the work of the confidential doctor has promoted and improved the detection and treatment of maltreated number of confidential doctors was expanded to nine in 1976 and to ten in 1977; the anticipated number of notifications amounts to about 1,000 per year.

94. This applies to, among others, the Triangel, a socio-therapeutic center where families can be admitted as a unit (parent(s) and child or children), for a three-month period on average. This form of residential “total” care has been used as an example by, among others, the National Center at Denver, where the same was attempted with the Circle House Project. Unfortunately, this project had to be ended owing to a lack of funds. Another example is the Medical Toddlers Day Center at Amsterdam, a home where (very) young children up to the age of six who have been physically abused or who have suffered serious neglect are treated by day.

95. Research has been undertaken in Groningen, in consultation with the local confidential doctor, into opportunities for applying social work methods in cases of child abuse. The results of the research are expected in the course of this year.
children by using the existing facilities. This is an important structural gain in that the maltreated child and his parents are no longer unnecessarily isolated by setting up institutions specially entrusted with the care of maltreated children. This group of children and parents enter through the same door as parents and children with other problems. No institutionalized distinction is drawn between problems of abuse and other problems of child-rearing, other than, of course, in treatment within the assisting organization.

These results were achieved without extensive legislation or incisive organizational changes and can be regarded as positive, though it should not be inferred that every maltreated child in the Netherlands receives the optimum in assistance. After all, the confidential doctor is involved on a voluntary basis. Many maltreated children never come to the confidential doctor's attention. They are detected either too late or not at all because there still are persons providing aid who do not (wish to) see the problem. In brief, much still has to be done in improving detection, the involvement of the confidential doctor and general awareness.

Maintaining Professional Secrecy

The appointment of the confidential doctors was intended particularly to give the treating doctors an opportunity to consult with another doctor on cases of child abuse. Data on notifiers indicates that, on average, one-third are medical men (family doctors, school doctors, specialists and the like). It can be inferred from this that doctors make reasonable use of the consultation opportunity offered. They are clearly prepared, despite their statutory duty of secrecy and without being obliged by law to do so, to submit cases of child abuse that they establish or suspect to the confidential doctor. It must be remembered that such "bringing to the attention of the confidential doctor" means in practice that others are also involved in the case (welfare workers and, sometimes, the Child Care and Protection Board and the family courts). It could be said that professional secrecy is breached via an interface: the confidential doctor. In formal legal terms, this is as much a breach of professional secrecy as if no confidential doctor were involved. Clearly, however, the confidential doctor's importance is especially a psychological one: it makes it easier for the attendant concerned to breach professional secrecy. Nonetheless, there is a strong suspicion that many doctors still hide behind their professional secrecy,

96. Such isolation of maltreated children would often amount to a stigma.
97. There are no reporting laws in the Netherlands.
i.e., on a suspicion of child abuse (and even on confirmation) they neglect further action for the benefit of the child by recourse to their duty of secrecy, apparently for fear of possible legal and other involvement.

Since September 1972, however, there has been really little cause for fear of the legal consequences of breaching professional secrecy. On September 28, 1972, the supreme medical disciplinary body in the Netherlands was first called upon to consider whether disciplinary action should be taken against a doctor who had reported child abuse to the Child Care and Protection Board and thereby breached professional secrecy. The supreme medical disciplinary body’s answer was “no.” Their reasoning shows that they feel that such cases are concerned with a conflict between the duty to remain silent on the one hand and the duty to help the child on the other. The doctor must resolve this conflict himself in the light of and tested against his entirely personal attitudes toward ethics, morality and society. The courts have no say in this decision by the doctor. Thus, if the suspicion of child abuse is based on careful examination and the suspicion is serious enough, the doctor may report it, even to the guardians of the law. It is the author’s opinion that insufficient use is as yet made of this legal freedom to report. The author strongly suspects that in the Netherlands appreciably more cases of child abuse occurred in 1975 than the 276 reported by the entire medical profession to confidential doctors’ offices in that year. The cause may possibly lie in the as yet inadequate information available, but the author feels it is also, and perhaps even chiefly, due to notification being made on a voluntary basis.

In conclusion, professional secrecy is no obstacle either legally or factually to reporting child abuse, both because of the institution of the confidential doctor and because of the decision discussed above of our supreme disciplinary body. Nevertheless, mandatory notification (such as the reporting laws in America) is desirable.

98. See also the discussion in the text under Medical Professional Secrecy and Disciplinary Liability, supra.
99. The supreme medical disciplinary body stated:

The duty of the disciplinary court which has to decide whether a complaint is founded as such is limited to examining whether the doctor against whom it is made carried out the examination on which his findings are based in a medically responsible way and therefore also with sufficient care; in addition, the disciplinary court need take account only of whether the doctor should reasonably have come to the conclusion on the basis of his findings that his duty as a doctor prompted him to act as he did. Any more far-reaching test, by balancing the interests particularly concerned in the case will, in the Central Body’s opinion, provide no clear criterion because, in such cases, full justice can often not be done to the entirely personal approach of the doctor himself, with which ultimately we are concerned.

Other Results

In the past six years, factual knowledge about the phenomenon of child abuse has increased appreciably. The collecting of data by the confidential doctor has proved its worth. A side effect of this improved knowledge is the ability to create more understanding for the abusive parents in particular. Further, by setting up central reporting points (i.e., the confidential doctors), experience in tackling the various situations in which child abuse may arise has been increased and concentrated in a few places accessible to everyone. Knowledge of how to manage the problem has increased and improved substantially in a relatively short period.

It may also be said that a good deal more is known now about the application of child care measures than in 1972. The measures most frequently adopted are provisional committal to the Child Care and Protection Board and placing the family under supervision. The first of these measures is normally used in crisis situations for the immediate security of the child (e.g., the child must be admitted to a hospital and the parents prevent this). A supervision order is normally made if the situation is to be supervised for a longer period (through a family guardian), supported by the authority of the juvenile judge. More radical steps (removal from custody and suspension of rights) are seldom applied.100

100. The following summary is derived from the annual reports:

Survey of child care and protection orders made in respect of maltreated children

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>1. Number of reported cases</td>
<td>430</td>
<td>628</td>
<td>823</td>
<td>815</td>
</tr>
<tr>
<td>2. Orders made before case reported</td>
<td>*</td>
<td>21</td>
<td>23</td>
<td>23</td>
</tr>
<tr>
<td>3. Orders applied for after case reported</td>
<td>32</td>
<td>60</td>
<td>69</td>
<td>72</td>
</tr>
<tr>
<td>4. Orders for committal to care of the Board whether made before or after case reported</td>
<td>*</td>
<td>12</td>
<td>30</td>
<td>15</td>
</tr>
<tr>
<td>5. Supervision orders, whether made before or after case reported</td>
<td>*</td>
<td>69</td>
<td>59</td>
<td>47</td>
</tr>
</tbody>
</table>

* No figures available

The drop in the number of care orders and supervision orders (nos. 4 and 5) in 1975 is a result of the increased number of orders made depriving parents of all authority over their children. It is not yet known whether this trend towards the use of more drastic measures continued in 1976.
Finally, a comment on the application of criminal law is noteworthy. Although appreciably more cases of child abuse became known after 1972 than hitherto, this has not led to a clear increase in the number of criminal sentences on abusive parents under article 304 of the Criminal Code. Between 1972 and 1977, the number of convictions for child abuse was minimal. The efforts of confidential doctors in preventing criminal action in cases where a child is maltreated by his parents are probably responsible for this low number.

New Problems

It is almost general in human experience that the solution of a particular problem almost always creates new ones. This also applies to the approach to combating child abuse via the confidential doctor; in fact, it is probably even more applicable in this case because an experiment was concerned in which much was left to practical developments. These practical developments now cover a six-year period and have given rise to as many organizational and legal problems.

For example, the humble set-up and the improvised housing of the confidential doctor under the wing of the Child Care and Protection Board undoubtedly proved useful but are now beginning to produce problems. As the confidential doctors’ offices grow, they want to act independently of the Board. They want to determine their own (staffing) policy and not appear as odd men out within the Board’s organization. In certain cases this has already led to the office seeking new quarters. Another problem is the precipitate growth from four to ten confidential doctors and from four part-time staff to a group of about twenty-five staff (some of them part-time). The differences which could still be surveyed and, if necessary, eliminated in the case of four confidential doctors become many times greater and more numerous in such a large group. They are not only methodical in nature but also organizational, because each office is independent of the Child Care and Protection Board in regard to staffing and further implementation.

Certain regional differences are, of course, unavoidable. But, after six years, the differences in the approach to their task have become so great between certain offices that the welfare bodies and others cooperating with the confidential doctors are beginning to feel uncertain. The differences are becoming too great. They include the difference in the approach to the family (some offices make direct contact, others make no contact at all) and the difference in organizational after-care

101. See also the discussion in the text under Organizational Development—From the Lone Ranger to Teamwork, supra.
(some offices see this function as far-reaching supervision of the welfare worker's work).

Here the plan suffers from the failure to create a central policy-making body after the experimental start (i.e., after two years). Such a central body, which would also have to have clear powers as a policy co-ordinator, has not yet been created. Consequently, there is a certain hiatus in development. The experience gained is not being translated into further action. The author's proposals\(^{102}\) were directed toward setting up such a central policy-creating, co-ordinating organization. The lines this should take would be the setting up of a separate institution combining the confidential doctors, their staffs and the Association against Child Abuse. The Association's office, which already has a national advisory function,\(^{103}\) could, with some reinforcement, act also as a central policy-making and co-ordinating center serving the ten confidential doctors' offices.\(^{104}\)

There are also various kinds of legal problems. As the experiment grows into an institution, the lack of clear statutory rules gives rise to many queries and uncertainties. By way of illustration, a few of these problems are:

1. From where does the confidential doctor or his staff obtain the right to gather information through various channels about a family referred to them? To what lengths does such information-gathering go and what are the rights of the parents and/or child in this case?
2. Is the gathering of information about a family, often without the family's knowledge a justifiable encroachment on the privacy of the family? Should the parent not have the right to see the file and have it destroyed after a certain period? It must be remembered in this connection that some reports prove to be incorrect on verification.
3. Does the confidential doctor also fall under the medical duty of secrecy? Does this mean that by passing on informa-

\(^{102}\) Id.

\(^{103}\) It is not possible to deal with the Association's work in this article. A brief comment should be made, however. The Association (further information from 27 Koningsplein, The Hague) has, since 1970, been concerned with providing information and has recently mounted a project in which the involvement of volunteers in child abuse cases is the central theme. The Association has also recently been actively concerned with initiating scientific research. This spring, a national Awareness Campaign is being started at the Association's request through advertisements in dailies and weeklies (in many respects it is comparable with the campaign by the National Committee for Prevention of Child Abuse in Chicago).

\(^{104}\) Compare these proposals with the plan suggested by Ray E. Helfer in Helfer, *The Center for the Study of Abused and Neglected Children*, in *Helping the Battered Child and His Family* 285 (1972).
tion he lays himself open to disciplinary proceedings (and becomes liable at criminal and civil law)? If the confidential doctor falls under the medical duty of secrecy (which is generally assumed) are we not then faced with a systematic violation of this duty? Or could his duty in this case be said to be diminished? If so, should that not be governed by statute? Does such a duty also apply to the confidential doctor’s staff, possibly derived from the doctor himself?

All in all, there are a good many queries which, after six years, demand an answer and which highlight the need for a statutory provision. Unfortunately, few concrete steps have been taken in this direction. The reason is probably that none of these queries have yet been exposed to a powerful legal action. It would, however, be regrettable if a statutory arrangement could only then be introduced.

To summarize, the confidential doctor has proved to be an exceptionally good instrument not only for enlarging our knowledge about child abuse in the short term (much data via the reports) but also and above all for mounting and maintaining suitable treatment for the benefit of maltreated children and their parents. Within a short period, much experience has been obtained in the management of rendering aid in cases of child abuse, experience concentrated in the confidential doctors’ offices. Up to the present, the offices have proved their usefulness to the maltreated child and his parents. The side effects, too, such as regular publicity and attention and a clearly recognizable institution to deal with child abuse have proved to be important.

The disadvantages which became apparent in the course of time are largely a result of the fact that the experiment has been transformed into an established system without any clear organizational and legal base. The continued lack of such a base is in turn a result of the absence of a forward-looking policy on the part of the three departments concerned (Public Health and Environmental Hygiene; Justice; and Culture, Recreation and Social Work).

The system proceeds on the unprompted willingness of doctors, social workers, etc. to cooperate. This voluntary approach i.e., no compulsory notification, no mandatory follow-up, is regarded by some in a positive light (it has in any event facilitated the rapid introduction

105. This article has already described why breach of professional secrecy, if committed after careful consideration, need not lead to penalization. (See text accompanying notes 98-99 supra.) But does this also apply to a confidential doctor who considers it precisely his job to use the information received from doctors or others, to discuss it with others, and to pass it on to others in order to initiate action for the benefit of the maltreated child?
of the reporting system via confidential doctors; no statutory provision was necessary) and by others, in a negative one.

It is the author's opinion that there is, at all events, evidence to show that notification on a voluntary basis produces an incomplete picture of the extent of child abuse. Further, an unreported abused child runs the risk of a repetition not being detected in time. This is one reason for seriously considering compulsory notification.

Dutch experience has proved that a country which wishes to adopt a planned and systematic approach may find the confidential doctor a particularly useful instrument. One proviso, however, is that the country must have a reasonable level of social assistance and health care. It is up to such assistance and care to detect child abuse. The confidential doctor is a means for not stopping at detection but also to proceed to give help. A second proviso is that the country concerned should not take an absolute stance on professional secrecy. Strict interpretation on this point could even make it impossible for doctors to notify a confidential doctor or, in any event, could lead to major legal conflict. A flexible approach to the duty of medical secrecy in the Netherlands enabled many doctors to involve the confidential referee.

While many problems, both organizational and legal, arose in the Netherlands after six years' experience, it should not be necessary for all the questions that cropped up to be anticipated and covered by a statutory arrangement. The attempt to do so is one of the reasons why, in Belgium, it has already taken a good three years to appoint the first medical referee. It is probably necessary, however, to appoint several confidential doctors as soon as possible with an eye to the problems which will arise. A (statutory) scheme to deal with these problems will have to be based on a properly thought out policy.

The author visited the United States between mid-September and end-October 1977. He was then able to confirm that it is a country which plays a pioneering role internationally in the prevention and treatment of child abuse. By comparison with other countries, attention to this problem has made great progress—thanks to the activities of the National Center in Washington, the National Committee in Chi-

106. For example, stringent application of the physician's duty of secrecy applies in France. Consequently, the law in that country makes an exception to the duty of secrecy with regard to child abuse. Act of June 15, 1971, No. 71-466, amending CODE PENAL art. 378 (Fr.). A doctor in France may now report suspected child abuse to a child abuse institution. This is not a mandatory notification, however. With regard to attitudes toward this amendment, see 9 TRIBUNE DE L'ENFANCE No. 84, at 36 (1971).

107. The problems that will probably arise in other countries can, and will no doubt be, different from those now being tackled in the Netherlands.
THE NETHERLANDS

cago, the National Center in Denver and the Children's Division of the American Humane Association, to mention only some of the most important. Since the sixties, their work has been based on the reporting laws\textsuperscript{108} system, which is being steadily improved. In short, such a country really does not need a confidential referee to deal with child abuse. Nevertheless, during his travels in the United States, it occurred to the author that despite the high quality of prevention and treatment of child abuse, further improvement is still possible.

For example, more doctors, and private practitioners in particular, should make early notification of abuses suspected by them. Insofar as this reticence on the part of the private practitioners (and of other doctors and welfare workers) is a consequence of the fact that the report must be made to a legal body or to a government authority, an independent confidential referee might well be a substantial improvement. Such an officer would enjoy greater confidence than a government agency and could therefore be more easily approached when child abuse was suspected. Further, if more emphasis is given to the possibility of consulting this officer, to ask him for advice and still to keep treatment in one's own hands, the maltreated child might receive the necessary assistance more rapidly than is now the case. This is an important point in favor of the medical referee system. If in such cases the confidential referee can record some of the more important data, it may allow recurring maltreatment of the child (reported by another) to be detected early. This, too, is a substantial point in its favor. Finally, the confidential referee, through his after-care, can prevent treatment from being broken off too soon or continuing too long pointlessly.

The conclusion, therefore, is that in the United States, too, the introduction of a confidential doctor—naturally adapted to local rules and circumstances—deserves serious consideration. The wide experience in the United States of the prevention and treatment of child abuse means that this institution can quickly be given a clear organizational and legal status, \textit{i.e.}, many of the organizational and legal problems that have arisen in the Netherlands can be avoided. The reporting laws already provide the necessary clarity (immunity) on the matter of professional secrecy and the doctor's liability where he reports child abuse in good faith. Precisely the existence of the reporting

\textsuperscript{108} Under mandatory reporting laws, anyone who suspects child abuse must report it to the proper governmental agency. See, \textit{e.g.}, ILL. REV. STAT. ch. 23, § 2054 (1975) (requiring professionals and other persons who come into contact with children in the course of their work to report suspected child abuse).
laws (with mandatory notification) could enhance the effect of a confidential referee of this kind much more than has hitherto been the case in the Netherlands. It would at least be worth trying.

A Final Word

In the Netherlands, we are trying to do something to help the maltreated child. The approach taken is that of using a medical referee, a "confidential doctor." Under the Dutch system, anyone who suspects that a child has been or is being abused may notify the confidential doctor whose main task is to protect the child and prevent further abuse. While the means used to effect this end may vary among the confidential doctors, they have been successful in combating child abuse. However, because the Netherlands program is based on voluntary notification, it is most likely that many cases of child abuse are still undetected. This article has suggested that a system of mandatory reporting, although not without its difficulties, would improve the effectiveness of the medical referee program.

Great Britain, West Germany, France, the Scandinavian countries, Canada and the United States are also trying to prevent child abuse. We must avoid the same errors being made elsewhere, i.e., an intensive exchange of experience is necessary, not only to allow others to benefit from our own positive experience, but also to let them learn from our mistakes.109

109. The International Society for Prevention of Child Abuse and Neglect (recently formed; address: 1205 Oneida Street, Denver, Colo. 80220) would like to be a means for this exchange of international experience. It is hoped that many will join the International Society and take an active part in its work. In fact, all of these activities have as their aim, in accordance with the Principles 2 and 9 of the International Declaration of the Rights of the Child, "to advance opportunities, facilities, research and organizations which will enable the children of all nations to develop physically, mentally and socially in a healthy and normal manner; in particular to advance the protection of every child in every country against all forms of neglect, cruelty and exploitation." INT'L SOC. FOR PREVENTION OF CHILD ABUSE AND NEGLECT CONST. art. 1.