

# Mandatory Reporting of Domestic Violence:

## The Law, Friend or Foe?

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### Abstract

Should physicians be mandated to report domestic violence involving a competent adult patient regardless of whether or not he or she consents to the report? This is a complex ethical and moral issue; in some states such as California, Colorado, Kentucky, New Hampshire, Rhode Island and New Mexico it has become a legal one as well. The Federal health privacy regulation instituted in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) addresses issues of privacy protection for survivors of domestic violence, but it does not preempt those state laws that are less (or more) protective of patient privacy. In the above states, physicians and/or health care providers are mandated to report acts of domestic violence to an agency, under their own circumstances, regardless of whether the physician or health care worker believes that reporting the violence is in the patient's best interest or not. But is mandatory reporting truly "good" or "bad" for the patient, the physician or society as a whole? This article explores the laws and the evidence (including evidence-based research) surrounding the issue of mandatory reporting of domestic violence when it pertains to a competent adult.

**Key Words:** Domestic violence, mandatory reporting, domestic assault, law, adult.

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### Case Presentation

A FORTY-ONE-YEAR-OLD FEMALE presents to the emergency department with a chief complaint of abdominal pain and vaginal bleeding. At triage she responded "yes" to the domestic violence screening questions of "Domestic violence ever?", "In danger tonight?", "Afraid of partner?", "Social worker referral accepted?" and added that the last assault was two weeks ago. The perpetrator is her husband.

Upon further questioning the patient states that she was sexually and physically abused by her husband last Saturday. She says he kicked her until her

leg was black and blue, and he assaulted her intravaginally with his fist. Patient reports that her partner has threatened to kill her if she reports him. She believes he would do this, as he has tried to choke her in the past.

She states that she has never reported previous incidents of domestic violence, although she has received medical treatment in the past. She is terrified to file a police report or orders of protection. She refused to allow photos of the injuries. She alleges that the violence has been escalating since her husband recently became involved with another woman, and that her husband and his girlfriend are abusing drugs and alcohol. She lives with her partner in a room in someone's apartment and she has no relatives who can take her in. At this time, she says it is safe for her to return home, because her husband promised her pastor that he would leave her alone. However, the patient also states that her husband is a big man and that she and her relatives are fearful of him.

On physical examination, the patient was found to have multiple upper and lower extremity bruises in various stages of healing, moderate blood in the vaginal vault, and a 2 cm laceration of the lateral vaginal wall. The laceration was noted and repaired by Gynecology in the Emergency De-

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partment. The patient was also treated for gonorrhea (GC) and chlamydia because she reported a foul, yellow vaginal discharge for 6 days, and she was counseled to use a condom with her husband if possible. A rapid plasma reagin (RPR) for syphilis was sent. The patient was found to have no other injuries and was scheduled to follow up with the Infectious Disease Clinic for HIV testing as well as the Women's Health Clinic in 1–2 days. She was counseled by the social worker, sexual assault coordinator and sexual assault and violence intervention (SAVI) advocate while in the Emergency Department. Finally, she was discharged and returned home.

The emergency department is often the first place that the battered turn to in times of distress. And the numbers of those affected are startlingly significant. Domestic violence affects 2–6 million adults per year, with 1 million adults assaulted per year. One-half of those assaults result in injury. Of these, 43,000 injuries are gunshot wounds, stabblings, broken bones, internal injuries and loss of consciousness. Another 53,000 injuries are intimate partner rape or sexual assault; 390,000 injuries are bruises, cuts, and swelling; and in 1996 some 1,800 murders were committed by an intimate partner. In all of these cases, a third of the survivors seek medical care in an emergency department or clinic (1).

The management of a patient who presents with injuries due to domestic violence raises a number of legal and ethical issues for the physician. What is a physician's legal responsibility in terms of reporting the act of violence to the appropriate law enforcement agency? Would it be in the patient's best interest for a mandatory reporting law of domestic violence for physicians to be in place? What are the laws currently in place regarding domestic violence and mandatory reporting for physicians?

When discussing issues of medical privacy regulations, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a good place to start. It mandates a federal health privacy regulation that addresses, among other things, the issue of privacy protections for survivors of domestic violence. HIPAA required that the secretary of the Department of Health and Human Services (HHS) issue health privacy regulations if Congress failed to do so by 1999. Congress failed to act by the deadline, so the secretary proposed regulations in November 1999 and published them in the Federal Register in December 2000. They were effective as of April 2001. The regulations are available at <http://aspe.hhs.gov/admsimp/>. Most health care entities that fall under this legislation must comply within 2 years of the effective date.

The caveat of HIPAA is that the health privacy regulations regarding consent and disclosure of health care information for domestic violence victims do not preempt state laws that are more or less protective of patient privacy. For instance, in cases of child abuse and neglect, no prior consent is needed to disclose this information for law enforcement purposes, jury and administrative purposes. All 50 states have mandatory reporting laws for child abuse and neglect. In addition, there are several circumstances in which entities may disclose protected health information without written consent from a competent adult. These circumstances include: (a) if the individual agrees, (b) if disclosure is required by law (mandatory reporting), or (c) if the disclosure is authorized by statute or regulation (2).

Thus far, six states have instituted mandatory reporting laws for domestic violence. These are summarized in the Table (3). There is currently no law in New York State that requires physicians or other health care workers to report domestic violence assault. The physician in the above case was therefore prohibited from reporting the incident described, even if the physician believed the woman to be in imminent danger. What is the right thing to do? Does reporting domestic abuse enhance patient safety or increase the danger?

Those who support mandatory reporting believe that it facilitates prosecution of batterers. This in turn sends a clear message to society that domestic violence is a crime and will not be tolerated. Many feel that the strongest deterrent to continued violence is incarceration or court-ordered counseling. In mandatory reporting states, the perpetrator can be convicted without the cooperation or participation of the victim. Mandatory reporting also encourages clinicians to identify domestic violence and improves data collection (4). In addition, advocates feel that documentation and treatment is improved by these laws, professional training is increased, perpetrators are held responsible for their actions, and patient safety is enhanced, since without the report the violence only escalates (1). In addition, many women state that the onus of reporting is removed from them and feel a sense of relief that it is put in the hands of someone else (5).

The literature is strewn with anecdotal evidence for and against mandatory reporting. Two cases in support of mandatory reporting follow:

1. A female patient seen by a physician was repeatedly strangled by her spouse and feared for her life. The patient was reluctant to seek help, and when she did, the physician reported the domestic violence

TABLE

State	Mandated Reporter	Receiving Agency	Basis
California	health care workers	police	"reasonable suspicion" of domestic violence
Colorado	physicians	police	"an injury caused by a criminal act (e.g., a weapon), including domestic violence"
Kentucky	health care worker	Cabinet for Human Resources, which then notifies police, investigates, drafts a report of findings and recommendations	"suspected abuse"
New Hampshire	health care worker	police	"an injury caused by a criminal act (e.g., a weapon), including domestic violence, unless the victim is older than 18 years old and objects"
Rhode Island	health care worker	police	"wounds from weapons and domestic violence for 5 years for data collection"
New Mexico	health care worker	police	"incidents of domestic violence"

to the police, as the physician was mandated to do by law. The reporting physician states, "Later I saw her again, and she said to me, 'There is not a day that goes by that I am not grateful for that report you made' "(6).

2. A physician treated a domestic violence victim, but despite police and social service efforts the victim was shot by her batterer the next morning. The physician states, "I recognized the signs, I was able to get her to tell her story. I know I did everything, along with police and the advocate, to try to help her. I can't imagine how I would feel if I had done nothing" (1).

There is also evidence-based literature supporting and opposing mandatory reporting. In support is an article published in *JAMA* in 2001, which found that a majority of recently abused female patients who presented to the emergency department supported mandatory reporting (4). According to Houry et al., 62% of emergency department patients felt that mandatory reporting laws did not make a difference in seeking health care, 27% were more likely to seek emergency department care and 12% were less likely to seek care due to the legislation (5). Both Malecha et al. and

Sachs et al. have concluded that laws do not deter patients from seeking care and that survivors don't believe laws put them at greater risk for future violence (3, 7).

Those opposing mandatory reporting feel that it will increase violence by perpetrators, diminish patient autonomy and compromise physician-patient confidentiality (4). This group also feels that mandatory reporting places patients at risk for retaliation and possibly deters patients from seeking medical care for their injuries. It is argued that the quality of medical care may suffer, because physicians may overlook injuries or they may not inquire about injuries if they are opposed to the legislation. Finally, the doctrine of nonmaleficence is violated (1). A physician is sworn to do no harm first and foremost, but in some cases, for reasons stated above, mandatory reporting may force the physician to perform an act that is thought to be harmful to the patient in that particular patient's circumstances.

Anecdotal reasons for opposing mandatory reporting can be as vivid as anecdotal reasons for supporting it.

1. Joanna was treated in the emergency department for facial injuries that were inflicted by her intimate partner. The physician did what was mandated and filed a re-

port. Joanna's husband was arrested and Joanna returned home thinking it was safe, since the perpetrator was behind bars. However, unknown to her, her partner had been released and was waiting for her at home. He proceeded to inflict even more severe injuries than the first time.

2. Another case involved a woman named Donna, who was injured by her boyfriend. She went to the hospital to seek help for her injuries but was afraid to enter because of the mandatory reporting laws. Instead she spent the night in her car in the hospital parking lot and did not receive the medical care she needed (1).

There is also literature opposing mandatory reporting. Gielen et al. found that two thirds of the women they surveyed believed that mandatory reporting decreased the likelihood of disclosing abuse. The abused women in the study felt that their autonomy was lost and they "resented" the physician. The abused women also felt that fear of the perpetrator was a barrier to disclosure (8). Rodriguez et al. reported that abused women felt that mandatory reporting jeopardizes safety of the survivor, deters the survivor from seeking medical care and compromises confidentiality and autonomy. In addition, the women feared increased violence and family separation, and had a general mistrust of the police (9). Finally, Feldhaus et al. published a study done in Colorado, a mandatory reporting state, and found that sexual assault victims don't want the crime reported, due to embarrassment, fear of the assailant and fear of others finding out (10).

There is much to be done before the issue of mandatory reporting can be resolved. First and foremost, more research is needed on the impact of the existing laws on survivors of abuse. Risks and benefits of mandatory reporting need to be studied and hypotheses need to be tested in large-scale, multi-center trials. The issue of women's safety must be specifically addressed during these trials. The National Academy of Sciences committee for the Institute of Medicine proposed that states with domestic violence laws be tested and evaluated by

research before enacting more mandatory reporting laws. The American Medical Association (AMA) proposed that mandatory reporting statutes that are in place should include patient identity protection and a clause for competent adults to opt out of reporting. Another suggestion is that reports be made out to public health agencies, which would then evaluate and investigate the report before turning it over to the police. The AMA also recommended that the mandatory reporting statutes have a "sunset clause" built in, so that the legislation would be in place for a limited number of years before it was re-evaluated. Understanding what is best will require well-designed research that involves professionals in the medical, social service and legal fields as well as survivors of abuse and patient advocates (1).

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