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# BATTERED SPOUSES' DAMAGE ACTIONS AGAINST NON-REPORTING PHYSICIANS

James T. R. Jones\*

## INTRODUCTION

The national disgrace of spouse abuse<sup>1</sup> continues to be an immense

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1. As one domestic violence scholar recently stated about the name for the type of behavior about which this Article is written:

In the social science literature, various terms have been used to describe violence and abuse within an intimate relationship (including spouse abuse, domestic violence, marital assault, woman abuse, and battering), although there is little substantive difference among them in the types of phenomena described. Throughout this Article and in the scientific field generally, these terms are used interchangeably to refer to the broad range of behaviors considered to be violent and abusive within an intimate relationship.

Mary Ann Dutton, *Understanding Women's Responses to Domestic Violence: A Redefinition of Battered Woman Syndrome*, 21 HOFSTRA L. REV. 1191, 1204 (1993) (footnotes omitted). This Article adopts this same approach to domestic violence terminology.

Exactly what sort of behavior qualifies as "abuse/domestic violence" is somewhat controversial. Kentucky basically defines spouse "abuse" as "a situation in which a person inflicts physical pain or injury upon a spouse . . ." KY. REV. STAT. ANN. § 209.020(7) (Michie/Bobbs-Merrill 1991). California defines "abuse of spouse or cohabitant" as "corporal injury resulting in a traumatic condition" where "'traumatic condition' means a condition of the body, such as a wound or external or internal injury, whether of a minor or serious nature, caused by a physical force." CAL. PENAL CODE § 273.5(a), (c) (West Supp. 1995). Most commentators define abuse far more broadly, focusing on both physical and emotional/mental injury and suffering. *E.g.*, Jean Abbott et al., *Domestic Violence Against Women: Incidence and Prevalence in an Emergency Department Population*, 273 JAMA 1763, 1764 (1995) ("either an injury (hitting, punching, slapping, or other trauma) or stress (from threats or violent behavior . . .)"); Council on Ethical & Judicial Affairs, American Medical Association, *Physicians and Domestic Violence: Ethical Considerations*, 267 JAMA 3190, 3190 (1992) [hereinafter *Physicians and Domestic Violence*] ("physical, sexual, and psychological abuse"); Dutton, *supra*, at 1204 ("physical, sexual, and psychological"); Howard Holtz & Kathleen K. Furniss, *The Health Care Provider's Role In Domestic Violence*, 8 TRENDS IN HEALTH CARE, L. & ETHICS 47, 47 (1993) ("physical abuse, emotional abuse, sexual abuse, economic control or destruction of pets or cherished property"); Christine A. Picker, *The Intersection of Domestic Violence and Child Abuse: Ethical Considerations and Tort Issues for Attorneys Who Represent Battered Women With Abused Children*, 12 ST. LOUIS U. PUB. L. REV. 69, 73 (1993) ("physical, sexual and psychological abuse within the family or household"). Obviously, a jurisdiction must settle on an exact definition of what behavior constitutes "spouse abuse/domestic violence" before it can hold physicians civilly liable for not reporting it. In many cases, the abuse will be physical and obvious, so no definitional problem should exist there. In cases involving non-physical harm, counsel for battered spouses must research the issue carefully and then be prepared to argue that what their clients suffered qualifies as "abuse."

modern tragedy<sup>2</sup> which afflicts large numbers<sup>3</sup> of mostly female<sup>4</sup> victims.<sup>5</sup> Various authors have suggested that one way to attack this ter-

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In this Article terms like "abused spouse," "battered spouse," "spouse abuse victim," and "domestic violence victim" refer to both the person who currently is legally married to her abuser and to the one who is not now (and may never have been) married to the abuser, i.e., to past or present intimate partnership relationships. See EVE S. BUZAWA & CARL G. BUZAWA, *DOMESTIC VIOLENCE: THE CRIMINAL JUSTICE RESPONSE* 9 (1990) (defining domestic violence as violence between adults who are living together or who have previously lived together in a conjugal relationship); [FLORIDA] GOVERNOR'S TASK FORCE ON DOMESTIC VIOLENCE, *THE FIRST REPORT OF THE [FLORIDA] GOVERNOR'S TASK FORCE ON DOMESTIC VIOLENCE* at v (Jan. 31, 1994) [hereinafter *TASK FORCE REPORT*] (indicating that a "partner" can be a wife, a husband, former spouse, or a co-habiting intimate in a heterosexual or homosexual relationship); James T. R. Jones, *Battered Spouses' State Law Damage Actions Against the Unresponsive Police*, 23 *RUTGERS L.J.* 1, 2 & n.4 (1991) [hereinafter *Battered Spouses' State Law Damage Actions*] (noting that many domestic violence situations involve those who never were married to each other).

2. For citations to some of the vast literature on this subject, see Daniel J. Jacobs, *Battered Women and Related Domestic Violence Issues: A Selective Bibliography*, 49 *REC. ASS'N B. CITY N.Y.* 786 (1994); Jones, *Battered Spouses' State Law Damage Actions*, *supra* note 1, at 1 n.1. For an interesting discourse on the history of domestic violence, see Henry Ansgar Kelly, *Rule of Thumb and the Folklaw of the Husband's Stick*, 44 *J. LEGAL EDUC.* 341 (1994).

3. See, e.g., BEVERLY BALOS & MARY LOUISE FELLOWS, *LAW AND VIOLENCE AGAINST WOMEN: CASES AND MATERIALS ON SYSTEMS OF OPPRESSION* 183 (1994); Michele Lang, *Recent Development, Professionals, Activists, Crows: The Family Violence Program at Boston University School of Medicine (Notes From the Field)*, 14 *HARV. WOMEN'S L.J.* 222, 223 (1991) ("One-third to one-half of all American women will be in violent relationship during their lifetime."); Joyce E. McConnell, *Beyond Metaphor: Battered Women, Involuntary Servitude and the Thirteenth Amendment*, 4 *YALE J.L. & FEMINISM* 207, 229 n.119 (1992) (stating that some authors estimate that battering occurs in 28 percent of all marriages); Antonia C. Novello, *A Medical Response to Domestic Violence*, 267 *JAMA* 3132, 3132 (1992) ("Domestic violence may touch as many as one-fourth of all American families."); M. VandeCastle et al., *Physical Violence During the 12 Months Preceding Childbirth—Alaska, Maine, Oklahoma, and West Virginia, 1990-1991*, 271 *JAMA* 1152, 1152 (1994) (noting that public and private health care settings indicate that four to seventeen percent of women experience violence during pregnancy).

4. See, e.g., BALOS & FELLOWS, *supra* note 3, at 183; *Physicians and Domestic Violence*, *supra* note 1, at 3190 (indicating that "domestic violence is predominately perpetuated by men against women"); Council on Scientific Affairs, American Medical Association, *Violence Against Women: Relevance for Medical Practitioners*, 267 *JAMA* 3184, 3185-86 (1992) [hereinafter *Violence Against Women*] ("In general, men perpetrate more aggressive actions against their female partners . . ."); Nancy S. Jecker, *Privacy Beliefs and the Violent Family: Extending the Ethical Argument for Physician Intervention*, 269 *JAMA* 776, 776 (1993). A recent Kentucky state profile of spouse abuse reports disclosed that from 1992-94 roughly 90% of Kentucky spouse abuse victims were women. KY. DEP'T FOR SOCIAL SERVS., CABINET HUMAN RESOURCES, *PROFILE ON ADULT ABUSE FISCAL YEAR 1994*, at 7 (1994) [hereinafter *PROFILE ON ADULT ABUSE*].

5. Many scholars agree that concepts of power and control are the key issues in domestic violence, as they are what the batterer really strives to gain through his behavior. See generally ELLEN PENCE & MICHAEL PAYMAR, *POWER AND CONTROL: TACTICS OF MEN WHO BATTER: AN EDUCATIONAL CURRICULUM* (1986); Mary E. Asmus et al., *Prosecuting Domestic Abuse Cases in Duluth: Developing Effective Prosecution Strategies From Understanding the Dynamics of Abusive Relationships*, 15 *HAMLIN L. REV.* 115, 132-34, app. A (1991); Andrea Brenneke, *Civil Rights Remedies for Battered Women: Axiomatic & Ignored*, 11 *LAW & INEQ. J.* 1, 11-14 (1992); Karla Fischer et al., *The Culture of Battering and the Role of Mediation in Domestic Violence Cases*, 46 *SMU L. REV.* 2117, 2126-39 (1993); Martha R. Mahoney, *Legal Images of*

ribly costly<sup>6</sup> problem is to compel the police<sup>7</sup> to get involved in

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*Battered Women: Redefining the Issue of Separation*, 90 MICH. L. REV. 1, 34 (1991); Joan S. Meier, *Notes From the Underground: Integrating Psychological and Legal Perspectives On Domestic Violence in Theory and Practice*, 21 HOFSTRA L. REV. 1295, 1317-21 (1993). A recent article described the most accepted theory as to

the dynamics that fuel domestic violence. Violence is the means by which control is attained. Lenore Walker, a psychologist who is one of the earliest social scientists to define domestic violence, suggests that there is a pattern in domestic violence, which she calls the Cycle of Violence. Although this theory does not accurately reflect every battering relationship, it is a helpful way to conceptualize the dynamics of domestic violence. The Cycle contains three stages. The first is called the tension-building phase. During this phase, minor battering incidents occur, such as verbal abuse, controlling behavior, slaps and pinches. The woman is aware of this tension, and usually tries to appease the batterer, in an attempt to prevent worsening abuse. However, this task is emotionally draining and frequently the batterer will perceive the emotional withdrawal of his victim. Because the violence stems from the batterer and not the woman, there is nothing a woman can do to prevent more violent attacks. She may be able to delay it or distract the batterer for a period of time, but ultimately, the next phase is reached, where acute battering occurs.

The most severe battering occurs during the acute battering phase. This stage of battering frequently includes broken bones, forced sexual relations, the use of weapons, death threats and sometimes even death. A woman is usually unable to escape during such an incident, as an attempt to do so could result in her death.

The final stage is the tranquil, loving phase. The batterer apologizes, and promises that he will never again hurt the woman. The woman, out of emotional need or economic dependency, wants to believe this and frequently will. The batterer again becomes the man the woman cared for at the beginning of the relationship, and for a period of time, there is no violence, and the interdependency of the couple grows. Unfortunately, this phase usually ends and the tension-building stage begins again.

There are several important implications of this Cycle of Violence theory. Dr. Walker notes that each rotation through the cycle usually results in increasing violence. For example, by the third time a woman has progressed through the cycle, the battering in the tension-building and acute battering phases is worse than it was the first time through the cycle and the tranquil, loving phase usually gets shorter.

Picker, *supra* note 1, at 74-75 (footnotes omitted). See Dutton, *supra* note 1, at 1208 (finding that "[t]he pattern of violence and abuse can be viewed as a single and continuous entity"); Mark Hansen, *New Strategy in Battering Cases*, A.B.A. J., Aug. 1995, at 14 (recognizing that domestic violence usually follows a cyclical pattern that becomes progressively worse). Readers who have watched the landmark made-for-television motion picture *The Burning Bed* (1984), have witnessed a remarkable depiction of this sort of abusive behavior. Experts agree that a battered spouse is in the greatest danger of death or serious injury at the time she tries to leave the abusive relationship, probably due to her challenge to the abuser's control over her. See, e.g., Dutton, *supra* note 1, at 1212; Fischer et al., *supra*, at 2138-39; Mahoney, *supra*, at 5-6; Joan Zorza, *Recognizing and Protecting the Privacy and Confidentiality Needs of Battered Women*, 29 FAM. L.Q. 273, 274-75 (1995) [hereinafter Zorza, *Privacy and Confidentiality Needs of Battered Women*].

6. The human and economic costs of domestic violence are incalculable. One recent author in particular has quantified some of the prices society pays because of this criminal behavior. Joan Zorza, *Women Battering: High Costs and the State of the Law*, 28 CLEARINGHOUSE REV. 383 (1994) [hereinafter Zorza, *High Costs*]. For example, the medical expense for spouse abuse may equal "\$31 billion per year nationally, or \$124 annually for each living person." *Id.* at 383. This does not consider the huge psychological costs and the expenses of counselling or providing medical treatment for children injured or traumatized when their mothers are battered, often

domestic violence cases by holding them civilly liable when they do not intervene and their inaction contributes to harm to a spouse abuse victim.<sup>8</sup> Numerous victims have asserted both state and federal causes of action against unresponsive law enforcement officials.<sup>9</sup> Victims in the United States<sup>10</sup> have ignored another potential class of defend-

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right in front of them. *Id.*; see also, e.g., Patricia Ann S. v. James Daniel S., 435 S.E.2d 6, 18 (W. Va. 1993) (Workman, C.J., dissenting) (noting the substantial amount of documentation supporting the fact that a spousal abuser's violence causes a variety of psychological problems for children); Howard A. Davidson, *Child Abuse and Domestic Violence: Legal Connections and Controversies*, 29 FAM. L.Q. 357, 359, 369-71 (1995) (addressing the costs and consequences to society of children exposed to domestic violence); Alan J. Tomkins et al., *The Plight of Children Who Witness Woman Battering: Psychological Knowledge and Policy Implications*, 18 LAW & PSYCHOL. REV. 137, 139 (1994) (noting the lack of attention devoted to an estimated three million children who witness their mothers being abused). The nation pays a high price when numerous infants are born suffering from birth defects because their mothers were attacked during pregnancy. Zorza, *High Costs*, *supra*, at 383. Abused women are far more likely to become alcoholics (sixteen times) and/or drug abusers (nine times) than those who are not abused, thereby causing society considerable expenditures for, inter alia, treatment, incarceration and foster child care. *Id.* at 384. Unfortunately, but perhaps predictably, while they are abused battered women may be more likely to abuse their own children than those who are not spouse abuse victims, thereby perpetuating a vicious cycle of violence from one generation to the next. See, e.g., Davidson, *supra*, at 359, 368-69; Picker, *supra* note 1, at 71, 104; Tomkins et al., *supra*, at 152-53. Housing the battered and their children costs millions, Zorza, *High Costs*, *supra*, at 384, while as many as half of homeless women and children in America are fleeing from domestic violence. Zorza, *Privacy and Confidentiality Needs of Battered Women*, *supra* note 5, at 276; Joan Zorza, *Woman Battering: A Major Cause of Homelessness*, 25 CLEARINGHOUSE REV. 421, 421 (1991). Employers of domestic violence victims lose up to thirteen billion dollars annually due to the abuse of their employees. Zorza, *High Costs*, *supra*, at 384-85. The police spend as much as one-third of their time responding to spouse abuse calls. *Id.* at 385. And the risk of suicide for battered women and their children who witness the battering is appallingly higher than that for those not subjected to such violence. *Id.* at 384, 385. Clearly, domestic violence is expensive enough for society to take all reasonable steps to reduce, if not eliminate it. See, e.g., FREDERICK J. COWAN, ATTORNEY GENERAL OF KENTUCKY, ADULT ABUSE, NEGLECT, AND EXPLOITATION: A MEDICAL PROTOCOL FOR HEALTH CARE PROVIDERS AND COMMUNITY AGENCIES 15 (1991); ANN JONES, NEXT TIME, SHE'LL BE DEAD: BATTERING & HOW TO STOP IT 145-46 (1994) [hereinafter A. JONES, BATTERING & HOW TO STOP IT]; Elizabeth A. Delahunta, *Hidden Trauma: The Mostly Missed Diagnosis of Domestic Violence*, 13 AM. J. EMERG. MED. 74, 74 (1994); Robert E. McAfee, *Physicians' Role in the Fight Against Family Violence: Breaking the Cycle, Controlling the Costs*, 55 N.C. MED. J. 398, 398 (1994).

7. In this Article, the terms "police" and "law enforcement" are used interchangeably.

8. See, e.g., James T. R. Jones, *Battered Spouses' Section 1983 Damage Actions Against the Unresponsive Police After DeShaney*, 93 W. VA. L. REV. 251, 254-55 (1991) [hereinafter Jones, *Battered Spouses' Section 1983 Damage Actions*] ("Many believe that the best way to encourage police intervention . . . is to hold police departments and their individual officers civilly liable . . ."); Jones, *Battered Spouses' State Law Damage Actions*, *supra* note 1, at 3-4 (listing the various types of suits battered spouses have pursued against police including negligence and state constitutional law claims).

9. See, e.g., Jones, *Battered Spouses' Section 1983 Damage Actions*, *supra* note 8; Jones, *Battered Spouses' State Law Damage Actions*, *supra* note 1.

10. This Article focuses on physicians and domestic violence victims in the United States, although this is truly an international problem. See Jones, *Battered Spouses' Section 1983 Damage Actions*, *supra* note 8, at 254 & n.6 (citing Torgbar, *Police Intervention in Domestic Vio-*

ants, the physicians<sup>11</sup> who treat injuries they recognize, or should suspect,<sup>12</sup> were caused by abuse yet do not report the harm to the authorities.<sup>13</sup>

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lence—A Comparative View, 1989 FAM. L. 195) (providing an overview of the international spouse abuse problem)).

11. This Article concentrates on the obligations of physicians. As provisions like those of Kentucky make clear, various other health care professionals such as nurses, hospital workers, coroners, medical examiners, dentists, optometrists and clinical psychologists may have similar responsibilities. KY. REV. STAT. ANN. § 209.030(2) (Michie/Bobbs-Merrill 1991); see *infra* note 40 (discussing the Kentucky statute further). Exactly how far the duty to report abuse extends may have to be explored as the case law develops, in particular in light of different considerations which may apply to non-physician health care worker observers of domestic violence. Cf., e.g., Jody Aaron, Note, *Civil Liability for Teachers' Negligent Failure to Report Suspected Child Abuse*, 28 WAYNE L. REV. 183, 186 n.14, 208-09 (1981); Lawrence W. Miles Jr., Comment, *The Guardian Ad Litem and Civil Liability in California Child Maltreatment Cases*, 12 U.C. DAVIS L. REV. 700, 707, 709-14 & n.92 (1979). Arguably all these (and similar) enumerated groups should be treated like physicians for both reporting and liability purposes in all reporting scenarios in order to uphold the principles which dictate mandatory reporting.

California has demonstrated how to deal with the situation which arises when multiple individuals have a reporting obligation as to the same domestic violence victim. See CAL. PENAL CODE § 11160(e) (West Supp. 1995).

12. This Article focuses on the physician's legal obligation to report spouse abuse to the authorities. As a preliminary matter, obviously the physician must at least suspect that a patient is a domestic violence victim before he or she will report the patient's condition. See KY. REV. STAT. ANN. § 209.030(2) (Michie/Bobbs-Merrill 1991); see also *infra* note 40 (discussing this statute further). That, in turn, requires professional evaluation and judgment. In *Landeros v. Flood*, 551 P.2d 389, 393-94 (Cal. 1976), a landmark child abuse case, the California Supreme Court discussed the common law duty properly to diagnose child abuse and indicated an unreasonable failure to diagnose could constitute negligence. See, e.g., Rowine Hayes Brown & Richard B. Truitt, *Civil Liability in Child Abuse Cases*, 54 CHI.-KENT L. REV. 753, 758-59 (1978); Richard J. Kohlman, *Malpractice Liability for Failing to Report Child Abuse*, 49 CAL. ST. B.J. 118, 122 (1974); Neil J. Lehto, *Civil Liability for Failing to Report Child Abuse*, 1977 DET. C.L. REV. 135, 145-47; Adrienne C. Mazura, Case Note, *Negligence—Malpractice—Physician's Liability for Failure to Diagnose and Report Child Abuse*, 23 WAYNE L. REV. 1187, 1194 (1977). When liability for failure to report is based on a civil and/or criminal statute, *Landeros* and most other authorities hold the non-reporting physician actually must have recognized the patient intentionally was abused and still not report the battering before being responsible for not doing so. E.g., *Landeros*, 551 P.2d at 397-98 (holding that a doctor must form the opinion that the injuries were intentionally inflicted to be held liable); Lehto, *supra*, at 153-55 (noting the disagreement as to the required state of mind a doctor needs before reporting); Mazura, *supra*, at 1196-97 (holding that a doctor's mental state must be adduced before a violation can be proven). In this Article, any discussion of a physician's obligation to report abuse is premised upon that physician being compelled by common law or statute at minimum to suspect the behavior is abuse.

13. This Article focuses upon physicians who fail to report injuries to their patients inflicted through spouse abuse and who learn of this abuse from their patients — the battered spouses — directly or by observation of the patients. The Article does not focus on physicians who learn of abuse from some other source, such as psychotherapy or counselling of the abuser. While there may, and probably ought to, be a duty under reporting statutes and/or common law to report abuse about which the physician learns from the abuser or someone else, this scenario arguably raises additional roadblocks to the civil liability of the non-reporting physician which are not present when the patient/victim is the source of information. The principal roadblock is confidentiality concerns of those treating abusers, including psychiatrists or other mental health workers, attorneys, or clergy. See, e.g., David Joseph Agatstein, *Child Abuse Reporting in New York*

The treating physician can be an important participant in the fight against domestic violence.<sup>14</sup> Many victims are very reluctant (if not downright unwilling) to go to the police about the attacks upon them, instead often turning to their physicians for aid.<sup>15</sup> Many women

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*State: The Dilemma of the Mental Health Professional*, 34 N.Y.L. SCH. L. REV. 115, 117-18 (1989); Phyllis Coleman, "Shrinking" the Clergy Exemption to Florida's Mandatory Child Abuse Reporting Statute, 12 NOVA L. REV. 115, 116 (1987); Phyllis Coleman, *Creating Therapist-Incest Offender Exception to Mandatory Child Abuse Reporting Statutes—When Psychiatrist Knows Best*, 54 U. CIN. L. REV. 1113, 1113 (1986) [hereinafter Coleman, *When Psychiatrist Knows Best*]; Mary M. Hurley, *Duties in Conflict: Must Psychotherapists Report Child Abuse Inflicted by Clients and Confided in Therapy?*, 22 SAN DIEGO L. REV. 645, 654-57 (1985); Murray Levine, *A Therapeutic Jurisprudence Analysis of Mandated Reporting of Child Maltreatment by Psychotherapists*, 10 N.Y.L. SCH. J. HUM. RTS. 711, 719-30 (1993); Robert D. Miller & Robert Weinstock, *Conflict of Interest Between Therapist-Patient Confidentiality and the Duty to Report Sexual Abuse of Children*, 5 BEHAVIORAL SCI. & LAW 161, 166-67 (1987); Robert P. Mosteller, *Child Abuse Reporting Laws and Attorney-Client Confidences: The Reality and the Specter of Lawyer as Informant*, 42 DUKE L.J. 203, 207 (1992); Steven R. Smith, *Mental Health Malpractice in the 1990s*, 28 HOUS. L. REV. 209, 250-52 (1991) [hereinafter Smith, *Mental Health Malpractice*]; Michele Smith-Bell & William J. Winslade, *Privacy, Confidentiality, and Privilege in Psychotherapeutic Relationships*, 64 AM. J. ORTHOPSYCHIATRY 180, 186-92 (1994). Certainly, any duty the therapist of the abuser would owe the domestic violence victim, about whose abuse the therapist only learned from the patient-abuser, would be more attenuated than the one she would have towards her own patient who told her of the abuse. See *infra* note 148.

14. As the Florida Governor's Task Force On Domestic Violence reported:

[T]he health professional can be a safe, primary focal point for the identification of battered women, the counselling of battered women, the referral of battered women to community resources and the advocacy for the prevention of battering. The role of the health professional is a critical one in lessening both the incidence and the destructiveness of domestic violence.

TASK FORCE REPORT, *supra* note 1, at 22. Indeed, in the early days of mandatory child abuse reporting laws the "statutes singled out the physician as the mandated reporter . . . because it was felt that they had the necessary training and expertise to identify child abuse. As a profession, they were mandated to report because it was felt that they often saw the child abuse case but chose not to report." Brian G. Fraser, *A Glance At the Past, A Gaze At the Present, A Glimpse At the Future: A Critical Analysis of the Development of Child Abuse Reporting Statutes*, 54 CHI.-KENT L. REV. 641, 656 (1978) (emphasis added); see also, e.g., Douglas J. Besharov, *The Legal Aspects of Reporting Known and Suspected Child Abuse and Neglect*, 23 VILL. L. REV. 458, 466-67 (1978) [hereinafter Besharov, *Child Abuse and Neglect*]; Ralph Slovenko, *Child Abuse and the Role of the Physician in the Proof of a Case*, 17 J. PSYCHIATRY & L. 477, 480-81 (1989); Alan Sussman, *Reporting Child Abuse: A Review of the Literature*, 8 FAM. L.Q. 245, 269-70 (1974).

15. BUZAWA & BUZAWA, *supra* note 1, at 37. See, e.g., COWAN, *supra* note 6, at 21; R. EMERSON DOBASH & RUSSELL DOBASH, *VIOLENCE AGAINST WIVES* 183, 249 (1979) (stating that the doctor may be the first person approached); Sandra K. Burge, *Violence Against Women as a Health Care Issue*, 21 FAM. MED. 368, 370 (1989) (stating women who are victims of violence turn more to physicians than to police officers); Robert E. McAfee, *Physicians and Domestic Violence: Can We Make a Difference?*, 273 JAMA 1790, 1790 (1995) [hereinafter McAfee, *Physicians and Domestic Violence*] (Dr. McAfee is President of the American Medical Association) (citing the national survey of attitudes toward family violence which revealed that than 85 percent of Americans felt they would tell a physician if they were a victim of family abuse—a considerably higher percentage than those stating they would tell a police officer); E. McLoughlin et al., *Emergency Department Response to Domestic Violence—California, 1992*, 42 MORBIDITY & MORTALITY WKLY. REP. 617, 618-19 (1993).

treated by physicians, especially in hospital emergency rooms, are there because of spouse abuse.<sup>16</sup> Physicians, in turn, can assist battered women by reporting the numerous known or suspected abuse cases they see to the proper authorities, who then can fulfill their various obligations such as to investigate, offer protective services, and, if appropriate, trigger arrest and/or prosecution of the batterers.<sup>17</sup> Yet physicians traditionally do not do so for a variety of reasons.<sup>18</sup>

Some physicians do not act because they fail to diagnose abuse. They often do not recognize its signs,<sup>19</sup> or they may be biased against

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16. See, e.g., J. Abbott et al., *supra* note 1, at 1766 (revealing in a study that 11.7 percent of women who had current husbands or boyfriends attributed their emergency room visits to domestic violence); Jacquelyn C. Campbell et al., *Battered Women's Experiences in the Emergency Department*, 20 J. EMERG. NURS. 280, 280, 286-87 (1994) [hereinafter Campbell et al., *Emergency Department*] (revealing that battering is the leading cause of trauma to women seen in emergency rooms); *Emergency Department Response to Domestic Violence—California, 1992*, 270 JAMA 1296, 1296 (1993) [hereinafter *Emergency Department Response*] (suggesting that as many as 30 percent of women treated in emergency rooms have injuries or symptoms related to physical abuse); Holtz & Furniss, *supra* note 1, at 48.

17. There is considerable evidence that the best way to prevent spouse abuse is to arrest and prosecute the abusers, who then are deterred from further misbehavior. See, e.g., Alana Bowman, *A Matter of Justice: Overcoming Juror Bias in Prosecutions of Batterers Through Expert Testimony of the Common Experiences of Battered Women*, 2 S. CAL. REV. L. & WOMEN'S STUD. 219, 225-26 (1992); Sarah Mausloff Buel, Recent Developments, *Mandatory Arrest for Domestic Violence*, 11 HARV. WOMEN'S L.J. 213, 215-16 (1988); *Developments in the Law—Legal Responses to Domestic Violence*, 106 HARV. L. REV. 1528, 1534-41 (1993); Nancy James, *Domestic Violence: A History of Arrest Policies and a Survey of Modern Laws*, 28 FAM. L.Q. 509, 513 (1994); Joan Zorza, *Must We Stop Arresting Batterers?: Analysis and Policy Implications of New Police Domestic Violence Studies*, 28 NEW ENG. L. REV. 929, 929 (1994). But see Miriam H. Ruttenger, *A Feminist Critique of Mandatory Arrest: An Analysis of Race and Gender in Domestic Violence Policy*, 2 AM. U.J. GENDER & L. 171, 172-74 (1994) (questioning racial impact of mandatory arrest policy); Donna M. Welch, Comment, *Mandatory Arrest of Domestic Abusers: Panacea or Perpetuation of the Problem of Abuse?*, 43 DEPAUL L. REV. 1133, 1156-64 (1994) (questioning wisdom of mandatory arrest policy in some situations).

18. See, e.g., Jacquelyn C. Campbell, *Public-Health Conceptions of Family Abuse*, in ABUSED AND BATTERED: SOCIAL AND LEGAL RESPONSES TO FAMILY VIOLENCE 35, 37-38 (Dean D. Knudsen & JoAnn L. Miller eds., 1991) [hereinafter Campbell, *Family Abuse*]; Andrea Dworkin, *16 Living in Terror, Pain: Being a Battered Wife*, in VIOLENCE AGAINST WOMEN: THE BLOODY FOOTPRINTS 237, 238 (Pauline B. Bart & Eileen Geil Moran eds., 1993); Carole Warshaw, *Limitations of the Medical Model in the Care of Battered Women*, in VIOLENCE AGAINST WOMEN: THE BLOODY FOOTPRINTS, *supra*, at 134, 142-44; Ronald A. Chez, *A Physician's Perspective on Woman Battering*, FLA. B.J., Oct. 1994, at 68, 69-71; Wesley B. Crenshaw et al., *Proposed Revisions to Mandatory Reporting Laws: An Exploratory Survey of Child Protective Service Agencies*, 73 CHILD WELFARE 15, 16 (1994); Andrew A. Skolnick, *Physician, Heal Thyself—Then Aid Abused Women*, 273 JAMA 1744, 1744-45 (1995); see also, e.g., Genell Sandberg et al., *Physician Reporting Practices In Child Physical Abuse*, 9 RESPONSE TO VICTIMIZATION WOMEN & CHILDREN 6 (1986).

19. See, e.g., Cynthia Lynne Pike, Note, *The Use of Medical Protocols in Identifying Battered Women*, 38 WAYNE L. REV. 1941, 1944 (1992); *Physicians and Domestic Violence*, *supra* note 1, at 3191; Virginia P. Tilden, *Response of the Health Care Delivery System to Battered Women*, 10 ISSUES IN MENTAL HEALTH NURS. 309, 314 (1989).



domestic violence victims.<sup>20</sup> They may accept the sometimes plausible-sounding non-abuse-related "alternative" explanations for their patients' injuries which their patients fabricate for various reasons, such as fear of retaliation or humiliation or the desire to protect their assailants.<sup>21</sup> Other physicians do not want to "trespass[ ] into the territory of social workers or the police,"<sup>22</sup> or to get involved with the legal system and risk being disciplined and/or sued for defamation, a breach of confidentiality/physician-patient privilege, or some other tort/ethical violation.<sup>23</sup> Physicians may suspect that if they intervene their action only will incite further violence against their patients by enraged abusers,<sup>24</sup> believe that domestic violence is a private matter to be dealt with within the family without outside interference,<sup>25</sup> think that victims want to be left alone,<sup>26</sup> or generally be so disheartened by society's lack of response to spousal violence that they feel the situation is hopeless and their intervention will accomplish nothing.<sup>27</sup> Physicians even may worry about their own safety or that of their loved ones if they report abuse against their patients and the abusers then discover who reported them.<sup>28</sup> Regardless of the reasons for physicians' inaction,<sup>29</sup> it has serious consequences for their battered patients.

Physician inaction can facilitate a variety of negative results. Failure properly to diagnose and act upon battering can permit it to continue, and even escalate in severity, with homicide of the abused, or

20. See, e.g., Campbell, *Family Abuse*, *supra* note 18, at 38-40; Campbell et al., *Emergency Department*, *supra* note 16, at 280, 283; David H. Gremillion & Gigi Evins, *Why Don't Doctors Identify and Refer Victims of Domestic Violence?*, 55 N.C. MED. J. 428, 428-29 (1994); Pike, *supra* note 19, at 1945; *Physicians and Domestic Violence*, *supra* note 1, at 3191.

21. See, e.g., Pike, *supra* note 19, at 1944.

22. Burge, *supra* note 15, at 372; see also Lucy M. Candib, *Violence Against Women: No More Excuses*, 21 FAM. MED. 339, 339 (1989); Pike, *supra* note 19, at 1945; Teri Randall, *Domestic Violence Begets Other Problems of Which Physicians Must Be Aware to Be Effective*, 264 JAMA 940, 940 (1990); Tilden, *supra* note 19, at 314.

23. See, e.g., Chez, *supra* note 18, at 69-70; Gremillion & Evins, *supra* note 20, at 430; Pike, *supra* note 19, at 1946, 1955.

24. See, e.g., Chez, *supra* note 18, at 70-71.

25. See, e.g., Burge, *supra* note 15, at 372; Gremillion & Evins, *supra* note 20, at 430; Jecker, *supra* note 4, at 777; *Physicians and Domestic Violence*, *supra* note 1, at 3191.

26. See, e.g., *Physicians and Domestic Violence*, *supra* note 1, at 3191.

27. See, e.g., Burge, *supra* note 15, at 372; Chez, *supra* note 18, at 70; Tilden, *supra* note 19, at 314; Carole Warshaw, *Domestic Violence: Challenges to Medical Practice*, 2 J. WOMEN'S HEALTH 73, 76-77 (1993) [hereinafter Warshaw, *Domestic Violence*].

28. See, e.g., Lorna Bell & Patrick Tooman, *Mandatory Reporting Laws: A Critical Overview*, 8 INT'L J.L. & FAM. 337, 344 (1994); Chez, *supra* note 18, at 70-71; David P. Sklar, *Emergency Medicine*, 271 JAMA 1665, 1665 (1994).

29. Cf. Linda L. Hale & Julie Underwood, *Child Abuse: Helping Kids Who Are Hurting*, 74 MARQ. L. REV. 560, 561 (1991) (listing interestingly similar reasons why educators do not report child abuse).

perhaps the abuser, their children, and others always a real possibility.<sup>30</sup> Inappropriate or harmful medical treatment, such as prescribing medications a domestic violence victim may use for addictive or suicidal purposes or which may tranquilize the victim and thus render her more vulnerable to abuse, also is possible.<sup>31</sup> Such physician behavior can contribute to the victim's already strong feelings of helplessness, entrapment, and victimization.<sup>32</sup> Finally, physician inaction even may encourage the abuser to continue the battering because the abuser may view the silent acquiescence by a high-status member of society as a form of acceptance or tolerance of the abusive behavior.<sup>33</sup>

Increasingly, the medical (and other<sup>34</sup>) establishments have recognized that physicians must become more involved with their patients who are spouse abuse victims. The Joint Commission on the Accreditation of Healthcare Organizations ("JCAHO")<sup>35</sup> now requires all

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30. See, e.g., Susan A. Collier, Comment, *Reporting Child Abuse: When Moral Obligations Fail*, 15 PAC. L.J. 189, 191 (1983); *Physicians and Domestic Violence*, supra note 1, at 3190; *Violence Against Women*, supra note 4, at 3184. "Among battered women who are first identified in a medical setting, 75% will go on to suffer repeated abuse." Warshaw, *Domestic Violence*, supra note 27, at 74.

31. See, e.g., Jecker, supra note 4, at 779; *Physicians and Domestic Violence*, supra note 1, at 3190; see also DOBASH & DOBASH, supra note 15, at 190-92; GILL HAGUE & ELLEN MALOS, DOMESTIC VIOLENCE: ACTION FOR CHANGE 159-61 (1993).

32. See, e.g., DOBASH & DOBASH, supra note 15, at 192; A. JONES, BATTERING & HOW TO STOP IT, supra note 6, at 148; Dworkin, supra note 18, at 238; *Physicians and Domestic Violence*, supra note 1, at 3190; Warshaw, *Domestic Violence*, supra note 27, at 76.

33. Cf. Collier, supra note 30, at 191 (discussing child abuse).

34. In 1991 the Attorney General of Kentucky noted that adult abuse cases:

usually require more than the traditional medical responses to serve victims adequately. Some reasons abuse victims require special attention are:

- Victims may present with problems not readily identified from a strictly medical standpoint; injuries may not be serious and complaints may not be supported with physical evidence.
- Victims may deny or minimize the abuse, neglect, or exploitation.
- Victims may be inappropriately diagnosed and treated, prescribed unnecessary medications or admitted to mental health facilities.
- Victims may return to the relationship in which they were abused, frustrating the service provider's attempts to deliver assistance and still at-risk of further maltreatment.
- Victims may be blamed for their situation and left to deal with it alone.

COWAN, supra note 6, at 3; see also Roberta Cooper Ramo, *ABA President-Elect Announces Domestic Violence Initiative*, 29 FAM. L.Q. at ix, ix-xi (1995).

35. The JCAHO accredits hospitals and hospital-sponsored ambulatory care facilities in the United States. Pike, supra note 19, at 1948. Effectively, such facilities cannot operate without JCAHO accreditation. *Id.* For more on JCAHO see, e.g., Carol Jack Scott & Roseanne M. Matricciani, *Joint Commission on Accreditation of Healthcare Organizations Standards to Improve Care for Victims of Abuse*, 43 MD. MED. J. 891, 891-92 (1994) (describing the JCAHO and its 1995 standards for abuse victims); Andrew A. Skolnick, *Joint Commission Will Collect, Publicize Outcomes*, 270 JAMA 165, 165, 168, 171 (1993) (discussing JCAHO, its policies, and its critics).

hospitals to develop and follow protocols to help in identifying, evaluating, and treating adult abuse victims.<sup>36</sup> Unfortunately, however, a failure properly to monitor the enforcement of this policy and a lack of adequate training of emergency department staff seriously may have hampered achieving these lofty goals.<sup>37</sup> The American Medical Association ("AMA") has determined that its members have an ethical duty to diagnose and treat domestic violence.<sup>38</sup> Significantly, however, the AMA generally advises a physician who diagnoses abuse of a competent adult patient not to report it to law enforcement authorities unless the victim consents for the physician to do so or a state statute requires such action.<sup>39</sup> Thus, in the states which lack such statutes, the AMA-mandated diagnosis and treatment of battered women will be of limited utility if the abused patient is unwilling for the physician to contact the authorities. In such cases, her batterer can continue his abusive behavior, possibly resulting in the serious injury or death of the patient, while the physician stands by silently.

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36. 1 THE JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS, 1995 ACCREDITATION MANUAL FOR HOSPITALS 7, 9, 10 (1994); see TASK FORCE REPORT, *supra* note 1, at 25; Teri Randall, *AMA, Joint Commission Urge Physicians Become Part of Solution to Family Violence Epidemic*, 266 JAMA 2524, 2524 (1991); Scott & Matricciani, *supra* note 35, at 892-98. For a discussion of the potential impact of such protocols, see Pike, *supra* note 19, at 1948-57 (analyzing the import of the JCAHO decision on medical and legal personnel). At least one medical center has instituted special training for physicians to assist them in evaluating trauma victims, specifically including battered spouses. See William S. Smock, *Development of a Clinical Forensic Medicine Curriculum for Emergency Physicians in the USA*, 1 J. CLINICAL FORENSIC MED. 27, 27 (1994) (program initiated by Department of Emergency Medicine at the University of Louisville School of Medicine and the Kentucky Medical Examiner's Office); William S. Smock et al., *Development and Implementation of the First Clinical Forensic Medicine Training Program*, 38 J. FORENSIC SCI. 835, 838 (1993).

37. See, e.g., FAMILY VIOLENCE PREVENTION FUND, CALIFORNIA HOSPITAL EMERGENCY DEPARTMENTS RESPONSE TO DOMESTIC VIOLENCE—SURVEY REPORT (1993); ARIELLA HYMAN, MANDATORY REPORTING OF DOMESTIC VIOLENCE BY HEALTH CARE PROVIDERS: A MISGUIDED APPROACH 1 (1994); *Emergency Department Response*, *supra* note 16, at 1296; Gremillion & Evins, *supra* note 20, at 431; Ariella Hyman et al., *Laws Mandating Reporting of Domestic Violence: Do They Promote Patient Well-Being?*, 273 JAMA 1781, 1781 (1995) [hereinafter Hyman et al., *Reporting of Domestic Violence*]; Nancy E. Isaac & Ricardo L. Sanchez, *Emergency Department Response to Battered Women in Massachusetts*, 23 ANNALS EMERG. MED. 855, 857-58 (1994); Demie Kurz, *Emergency Department Responses to Battered Women: Resistance to Medicalization*, 34 SOC. PROBS. 69, 71-75 (1987).

38. *Physicians and Domestic Violence*, *supra* note 1, at 3190; see Dianne Aprile, *Popping the Question*, LOUISVILLE COURIER-JOURNAL, Oct. 6, 1992, at C1; Jill Smolowe, *What the Doctor Should Do*, TIME, June 29, 1992, at 57; *infra* notes 190-91 and accompanying text (discussing in more detail the ethical basis for the AMA's finding). For more on the AMA's response to the family violence issue, see its president's recent editorial on the subject. McAfee, *Physicians and Domestic Violence*, *supra* note 15, at 1790-91 (encouraging physician intervention in domestic violence cases).

39. *Physicians and Domestic Violence*, *supra* note 1, at 3192. The result is different in cases of child abuse or abuse of the elderly or disabled. *Id.*

Some states have chosen to demand more of physicians via statute, to *require* them to report the abuse of their patients to the authorities. For example, in Kentucky a physician must report known or suspected abuse of an adult to the Commonwealth's Department for Social Services, Cabinet for Human Resources for investigation and the offer of protective services (usually voluntary) where appropriate.<sup>40</sup> The physician is immune from civil or criminal liability for reporting in good faith<sup>41</sup> (so the traditional physician-patient privilege<sup>42</sup> is inapplicable<sup>43</sup>), and is guilty of a misdemeanor upon failing to report abuse.<sup>44</sup>

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40. A Kentucky statute provides, in pertinent part that:

(2) Any person, including, but not limited to, *physician*, law enforcement officer, *nurse*, social worker, cabinet [for Social Services] personnel, *coroner*, *medical examiner*, alternate care facility employee, or caretaker, having reasonable cause to suspect that an adult has suffered abuse, neglect, or exploitation, shall report or cause reports to be made in accordance with the provisions of this chapter. Death of the adult does not relieve one of the responsibility for reporting the circumstances surrounding the death.

(3) An oral or written report shall be made immediately to the cabinet upon knowledge of the occurrence of suspected abuse, neglect, or exploitation of an adult. Any person making such a report shall provide the following information, if known: The name and address of the adult, or of any other person responsible for his care; the age of the adult; the nature and extent of the abuse, neglect, or exploitation, including any evidence of previous abuse, neglect, or exploitation; the identity of the perpetrator, if known; the identity of the complainant, if possible; and any other information that the person believes might be helpful in establishing the cause of abuse, neglect, or exploitation.

(4) Upon receipt of the report, the cabinet [for Human Resources] shall take the following action as soon as practical:

- (a) Notify the appropriate law enforcement agency;
- (b) Initiate an investigation of the complaint; and
- (c) Make a written report of the initial findings together with a recommendation for further action, if indicated.

KY. REV. STAT. ANN. § 209.030 (Michie/Bobbs-Merrill 1991) (emphasis added); *see, e.g.*, Chris Gorman, *Reporting of Spouse and Partner Abuse: Legal Responsibilities and Liabilities*, LOUISVILLE MED., Apr. 1992, at 24; Stephen L. Henry et al., *Domestic Violence—The Medical Community's Legal Duty*, 90 KY. MED. ASS'N J. 163, 166-68 (1992). The physician must report abuse regardless of the wishes of the patient. Henry, *supra*, at 166.

41. KY. REV. STAT. ANN. § 209.050 (Michie/Bobbs-Merrill 1991); *see* Gorman, *supra* note 40, at 26; Henry, *supra* note 40, at 166-67.

42. *See infra* note 180 and accompanying text (discussing related, but different, concepts of physician-patient confidentiality and privilege).

43. A Kentucky Attorney General's opinion concluded that the mandatory reporting statute controls over any privilege claim, whether physician-patient or psychotherapist-patient. Op. Ky. Att'y Gen. 83-187 (1983). "In a legal opinion (February 12, 1991) from the Cabinet for Human Resources on the subject of privileged communications of psychologists as it relates to the reporting requirements of both child and adult abuse, neglect or exploitation it was determined that psychologists have the legal obligation to report both child and adult maltreatment." Gorman, *supra* note 40, at 24. The actual opinion concluded that "psychologists have the obligation to report both child abuse . . . and adult abuse . . . notwithstanding . . . the statute in Kentucky which addresses the psychologist-patient privilege." Privileged Communications of Psychologists, Op. Off. Counsel, Ky. Cabinet Human Resources 1 (Feb. 12, 1991). Another opinion found an exception when attorney-client privilege was the issue. Op. Ky. Att'y Gen. 83-

Similarly, since 1994, California physicians must report to a local law enforcement agency, among other things, injuries to their patients inflicted in the course of spouse abuse.<sup>45</sup> They are immune from liability for making the reports,<sup>46</sup> and physician-patient privilege is abrogated.<sup>47</sup> They commit a misdemeanor when they do not report.<sup>48</sup> New Mexico has a similar, albeit less developed, provision.<sup>49</sup> Various other states have statutes requiring that physicians report some criminal/violent behavior against their patients, including certain domestic violence victims.<sup>50</sup> Unfortunately, however, many physicians do not act notwithstanding such laudable provisions. A 1992 study of physicians in Louisville, Kentucky disclosed that only 24% had ever filed a spouse abuse report, versus 63% who had reported instances of child

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367 (1983). For more on the privilege issue, see, e.g., KY. REV. STAT. ANN. § 209.060 (Michie/Bobbs-Merrill 1991); Gorman, *supra*, at 24-26; Henry, *supra* note 40, at 166-67; Steven R. Smith, *Medical and Psychotherapy Privileges and Confidentiality: On Giving With One Hand and Removing With the Other*, 75 KY. L.J. 473, 511-12 (1986-87) [hereinafter Smith, *Privileges and Confidentiality*]. Cf. Dawson v. Commonwealth, 867 S.W.2d 493, 495 (Ky. Ct. App. 1993) (spousal testimony privilege does not permit abusive husband to bar hearsay statements of his spouse abuse victim-wife).

44. KY. REV. STAT. ANN. § 209.990(1) (Michie/Bobbs-Merrill 1991), provides that: "Anyone knowingly and willfully violating the provisions of KRS 209.030(2) shall be guilty of a Class B misdemeanor as designated in KRS 532.090. Each violation shall constitute a separate offense." See Henry, *supra* note 40, at 167 (discussing the consequences of statutory violations).

45. CAL. PENAL CODE §§ 11160-11161 (West Supp. 1995).

46. *Id.* § 11161.9. In addition, the California Legislature gives health practitioners protection against being sued for making reports pursuant to Section 11160 by allowing them to recover from the California State Board of Control for any obligation for attorneys' fees they incur while defending themselves from suit. *Id.* § 11163.

47. *Id.* § 11163.2.

48. *Id.* § 11162.

49. N.M. STAT. ANN. §§ 27-7-30, -31 (Michie 1994), require anyone who has reasonable cause to believe an adult has been abused to report this knowledge or be guilty of a misdemeanor. It grants a good faith reporter immunity from civil or criminal liability for making the report. *Id.*

50. See *infra* note 286 and accompanying text.

abuse.<sup>51</sup> Thus, physicians do not report abuse even though they risk criminal, and potential civil,<sup>52</sup> liability for not doing so.<sup>53</sup>

Should the physician who treats a domestic violence victim be liable in damages to the patient or her survivors for failing to report the abuse before it was too late? Should the physician have a legal duty to act whether or not a statute requires the physician to do so? The better answer is yes in both the analogous child abuse<sup>54</sup> situation<sup>55</sup> and in the elder-abuse one as well.<sup>56</sup> When the patient is an apparently competent adult, the answer may be less clear. This Article will discuss the various issues which will determine whether the law effectively will require physicians to report spouse abuse to the proper authorities by holding them civilly liable when they fail to do so and

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51. Henry, *supra* note 40, at 164-65. The same report disclosed that only 29 percent of the physicians surveyed knew about the Kentucky statutes which require them to report spouse abuse as compared with over 81 percent who knew about the laws requiring them to report child abuse. Henry, *supra*, at 164; *see also supra* notes 40-41, 43-44 and accompanying text (discussing Kentucky's statute mandating that a physician must report known or suspected abuse of an adult); John D. McDowell et al., *Recognizing and Reporting Domestic Violence: A Survey of Dental Practitioners*, 14 SPECIAL CARE IN DENTISTRY 49 (1994) (similar results from survey of Colorado dentists). For comparable data on child abuse reporting, *see, e.g.*, Seth C. Kalichman & Cheryl L. Brosig, *Practicing Psychologists' Interpretations of and Compliance with Child Abuse Reporting Laws*, 17 LAW & HUM. BEHAV. 83, 90 (1993) (indicating that in a survey, 32 percent of professional psychologists failed to report suspected abuse of a child); Sandberg et al., *supra* note 18. In 1994, hospital personnel initially reported a mere three percent of the spouse abuse reported to Kentucky state investigators. PROFILE ON ADULT ABUSE, *supra* note 4, at 21. Physicians initially reported a minuscule .002% of the spouse abuse. *Id.*

52. *See* Smith, *Privileges and Confidentiality*, *supra* note 43, at 530 (stating failure to report abuse may lead to civil liability).

53. Interestingly, Kentucky reports that state investigators consistently substantiate roughly 70% of all reports of abuse of adults which are filed with them. PROFILE ON ADULT ABUSE, *supra* note 4, at 6. From 1988-94, investigators substantiated approximately 76% of spouse abuse reports. *Id.* at 9.

54. This Article frequently cites precedents or authorities involving child abuse because courts often treat abuse victims essentially the same regardless whether they are children or spouses. *See, e.g.*, *DeShaney v. Winnebago County Dep't of Social Servs.*, 489 U.S. 189, 197 n.4 (1989); *Turner v. District of Columbia*, 532 A.2d 662, 663 (D.C. 1987); *Florida Dep't of Health & Rehabilitative Servs. v. Yamuni*, 529 So. 2d 258, 262 (Fla. 1988); *Sorichetti v. City of New York*, 482 N.E.2d 70, 75 (N.Y. 1985); A. JONES, *BATTERING & HOW TO STOP IT*, *supra* note 6, at 223-24; American College of Obstetricians and Gynecologists, *The Battered Woman*, ACOG TECHNICAL BULL., No. 124, Jan. 1989, at 2; Jacquelyn C. Campbell, *Child Abuse and Wife Abuse: The Connections*, 43 MD. MED. J. 349, 349 (1994); Davidson, *supra* note 6; Mary McKernan McKay, *The Link between Domestic Violence and Child Abuse: Assessment and Treatment Considerations*, 73 CHILD WELFARE 29 (1994); Charles Marwick, *Health and Justice Professionals Set Goals to Lessen Domestic Violence*, 271 JAMA 1147, 1147 (1994); Picker, *supra* note 1, at 71, 79; Smith, *Privileges and Confidentiality*, *supra* note 43, at 530.

55. *See infra* notes 85-127 and accompanying text (discussing a physician's duty to report child abuse).

56. *See infra* notes 128-36 and accompanying text (discussing a physician's duty to report elder abuse).

the patient subsequently suffers further abuse.<sup>57</sup> The threat of civil liability can be a powerful incentive to inspire physicians to act,<sup>58</sup> while the imposition of liability will have the additional beneficial effect of compensating the injured or her survivors.<sup>59</sup> Much like the

57. Of course, any liability will be for injuries suffered *subsequent* to the time when the abuse should have been reported. As a leading child abuse expert has explained:

The only harms or injuries that are considered are those that occurred *after* the report should have been made. Potential reporters are not held responsible for maltreatment that occurred before they knew or should have known about the . . . situation. And, of course, there is no liability if there is no further maltreatment.

DOUGLAS J. BESHAROV, *THE VULNERABLE SOCIAL WORKER* 38 (1985) [hereinafter BESHAROV, *THE VULNERABLE SOCIAL WORKER*]; see also, e.g., Thelen *ex rel.* Thelen v. St. Cloud Hosp., 379 N.W.2d 189, 194 (Minn. Ct. App. 1985); Aaron, *supra* note 11, at 190, 207.

58. For more on the incentive value of civil litigation against non-reporting physicians, see, e.g., Besharov, *Child Abuse and Neglect*, *supra* note 14, at 481 (stating that the prospect of a civil lawsuit is a strong incentive for complying with reporting mandates); Jeffrey W. Kelley, *The Child Abuse Epidemic: Illinois' Legislative Response and Some Further Suggestions*, 1974 U. ILL. L. REV. 403, 409, 412-13 (discussing advantages civil liability has over criminal liability for deterrence of physician inaction); Kohlman, *supra* note 12, at 121, 185 (claiming that criminal sanctions for non-reporting in child abuse cases are ineffectual and the only viable alternative is civil sanction); Richard Allen McDonald, Note, *Torts: Civil Action Against Physician for Failure to Report Cases of Suspected Child Abuse*, 30 OKLA. L. REV. 482, 485, 487 (1977); Jerry A. Ramsey & Byron J. Lawler, *The Battered Child Syndrome*, 1 PEPP. L. REV. 372, 374, 381 (1974) (maintaining that the imposition of civil liability will provide a financial deterrent for physician inaction); cf. Bradley v. Ray, 904 S.W.2d 302, 314 (Mo. Ct. App. 1995); BESHAROV, *THE VULNERABLE SOCIAL WORKER*, *supra* note 57, at 27 (discussing the incentive value of civil litigation and criminal prosecution against non-reporting social workers and other defendants); Aaron, *supra* note 11, at 186 (incentive value of civil litigation against non-reporting teachers); Jones, *Battered Spouses' Section 1983 Damage Actions*, *supra* note 8, at 255 & n.11 (incentive value of civil litigation against unresponsive police); Jones, *Battered Spouses' State Law Damage Actions*, *supra* note 1, at 4 & n.10 (citing sources discussing whether the availability of damage actions against police would encourage action). *Contra* Mazura, *supra* note 12, at 1198-1201 (claiming that more than civil litigation is needed to encourage abuse reporting). As one article discussing the analogous child abuse reporting problem noted:

The number of [children] in our institutions cry out for an effective method to encourage those who fail to report to take a hard look at their dereliction of duty. A civil tort action . . . tried before a cross section of society who can impose an effective dollar penalty, will provide such encouragement. With the penalty measured in the tens and hundreds of thousands of dollars, the inconvenience of reporting and becoming involved will shrink into insignificance. It is a language that most professionals understand . . . . Only then will the [children] of our society have the opportunity for a childhood free of physical abuse.

Ramsey & Lawler, *supra*, at 381. Anecdotal evidence indicates that the actual imposition of civil liability will cause many more physicians to report abuse. See Douglas J. Besharov, *Child Abuse and Neglect: Liability for Failing To Report*, TRIAL, Aug. 1986, at 67, 71 [hereinafter Besharov, *Failing to Report*] (finding that the prospect of civil litigation for damages is a strong incentive for compliance with reporting mandates); Kalichman & Brosig, *supra* note 51, at 90 (stating that legal concerns influence a psychologist's decision to report child abuse); Kelley, *supra*, at 409 n.43 (citing an increase in reporting of abuse in areas where civil liability for non-action is publicized).

59. See, e.g., Brown & Truitt, *supra* note 12, at 762; Collier, *supra* note 30, at 192; Mazura, *supra* note 12, at 1192-93.

unresponsive police, physicians may find themselves held liable for not preventing abuse they did not directly cause on theories of common law<sup>60</sup> negligence,<sup>61</sup> common law statutory tort,<sup>62</sup> or perhaps express statutory provision.<sup>63</sup>

### I. BATTERED SPOUSES' NEGLIGENCE SUITS

In order to prevail in a negligence action against a physician who did not report abuse of a patient to the authorities, the patient (or her survivors) must prove the traditional elements of negligence—duty, breach of duty, causation (both in fact and proximate), and actual injury.<sup>64</sup> While proximate cause could prove problematic,<sup>65</sup> the ultimate

60. This Article focuses on private physicians treating private patients. If the physician is a state or federal governmental agent, other issues may be present, such as sovereign and official immunity, civil rights violation, tort liability of federal officials, the public duty rule, etc. For an overview of these issues, see Jones, *Battered Spouses' Section 1983 Damage Actions*, *supra* note 8; Jones, *Battered Spouses' State Law Damages Actions*, *supra* note 1, at 5-13, 15-31, 70-74.

This Article does not discuss possible remedies under the Civil Rights Remedies for Gender-Motivated Violence Act as codified at 42 U.S.C. § 13981 (1994). It is uncertain whether domestic violence victims could use this new civil rights law against non-reporting physicians.

61. See *infra* notes 64-326 and accompanying text.

62. See *infra* notes 327-46 and accompanying text.

63. See *infra* notes 347-48 and accompanying text.

For the possibility of holding an abuse non-reporter civilly liable on an "aiding and abetting" cause of action, see *Bradley v. Ray*, 904 S.W.2d 302, 315 (Mo. Ct. App. 1995) (holding that the plaintiff failed to plead adequate facts to consider aiding and abetting as a theory of recovery); W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 46 (5th ed. 1984 & Supp. 1988). For (probably unsuccessful) use of the "prima facie" tort in this context, see *Bradley*, 904 S.W.2d at 315.

64. *E.g.*, *Leake v. Cain*, 720 P.2d 152, 155 (Colo. 1986) (en banc); *A.L. v. Commonwealth*, 521 N.E.2d 1017, 1020 (Mass. 1988); *Millman v. County of Butler*, 458 N.W.2d 207, 215 (Neb. 1990); KEETON ET AL., *supra* note 63, § 30; TERRENCE F. KIELY, MODERN TORT LIABILITY: RECOVERY IN THE '90s § 6.2 (1990); *cf.* RESTATEMENT (SECOND) OF TORTS § 281 (1965).

65. A battered spouse must establish that the physician was both a cause in fact and a proximate cause of the spouse's injuries. See KEETON ET AL., *supra* note 63, §§ 30, 41-45 (discussing causation). Proximate causation is a public policy-oriented doctrine. Under it, courts can absolve defendants even though their breaches of duty harmed others. Thus, proximate causation is clearly analogous with duty. See, e.g., *Petition of Kinsman Transit Co.*, 388 F.2d 821 (2d Cir. 1968) (addressing the proximate causation of a negligently moored ship which damaged a bridge, causing flooding and eventually hindering plaintiff's ability to load cargo); *Kelly v. Gwinnell*, 476 A.2d 1219 (N.J. 1984) (discussing liability of host who served alcohol to an eventual drunk driver); *Palsgraf v. Long Island R.R. Co.*, 162 N.E. 99 (N.Y. 1928) (majority spoke in terms of duty rather than proximate cause). For more on the vast field of proximate causation law, see generally, e.g., 3 FOWLER V. HARPER ET AL., THE LAW OF TORTS § 18.1, at 650 (2d ed. 1986 & Supp. 1995); 4 FOWLER V. HARPER ET AL., *supra* §§ 20.1, 20.4-6; KEETON ET AL., *supra*, §§ 42-44; Patrick J. Kelley, *Proximate Cause in Negligence Law: History, Theory, and the Present Darkness*, 69 WASH. U.L.Q. 49 (1991); Jane Stapleton, *Law, Causation and Common Sense*, 8 OXFORD J. LEGAL STUD. 111 (1988); E. Wayne Thode, *Tort Analysis: Duty-Risk v. Proximate Cause and the Rational Allocation of Functions Between Judge and Jury*, 1977 UTAH L. REV. 1.

Numerous cases have held, directly or implicitly, that the police are a cause in fact and proximate cause of the injuries an abusive spouse inflicts when they did not arrest him. Hence, the



inquiry is one of duty—did the physician owe the patient a duty to report suspected abuse to the authorities, and if so did the physician satisfy this obligation. One who does not owe another a duty to act reasonably is not liable to the other even when he or she carelessly harms that other person.<sup>66</sup> Conversely, one must act reasonably towards those to whom one owes a duty. Where tribunals draw the line on duty can determine important policy concerns,<sup>67</sup> and their decisions are driven, to a large extent, by public policy considerations akin to those in proximate cause cases.<sup>68</sup> As the following discussion demonstrates, courts also resolve disputes about the liability of physicians when they set the parameters of duty.

### A. General Common Law Rule of No Duty to Help Others

At common law parties have no duty to aid or protect others unless the parties have some form of "special relationship" with those others.<sup>69</sup> This rule has led to a number of shocking decisions which

police are liable in damages for the harm the spouse causes. *E.g.*, *Rauci v. City of Rotterdam*, 902 F.2d 1050, 1058 (2d Cir. 1990) (applying New York law); *Adams v. State*, 555 P.2d 235, 241 & n.14 (Alaska 1976); *Schear v. Board of County Comm'rs*, 687 P.2d 728, 730 (N.M. 1984); *Berliner v. Thompson*, 540 N.Y.S.2d 374, 376-77 (App. Div. 1989); Caitlin E. Borgmann, Note, *Battered Women's Substantive Due Process Claims: Can Orders of Protection Deflect DeShaney?*, 65 N.Y.U. L. REV. 1280, 1309-14 (1990); Jones, *Battered Spouses' State Law Damage Actions*, *supra* note 1, at 15 n.44. The law is less developed in the physician context, but should lead to the same result. In *Landeros v. Flood*, 551 P.2d 389, 395-96 (Cal. 1976), the California Supreme Court ruled that a physician who failed to report an instance of child abuse to the authorities, when the abuser then inflicted additional injuries on the child after the physician treated her, may be liable in negligence for the child's subsequent injuries. As the court observed, a jury could find that the *Landeros* victim's subsequent mistreatment by her mother and her mother's common law husband was foreseeable to the treating physician given what he had witnessed when he saw the eleven month old child in the hospital, and thus that he helped cause the harm. *Id.* See *J.A.W. v. Roberts*, 627 N.E.2d 802, 811-12 (Ind. Ct. App. 1984) (dealing with a suit against a clergyman and a marital counselor for a failure to report abuse, is to the same effect).

The foreseeable criminal conduct of an abusive spouse is not a superseding intervening cause. Thus, it does not exculpate the defendant. See *Landeros*, 551 P.2d at 395; KEETON ET AL., *supra*, § 44, at 305; Jones, *supra*, at 15 n.44.

66. See, e.g., KEETON ET AL., *supra* note 63, § 53; KIELY, *supra* note 64, §§ 6.1-.3.

67. For a discussion on the process of determining the existence of a duty, see, e.g., KEETON ET AL., *supra* note 63, § 53; KIELY, *supra* note 64, §§ 6.1-.3; Fleming James, Jr., *Scope of Duty in Negligence Cases*, 47 Nw. U.L. REV. 778 (1953).

68. See *supra* note 65 (discussing proximate causation).

69. See, e.g., *Stangle v. Fireman's Fund Ins. Co.*, 244 Cal. Rptr. 103, 104 (Cal. Ct. App. 1988). For further discussion of the common law duty to aid and protect others, see generally RESTATEMENT (SECOND) OF TORTS §§ 314, 314A, 314B (1965); KEETON ET AL., *supra* note 63, § 56; John M. Adler, *Relying Upon the Reasonableness of Strangers: Some Observations About the Current State of Common Law Affirmative Duties to Aid or Protect Others*, 1991 WIS. L. REV. 867; James B. Ames, *Law and Morals*, 22 HARV. L. REV. 97, 111-13 (1908); Francis H. Bohlen, *The Moral Duty to Aid Others as a Basis of Tort Liability* (pts. 1-2), 56 U. PA. L. REV. 217, 316 (1908); Jones, *Battered Spouses' State Law Damage Actions*, *supra* note 1, at 32-40, 74-77 (from which this material is excerpted); Saul Levmore, *Waiting for Rescue: An Essay On the Evolution and*

have exculpated morally censurable, but legally blameless, defendants who did not help those they easily could have saved.<sup>70</sup> Thus, the priest and the Levite from the renowned New Testament parable, who refused to aid the crime victim the good Samaritan finally rescued,<sup>71</sup> may have had a moral obligation to intervene. The common law, however, would not hold them liable in tort for their inaction.<sup>72</sup> In the words of an influential early ruling:

For withholding relief from the suffering, for failure to respond to the calls of worthy charity, or for faltering in the bestowment of brotherly love on the unfortunate, penalties are found not in the

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*Incentive Structure of the Law of Affirmative Obligations*, 72 VA. L. REV. 879 (1986); Robert A. Prentice, *Expanding The Duty To Rescue*, 19 SUFFOLK U. L. REV. 15 (1985); Jay Silver, *The Duty to Rescue: A Reexamination and Proposal*, 26 WM. & MARY L. REV. 423 (1985); Ernest J. Weinrib, *The Case for a Duty to Rescue*, 90 YALE L.J. 247 (1980); Daniel B. Yeager, *A Radical Community of Aid: A Rejoinder To Opponents of Affirmative Duties to Help Strangers*, 71 WASH. U. L.Q. 1 (1993). As *Restatement (Second) of Torts* § 314 (1965) states: "The fact that the actor realizes or should realize that action on his part is necessary for another's aid or protection does not of itself impose upon him a duty to take such action." *Restatement (Second) of Torts* § 315 (1965) specifically provides that:

There is no duty so to control the conduct of a third person so as to prevent him from causing physical harm to another unless

- (a) a special relation exists between the actor and the third person which imposes a duty upon the actor to control the third person's conduct, or
- (b) a special relation exists between the actor and the other which gives to the other a right to protection.

70. See, e.g., *Miller v. Arnal Corp.*, 632 P.2d 987, 990 (Ariz. Ct. App. 1981) (ski resort not liable for failing to rescue a hiker stranded in snowstorm); *Union Pac. Ry. v. Cappier*, 72 P. 281 (Kan. 1903) (railroad employees who did not immediately help trespasser, whom train ran over, owed no duty to him); *Osterlind v. Hill*, 160 N.E. 301 (Mass. 1928) (lessor of canoe who disregarded cries for help from lessee after canoe overturned on lake surface had no duty to rescue); *Sullenger ex rel. Sullenger v. Setco Northwest, Inc.*, 702 P.2d 1139 (Or. Ct. App. 1985) (pediatrician had no duty to help child who suffered permanent brain damage because no formal physician-patient relationship had arisen between them); *Yania v. Bigan*, 155 A.2d 343 (Pa. 1959) (landowner had no duty to help his drowning invitee); see generally, e.g., MARSHALL S. SHAPO, *THE DUTY TO ACT: TORT LAW, POWER AND PUBLIC POLICY* (1977) (discussing several examples where no duty was found).

71. *Luke* 10:30-37. At the conclusion of the parable, the author of the gospel reported that Christ raised a question: "Which now of these three [the priest, the Levite, or the Samaritan], thinkest thou, was neighbour unto him that fell among the thieves?" *Id.* at 10:36. The response, appropriately, was: "He that shewed mercy on him." *Id.* at 10:37. Christ's final exhortation was "Go, and do thou likewise," *id.*, an obligation the courts often have refused to enforce. See *infra* note 72 and accompanying text; *supra* notes 69-70 and accompanying text (discussing court's traditional approaches to duty-to-rescue cases).

72. See *Buch v. Amory Mfg. Co.*, 44 A. 809, 810 (N.H. 1898) (stating the common law rule). As the *Buch* court elaborated:

Suppose A., standing close by a railroad, sees a two year old babe on the track, and a car approaching. He can easily rescue the child, with entire safety to himself, and the instincts of humanity require him to do so. If he does not, he may, perhaps, justly be styled a ruthless savage and a moral monster; but he is not liable in damages for the child's injury . . .

*Id.*

laws of men, but in that higher law, the violation of which is condemned by the voice of conscience, whose sentence of punishment for the recreant act is swift and sure.<sup>73</sup>

This principle obviously could make it difficult for those who need assistance to hold inactive physicians answerable for their failure to report abuse inflicted upon their patients.<sup>74</sup>

### B. "Special Relationship" Exceptions to No Duty Rule

Notwithstanding the traditional no duty rule, one may have a responsibility to protect another when he or she has a "special relationship" with the other.<sup>75</sup> Courts have found special relationships in a variety of situations. Many agree, for example, that occupiers of land have the burden of shielding their invitees.<sup>76</sup> A party may have to prevent another from harming a third person either because the party must control the other's conduct or because the party is charged with protecting the third person from harm.<sup>77</sup> A tribunal also may hold liable one who voluntarily assumes an obligation he or she ordinarily

73. *Union Pac. Ry.*, 72 P. at 282.

74. For more on the continued validity of the no duty to rescue doctrine, see Jones, *Battered Spouses' State Law Damage Actions*, *supra* note 1, at 74-77.

75. See, e.g., *Stangle v. Fireman's Fund Ins. Co.*, 244 Cal. Rptr. 103, 104 (Cal. Ct. App. 1988) (finding no special relationship between insurance company and plaintiff whose ring was stolen in the insurance company's office); *Felger v. Larimer County Bd. of County Comm'rs*, 776 P.2d 1169, 1171-72 (Colo. Ct. App. 1989) (sheriff had special relationship with probationer in public service program); *Cansler v. State*, 675 P.2d 57, 61-63 (Kan. 1984) (special relationship required county to notify local police of escapes from county jail); KEETON ET AL., *supra* note 63, § 56, at 376-85 (discussing special relationships which may give rise to a duty).

76. E.g., RESTATEMENT (SECOND) OF TORTS § 314A(3) (1965); see, e.g., *L. S. Ayres & Co. v. Hicks*, 40 N.E.2d 334 (Ind. 1942) (construing a duty of store owners to the its patrons); *Mostert v. CBL & Assocs.*, 741 P.2d 1090 (Wyo. 1987).

77. RESTATEMENT (SECOND) OF TORTS § 315 (1965).

Specific sections of the Restatement outline the duty of parents to control the conduct of their children, RESTATEMENT (SECOND) OF TORTS § 316 (1965); e.g., *Boyd v. Connell*, 739 S.W.2d 536 (Ark. 1987); *Huston v. Konieczny*, 556 N.E.2d 505 (Ohio 1990), masters the actions of their servants when the servants are acting outside the scope of their employment, RESTATEMENT (SECOND) OF TORTS § 317 (1965); e.g., *Nazareth v. Herndon Ambulance Serv.*, 467 So. 2d 1076 (Fla. Dist. Ct. App.), *review denied*, 478 So. 2d 53 (Fla. 1985); *Palmer v. Keene Forestry Ass'n*, 112 A. 798 (N.H. 1921), and possessors of land or chattels the actions of their licensees. RESTATEMENT (SECOND) OF TORTS § 318 (1965); e.g., *Wheeler v. Darmochwat*, 183 N.E. 55 (Mass. 1932); *Parks v. Pere Marquette Ry. Co.*, 23 N.W.2d 196 (Mich. 1946).

RESTATEMENT (SECOND) OF TORTS § 320 (1965) requires:

One who is required by law to take or who voluntarily takes the custody of another under circumstances such as to deprive the other of his normal power of self-protection or to subject him to association with persons likely to harm him, is under a duty to exercise reasonable care so to control the conduct of third persons as to prevent them from intentionally harming the other or so conducting themselves as to create an unreasonable risk of harm to him, if the actor

(a) knows or has reason to know that he has the ability to control the conduct of the third persons, and

would not have and then performs it carelessly, if at all, to endanger another person.<sup>78</sup> In the words of the leading treatise: "the good Samaritan who tries to help may find himself mulcted in damages, while the priest and the Levite who pass by on the other side go on their cheerful way rejoicing."<sup>79</sup>

Many courts hold that some statutes and related enactments, including both municipal ordinances and administrative regulations,<sup>80</sup> can generate a duty if their legislative enactor so intended.<sup>81</sup> When someone violates such a law, the tribunals then may find that he or she has breached the duty.<sup>82</sup> The disobedience is labelled statutory negligence, and may provide an injured plaintiff with evidence of

(b) knows or should know of the necessity and opportunity for exercising such control.

A number of courts have imposed duties on defendants in cases which may be classified under this *Restatement* section. See, e.g., *Felger v. Larimer County Bd. of County Comm'rs*, 776 P.2d 1169, 1172 (Colo. Ct. App. 1989) (sheriff had duty to protect drunk driver ordered to perform community service as atonement); *Comuntzis v. Pinellas County Sch. Bd.*, 508 So. 2d 750 (Fla. Dist. Ct. App. 1987) (school had duty to protect pupil from attack by other student); *Sylvester v. Northwestern Hosp.*, 53 N.W.2d 17 (Minn. 1952) (hospital had duty to protect patient from attack by other patient).

78. See, e.g., *Papastathis v. Beall*, 723 P.2d 97, 99 (Ariz. Ct. App. 1986) (franchisor which undertook inspection of soft drink dispenser rack was liable for injuries caused by rack); *Bloomberg v. Interinsurance Exch.*, 207 Cal. Rptr. 853, 856 (Cal. Ct. App. 1984) (motor club which dispatched tow truck could be liable for wrongful death of stranded motorist which occurred after tow truck failed to locate the motorist); *Crowley v. Spivey*, 329 S.E.2d 774, 785 (S.C. 1985) (grandparents who undertook supervision of grandchildren were liable for their wrongful deaths which occurred after they supervised them negligently); *RESTATEMENT (SECOND) OF TORTS* §§ 323, 324, 324A (1965).

79. *KEETON ET AL.*, *supra* note 63, § 56, at 378.

80. *Id.* § 36, at 220 & nn.3-4.

81. For examples and discussion of statutes generating a duty, see *RESTATEMENT (SECOND) OF TORTS* §§ 285(a)-(b), 286 (1965); *KEETON ET AL.*, *supra* note 63, § 36; James T. R. Jones, *Trains, Trucks, Trees and Shrubs: Vision-Blocking Natural Vegetation and a Landowner's Duty to Those Off the Premises*, 39 *VILL. L. REV.* 1263, 1284-88 (1994); Paul Sherman, *Use of Federal Statutes in State Negligence Per Se Actions*, 13 *WHITTIER L. REV.* 831, 879-83 (1992).

82. Once tribunals find such a duty, they determine the effect of their discovery by following *Restatement (Second) of Torts* § 288B (1965). It specifies:

(1) The unexcused violation of a legislative enactment or an administrative regulation which is adopted by the court as defining the standard of conduct of a reasonable man, is negligence itself.

(2) The unexcused violation of an enactment or regulation which is not so adopted may be relevant evidence bearing on the issue of negligent conduct.

*Id.* Thus, in either event the statutory authority can give rise to a duty, and accordingly a special relationship.

For more on determining whether a particular statute creates such a responsibility, as well as the effect of a finding that it does, see, e.g., *Crown v. Raymond*, 764 P.2d 1146 (Ariz. Ct. App. 1988) (dealing with a statute prohibiting the sale of handguns to minors); *Sanchez v. Galey*, 733 P.2d 1234 (Idaho 1986) (construing OSHA regulations); *Martin v. Herzog*, 126 N.E. 814 (N.Y. 1920) (adjudicating an issue arising from a statute requiring certain lights on a motor vehicle); *KEETON ET AL.*, *supra* note 63, § 36.

fault. The wrongdoer even can be conclusively negligent—negligent per se—as a result.<sup>83</sup> Thus, judicial construction effectively creates a special relationship between those the legislature orders to behave in a certain way and those benefitted by that designation.

In sum, physicians have no common law duty to help battered women (or anyone else) unless they have special relationships with them. This situation may be distressing and distasteful, but courts continue to enforce it.<sup>84</sup> Thus, the relevant question becomes can a domestic violence victim establish a special relationship between herself and the physician(s) she consulted during the abuse process sufficient to generate a duty of protection from the physician for whose breach the physician will be held liable when he or she unreasonably fails to report the abuse. The answer is yes.

### 1. Physician Duty to Report Child Abuse

At the outset, one notes the dearth of authority on physicians, special relationships, and domestic violence victims. Such a dearth does not exist, however, in the closely related child abuse field.<sup>85</sup> Much has been written about physician (and other)<sup>86</sup> liability for failure to re-

83. See, e.g., *Thelen ex rel. Thelen v. St. Cloud Hosp.*, 379 N.W.2d 189, 192-93 (Minn. Ct. App. 1985); *McRee v. Raney*, 493 So. 2d 1299, 1300 (Miss. 1986); KEETON ET AL., *supra* note 63, § 36, at 229-31 (discussing negligence per se).

In this Article, the concept of statutory negligence refers to judicial applications of both the evidence of negligence and negligence per se approaches. When a court concludes that a non-reporting physician or other defendant is guilty of negligence per se, its holding is considerably worse for him or her than if it merely ruled that it would use his or her violation of the law as evidence of negligence.

For more on statutory negligence in the non-reporting physician context, see *infra* notes 283-309 and accompanying text.

84. See *Jones, Battered Spouses' State Law Damage Actions*, *supra* note 1, at 38 n.168, 74-77. For a discussion about why the rule which says those like physicians have no duty to help others absent a special relationship with them is bad policy, see *id.* at 74-77.

85. See *infra* notes 128-36 and accompanying text (discussing elder abuse laws).

86. Those other than physicians, such as school or child welfare workers, counsellors, attorneys, or clergy could face liability for failing to report child abuse. See generally, e.g., *Letlow v. Evans*, 857 F. Supp. 676 (W.D. Mo. 1994) (educational defendants); *Thelma D. v. Board of Educ.*, 669 F. Supp. 947 (E.D. Mo. 1987) (educational defendants); *Doe "A" v. Special Sch. Dist.*, 637 F. Supp. 1138 (E.D. Mo. 1986), *aff'd*, 901 F.2d 642 (8th Cir. 1990) (educational defendants); *Nelson v. Freeman*, 537 F. Supp. 602 (W.D. Mo. 1982), *aff'd*, 706 F.2d 276 (8th Cir. 1983) (child welfare defendants); *Freehauf v. School Bd.*, 623 So. 2d 761 (Fla. Dist. Ct. App. 1993) (educational defendants); *J.A.W. v. Roberts*, 627 N.E.2d 802 (Ind. Ct. App. 1994) (counsellor and clergy defendants); *Borne ex rel. Borne v. Northwest Allen County School Corp.*, 532 N.E.2d 1196 (Ind. Ct. App. 1989) (educational defendants); *Kansas State Bank & Trust Co. v. Specialized Transp. Servs., Inc.*, 819 P.2d 587 (Kan. 1991) (educational defendants); *Williams v. Coleman*, 488 N.W.2d 464 (Mich. Ct. App. 1992) (social worker defendants); *BESHAROV, THE VULNERABLE SOCIAL WORKER*, *supra* note 57, at 22-50 (social worker defendants); *Aaron*, *supra* note 11 (educational defendants); *William A. Cole, Religious Confidentiality and the Reporting of Child Abuse: A Statutory and Constitutional Analysis*, 21 COLUM. J.L. & SOC. PROBS.

port child abuse.<sup>87</sup> A number of courts have ruled in this area.<sup>88</sup>

1, 7 (1987) (clergy defendants); Mary Harter Mitchell, *Must Clergy Tell? Child Abuse Reporting Requirements Versus the Clergy Privilege and Free Exercise of Religion*, 71 MINN. L. REV. 723, 732-33 (1987) (clergy defendants); Mosteller, *supra* note 13 (attorney defendants); Raymond C. O'Brien & Michael T. Flannery, *The Pending Gauntlet to Free Exercise: Mandating That Clergy Report Child Abuse*, 25 LOY. L.A. L. REV. 1 (1991) (clergy defendants); Robin A. Rosencrantz, *Rejecting "Hear No Evil Speak No Evil": Expanding the Attorney's Role in Child Abuse Reporting*, 8 GEO. J. LEGAL ETHICS 327 (1995) (attorney defendants); Lisa M. Smith, *Lifting the Veil of Secrecy: Mandatory Child Abuse Reporting Statutes May Encourage the Catholic Church to Report Priests who Molest Children*, 18 LAW & PSYCHOL. REV. 409, 419-20 (1994) (clergy and other church official defendants). The same legal principles should apply to all those mandated by law to report abuse.

87. See generally, e.g., Agatstein, *supra* note 13, at 148-49 (discussing liability of mental health professionals for failure to report); Martha Bailey, *The Failure of Physicians to Report Child Abuse*, 40 U. TORONTO FAC. L. REV. 49, 59-64 (1982) (construing Canadian law); Besharov, *Failing to Report*, *supra* note 58; Besharov, *Child Abuse and Neglect*, *supra* note 14, at 480-83; Brown & Truitt, *supra* note 12; James N. Clymer, Comment, *Torts: The Battered Child—A Doctor's Civil Liability for Failure to Diagnose and Report*, 16 WASHBURN L.J. 543 (1977); Collier, *supra* note 30; Orville R. Endicott, *Civil Liability for Failure to Report Child Abuse*, 3 CHILD ABUSE & NEGLECT 633 (1979) (construing Canadian law); Fraser, *supra* note 14, at 666-67 (discussing possible liability of physicians and other professionals); Jeffrey Hannig, Recent Case, 52 N.D. L. REV. 736 (1976) (discussing *Landeros v. Flood*); Hurley, *supra* note 13 (discussing liability for psychotherapists' failure to report); Lon B. Isaacson, *Child Abuse Reporting Statutes: The Case for Holding Physicians Civilly Liable for Failing to Report*, 12 SAN DIEGO L. REV. 743 (1975); Kohlman, *supra* note 12 (discussing physician liability for failure to report abuse); Lehto, *supra* note 12 (discussing physician liability for failure to report abuse); Mazura, *supra* note 12 (discussing liability of physicians for failure to report); McDonald, *supra* note 58 (discussing liability of physicians for failure to report); Miles, *supra* note 11, at 707-17 (discussing liability of physicians and other professionals for failure to report abuse); Monrad G. Paulsen, *Child Abuse Reporting Laws: The Shape of the Legislation*, 67 COLUM. L. REV. 1, 34-36 (1967) [hereinafter Paulsen, *Child Abuse Reporting Laws*]; *Physician's Civil Liability for Negligent Noncompliance with Child Abuse Reporting Statute*, 27 ATLA L. REP. 391 (1984) [hereinafter *Physician's Civil Liability*] (discusses three successful suits against physicians who did not report child abuse); Melvin Rogow, Note, *Child Abuse — The Battered Child Syndrome — Liability Arising From Reporting Laws — Landeros v. Flood*, 1 GLENDALE L. REV. 292 (1976); Slovenko, *supra* note 14, at 484; Thomas A. Moore, *Physician Liability for Failure to Report Child Abuse* (pts. I & II), N.Y. L.J., Jan. 7, 1992, at 3 & Feb. 4, 1992, at 3 (discussing physician liability).

88. See, e.g., *Letlow*, 857 F. Supp. at 676 (educational defendants); *Thelma D.*, 669 F. Supp. at 947 (educational defendants); *Doe "A"*, 637 F. Supp. at 1138 (educational defendants); *Nelson*, 537 F. Supp. at 602 (child welfare defendants); *Landeros v. Flood*, 551 P.2d 389 (Cal. 1976); *Freehauf*, 623 So. 2d at 761 (educational defendants); *Fischer v. Metcalf*, 543 So. 2d 785 (Fla. Dist. Ct. App. 1989) (psychiatrist defendant); *Cechman v. Travis*, 414 S.E.2d 282 (Ga. Ct. App. 1991) (hospital and other medical professional defendants); *J.A.W.*, 627 N.E.2d at 802 (counselor and clergy defendants); *Borne*, 532 N.E.2d at 1196 (educational defendants); *Kansas State Bank*, 819 P.2d at 587 (educational defendants); *Marcelletti v. Bathani*, 500 N.W.2d 124 (Mich. Ct. App. 1993) (physician defendants); *Williams*, 488 N.W.2d at 464 (social worker defendants); *Physician's Civil Liability*, *supra* note 87 (discussing three successful suits, including *Landeros*, against physicians who did not report child abuse); see also, e.g., *Commonwealth v. Cadwell*, 372 N.E.2d 246, 253 n.8 (Mass. 1978) (criminal homicide case); *Commonwealth v. Labbe*, 373 N.E.2d 227, 233 (Mass. App. Ct. 1978) (Brown, J., concurring) (criminal homicide case in which the concurring justice noted that a battered child may bring a tort action for "failure to report a probable case of child abuse, where subsequently there is further injury to the child. In addition, an attending physician may be subject to personal liability for the consequences of any negligent

These authorities help indicate the appropriate result when a battered woman seeks to recover for a physician's failure to report her abuse.

When failure to report child abuse is at issue, courts have considered several theories for imposing civil liability—most frequently common law negligence,<sup>89</sup> statutory negligence,<sup>90</sup> or perhaps an express statutory liability provision.<sup>91</sup> As a starting point, by statute all states require physicians to report known or suspected child abuse to specified authorities.<sup>92</sup> What is the effect of not following the law? Many states impose criminal penalties for a failure to report child abuse.<sup>93</sup> While criminal prosecutions for violations are rare, they are not unprecedented.<sup>94</sup> Still, their infrequency markedly reduces whatever incentive to report the existence of criminal sanctions otherwise would provide. Moreover, criminal penalties do little or nothing actually to help the individual child who was battered or killed. Thus, civil suits are brought both to compensate the injured and to motivate recalcitrant physicians to report abuse of future patients.<sup>95</sup>

*Landeros v. Flood*<sup>96</sup> is the leading pro-liability decision. In that case, the mother of an eleven month old child and the mother's common law husband took the child to a California hospital for treatment. The child evidenced severe battering, but the examining physician

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failure to recognize the battered child syndrome") (citations omitted); *Settlement in Case Involving Failure to Diagnose Battered Child Syndrome*, 8 VERDICTS, SETTLEMENTS & TACTICS 166 (1988) (report on substantial 1988 settlement of suit against United States Air Force under Federal Tort Claims Act, applying California malpractice law, after Air Force physicians failed to diagnose child abuse, abuse continued, and child suffered severe and permanent injuries as a result).

89. See *infra* notes 100-03, 107-18 and accompanying text.

90. See *infra* notes 104, 119-24, 294-308 and accompanying text.

91. See *infra* notes 125-27 and accompanying text.

92. In 1967 Professor Monrad G. Paulsen performed a landmark study on child abuse reporting laws which has admirably withstood the passage of nearly thirty years. Paulsen, *Child Abuse Reporting Laws*, *supra* note 87. For more recent discussion on this subject, see, e.g., Brooks et al., *Child Abuse and Neglect Reporting Laws: Understanding Interests, Understanding Policy*, 12 BEHAVIORAL SCI. & LAW 49, 49 (1994); Fraser, *supra* note 14; Mitchell, *supra* note 86, at 725; Mosteller, *supra* note 13, at 211-14; John E.B. Myers, *A Survey of Child Abuse and Neglect Reporting Statutes*, 10 J. JUV. L. 1 (1986); Rosencrantz, *supra* note 86, at 339-42.

93. For a discussion of criminal penalties for failure to report abuse, see, e.g., BESHAROV, THE VULNERABLE SOCIAL WORKER, *supra* note 57, at 25-29; Aaron, *supra* note 11, at 188; Fraser, *supra* note 14, at 665-66; Mitchell, *supra* note 86, at 732-33; Myers, *supra* note 92, at 62-71.

94. For cases featuring criminal prosecutions for failure to report child abuse, see, e.g., Barber v. State, 592 So. 2d 330 (Fla. Dist. Ct. App. 1992); Gladson v. State, 376 S.E.2d 362 (Ga. 1989); People v. Caviani, 432 N.W.2d 409 (Mich. Ct. App. 1988); State v. Grover, 437 N.W.2d 60 (Minn. 1989); Morris v. State, 833 S.W.2d 624 (Tex. Ct. App. 1992), *cert. denied*, 113 S. Ct. 1387 (1993). For a discussion of criminal prosecutions, see, e.g., BESHAROV, THE VULNERABLE SOCIAL WORKER, *supra* note 57, at 27-29; Slovenko, *supra* note 14, at 483-84.

95. Kohlman, *supra* note 12, at 122; Miles, *supra* note 11, at 704, 709-10.

96. 551 P.2d 389 (Cal. 1976).

failed to diagnose battered child syndrome<sup>97</sup> and did not report the child's condition to the authorities for appropriate intervention. Instead, the child was sent home with her mother. Once there, she suffered further severe abuse until another doctor at another hospital correctly diagnosed the child's battered child syndrome, promptly reported it, and the child was taken from her mother and placed in protective custody.<sup>98</sup> The child's representative then sued the original physician and hospital in common law and statutory negligence<sup>99</sup> for the injuries she suffered after she was discharged into the care of her mother. The California Supreme Court upheld her two causes of action.

Turning initially to common law negligence, the *Landeros* court first held the standard of care in medical malpractice cases may require physicians to know how to diagnose and treat the battered child syndrome, depending on the opinions of experts.<sup>100</sup> It then found the essential physician's duty to report because of the reporting statutes,<sup>101</sup> which "evidence a determination by the Legislature that in the event a physician does diagnose a battered child syndrome, due care includes a duty to report that fact to the authorities."<sup>102</sup> Because it concluded that it was a question of fact whether the defendant physician should have foreseen that the child further would be injured if he

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97. *Id.* at 393-94. Dr. C. Henry Kempe and others wrote the seminal work on this syndrome in 1962. C. Henry Kempe et al., *The Battered Child Syndrome*, 181 JAMA 17 (1962). As one author has described:

"Battered child syndrome" describes the condition of children who have sustained repeated and/or serious physical injuries by non-accidental means. Injuries are characteristically inflicted by someone who is caring for the child, and there is usually a marked discrepancy between clinical findings and the child's medical history as supplied by his parents or guardians. Several factors are characteristic of the condition: evidence of multiple bone injuries; subdural hematomas with or without skull fractures; serious, unexplained physical injury; evidence of soft tissue injury; evidence of sexual abuse or general neglect; and multiple injuries present at the same time. Evidence of nutritional neglect and emotional abuse are also indicative of the syndrome.

Aaron, *supra* note 11, at 183 n.3 (citations omitted).

98. The child's mother and her common law husband subsequently were convicted of the crime of child abuse. *Landeros*, 551 P.2d at 391-92.

99. The child alleged statutory negligence due to failure to report under the mandates of the child abuse statute and two related laws requiring physicians and hospitals to report injuries inflicted in violation of the criminal law. *Id.* at 392.

100. *Id.* at 393-94.

101. *Id.* at 392; see *supra* note 99.

102. *Landeros*, at 394 n.8. Thus, apparently the court's finding of a duty was based on the reporting statutes rather than any common law duty to act. Actually, the duty should have been based on a special relationship between the treating physician and the abused child rather than the fact that the statute existed. The statute would be relevant when statutory negligence, rather than common law negligence, was the issue. See Miles, *supra* note 11, at 710 & n.67 (discussing the source of the duty to report abuse).



merely discharged the child to her mother without first reporting the abuse, the California Supreme Court rejected the physician's contention of supervening intervening cause/proximate cause as a matter of law. Finally, and as an alternative to common law negligence, the *Landeros* court upheld the use of statutory negligence as a means of finding a physician who did not report child abuse to the authorities civilly liable pursuant to the requirements of a reporting statute.<sup>103</sup>

*Landeros's* landmark status perhaps was best illustrated by the spate of predominantly laudatory articles which appeared soon after the California Supreme Court decided it.<sup>104</sup> Indeed, health journals and related sources frequently have reported its holdings as if they were the governing law nationwide.<sup>105</sup> However, the judicial reception has been much more guarded. On the common law negligence front, only a few courts really have endorsed imposing a duty to report abuse. In *J.A.W. v. Roberts*,<sup>106</sup> a former child sexual abuse victim sued a number of individuals who knew about his abuse but did not report it, alleging they had a duty to act, did not, and thus acted unreasonably and were negligent. The trial court held the defendants owed the plaintiff no duty to report the molestation.<sup>107</sup> On appeal, the Court of Appeals of Indiana evaluated the relationship between the plaintiff and each individual defendant to see if a special relationship, and thus a duty, was present. The court reaffirmed the law that "knowledge of another's peril, even knowledge of the existence of criminal activity, standing alone, imposes no common law duty on one possessing such knowledge to take any affirmative action."<sup>108</sup> The court then rejected

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103. *Landeros*, 551 P.2d at 396-97.

The court did somewhat limit its *Landeros* holding, as it found that a non-reporting physician would be liable civilly only if he or she *intentionally* failed to report—i.e., that the physician thought reportable abuse was present yet did not act. *Id.* at 397-98.

104. *See, e.g.*, Aaron, *supra* note 11; Brown & Truitt, *supra* note 12; Clymer, *supra* note 87; Lehto, *supra* note 12; Susan Maidment, *Some Legal Problems Arising out of the Reporting of Child Abuse*, 31 CURRENT LEGAL PROBS. 149, 158-59, 165-66 (1979); McDonald, *supra* note 58. *But see* Mazura, *supra* note 12 (criticizing the imposition of civil liability in *Landeros*).

105. *See, e.g.*, AMERICAN MEDICAL ASSOCIATION DIAGNOSTIC AND TREATMENT GUIDELINES ON CHILD SEXUAL ABUSE 11, 13-14 (stating that "[i]n every state, a potential cause of action exists for a physician's failure to diagnose and report child abuse"); Mark B. DeKraai & Bruce D. Sales, *Liability in Child Therapy and Research*, 59 J. CONSULTING & CLINICAL PSYCHOL. 853, 858 (1991) ("States provide various penalties for failure to report and include both civil and criminal liability."); Janine Fiesta, *Protecting Children: A Public Duty to Report*, NURSING MGMT., July 1992, at 14, 14-15; Kathryn C. Halverson et al., *Legal Considerations in Cases of Child Abuse*, 20 PRIMARY CARE 407, 408 (1993) ("Failure to report could also be the basis for a civil lawsuit that could result in the physician being held financially responsible for the harm to the child that followed a failure to report."); Sandberg et al., *supra* note 18, at 6, 7.

106. 627 N.E.2d 802 (Ind. Ct. App. 1994).

107. *Id.* at 806.

108. *Id.* at 809. The *J.A.W.* court elaborated:

the plaintiff's contention that the sister of the plaintiff's chief molester (the plaintiff's foster father) had a duty to report the molestation because it held she and the plaintiff lacked a "level of interaction or dependency between the parties that surpasses what is common or usual,"<sup>109</sup> the hallmark of a special relationship. Similarly, the court found no special relationship between the plaintiff and both a clergyman and a counsellor who knew of the abuse but lacked "a level of interaction or dependency which can be characterized as a special relationship."<sup>110</sup> Thus, merely knowing about the abuse did not impose a duty; there had to be more—a special relationship.<sup>111</sup>

When it considered another clergyman/defendant, however, the *J.A.W.* court tentatively found differently.<sup>112</sup> The plaintiff alleged he and this clergyman had spoken over fifty times over a four year period about the plaintiff's sexual relationship with his foster father, with the clergyman counselling the plaintiff on spiritual matters. If this were true, the court held a special relationship would have existed between the plaintiff and this clergyman which could generate a duty to report the abuse.<sup>113</sup> The court noted that it was foreseeable to the clergyman that the plaintiff's foster father would continue molesting the plaintiff unless the clergyman reported the abuse to the authorities, and ruled that "the foreseeability of continued abuse weighs in favor of impos-

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Generally, one has no legal obligation to go to the aid of a victim in peril. As one commentator observed "[t]here is no legal duty to be a Good Samaritan. Such a rule represents an attitude of rugged, perhaps heartless, individualism, and the tendency of the courts is to increasingly restrict it." This court has held that when a defendant's alleged negligence arises from nonfeasance, the complete omission or failure to perform, as opposed to misfeasance, negligent conduct or active misconduct, then the duty to act must arise from a special relationship between the parties. Absent a special relationship between a plaintiff and a defendant, we will not impose a duty on the defendant to take affirmative steps to prevent harm to the plaintiff.

*Id.* (citations omitted). As the court ultimately concluded: "Absent codification, we are not convinced that extending a civil remedy to a victim of abuse or neglect against all persons who know of child abuse and fail to report child abuse is good public policy." *Id.* at 813.

109. *Id.*

110. *Id.* at 810. The counsellor was a marriage counsellor who was counselling the plaintiff's foster mother and father. *Id.* The counsellor learned of the foster father's abuse of the plaintiff during the counselling sessions, but apparently did not individually counsel the plaintiff. *Id.* The plaintiff spoke with the clergyman about the abuse at church and at social or church functions, but the court deemed this insufficient for a special relationship. *Id.* "[K]nowledge of criminal activity, standing alone, is not enough to impose a common law duty on the person in possession of such knowledge." *Id.*

111. *Id.* at 812-13.

112. The court ultimately reversed the lower court's grant of summary judgment for the second clergyman-defendant and sent the case back to the trial court for it to resolve whether a special relationship existed between the plaintiff and the clergyman. *Id.* at 811, 813-14.

113. *Id.* at 811.

ing a common law duty to report alleged child abuse to the authorities."<sup>114</sup>

*J.A.W.* holds that there can be a common law tort duty to report child abuse, but only when a special relationship exists between the abuse victim and the person who failed to report. A Michigan court in *Marcelletti v. Bathani*<sup>115</sup> indicated that a duty to report can arise between a physician and his or her abused child/patient when a special relationship is present.<sup>116</sup> Other tribunals have been less charitable. A number have indicated there is no common law duty to report possible child abuse.<sup>117</sup> It is uncertain whether future courts will emulate *Landeros*, *J.A.W.*, and *Marcelletti* or apply the traditional no-duty approach.

When courts have considered the statutory negligence issue in failure to report child abuse liability cases, the post-*Landeros* record also has been mixed. At least one tribunal has agreed with *Landeros* that statutory negligence applies to physicians and other mandatory abuse reporters who do not report.<sup>118</sup> A number of other jurisdictions, however, have refused to extend statutory negligence to violations of child abuse reporting statutes.<sup>119</sup> For example, in *Borne ex rel. Borne v.*

114. *Id.* at 812.

115. 500 N.W.2d 124 (Mich. Ct. App. 1993).

116. *Id.* at 129-30. For more on special relationships between physicians and their patients, see *infra* notes 139-147 and accompanying text.

117. See, e.g., *Letlow v. Evans*, 857 F. Supp. 676, 678 (W.D. Mo. 1994) (finding no private cause of action against school official); *Thelma D. v. Bd. of Educ.*, 669 F. Supp. 947, 950-51 (E.D. Mo. 1987) (holding that school teacher owed no common law duty to student to report suspected child abuse); *Freehauf v. School Bd.*, 623 So. 2d 761, 764 (Fla. Dist. Ct. App. 1993) (finding no private cause of action against school board for failure to report suspected child abuse); *Cechman v. Travis*, 414 S.E.2d 282, 285-86 (Ga. Ct. App. 1991) (finding no tort action against doctor for not reporting suspected abuse); *Borne ex rel. Borne v. N.W. Allen County Sch. Corp.*, 532 N.E.2d 1196, 1203 (Ind. Ct. App. 1989) (holding that there is no civil tort action for failure to report child abuse). For the English view, apparently imposing no duty in child abuse cases, see generally W. V. H. ROGERS, WINFIELD AND JOLOWICZ ON TORT at vii-ix (14th ed. 1994); W. V. H. Rogers, *Tort Law and Child Abuse: An Interim View from England*, 3 TORTS L.J. 257, 265-73 (1994).

118. *Williams v. Coleman*, 488 N.W.2d 464, 471-72 (Mich. Ct. App. 1992); see *Doran v. Priddy*, 534 F. Supp. 30, 33 (D. Kan. 1981) (containing dicta endorsing *Landeros*' statutory negligence holding); *Kansas State Bank & Tr. Co. v. Specialized Transp. Servs.*, 819 P.2d 587, 611-13 (Kan. 1991) (Lockett, J., concurring in part on other grounds and dissenting) (disagreeing with majority opinion that Kansas legislature did not intend a statutory negligence action).

119. See, e.g., *Isely v. Capuchin Province*, 880 F. Supp. 1138 (E.D. Mich. 1995) (holding that Michigan reporting statute does not create a statutory negligence action); *Letlow v. Evans*, 857 F. Supp. 676 (W.D. Mo. 1994) (holding that Missouri statute requiring school officials to report suspected child abuse does not create a statutory negligence action); *Thelma D. v. Board of Educ.*, 669 F. Supp. 947 (E.D. Mo. 1987) (holding no Section 1983 cause of action against non-supervisory teacher for failure to report suspected child abuse); *Doe "A" v. Special Sch. Dist.*, 637 F. Supp. 1138 (E.D. Mo. 1986), *aff'd*, 901 F.2d 642 (8th Cir. 1990) (holding that Missouri reporting statute creates a duty owed to general public and not for individuals); *Nelson v. Free-*

*Northwest Allen County School Corp.*,<sup>120</sup> the Indiana Court of Appeals concluded that the legislative purpose in enacting Indiana's child abuse statutory scheme was not to create a private right of action against non-reporters of abuse: "When the provisions of the act are considered as a whole, there is no apparent intent to authorize a civil action for failure of an individual to make the oral report that may be the means of initiating the central procedures contemplated by the act."<sup>121</sup> Since the legislature did not intend for a private right of action, statutory negligence, in turn, would not lie and the plaintiff had no cause of action.<sup>122</sup> Several other courts have agreed with *Borne's* characterization of the nature of legislatures' intent when enacting mandatory child abuse reporting laws.<sup>123</sup>

*Landeros* did not consider a final way to establish an abused child's case against a non-reporting physician—use of an express statutory liability provision.<sup>124</sup> Several jurisdictions have laws which mandate civil liability against those who do not fulfill their statutory duty to report child abuse.<sup>125</sup> Absent problems like proximate cause, it

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man, 537 F. Supp. 602 (W.D. Mo. 1982), *aff'd*, 706 F.2d 276 (8th Cir. 1983) (concurring with *Doe "A"*); *Freehauf*, 623 So. 2d 761 (holding that Florida reporting statute does not create a statutory negligence action); *Fischer v. Metcalf*, 543 So. 2d 785 (Fla. Dist. Ct. App. 1989) (finding no civil cause of action for psychologist's failure to report suspected child abuse); *Cechman*, 414 S.E.2d 282 (finding a doctor's failure to report suspected child abuse does not create a statutory negligence action); *J.A.W. v. Roberts*, 627 N.E.2d 802 (Ind. Ct. App. 1994) (holding that absent codification, imposing civil liability against all who fail to report suspected child abuse would be against public policy); *Borne ex rel. Borne*, 532 N.E.2d 1196 (holding no statutory negligence action against school, principal or teacher for failure to report suspected child abuse of student); *Kansas State Bank*, 819 P.2d 587 (holding that statute did not create a statutory negligence action for psychologist's failure to report suspected child abuse); *Bradley v. Ray*, 904 S.W.2d 303, 312-14 (Mo. Ct. App. 1995) (indicating that statute did not create statutory negligence action for psychologist's failure to report suspected child abuse).

120. 532 N.E.2d 1196 (Ind. Ct. App. 1989).

121. *Id.* at 1203.

122. *Id.*; see *supra* notes 80-83 and accompanying text (discussing how legislative intent can allow for a special relationship to be created).

123. See, e.g., *Isely*, 880 F. Supp. at 1148 (interpreting Wisconsin reporting statute and determining that legislature did not intend a statutory negligence action for failure to report); *Letlow*, 857 F. Supp. at 678 (denying statutory negligence action because Missouri legislature did not establish it); *Freehauf*, 623 So. 2d at 763-64 (indicating legislative intent was to provide for welfare of public and not to create a statutory negligence action for an individual); *J.A.W.*, 627 N.E.2d at 813 (reporting that Indiana legislature has declined to create statutory negligence action for an individual); *Kansas State Bank*, 819 P.2d at 603-04 (suggesting that if Kansas legislature had intended a statutory negligence action it expressly would have provided for it).

124. See, e.g., BESHAROV, *THE VULNERABLE SOCIAL WORKER*, *supra* note 57, at 31-32 (indicating that about eight states have statutory liability for violating reporting statutes); Besharov, *Failing to Report*, *supra* note 58, at 67-68; Lehto, *supra* note 12, at 158-60.

125. For code sections imposing civil liability for damages proximately caused by failure to report child abuse, see, e.g., ARK. CODE ANN. § 12-12-504(b) (Michie Supp. 1993); COLO. REV. STAT. § 19-3-304(4)(b) (Supp. 1994); IOWA CODE ANN. § 232.75(2) (West 1994); MICH. COMP.

should be relatively easy to establish physician liability in such a state.<sup>126</sup>

In sum, the promise of *Landeros* only partially has been realized. Some child abuse victims have prevailed against physicians who did not report abuse, but others have been thwarted in their efforts. The surest road to recovery, the express statutory liability provision, was not even an issue in *Landeros* and is viable in only a few states. The overall uncertain nature of this most-explored basis for civil liability for non-reporting may (but ought not to) portend an equally unsure course for domestic violence victims considering claims against their physicians.

## 2. *Physician Duty to Report Elder Abuse*

Elder abuse law presents much the same non-reporting civil liability issues as the child abuse area, albeit in a less developed fashion. Elder abuse is another serious national problem.<sup>127</sup> Much has been written about mandatory reporting of elder abuse<sup>128</sup>—a good deal of it nega-

LAWS ANN. § 722.633(1) (West Supp. 1994); N.Y. SOC. SERV. LAW § 420 (McKinney 1992); R.I. GEN. LAWS § 40-11-6.1 (1990). The Montana statute is typical, and provides, in pertinent part: "Any person, official, or institution required by law to report known or suspected child abuse or neglect who fails to do so or who prevents another person from reasonably doing so is civilly liable for the damages proximately caused by such failure of prevention." MONT. CODE ANN. § 41-3-207(1) (1993).

126. See, e.g., *Marcelletti v. Bathani*, 500 N.W.2d 124, 127-28 (Mich. Ct. App. 1993); *Williams v. Coleman*, 488 N.W.2d 464, 472 (Mich. Ct. App. 1992); *Bartels v. County of Westchester*, 429 N.Y.S.2d 906, 909 (N.Y. App. Div. 1980); see also *Gross v. Myers*, 748 P.2d 459, 461 (Mont. 1987).

127. See, e.g., Frank Glendenning, *What is Elder Abuse and Neglect?*, in *THE MISTREATMENT OF ELDERLY PEOPLE* 11-14 (Peter Decalmer & Frank Glendenning eds., 1993) (providing a detailed analysis of rates of various forms of elder abuse); Anthony J. Costa, *Elder Abuse*, 20 *PRIMARY CARE* 375, 377 (1993) (reporting various countries' rates of elder abuse); Margaret F. Hudson, *Elder Mistreatment: Current Research*, in *ELDER ABUSE: CONFLICT IN THE FAMILY* 152-53 (Karl A. Pillemer & Rosalie S. Wolf eds., 1986) (indicating that studies show up to ten percent of elders are abused); Vicki Gottlich, *Beyond Granny Bashing: Elder Abuse in the 1990s*, 28 *CLEARINGHOUSE REV.* 371, 372 (1994) ("[I]n 1991 alone, 1.57 million older persons were victims of physical abuse, neglect, and exploitation."); Jeffrey S. Jones, *Elder Abuse and Neglect: Responding to a National Problem*, 23 *ANNALS EMERG. MED.* 845, 845, 848 (1994) [hereinafter J. Jones, *Elder Abuse*] (reporting that one in every twenty older Americans are victims of elder abuse); Audrey S. Garfield, Note, *Elder Abuse and the States' Adult Protective Services Response: Time for a Change in California*, 42 *HASTINGS L.J.* 859, 863-66 (1991) (discussing Congressional finding that elder abuse is increasing yearly and is much more likely to go unreported than child abuse).

128. See, e.g., Stephen Crystal, *Social Policy and Elder Abuse*, in *ELDER ABUSE: CONFLICT IN THE FAMILY*, *supra* note 127, at 336-39; Rick A. Brewer & Jeffrey S. Jones, *Reporting Elder Abuse: Limitations of Statutes*, 18 *ANNALS EMERG. MED.* 1217 (1989); Lawrence R. Faulkner, *Mandating the Reporting of Suspected Cases of Elder Abuse: An Inappropriate, Ineffective and Ageist Response to the Abuse of Older Adults*, 16 *FAM. L.Q.* 69, 69-71 (1982); Note, *Elder Abuse: The Merit of Mandatory Reporting Laws and the Minnesota Response*, 9 *WM. MITCHELL L. REV.*

tive<sup>129</sup>—and a number of states have statutes, patterned after the mandatory child abuse reporting laws,<sup>130</sup> requiring that it be reported.<sup>131</sup> From the spouse abuse perspective, elder abuse is even more relevant than child abuse since it typically involves competent *adults* rather than children.<sup>132</sup> While there is no case authority on the point, many commentators, including those in various health-related fields,<sup>133</sup> agree that courts may apply the principles of *Landeros* to

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365 (1984) [hereinafter *Mandatory Reporting Laws*]; Thomas J. Hierl, Note, *The Prevention, Identification, and Treatment of Elder Abuse Act of 1987: Is It A Proper Federal Response to Elder Abuse?*, 6 N.Y.L. SCH. J. HUM. RTS. 383, 390-95 (1989); Katheryn D. Katz, *Elder Abuse*, 18 J. FAM. L. 695 (1980); Garfield, *supra* note 127, at 874-85; Dorothy Ann Gilbert, *The Ethics of Mandatory Elder Abuse Reporting Statutes*, 8 ADVANCES NURSING SCI. 51 (1986); Gottlich, *supra* note 128, at 374-75; Dyana Lee, Note, *Mandatory Reporting of Elder Abuse: A Cheap But Ineffective Solution to the Problem*, 14 FORDHAM URB. L.J. 723 (1986); David P. Mathews, Comment, *The Not-So-Golden Years: The Legal Response to Elder Abuse*, 15 PEPP. L. REV. 653, 661-67 (1988); Christine A. Metcalf, Comment, *A Response to the Problem of Elder Abuse: Florida's Revised Adult Protective Services Act*, 14 FLA. ST. U. L. REV. 745 (1986); John Palincsar & Deborah Crouse Cobb, *The Physician's Role in Detecting and Reporting Elder Abuse*, 3 J. LEGAL MED. 413 (1982).

129. See, e.g., Brewer & Jones, *supra* note 128, at 1219 (indicating that a physician's report of elder abuse may actually make the patient's situation worse); Crystal, *supra* note 128, at 336-39 (discussing various faults with elder abuse reporting laws); Faulkner, *supra* note 128, at 89-90 (arguing that reporting laws can be intrusive and negatively effect elder persons' lives); Garfield, *supra* note 127, at 877-85 (criticizing reporting laws because they imply elders are incompetent); Hierl, *supra* note 128, at 394-95 (claiming that reporting laws may cause unconstitutional invasion of privacy in elder persons' lives); Katz, *supra* note 128, at 711 (expressing concern about elder's loss of freedom resulting from reporting laws); Lee, *supra* note 128, at 730-35, 764-65 (indicating that reporting laws can hinder elder's freedom and promote age discrimination); Mathews, *supra* note 128, at 662-67, 675-76 (arguing that mandatory reporting laws infantilize elders); Metcalf, *supra* note 128, at 754 (indicating that reporting laws can result in elders being removed from their homes).

130. See, e.g., Costa, *supra* note 127, at 386 (criticizing the fact that elder abuse laws are based on child abuse laws despite the fact that they are separate entities); Crystal, *supra* note 128, at 334-35 (finding that many states pattern elder abuse laws on child abuse laws); Faulkner, *supra* note 128, at 74 (indicating elder abuse reporting laws are modeled after their child abuse counterparts); Gottlich, *supra* note 127, at 374 (indicating many states pattern elder abuse reporting laws after child abuse laws); Lee, *supra* note 128, at 727 (reporting that first major study on elder abuse recommended modeling reporting laws on child abuse laws); Mathews, *supra* note 128, at 662 (criticizing elder abuse reporting laws based on distinctions between children and elders); Metcalf, *supra* note 128, at 775 (suggesting that elder abuse reporting statutes should be modeled after spousal abuse laws instead of child abuse laws); see generally Katz, *supra* note 128, at 716-17 (comparing similarities between abused children and elders).

131. See, e.g., Gottlich, *supra* note 127, at 374 (reporting in 1990 that 42 states had mandatory reporting laws for elder abuse); Lee, *supra* note 128, at 766-71 (containing chart describing various state elder abuse reporting statutes).

132. Battered spouses and abused elders have much in common. Indeed, some battered spouses *are* elders, so they fit both categories. See, e.g., Faulkner, *supra* note 128, at 86 (describing similar characteristics of abused elders and abused spouses); Metcalf, *supra* note 128, at 775 (stating that "approximately one-fifth of elder abuse is among elderly couples").

133. See, e.g., *Diagnostic and Treatment Guidelines on Elder Abuse and Neglect*, 2 ARCHIVES FAM. MED. 371, 380 (1993); Brewer & Jones, *supra* note 128, at 1220; J. Jones, *Elder Abuse*, *supra* note 127, at 847.

non-reporters of elder abuse.<sup>134</sup> These authors tend not to distinguish between *Landeros's* common law and statutory negligence aspects. Several states have statutes which expressly hold those mandated to report elder abuse civilly liable for injuries elders suffer after the reporter fails to report the abuse.<sup>135</sup>

### 3. *Physician Duty to Report Spouse Abuse*

As noted above, a battered spouse who desires to sue her non-reporting physician in negligence must establish a special relationship with that physician.<sup>136</sup> As *Landeros* demonstrated, that can be done through the common law and/or statutory negligence routes. While the statutory negligence approach may be easier to pursue in states which have appropriate legislation, the common law one is more universal since it should be available in all jurisdictions regardless of their statutory schemes.<sup>137</sup> Various sources, both legal and medical, dutifully have predicted that physicians who do not report domestic violence of their patients may be civilly liable in negligence when the patients suffer subsequent harm.<sup>138</sup> To date, no case law supports (or definitively undermines) this prophecy. It is, however, very appropriate that courts find that physicians have a duty to report the spouse abuse of their patients, whether or not their jurisdictions feature some form of mandatory reporting law.

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134. See, e.g., Katz, *supra* note 128, at 713 (indicating that professionals may be criminally or civilly liable for their failure to report); Metcalf, *supra* note 128, at 753 (suggesting that physicians and clergy might be civilly liable for not reporting suspected elder abuse); Palincsar & Cobb, *supra* note 128, at 424 (indicating that a physician who fails to report elder abuse may be liable for victim's subsequent harm). But see Lee, *supra* note 128, at 743-44 (expressing uncertainty about whether courts would apply liability to professionals who fail to report elder abuse).

135. See, e.g., ARK. CODE ANN. § 5-28-202(b) (Michie 1993); MICH. COMP. LAWS ANN. § 400-11e(1) (West 1988); MINN. STAT. ANN. § 626.557(7)(b) (West 1983).

136. See *supra* notes 75-84 and accompanying text (indicating that a special relationship must exist for a negligence action to exist against a physician for failing to report suspected abuse).

137. As the *Landeros* ruling demonstrated, courts in jurisdictions with mandatory spouse abuse reporting statutes may—albeit probably inappropriately—use them to generate a common law duty to report. See *supra* notes 101-02 and accompanying text (discussing this principle and, in particular, suggesting duty usually is based on a special relationship).

138. See, e.g., AMERICAN MEDICAL ASSOCIATION DIAGNOSTIC AND TREATMENT GUIDELINES ON DOMESTIC VIOLENCE 12-13 (1992) (discussing the AMA's warning to physicians about the consequences for failure to report suspected child abuse); *Guidelines for Identifying and Helping Abused Patients*, 82 J. MED. ASS'N GA. 327, 332 (1993) [hereinafter *Guidelines*] (indicating that most physicians will encounter domestic abuse in their practices and should be aware of the potential liability for failure to report it); Smith, *Mental Health Malpractice*, *supra* note 13, at 251 (stressing possible negligence liability against mental health professionals for failure to report suspected abuse); Smith, *Privileges and Confidentiality*, *supra* note 43, at 530 (indicating that physicians have affirmative duty to report child, spouse, and elder abuse and may face civil liability for their failure to do so).

## a. Common Law Negligence

Tort law long has recognized that public policy can dictate a special relationship, and hence a duty, between doctor and patient.<sup>139</sup> This can include a duty to disclose things against the wishes of the patient for the benefit of others, such as in the contagious disease cases<sup>140</sup> or their offshoot, the well-known *Tarasoff v. Regents of the University of California*<sup>141</sup> line of authorities. Indeed, in *Tarasoff* the California Supreme Court specifically held a special relationship exists between physicians and their patients,<sup>142</sup> a result which various other jurisdictions also have reached.<sup>143</sup> Courts have generally unfettered discre-

139. See, e.g., Lehto, *supra* note 12, at 148-49 (stating that patient-physician relationship is sufficient to impose an affirmative duty to warn, rescue, or report). For articles indicating that a physician has a duty when his or her patient is a child, see, e.g., Hurley, *supra* note 13, at 657; Isaacson, *supra* note 87, at 770-71.

140. See, e.g., Davis v. Rodman, 227 S.W. 612 (Ark. 1921) (holding physician had duty correctly to warn about patient's typhoid); Reisner v. Regents of Univ. of Cal., 37 Cal. Rptr. 2d 518 (Cal. Ct. App. 1995) (holding physician had duty correctly to warn about patient's AIDS); Hoffmann v. Blackmon, 241 So. 2d 752 (Fla. Dist. Ct. App. 1970) (holding physician had duty correctly to warn about patient's tuberculosis); Skillings v. Allen, 173 N.W. 663 (Minn. 1919) (holding physician could have duty correctly to warn about patient's scarlet fever); Edwards v. Lamb, 45 A. 480 (N.H. 1899) (holding physician had duty correctly to warn about patient's infection); Jones v. Stanko, 160 N.E. 456 (Ohio 1928) (holding physician had duty correctly to warn about patient's smallpox); Simonsen v. Swenson, 177 N.W. 831 (Neb. 1920) (holding physician had duty to warn about patient's syphilis); DiMarco v. Lynch Homes-Chester County, Inc., 583 A.2d 422 (Pa. 1990) (holding physician had duty correctly to warn about patient's hepatitis B); Bradshaw v. Daniel, 854 S.W.2d 865 (Tenn. 1993) (holding physician had duty to warn about patient's Rocky Mountain Spotted Fever); Frederick R. Fahrner, Comment, *The Physician's Duty to Warn Non-Patients: AIDS Enters the Equation*, 5 COOLEY L. REV. 353 (1988). For a discussion of a physician's duty to warn third parties at risk of contracting AIDS from their patients, despite physician-patient confidentiality, see, e.g., Kenneth E. Labowitz, *Beyond Tarasoff: AIDS and the Obligation to Breach Confidentiality*, 9 ST. LOUIS U. PUB. L. REV. 495 (1990); Jill Suzanne Talbot, Note, *The Conflict Between a Doctor's Duty to Warn a Patient's Sexual Partner that the Patient has AIDS and a Doctor's Duty to Maintain Patient Confidentiality*, 45 WASH. & LEE L. REV. 355 (1988).

141. 551 P.2d 334 (Cal. 1976).

142. *Id.* at 343; accord, e.g., Reisner, 37 Cal. Rptr. 2d at 520 (following *Tarasoff*, holding that special relationship exists between physician and patient); Collier, *supra* note 30, at 203 (reporting that the California Supreme Court has found a special relationship between a psychiatrist and patient); Miles, *supra* note 11, at 711 (indicating that courts view the physician-patient relationship as being a special relationship); Talbot, *supra* note 141, at 377 (stating that duty to warn third party of risk of AIDS from patient arises out of special relationship between physician and patient).

143. See, e.g., Mahomes-Vinson v. United States, 751 F. Supp. 913, 923 (D. Kan. 1990) (indicating that a special relationship could exist between a psychiatrist and third party victim if the doctor's patient posed a foreseeable risk of harm to the victim); Chrite v. United States, 564 F. Supp. 341, 345 (E.D. Mich. 1983) (citing cases that hold the psychotherapist-patient relationship satisfies the special relationship necessary to impose a duty to warn identifiable victims); Lipari v. Sears, Roebuck & Co., 497 F. Supp. 185, 189 (D. Neb. 1980) (holding therapist-patient relationship imposed duty for benefit of third party); Hamman v. County of Maricopa, 775 P.2d 1122, 1129 (Ariz. 1989) (holding special relationship exists between psychiatrist and patient);



tion whether or not to recognize a duty,<sup>144</sup> and do so when “a weighing of the relationship of the parties, the nature of the risk involved, and the public interest in imposing the duty under the circumstances”<sup>145</sup> shows it to be appropriate to find one.<sup>146</sup> It clearly is appropriate for courts to find that physicians owe a duty to their battered patients. They have a close professional link with these patients which far surpasses the typical one which exists in society at large, a truly “special” relationship.<sup>147</sup>

Assuming that physicians owe a common law duty to their patients, then the real question is the scope of the duty—should it extend so far as to require the physician to notify the authorities that the patient is being battered, whether or not the patient agrees to the notification and whether or not the patient is a competent adult? Notwithstanding the apparent opinions of much of the medical establishment,<sup>148</sup> the

Seibel v. City & County of Honolulu, 602 P.2d 532, 538 (Haw. 1979) (finding doctor-patient relationship sufficient to create duty to warn third party of foreseeable harm); Bell & Hudson, P.C. v. Buhl Realty Co., 462 N.W.2d 851, 853 (Mich. Ct. App. 1990) (stating that doctor-patient relationship is special under Michigan law); Bradley v. Ray, 904 S.W.2d 302, 311 (Mo. Ct. App. 1995) (holding special relationship exists between psychologist and patient); MacIntosh v. Milano, 403 A.2d 500, 509-12 (N.J. Super. Ct. 1979) (holding that psychiatrist-patient relationship created duty for doctor to protect third party from danger by patient); Petersen v. State, 671 P.2d 230, 237 (Wash. 1983) (concluding that psychologist had duty to protect persons at risk from being harmed by patient); *Guidelines*, *supra* note 138, at 332 (citing a Georgia statute which requires certain health care workers to report); *see also* THOMAS G. GUTHEIL & PAUL S. APPELBAUM, CLINICAL HANDBOOK OF PSYCHIATRY AND THE LAW 141 (2d ed. 1991) (indicating that New Jersey and Nebraska have followed the *Tarasoff* holding).

144. *See, e.g.*, Aaron, *supra* note 11, at 194.

145. *MacIntosh*, 403 A.2d at 508.

146. *See, e.g.*, KEETON ET AL., *supra* note 63, § 53 (describing “duty” under the law); Collier, *supra* note 30, at 196-200, 202-07 (explaining factors to be considered when determining if a special relationship exists and citing examples).

147. *See, e.g.*, J.A.W. v. Roberts, 627 N.E.2d 802, 809 (Ind. Ct. App. 1994). This relationship could stretch beyond the physician-patient relationship to encompass the situation where the therapist of a spouse abuser learns of what her patient is doing to his victim and generates a duty from the therapist to the victim along the lines of *Tarasoff* or the infectious disease cases. This Article does not consider extending a duty this far. *See supra* note 13 (limiting the scope of this Article to cases where a physician learns of the abuse directly from the victim and not a third party).

148. *See, e.g.*, Wanda G. Bryant & Sondra Panico, *Physicians' Legal Responsibilities to Victims of Domestic Violence*, 55 N.C. MED. J. 418, 420-21 (1994) (suggesting that requiring physicians to report abuse of their patients may prevent the formation of the trusting relationship that is necessary between a physician and patient); Loretta M. Frederick, *The Physician's Response to Domestic Violence: Legal Issues*, MINN. MED., Feb. 1992, at 35, 37 (discussing patient confidentiality concerns with regard to reporting abuse); Holtz & Furniss, *supra* note 1, at 50-51; Hyman et al., *Reporting of Domestic Violence*, *supra* note 37, at 1783-86 (expressing view that doctors should not be required to report because it can result in further harm to victims, loss of autonomy, and compromises their privacy); Letter, *Reporting Abuse of Competent Patients*, 268 JAMA 2377, 2377-78 (1992) (indicating that AMA Council of Ethical and Judicial Affairs opposes mandatory reporting of elder abuse); Jane C. Murphy, *Legal Protection for Domestic Violence Victims: A*

answer should be yes. Just as in the analogous *J.A.W. v. Roberts*<sup>149</sup> and *Marcelletti v. Bathani*<sup>150</sup> child abuse cases, if/when a physician has the requisite special relationship with his battered spouse patient he should have the duty to report abuse of that patient irregardless of the existence of a mandatory reporting law and should be civilly liable for any injuries the patient suffers which are proximately caused by the physician's failure to discharge that obligation. In reaching that conclusion, one must deal with various criticisms of reporting, including those based on physician-patient confidentiality and on potentially detrimental effects of reporting on the abused patient. Debate has raged over compulsory reporting in the context of whether legislatures should enact laws requiring it,<sup>151</sup> and while that issue is slightly different from the question whether or not a common law court effectively should command it, the two are close enough to consider the legislative arguments in the judicial forum.

When the advisability of mandatory reporting of abuse—whether child, elder, or spouse—is the question, there is no immediate, clear-cut answer. Instead, there are various factors which weigh one way or another, good arguments to be made on both sides. Evaluating mandatory reporting requires a real balancing process as one considers the patient's rights to privacy, confidentiality, and self-determination on the one hand and society's need to protect the abused, even when doing so may be against their own wishes, on the other.<sup>152</sup> What one values more, as well as how one assesses the results of reporting, can determine how one feels about obligatory reporting.

Those who favor making physicians and others notify the authorities of abuse point to various results, which they perceive as beneficial, which flow from that behavior. Such a requirement increases the quantity of abuse reports turned in to the authorities<sup>153</sup>; reporting pro-

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*Guide for the Treating Physician*, 43 MD. MED. J. 899, 901-02 (1994); see also *supra* note 129 and accompanying text (discussing the negative reaction to mandatory reporting of elder abuse).

149. See *supra* notes 106-14 and accompanying text (discussing the *J.A.W.* opinion).

150. See *supra* notes 115-16 and accompanying text (discussing the *Marcelletti* opinion).

151. Controversy occurs in states like Kentucky and California which have enacted mandatory reporting in domestic violence cases. See *supra* notes 40-49 and accompanying text.

152. See, e.g., Cole, *supra* note 86, at 2; Gilbert, *supra* note 128, at 59-60; Metcalf, *supra* note 128, at 746; Smith-Bell & Winslade, *supra* note 13, at 180; George Thomson, *Confidentiality and the Compulsory Reporting of Child Abuse*, 2 HEALTH L. CAN. 15, 15 (1981).

153. See, e.g., BESHAROV, THE VULNERABLE SOCIAL WORKER, *supra* note 57, at 24 (finding that reported cases of child abuse went from 150,000 in 1963 to 1.3 million in 1981); Aaron, *supra* note 11, at 189-90 (indicating that reporting laws have increased the number of reports of suspected abuse, but professionals are still not in full compliance); Douglas J. Besharov, "Doing Something" About Child Abuse: The Need to Narrow the Grounds for State Intervention, 8 HARV. J.L. & PUB. POL'Y 539, 545 (1985) [hereinafter Besharov, "Doing Something"] (reporting a dramatic increase in reports of child abuse and attributing it in part to mandatory reporting

ponents view this as advantageous because these reports help society detect and prevent crime (abuse), identify and protect the victims of abuse, and collect data on the problem of family violence (domestic violence in the spouse abuse context).<sup>154</sup> Identification particularly is advanced since it is very difficult for the authorities to determine which individuals are abuse victims—who so often do not come forward on their own—unless either the abuse is reported or is so bad for so long that it becomes obvious (and quite possibly causes permanent injuries or is fatal).<sup>155</sup> Data collection is also a real issue as without obligatory reports there is significantly less information available for measuring this type of criminal activity (and if statistics show abuse is a major problem, society is much more likely to respond to it both with attention and adequate resources<sup>156</sup>).<sup>157</sup>

If courts require reporting this will demonstrate concern over family violence and a commitment to public action.<sup>158</sup> Without reporting, ultimately abusers often continue their behavior until they kill or severely injure their victims.<sup>159</sup> Mandatory reporting reminds the many physicians who are reluctant to report abuse that they *have* to whether

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laws); Maidment, *supra* note 104, at 151 (citing conclusion that increased reports of child abuse is a desirable effect of reporting laws); Jessica Yelas, *Mandatory Reporting of Child Abuse and the Public/Private Distinction*, 7 AUCKLAND U. L. REV. 781, 788 (1994). One way mandatory reporting generates more of a response from the medical community is slightly convoluted, but works like this: if reporting is obligatory, failure to report will be actionable negligence. A hospital or other employer could be vicariously liable for its medical employee's negligent nonfeasance. Knowing this, the employer would be likely to discipline or discharge employees who put it at risk by not reporting abuse, whether or not litigation resulted from this inaction. And, finally, knowing all this, and wanting to stay employed in good standing, the employee will report abuse, thereby obeying the law, doing the right thing, and promoting the goals of reporting. See BESHAROV, *THE VULNERABLE SOCIAL WORKER*, *supra* note 57, at 42-43 (indicating that some employers discharge their employees who fail to report suspected child abuse).

154. See, e.g., Bell & Tooman, *supra* note 28, at 338; Brooks et al., *supra* note 92, at 50; Barbara Daly, *Willful Child Abuse and State Reporting Statutes*, 23 U. MIAMI L. REV. 283, 303 (1969); Gottlich, *supra* note 127, at 374 (indicating that advocates believe mandatory reporting laws will result in more reports and increased awareness of the problem); Hyman et al., *Reporting of Domestic Violence*, *supra* note 37, at 1781, 1783; Maidment, *supra* note 104, at 154.

155. See, e.g., Aaron, *supra* note 11, at 184 (suggesting that identification of abuse victims is an essential step in preventing further abuse); Hierl, *supra* note 128, at 390-91; Kohlman, *supra* note 12, at 120; Mathews, *supra* note 128, at 662 (indicating that reporting laws are necessary because many abused elders will not come forward).

156. See, e.g., *Mandatory Reporting Laws*, *supra* note 128, at 387 (suggesting that recognition of problem is an incentive for improvement).

157. See, e.g., Gilbert, *supra* note 128, at 54 (indicating that in order to prevent elder abuse data is needed to understand it); Mathews, *supra* note 128, at 662.

158. See, e.g., Yelas, *supra* note 153, at 788-89.

159. See, e.g., Bell & Tooman, *supra* note 28, at 347; Besharov, *Failing to Report*, *supra* note 58, at 67 (reporting that over 40 percent of the children that died from abuse in Texas over a three year period were the result of failure to report previous abuse).

they want to or not.<sup>160</sup> Domestic violence is a crime which will not truly be curtailed until it is reported to the appropriate authorities as fully as any other offense.<sup>161</sup> Once they learn of the violation, the authorities can take suitable steps, including the offer of voluntary protective services to the victim and the possible prosecution of the abuser. This can protect and empower the victim as well as hold the batterer accountable for his actions, which in turn helps his victim (by stopping the abuse—hopefully permanently). It also can aid the batterer himself by forcing him to obey the rules, obtain any needed treatment services, and learn the consequences of not doing so.<sup>162</sup>

Required reporting helps those victims who are too dependent on their batterers, and too afraid of them, to seek help on their own.<sup>163</sup> It gives physicians and others a means for having possible abuse cases investigated, a central place to take information about their battered patients.<sup>164</sup> It can encourage some to report what they otherwise might fear to bring out absent the defense mandatory reporting provides.<sup>165</sup> It lets the physician see her report of abuse taken seriously

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160. See, e.g., BESHAROV, *THE VULNERABLE SOCIAL WORKER*, *supra* note 57, at 25, 27; Monrad G. Paulsen, *The Law and Abused Children*, in *THE BATTERED CHILD* 153, 163 (Ray E. Helfer & C. Henry Kempe eds., 2d ed. 1974) [hereinafter Paulsen, *Abused Children*]; Maidment, *supra* note 104, at 170.

One again should note, see *supra* note 14, that when the first obligatory child abuse reporting statutes were enacted, they only applied to physicians; this was in part because lawmakers believed that physicians were uniquely able to detect and report abuse, but also because many physicians would not report abuse absent such a requirement. See, e.g., Paulsen, *Child Abuse Reporting Laws*, *supra* note 87, at 3-4 (discussing reasons why model reporting statutes limited reporting requirement to doctors). The AMA opposed these laws, while the American Academy of Pediatrics supported them. *Id.* at 5; Sussman, *supra* note 14, at 271. As noted, the AMA and the medical establishment today oppose mandatory reporting, by physicians, of domestic violence inflicted upon their patients; indeed, in *Physicians and Domestic Violence*, *supra* note 1, the AMA steadfastly resisted it. See *supra* notes 38-39 and accompanying text (discussing further the *Physicians and Domestic Violence* article). Various United States Surgeons General have adopted this view, with one notable exception. See, e.g., A. JONES, *BATTERING & HOW TO STOP IT*, *supra* note 6, at 148 (indicating that Surgeon General Novello recommended mandatory reporting of suspected child abuse); Pike, *supra* note 19, at 1953 (reporting that former Surgeon General Koop did not advocate mandatory reporting of domestic violence). Their positions are certainly consistent with physicians' general aversion to reporting, outlined *supra* notes 18-29 and accompanying text.

161. Bryant & Panico, *supra* note 148, at 420.

162. See, e.g., Bell & Tooman, *supra* note 28, at 345; Smith-Bell & Winslade, *supra* note 13, at 189 (indicating that supporters of reporting laws believe they can be beneficial for the abuser by subjecting them to rules and consequences); Catherine L. Waltz, *The Effectiveness of Intervention With Batterers*, FLA. B.J., Oct. 1994, at 78, 80.

163. Gottlich, *supra* note 127, at 374.

164. Palincsar & Cobb, *supra* note 128, at 437, 438.

165. As one commentator has noted:

Professionals are often faced with difficult decisions whether to report their awareness of abuse. For example, in a small rural town, professionals may be frightened to

by the authorities,<sup>166</sup> and forces all physicians — not just the ones who report abuse voluntarily — to bear ratably the various economic and non-economic costs of reporting (e.g., time spent in filing reports and, perhaps, testifying in court; lost income for time spent on reporting rather than treating other patients; cost of office staff who help in the reporting process; and lost income from patients who change physicians as they do not want a physician who reports abuse to treat them or their victims—clearly not a problem if *all* physicians report pursuant to an obligatory rule).<sup>167</sup>

In sum, to quote one distinguished author who wrote on the mandatory reporting of child abuse:

A real need exists in this country to stimulate more consistent and frequent reporting of physical abuse . . . [B]attering has reached truly epidemic proportions. . . .

The cure . . . is protection for the innocent victim and psychological treatment for [her] tormentor. Recurrent abuse . . . can only be prevented by disclosure and identification of the battered [victim]. [She] must be sought out. . . . Without minimizing the necessity for every citizen to report incidents of . . . abuse, doctors and hospitals are particularly skilled and strategically located to accomplish the enormous task of locating and identifying this growing group of suffering [victims]. All necessary diagnostic tools are available. Civil and criminal immunity is accorded those who report. Legal and social units are trained and ready to respond to incident reports. But complete cooperation of doctors and hospitals is lacking . . .<sup>168</sup>

Such cooperation will be far more forthcoming if reporting is mandatory and unexcused failure to report violates the standard of care and thus subjects the non-reporting physician to civil tort liability.

Notwithstanding the numerous factors which support the policy of requiring physicians to report abuse, many criticize it harshly for a variety of reasons, some ethical and some more pragmatic.<sup>169</sup> The

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report because of pressure from others in the community. Such a feeling emerged at a meeting of nurses and other professionals in one small town: "[E]veryone [knows] everyone else and it [is] impossible to hide the identity of the person who [reports] the abuse—especially when there [is] no 'need' to do so.

There was consensus at that meeting that "mandatory reporting would provide some measure of protection."

Yelas, *supra* note 153, at 788 (footnotes omitted).

166. Bell & Tooman, *supra* note 28, at 348.

167. *Id.* at 352.

168. Kohlman, *supra* note 12, at 185. Mr. Kohlman was co-counsel to the plaintiff-child abuse victim in the landmark *Landeros v. Flood*, 551 P.2d 389, 390 (Cal. 1976). See *supra* notes 96-103 and accompanying text.

169. See, e.g., RONALD MUNSON, INTERVENTION AND REFLECTION: BASIC ISSUES IN MEDICAL ETHICS 32-34 (4th ed. 1992) (discussing ethical considerations, such as beneficence and nonmaleficence); Garfield, *supra* note 127, at 884-85 (noting that mandatory reporting can en-

ethical objections to mandatory reporting mainly center upon the concepts of an abuse victim's rights to self-determination and confidentiality/privacy. As numerous authors in the abuse literature have noted, spouse abuse victims (and many elder abuse victims) usually are competent adults.<sup>170</sup> Unfortunately, they often choose, for whatever reason, not to call in the authorities to help deal with their abusive situations. Should the state force third parties to do this for them by mandating reporting and imposing penalties on those who do not report? If it does, is it violating every woman's right to determine her own fate and deal with her problems and relationships as she believes best, even if that means staying in an abusive predicament—with all that entails—until/if *she* chooses to abandon it or seek outside intervention to ameliorate it?

*Landeros*, which found a duty to report, featured *child* abuse, and there is a big difference between children and adults. Children are, by definition, incapable of self-determination as they cannot make informed decisions, such as whether to allow abuse to continue, and generally cannot save themselves from others without some outside intervention.<sup>171</sup> Battered women, on the other hand, are legally competent to manage their own lives. Many argue that these victims should take control over *themselves* and seek assistance via a protective order, battered women's shelter, and related remedies rather than depend upon an outsider for help.<sup>172</sup> Critics argue that domestic violence victims already feel disempowered, and when the state injects itself into an abuse situation against the victim's will, it may worsen

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courage ageism by creating the appearance that the elderly are incompetent); Hyman et al., *Reporting of Domestic Violence*, *supra* note 37, at 1785 (stating that mandatory reporting reduces patient autonomy).

170. See, e.g., Garfield, *supra* note 127, at 878 (“[O]nce the age of majority is reached the making power over one's life belongs to the individual. . . .”) (quoting Katz, *supra* note 128, at 717 (1979-1980)). Different considerations would come into play if the victims were not competent adults. These should dictate that they be treated, for mandatory reporting purposes, like the major groups of incompetent abuse victims: children and incompetent elders. See also *id.* at 877-78 (explaining that the law helps to protect children because of their own ignorance and vulnerability).

171. See, e.g., Garfield, *supra* note 127, at 877-78 (stating that in child abuse cases, the state has a role to act for those who cannot speak for themselves); Hyman et al., *Reporting of Domestic Violence*, *supra* note 37, at 1785 (stressing the importance of outside intervention); Katz, *supra* note 128, at 717 (noting the need for a supervisory role); Lee, *supra* note 128, at 730-31 (calling the state the *parens patriae*, who must protect abused children).

172. See, e.g., Bryant & Panico, *supra* note 148, at 420; Gottlich, *supra* note 127, at 375; Holtz & Furniss, *supra* note 1, at 50, 52; Katz, *supra* note 128, at 719; Palincsar & Cobb, *supra* note 128, at 439, 440.

the victim's sense of powerlessness.<sup>173</sup> Some elder abuse victims may believe they have good reasons to remain in an abusive environment (such as the fear that institutionalization—and early death—is their only alternative) and thus oppose mandatory reporting.<sup>174</sup> Battered women also may feel that way for equally valid-seeming grounds and similarly may not welcome state intervention. Some characterize this state action as a form of paternalism, of the state treating this competent adult as if she is unable to care for herself, and making for her the choices society permits and expects of adults.<sup>175</sup> They would argue that mandatory reporting perpetuates society's perception that spouse abuse victims are helpless and childlike,<sup>176</sup> and that it goes against the basic medical ethical emphasis on promoting patient autonomy.<sup>177</sup> Several scholars have pointed out that society permits competent adults to exercise the "right to die" by refusing medical treatment, and ask why one who has the right to choose to die cannot have the right to decide whether or not to seek state assistance when she is in an abusive environment.<sup>178</sup>

The second major ethical component of the attack against mandatory reporting<sup>179</sup> of spouse abuse focuses on the right of a com-

173. See, e.g., Letter, *supra* note 148, at 2378 (stating that mandatory reporting further disempowers the patient); *Physicians and Domestic Violence*, *supra* note 1, at 3192. This could have serious effects, such as feelings of hopelessness and/or depression.

174. For sources explaining that an elder's decision to stay in an abusive relationship often can be a reasoned one, see Crystal, *supra* note 128, at 336-37; Kim Curtin, *Intervention in Elder Abuse: A Swift Blade, Or a Dull-Edged Saw?*, 152 CANADIAN MED. ASS'N J. 1121 (1995); Faulkner, *supra* note 128, at 84-85; Garfield, *supra* note 127, at 879; Katz, *supra* note 128, at 710-11; Lee, *supra* note 128, at 731-33; Palincsar & Cobb, *supra* note 128, at 436. Of course, most states have chosen to ignore such sentiments and mandate elder abuse reporting for reasons which seem compelling. See *supra* note 132 and accompanying text.

175. For sources arguing that mandatory reporting infantilizes the abused and reinforces the misconceived notion of their helplessness, see Faulkner, *supra* note 128, at 90; Garfield, *supra* note 127, at 878; Hyman et al., *Reporting of Domestic Violence*, *supra* note 37, at 1785; Mathews, *supra* note 128, at 663-64.

176. See Garfield, *supra* note 127, at 884-85.

177. See, e.g., Gilbert, *supra* note 128, at 60 (discouraging mandatory reporting as defeating to the patient's well-being); Hyman et al., *Reporting of Domestic Violence*, *supra* note 37, at 1785 (stating that mandatory reporting reduces patient autonomy); see also EDMUND D. PELLEGRINO & DAVID C. THOMASMA, *FOR THE PATIENT'S GOOD: THE RESTORATION OF BENEFICENCE IN HEALTH CARE* 12-22, 43-50 (1988) (arguing that although autonomy is important to society, the real hallmark of a peaceable society is a proper balance between individual autonomy and limiting that autonomy for the common good).

178. See Garfield, *supra* note 127, at 879-81 (explaining that granting an elder the right to die by refusing medical treatment but depriving that person of the right to decide whether to seek state assistance permits him or her to decide when to end his or her life but not how to live it); Katz, *supra* note 128, at 720 (explaining that if a patient has the right to refuse medical treatment, then a patient should have the right to make less life-threatening decisions).

179. See GUTHEIL & APPELBAUM, *supra* note 143, at 4 (phrasing this issue as merely an offshoot of a patient's right to self-determination/privacy).

petent adult patient and her physician to maintain the confidentiality of their relationship. The twin concepts of physician-patient privilege and confidentiality are, of course, both well-established and time-honored.<sup>180</sup> Many argue that forcing physicians to report abuse of their patients seriously may disrupt the essential confidential and trusting relationship between a woman and her physician, possibly forcing her to hide things from the physician lest they be disclosed to the authorities.<sup>181</sup> The critics contend the harm from such disclosure will outweigh any benefit which may be derived from it.<sup>182</sup> They also believe that disclosure is unethical for deontological<sup>183</sup> reasons, that patients reveal personal information to physicians because the physicians create "situations in which confidentiality is implicitly or explicitly promised" and as a result the physician must keep the confidence.<sup>184</sup>

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180. They may, however, be honored in the breach. See Smith, *Privileges and Confidentiality*, *supra* note 43 (providing an extensive review of physician-patient confidentiality); *infra* notes 272-77 and accompanying text (discussing not honoring confidentiality when a physician reports in good faith).

For sources explaining the difference between confidentiality, the right not to have certain communications conveyed to third parties, from privilege, which is the right legally to bar a person with those confidential communications from testifying, see GUTHEIL & APPELBAUM, *supra* note 143, at 4; Coleman, *When Psychiatrist Knows Best*, *supra* note 13, at 1137.

181. See, e.g., Bell & Tooman, *supra* note 28, at 349-50 (noting the resulting disruptions to the physician-patient relationship caused by mandatory reporting); Bryant & Panico, *supra* note 148, at 420 (stating that a trusting relationship cannot be created with mandatory reporting); Frederick, *supra* note 148, at 37 (noting the ensuing dangers to the physician-patient relationship); Hurley, *supra* note 13, at 662-63 (finding that without a promise of confidentiality, a victim may not disclose information to her physician). Note the common wisdom that a physician who must report abuse to the authorities must warn the patient of that obligation before treating her, thereby alerting her to the possibility of disclosure and thus perhaps depriving her of medical care or, at a minimum, adversely affecting her candor. See, e.g., GUTHEIL & APPELBAUM, *supra* note 143, at 25; James C. Beck, *The Basic Issues, in CONFIDENTIALITY VERSUS THE DUTY TO PROTECT: FORESEEABLE HARM IN THE PRACTICE OF PSYCHIATRY* 1, 5 (James C. Beck ed., 1990); Levine, *supra* note 13, at 722-26; Smith, *Privileges and Confidentiality*, *supra* note 43, at 543-44; Smith-Bell & Winslade, *supra* note 13, at 190; *infra* note 192 and accompanying text (discussing how some victims subsequently may not receive medical care).

One author opined that mandatory reporting forces a physician to breach his implied contract of confidentiality with his patient. Agatstein, *supra* note 13, at 141-43. That author further has expressed the view that attorneys are quick to demand confidentiality for themselves and their clients yet are swift to deprive other professionals and those with whom they work, like physicians and their patients, of the same right (and thus, perhaps, are hypocritical?). *Id.* at 141. The Kentucky Attorney General's opinion exempting attorneys from the spouse abuse disclosure law is interesting in that regard. See *supra* note 43.

182. See, e.g., GUTHEIL & APPELBAUM, *supra* note 143, at 5.

183. "[D]ependent on an analysis of moral duties rather than on the consequences of the act." *Id.*

184. *Id.* See Smith, *Privileges and Confidentiality*, *supra* note 43, at 479 (stating that physicians keep confidence as a matter of honor).



Two other points should be mentioned. First, some argue that required reporting fosters classism and racial stereotyping because it impacts disproportionately on poor and minority women and resulting figures incorrectly will make domestic violence seem to be focused on those groups.<sup>185</sup> Second, others, mostly medical ethicists, focus on medical concepts like beneficence (“to help”)<sup>186</sup> and nonmaleficence (“to do no harm”)<sup>187</sup> and how they impact mandatory reporting requirements. Under the nonmaleficence doctrine, physicians should subject their patients to no *unnecessary* or *unjustified* risks lest the physicians thereby leave the patients worse off than when they first came to the physicians.<sup>188</sup> Reporting critics argue that reporting does exactly that, because it may bring down retribution and other negative consequences upon domestic violence victims, allegedly without offering them any tangible benefit.<sup>189</sup> Beneficence orders physicians to help others—especially their patients—when the physicians are able to do so,<sup>190</sup> and this forms a significant portion of the basis for the AMA’s aforementioned call for physician involvement in domestic violence (albeit not through mandatory reporting).<sup>191</sup> Proponents of beneficence and nonmaleficence emphasize educating physicians about the horrors of domestic violence and having them advise their battered patients about available resources (counselling, spouse abuse

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185. See Hyman et al., *Reporting of Domestic Violence*, *supra* note 37, at 1784 (arguing that mandatory reporting may perpetuate stereotypes); Yelas, *supra* note 153, at 791-92 (stating that reporting and intervention can be classism because of a disproportionate impact on the poor).

186. For sources discussing how beneficence is the ethical principle of attempts to “do good,” see JOHN G. BRUHN & GEORGE HENDERSON, *VALUES IN HEALTH CARE: CHOICES AND CONFLICTS* 304 (1991); MUNSON, *supra* note 169, at 34; PELLEGRINO & THOMASMA, *supra* note 177; Hyman et al., *Reporting of Domestic Violence*, *supra* note 37, at 1784-85; *Physicians and Domestic Violence*, *supra* note 1, at 3190.

187. For a discussion of how nonmaleficence is the ethical guideline mandating that a physician should not do harm to a patient, see BRUHN & HENDERSON, *supra* note 186, at 304; MUNSON, *supra* note 169, at 32; PELLEGRINO & THOMASMA, *supra* note 177, at 26; Hyman et al., *Reporting of Domestic Violence*, *supra* note 37, at 1784-85; *Physicians and Domestic Violence*, *supra* note 1, at 3190.

188. See, e.g., MUNSON, *supra* note 169, at 32-34; Hyman et al., *Reporting of Domestic Violence*, *supra* note 37, at 1784-85; Jecker, *supra* note 4, at 779.

189. See Hyman et al., *Reporting of Domestic Violence*, *supra* note 37, at 1785.

190. See, e.g., MUNSON, *supra* note 169, at 34; Hyman et al., *Reporting of Domestic Violence*, *supra* note 37, at 1784-85.

191. Hyman et al., *Reporting of Domestic Violence*, *supra* note 37, at 1784-85; Jecker, *supra* note 4, at 779; *Physicians and Domestic Violence*, *supra* note 1, at 3190; see *supra* notes 38-39 and accompanying text. Dr. Nancy S. Jecker contends that an additional medical ethical duty, justice, applies here via fostering a patient’s self-respect in the face of the onslaught of a spouse batterer’s abusive treatment of the patient. Jecker, *supra* note 4, at 779-80. She feels that justice requires physicians to respond to domestic violence more strongly than beneficence or nonmaleficence. *Id.* at 779.

centers, orders of protection, etc.) rather than forcing them to report abuse.<sup>192</sup>

Among the litany of practical objections to mandatory reporting, some are based upon the possible impact of reporting on the victim or her immediate family unit. Many contend that if compulsory reporting is instituted, it effectively will deprive the abused from medical care either (1) because the victim will be afraid that the physician will report the abuse if she seeks treatment, so the victim will not seek it (or else will not be candid if she does), or (2) because her *assailant* will fear being reported, and accordingly will stop the victim from going for any medical assistance.<sup>193</sup> Some argue that reporting risks inciting serious retaliation by the abuser against the victim<sup>194</sup> or even the abuse reporter (typically the physician),<sup>195</sup> thereby worsening an already bad situation. Some contend that it may disrupt, or even destroy, the victim's family unit<sup>196</sup> and further upset the victim, who may feel *she* destroyed her family.<sup>197</sup> Reporting accomplishes something she may not have wanted to do—turn in her own spouse to the authorities<sup>198</sup>—and in the process publicizes her very private suffering to others, potentially to the entire community, nation, or world.<sup>199</sup> Watching her partner arrested (and possibly jailed), prosecuted and tried for his crimes may be particularly traumatic for the battered

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192. See, e.g., Bryant & Panico, *supra* note 148, at 420 (emphasizing physician education on abuse topics); Hyman et al., *Reporting of Domestic Violence*, *supra* note 37, at 1786 (stating that policy alternatives to mandatory reporting should be considered, such as developing medical staff programs on domestic violence); Jecker, *supra* note 4, at 779-80; Lee, *supra* note 128, at 761-64 (stating that even with mandatory testing, abuse education programs are a key factor in increasing the reports of abuse). For a discussion of the medical ethical concept of justice in the domestic violence context, see Jecker, *supra* note 4, at 779-80.

193. For sources stating that mandatory reporting may prevent abuse victims from obtaining medical treatment altogether, see Brewer & Jones, *supra* note 128, at 1219; Bryant & Panico, *supra* note 148, at 420; Chez, *supra* note 18, at 70; Frederick, *supra* note 148, at 37; Gottlich, *supra* note 127, at 375; Mathews, *supra* note 128, at 667; Metcalf, *supra* note 128, at 753; Murphy, *supra* note 148, at 901; Pike, *supra* note 19, at 1956.

194. See Agatstein, *supra* note 13, at 140; Hyman et al., *Reporting of Domestic Violence*, *supra* note 37, at 1783; Smith-Bell & Winslade, *supra* note 13, at 190. Cf. Brooks et al., *supra* note 92, at 51; Chez, *supra* note 18, at 69-70.

195. Bell & Tooman, *supra* note 28, at 344.

196. See, e.g., Agatstein, *supra* note 13, at 137-39; Brooks et al., *supra* note 92, at 51; Smith-Bell & Winslade, *supra* note 13, at 190. This is a particular problem when the abusive family member is incarcerated. See Agatstein, *supra* note 13, at 139.

197. See Brooks et al., *supra* note 92, at 51.

198. See Meier, *supra* note 5, at 1344-45 (explaining why some women may not wish to report their abuse); Palincsar & Cobb, *supra* note 128, at 429.

199. See Brooks et al., *supra* note 92, at 51 (recognizing the harms from publicity, such as having loyalties interrupted, being the object of retaliation, and being blamed for the report). Notably, the O.J. Simpson case started out as an all-too-common type of domestic violence situation which happened to feature a celebrity wife batterer.

spouse.<sup>200</sup> Erroneous reports may destroy the reputations of supposed abusers,<sup>201</sup> and even correct ones can have adverse consequences for one the domestic violence victim did not wish to see suffer.<sup>202</sup>

Critics of required reporting point to other problems they state it may cause or exacerbate. They attack the number and quality of reports which will be filed, first contending that mandating physicians to report will open the floodgates, inundating state officials in paper as physicians take the course of least resistance, practice "defensive medicine," and report all remotely questionable patient complaints as abuse.<sup>203</sup> In this anticipated torrent of reports, critics claim that serious ones will get lost in the pile. Moreover, they charge that most of the valid accounts will be needlessly duplicative because the authorities already may know about the vast majority of the abuse situations physicians report to them even before the reports are filed.<sup>204</sup> Finally, they allege erroneous descriptions will be a serious problem, causing great difficulty for the innocent and potentially paralyzing the agencies which must evaluate the reports.<sup>205</sup> They also adversely might affect the quality of the data on abuse which is collected (and thus undermine one of the rationales for reporting).<sup>206</sup>

Critics of mandatory reporting further focus on its effect on government and the legal system. Initially, they contend that government currently is unable adequately to serve those abuse victims of whom it is aware.<sup>207</sup> Then, they argue that if agencies cannot help this number, mandatory reporting only will overwhelm the already overtaxed sup-

200. For a description of the emotional costs to the family following an abuser's legal prosecution, see Brooks et al., *supra* note 92, at 51-52; Levine, *supra* note 13, at 721; Smith-Bell & Winslade, *supra* note 13, at 190.

201. See Besharov, "Doing Something," *supra* note 153, at 554-62; Yelas, *supra* note 153, at 791.

202. See Brooks et al., *supra* note 92, at 52-53. All too often, some allege, the abusers themselves are victims whom society did not help when they needed assistance. Costa, *supra* note 127, at 386.

203. See, e.g., BESHAROV, THE VULNERABLE SOCIAL WORKER, *supra* note 57, at 24-25; Cole, *supra* note 86, at 7-8.

204. See Crystal, *supra* note 128, at 331, 336; Faulkner, *supra* note 128, at 78; Garfield, *supra* note 127, at 882.

205. See, e.g., Bell & Tooman, *supra* note 28, at 346; Besharov, "Doing Something," *supra* note 153, at 556 (discussing unfounded reports); Costa, *supra* note 127, at 386 (discussing the problems with erroneous descriptions); Metcalf, *supra* note 128, at 753.

206. For a discussion of problems with inaccurate data collection, see Gottlich, *supra* note 127, at 374; Hierl, *supra* note 128, at 392; Hyman et al., *Reporting of Domestic Violence*, *supra* note 37, at 1784. Connecticut legislators apparently let a reporting law lapse due to this quality of data issue. See *id.*

207. For claims that agencies often cannot handle the number of cases they have under the current system, see Bryant & Panico, *supra* note 148, at 420; Crystal, *supra* note 128, at 336-37,

port system.<sup>208</sup> They then conclude that since overburdened agencies will not help the abused, there is no reason to risk retaliation and other related problems by having reporting in the first place.<sup>209</sup> They also note the negative effects of reporting on others who must deal with it within the legal system. These include law enforcement officers, who must exercise considerable discretion, expend significant financial resources, and assume great risk of physical harm when responding to violence reports<sup>210</sup>; attorneys<sup>211</sup>; and judges.<sup>212</sup> This further encompasses a more amorphous group, all those who are disheartened, discouraged, and disillusioned by the system's alleged failure adequately to respond to reports of abuse—be they the victim (whose hopes may have been raised when her abuse was reported, then dashed if nothing was done about it), the reporting physician (whom the law required to report when he or she may not have wanted to get involved and then saw nothing done with the information he or she provided),<sup>213</sup> the agency employee, the police officer, attorney, judge, or an ordinary citizen-onlooker.<sup>214</sup>

A final group of practical concerns centers on the mandatory reporter, typically the victim's physician. First, of course, there are the aforementioned direct and indirect financial costs to the physician of

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339; Hyman et al., *Reporting of Domestic Violence*, *supra* note 37, at 1784; Mathews, *supra* note 128, at 664; *Physicians and Domestic Violence*, *supra* note 1, at 3192.

208. The mere requirement of reporting will not help without funding to handle these cases. Besharov, "Doing Something," *supra* note 153, at 563; Brooks et al., *supra* note 92, at 57-58; Katz, *supra* note 128, at 707-08; Lee, *supra* note 128, at 752; Yelas, *supra* note 153, at 790-91.

209. See Brewer & Jones, *supra* note 128, at 1219; Faulkner, *supra* note 128, at 77, 81; Garfield, *supra* note 127, at 884; Lee, *supra* note 128, at 733-34, 752; Letter, *supra* note 148, at 2378.

210. Brooks et al., *supra* note 92, at 59; Jones, *Battered Spouses' Section 1983 Damage Actions*, *supra* note 8, at 254-55; Jones, *Battered Spouses' State Law Damage Actions*, *supra* note 1, at 8-9 & n.8.

211. Brooks et al., *supra* note 92, at 59-60.

212. *Id.* at 60-61.

213. The reporting physician also may have incurred significant costs by reporting. See *supra* note 167 and accompanying text (listing costs, such as time spent in filing reports, lost income from time spent filing reports rather than treating patients, extra office staff, and lost income from patients who change physicians because of reporting). Note the special problem of the whistleblowing employee/reporter who may have endangered her position by filing a report. See BESHAROV, *THE VULNERABLE SOCIAL WORKER*, *supra* note 57, at 43-45 (noting that employees of agencies who report institutional maltreatment of children are often retaliated against by the agency through dismissal).

214. See, e.g., Brewer & Jones, *supra* note 128, at 1219 (stating that laws mandating reporting, yet failing to provide adequate resources can be harmful by causing false expectations); Brooks et al., *supra* note 92, at 58 (describing the demoralization inaction on reports can have upon those working in the system); J. Jones, *Elder Abuse*, *supra* note 127, at 847 (noting that mandatory reporting may inflict harm through false expectations).

reporting.<sup>215</sup> Physicians point to other potential "costs," mostly non-economic, of reporting. They say that it may irretrievably rupture their relationship with an abused patient who does not want them to report the abuse and feels betrayed when they do so.<sup>216</sup> They worry that patients can sue them on the grounds of invasion of privacy, breach of confidentiality, or some related cause of action when they report abuse against the patient's wishes.<sup>217</sup> Reporting can create a sense of disempowerment and/or internal conflict of interest for physicians, who may not believe it will help a particular patient yet must do so or else face civil and/or criminal liability.<sup>218</sup> One critic of mandatory reporting of elder abuse makes a final, somewhat meta-physical, point about physicians, a rhetorical question which asks whether physician time and resources should be expended in reporting abuse against a competent adult who should take care of herself (presumably by calling the authorities herself, or taking some other remedial action).<sup>219</sup>

In conclusion, legal and medical critics have raised a number of objections, both practical and ethical, to requiring physicians to report abuse of their adult patients to the authorities. One author has summarized these complaints succinctly yet thoroughly: "Mandatory reporting may threaten the safety of battered women, discourage them from seeking care, fail to improve the health care of battered patients, lead to inadequate responses to reports of abuse, result in biased case identification, and violate patient autonomy and confidentiality."<sup>220</sup> Although some of these points are well-taken, on balance<sup>221</sup> the merits of mandatory reporting outweigh the criticisms.

Many of the common arguments against required abuse reporting are refutable. Others can be, and in fact have been, addressed through law or policy. On the ethical front, the primary focus is on the domestic violence victim's right to determine her own fate, including whether or not to have government assistance in coping with her situ-

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215. See *supra* note 167 and accompanying text (listing types of pecuniary losses to physicians resulting from mandatory reporting).

216. See, e.g., Bell & Tooman, *supra* note 28, at 349-50; Brooks et al., *supra* note 92, at 55; Hurley, *supra* note 13, at 662-63; *Physicians and Domestic Violence*, *supra* note 1, at 3192.

217. For a discussion of doctor's liabilities for disclosing information, see DeKraai & Sales, *supra* note 105, at 856; Mark A. Hall, *Hospital and Physician Disclosure of Information Concerning a Patient's Crime*, 63 U. DET. L. REV. 145, 146-47 & n.3, 147-51 (1985); Hyman et al., *Reporting of Domestic Violence*, *supra* note 37, at 1783; *supra* note 23 and accompanying text.

218. Agatstein, *supra* note 13, at 148-51; Brooks et al., *supra* note 92, at 55.

219. Palincsar & Cobb, *supra* note 128, at 436-37.

220. Hyman et al., *Reporting of Domestic Violence*, *supra* note 37, at 1786.

221. See *supra* note 152 and accompanying text (discussing the balancing of interests).

ation forced upon her.<sup>222</sup> The right of self-determination is fundamental,<sup>223</sup> and any effort to hinder it must be both strictly justified and limited. But mandatory reporting need not disrupt self-determination. Granted, any reporting system which does anything with reports beyond merely compile data will interfere, to some degree, with a battered spouse's life. But it need not meddle unduly. Perhaps some of the self-determination debate involves differing views over how intrusively government will act. This Article does not purport to define exactly how agencies should respond to reports, a topic which exceeds its scope. Courts considering whether to impose a duty to report on physicians need merely determine if government *can* respond appropriately and, if so, find whether the costs of it so doing outweigh the benefits. Clearly, agencies can, as demonstrated by the Kentucky experience.<sup>224</sup> There, spouse abuse reports are evaluated and investigated by the agency charged with overseeing them, and agency workers offer various protection and advocacy services to the spouse abuse victim. This is akin to how many states handle mandatory elder abuse reports, offering services to victims without necessarily intruding unduly into their lives.<sup>225</sup> At times law enforcement must get involved, but its reaction can be tempered by the circumstances. Thus, interference with self-determination is minimized.

Still, mandatory reporting and subsequent state follow-up, no matter how measured, does inject the state into the battered spouse's life without her consent. Is this appropriate governmental concern over the safety of its citizens or officious intermeddling in a competent adult's life which is intolerable in a free society? Answering that question requires considering again the nature of domestic violence. As noted, spouse abuse is a terrible social problem involving *controlling, violent, criminal* behavior against those often unable to protect themselves.<sup>226</sup> If such conduct happened in any other context, society would never tolerate it. But because it typically arises between people in relationships, usually with women as the victims, traditionally it has been treated differently—as a “private” concern, not for state inter-

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222. See *supra* notes 169-78 and accompanying text (discussing ethical arguments regarding mandatory reporting).

223. See BRUHN & HENDERSON, *supra* note 186, at 304 (stating that autonomy is fundamental to a value system).

224. See *supra* notes 39-40 and accompanying text.

225. See, e.g., Garfield, *supra* note 127, at 892-98 (discussing ways in which agencies can minimize intrusion into victims' lives). Note how in the case of the female elder abuse victim discussed in Curtin, *supra* note 174, at 1121-22, she ultimately rejected all proffers of assistance and remained with her abusive spouse despite heroic efforts to convince her to leave him.

226. For an explanation of the power and control that an abuser seeks through his violence, see sources cited at *supra* note 5.

vention.<sup>227</sup> However, violent, criminal acts are not "private," regardless of against whom they are directed.<sup>228</sup> Spouse battering is as "public" a problem as any robbery or assault, rape or murder, and needs to be pursued just as vigorously, whether or not the victim (or her survivors) demands outside intervention. Various writers have explored the essence of the family unit and concluded that it is inappropriate to retreat from its legal issues by using the label "private concern."<sup>229</sup> For all too long, areas involving mostly women have been designated as "private," places government should avoid (or at least handle differently)<sup>230</sup> regardless of what is being done to those there. By keeping them "private," society has kept them out of view, and also out of thought. Such treatment has meant problems like child abuse, elder abuse, and spouse abuse have continued on for centuries without serious governmental interference or restriction.<sup>231</sup> Finally, government is starting to get involved, making a dent in these problems; claims that they are "private" matters can only hinder its efforts.

When a problem is public, the government must try to deal with it, and that can mean prosecuting or otherwise pursuing criminals regardless of the wishes of the victims because crime is an offense against both individual victims and *society*, not just the victims alone. Victim safety and wishes *should* be considered, but cannot govern

227. See *Chez*, *supra* note 18, at 70; *Jecker*, *supra* note 4, at 780.

228. See *Chez*, *supra* note 18, at 70; *Jecker*, *supra* note 4, at 780.

229. For a discussion of the public and private natures of domestic abuse, see Besharov, "Doing Something," *supra* note 153, at 554; Burge, *supra* note 15, at 372; Ruth Gavison, *Feminism and the Public/Private Distinction*, 45 STAN. L. REV. 1 (1992); *Jecker*, *supra* note 4, at 777-79, 780; Elizabeth M. Schneider, *The Violence of Privacy*, 23 CONN. L. REV. 973 (1991); Yelas, *supra* note 153. As one recent article explained:

[T]he public/private distinction . . . has defined the limits of governmental intervention in the lives of individuals by asserting that there are certain areas of human existence in which government should not intervene. The family has traditionally been considered one of these areas. Attempts to combat . . . abuse, a social problem centered in the family, have thus encountered difficulties. [T]oo many of th[e] arguments [surrounding the mandatory reporting debate] rely on some form of the public/private distinction as an excuse not to intervene effectively where . . . abuse most often occurs.

Yelas, *supra* note 153, at 781-82.

Even the AMA recognizes the negative effects of assuming domestic violence is a "private" matter. *Physicians and Domestic Violence*, *supra* note 1, at 3191-92.

230. Police traditionally managed violence in the home very differently from violence on the street. They tried to mediate domestic "disputes," i.e., have the abuser walk around the block and attempt to calm things down. The message was that assaults in the home were permissible; victims were not afforded adequate protection and assailants were not subject to consequences.

Holtz & Furniss, *supra* note 1, at 50.

231. "Injustices towards women, both discreet and discrete (in the sense that they have been seen as one-off, personal mishaps, rather than systemic abuse) have remained undocumented and hence ignored by legislators and other social architects." Yelas, *supra* note 153, at 796.

whether the issue is whether to prosecute or the more threshold issue of whether to report something which will not be discovered, much less prosecuted, unless *someone* brings it to public attention. After all, the victim's "wishes" may not be her own at all, but rather those of the *batterer* who controls her.<sup>232</sup> The state does intrude into the victim's life when it acts on mandatory abuse reports, but then it frequently meddles with people's lives (hopefully for valid reasons) through tax laws, motor vehicle registration and drivers' licensing provisions, seat belt use and motorcycle helmet wearing requirements, etc. without having these actions successfully challenged for violating individual independence and self-determination.<sup>233</sup>

Requiring reporting, and follow-up investigations, is not so onerous for the victims that the community ought to ignore the abuse inflicted upon them in order to protect their right to be left alone.<sup>234</sup> This is particularly true in light of society's distinct interest in preventing an ongoing pattern of violence from permanently injuring or killing its members, as domestic violence tends to be continuing behavior rather than an isolated criminal act. If victims cannot,<sup>235</sup> or will not, protect themselves then government must step in to prevent worse things from happening in the future. Their psychological needs, including worsened senses of powerlessness, can be met through counselling and other spouse abuse resources *after* their physical safety is assured. Helping those in severe need is not really "paternalistic," or at least not in any negative sense—society has to look after itself and its members, even if that can entail some interference with someone's present

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232. See, e.g., Asmus et al., *supra* note 5, at 118 (providing an example of the technique an abuser might use to impose his will upon the victim).

233. *Id.* at 800.

234. Indeed, the follow-up can prove very beneficial both when it helps protect the abused and when it leads to the dismissal of unsubstantiated abuse charges.

235. This raises the possible issue of the "battered woman syndrome," which describes a symptom complex characterized by repetitive, deliberate physical trauma and multiple injuries, often escalating over time. Psychologically, there is a loss of self-esteem and symptoms of anxiety or depression. The term battered woman syndrome has also been used to describe a psychological response similar to the post-traumatic stress disorder. This definition of the battered woman syndrome has been used successfully as a legal defense in criminal prosecutions of battered women who have retaliated against their abusers.

Holtz & Furniss, *supra* note 1, at 47. For more detailed explanations of the battered woman syndrome, see Dutton, *supra* note 1, at 1215-42; Meier, *supra* note 5, at 1314-17. At the risk of incurring the charge of paternalism, one must observe that to the extent that spouse abuse victims are rendered incapable of caring for themselves by their batterers' actions, state intervention through the mandatory reporting route may be justified. See Bryant & Panico, *supra* note 148, at 420 (stating that an abused woman may be as vulnerable as a child); Jones, *Battered Spouses' State Law Damage Actions*, *supra* note 1, at 40-41 (noting that abuse victims can be incapable of caring for themselves).



perceptions, perhaps ill-founded,<sup>236</sup> of her wishes.<sup>237</sup> The right to die, even according to some who raise it in the right of self-determination context, is not really comparable to the right to veto the filing of abuse reports.<sup>238</sup> Thus, although the issue is not without doubt, on balance the fundamental right to self-determination should not overcome the state's obligation to protect its citizens and enforce the law. Mandatory reporting is a valuable, measured tool which must be upheld, although it certainly should be implemented so as to minimize any negative effects it may have upon some of the women it is designed to help.

The other major category of ethical objections to mandatory reporting focuses on medical and legal concepts of confidentiality in the physician/patient relationship.<sup>239</sup> A partial answer is that it clearly is legally permissible to relate otherwise confidential information to the authorities when some compelling public purpose, such as protecting battered women from further abuse, is served by so doing.<sup>240</sup> But that may not completely resolve the ethical question of whether a breach of confidentiality truly is justified, even in egregious domestic violence situations so that it precludes further discussion. As a practical matter, this may be a non-issue with most battered spouses because there is evidence that most patients do not know about their right of confidentiality in the first place. Hence, they cannot be deterred from going to their physicians by fears about something whose very existence is unknown to them.<sup>241</sup> As for those who know about the right (and all the others who are entitled to it whether or not they know about it), they face an ethical balancing process as their interest in confiden-

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236. If battered spouses knew the resources which would be brought to their assistance if their plight were reported, would as many be reluctant to seek government aid on their own (or object to physician reporting)?

237. Note that, in a sense, universal reporting of abuse—whether child, elder, or spouse—helps offset this problem. It is harder to argue that battered women are treated paternalistically or discriminatorily by mandatory reporting when the state handles *all* abuse victims the same. See, e.g., Mathews, *supra* note 128, at 675 (stating that if reporting is made mandatory, it should be aimed at reporting abuse of any adult, not just the elderly, thereby avoiding the promotion of the notion that the elderly are incompetent).

238. See, e.g., Garfield, *supra* note 127, at 881 (arguing that the right to die and the right to prevent the filing of reports are not really analogous, because abuse reporting implicates a less significant interest than the refusal of medical treatment—the interest in preventing reporting being liberty or privacy, while in medical treatment, the interest involves one's right to choose between life or death).

239. See *supra* notes 179-84 and accompanying text (discussing confidentiality).

240. See *infra* notes 269-82 and accompanying text (discussing when physicians may report).

241. GUTHEIL & APPELBAUM, *supra* note 143, at 5; see also Smith, *Privileges and Confidentiality*, *supra* note 43, at 548-49 (stating that most patients probably do not understand the limits of confidentiality).

tiality is measured against society's interest in protecting them from further abuse. There must be exceptions to confidentiality when they are necessary for the welfare of the patient or others.<sup>242</sup> That should resolve the ethical confidentiality issue in favor of disclosure.<sup>243</sup>

Turning to classism and racial stereotyping,<sup>244</sup> it must be made clear that domestic violence cuts essentially equally across racial and socio-economic lines.<sup>245</sup> Mandatory reporting will help document this fact, as if all physicians report then the true number of upper and middle class abuse victims will become apparent. When beneficence and nonmaleficence are considered,<sup>246</sup> they should not pose significant problems for reporting. If one assumes that reporting proves beneficial for the battered woman, or at least does her no harm, both doctrines will be furthered.<sup>247</sup>

Addressing the more practical objections to reporting, it is possible that reporting will keep some battered women from seeking medical care.<sup>248</sup> Effectively being deprived of healthcare would, of course, be a serious problem for domestic violence victims. But it seems unlikely that the injured will shun physicians. Parents take their abused children to hospitals and physicians for treatment notwithstanding mandatory reporting laws,<sup>249</sup> and adult women should act similarly when they themselves are the victims.<sup>250</sup> It is equally possible, or even likely, that some abusers will retaliate against the battered spouse and/

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242. See *infra* notes 277-82 and accompanying text (noting exceptions to confidentiality, such as universal child abuse reporting laws, elder abuse reporting provisions, and some communicable disease reporting legislation).

243. Such will be consistent with the sense of such recent rulings as the United States Supreme Court's decision in *Veronia School District 47J v. Acton*, 115 S. Ct. 2386 (1995), that the benefits of mandatory random drug testing of student athletes outweigh their privacy concerns and the New Jersey Supreme Court's determination in *Doe v. Poritz*, 662 A.2d 367 (N.J. 1995), that notifying residents when a convicted sex offender moves into their neighborhood does not transgress the offender's confidentiality rights.

244. See *supra* note 185 and accompanying text (noticing that some argue mandatory reporting impacts the poor and minorities disproportionately).

245. See *LOUIS HARRIS & ASSOCS., INC., A SURVEY OF SPOUSAL VIOLENCE AGAINST WOMEN IN KENTUCKY* 2, 16-18 (1979); Asmus et al., *supra* note 5, at 121; Dutton, *supra* note 1, at 1214; *Physicians and Domestic Violence*, *supra* note 1, at 3191. *But see* Welch, *supra* note 17, at 1136 (stating that domestic abuse is not restricted to discrete segments of society).

246. See *supra* notes 186-92 and accompanying text.

247. See Gilbert, *supra* note 128, at 53-54 (arguing that mandatory reporting removes harm by stopping abuse of an older adult and by alerting nurses to the problem).

248. See *supra* note 193 and accompanying text (arguing that if compulsory reporting is instituted, the abused practically may be deprived of medical care).

249. See, e.g., Paulsen, *Child Abuse Reporting Laws*, *supra* note 87, at 9 (contending that only a small number of parents will put their own safety before the lives of their children).

250. This will be particularly true assuming the governmental response to abuse reports is adequate. See *infra* notes 259-63 and accompanying text (explaining the social and political forces which foster governmental reaction to the abuse problem).

or the reporting physician when they learn they have been reported to the authorities,<sup>251</sup> but confidential protective service action and a cautious police response can reduce this problem. Moreover, society does not disregard other types of criminal behavior because of the risk that case investigation or the offer of protective services will spark retribution against the victim or the citizen who reported the crime. Sometimes victims and/or witnesses are injured or killed, but not seeking to offer protective services to victims and to hold perpetrators accountable to avoid such instances would be unconscionable and would encourage criminals to continue their activities unchecked. Leaving the scourge of domestic violence to continue to spread because of fear of retaliation simply makes no sense. Other factors may ameliorate these problems as well. Some have noted that when reporting is mandatory, the abuser is more likely to be angry at the person who reported the abuse than the victim, who truthfully can say all she did was seek medical treatment; she did not call the police or any other state agent for help.<sup>252</sup> If the batterer considers turning his anger towards the reporting physician, he can consider that the physician merely was obeying the mandates of the law in an almost ministerial fashion, so the physician is not a good target for his rage either.<sup>253</sup>

When one considers the multitude of other complaints about the impact of reporting on the spouse abuse victim or her batterer,<sup>254</sup> none are sufficiently compelling to bar it. Reporting and its consequences very likely *will* change the victim's family, hopefully for the better. The status quo before reporting presumably was not so wonderful that it ought to be preserved at the expense of continued abuse, and possible death. It is unfortunate if some battered women blame themselves for the changes in their families, but hopefully family, friends, the police, and other support personnel can help them understand that the real individuals who altered their households were the men who battered them. It also is unfortunate either if reporting brings an abuse victim's plight to the attention of her neighbors or even the public at large when she wants to maintain her privacy or if the victim is traumatized over her partner's fate. However, information, advocacy, and related assistance can show her that she has nothing to be ashamed about and that her assailant brought whatever

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251. See *supra* notes 194-95 and accompanying text.

252. See, e.g., Paulsen, *Abused Children*, *supra* note 160, at 162; Bryant & Panico, *supra* note 148, at 420.

253. See, e.g., Paulsen, *Abused Children*, *supra* note 160, at 163 (arguing that parents will find a physician's actions in reporting more palatable if required by law).

254. See *supra* notes 195-201 and accompanying text.

happens to him on himself. Above all, the domestic violence victim's situation here is essentially the same as many other crime victims, yet society does not ignore serious criminal behavior against *those* victims because of the fear of the impact of prosecution on the victim. Certainly, mandatory reporting of child abuse, elder abuse, and crimes committed with dangerous weapons,<sup>255</sup> along with general investigation and prosecution of offenses like rape, arson, assault and battery, statutory rape, incest, and numerous others all proceed despite the existence of concerns like those raised about spouse abuse victims.<sup>256</sup> When society balances these victim interests against the need to stop crime and punish criminals, it has to enforce the law first and worry about the victim's feelings second.<sup>257</sup> Finally, it is both important not wrongly to accuse men of being wife batterers, and unfortunate for even the rightly accused to be forced to suffer the consequences of their actions.<sup>258</sup> However, this is true of all crimes and criminals. There is nothing unique about these issues in the spouse abuse context which should bar the sort of mandatory reporting which is the law in other cases, including child or elder abuse.

Turning to attacks on the impact of reporting on government,<sup>259</sup> the state simply will have to adapt to the volume of reports. If additional resources are needed, they will have to be found. It is unconscionable to argue that a crime like domestic violence must continue on as it is because it is too expensive to take the steps necessary to control it.<sup>260</sup>

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255. See *infra* note 286 and accompanying text (discussing the state statutes which require mandatory reporting by physicians treating certain injuries).

256. Consider in this regard, for example, the recent sex offense prosecution and jury conviction of Congressman Mel Reynolds of Illinois. Maurice Possley & Peter Kendall, *The Reynolds Trial; Judge Lectures Heard About Silence*, CHI. TRIB., July 28, 1995, at 1. Not only was he prosecuted against the express wishes of his teenaged alleged victim, but the victim herself was incarcerated until she testified about events which transpired when she was sixteen. Although this author is not necessarily advocating incarcerating battered women who refuse to testify against their abusers, the Reynolds case does show a court emphasizing the societal interest in prosecuting the guilty even over the victim's objections.

257. These concerns may reflect aspects of the "public/private" nature of domestic violence conundrum. See *supra* notes 223-33 and accompanying text (pointing out that this is a public legal issue which must be dealt with like other violations of the criminal law. It cannot be swept under the carpet by treating it as a "private," "family" matter, lest the problem continue to grow unabated).

258. For the point that spouse abusers often were abuse victims themselves, see *supra* note 202. This may be something for a court or other agency to consider when it considers treatment or other alternatives for the abusers. It certainly is no reason to allow wife battering to go unreported and, thereby, to possibly continue unabated potentially indefinitely.

259. See *supra* notes 202-05 and accompanying text (arguing that required reporting will paralyze the agencies who evaluate the reports).

260. See Yelas, *supra* note 153, at 800-01. Perhaps this is another reason that spousal abuse must be recognized as a public, criminal law concern rather than a private one to be downplayed and ignored by the authorities. See *supra* notes 222-33 and accompanying text.

And, it can be managed without bankrupting government.<sup>261</sup> Some reports may be duplicative,<sup>262</sup> but they can be dealt with; duplication certainly is no reason not to receive those reports which are not. Government carefully can evaluate reports to minimize problems with erroneous ones (such as by classifying them as substantiated versus unsubstantiated reports), thus maintaining the integrity of the data base on the nature and extent of spouse abuse. Difficulties cannot be eliminated entirely, but an important resource in the attack on domestic violence should not be abandoned simply because of the possibility that some mistakes in reporting will happen.<sup>263</sup>

Complaints about the quality of government's past response to wife beating, and some skepticism about its present and future commitment to stopping it, certainly are justified. Many, including this author, have written about the historically pathetic police response in this area.<sup>264</sup> If that tradition were to persist, it would be doubtful whether mandatory reporting (or *any* intervention, for that matter) should be required—it certainly would make no sense to risk any of the possible negative consequences of reporting if nothing were to be done with the reports. But that pattern cannot continue. As with the increasing litigation against the nonresponsive police, physician liability for failure to report will help hold those professionals accountable—as decisions like *Landeros* and its more numerous law enforcement liability decision cousins<sup>265</sup> are decided and publicized, police and physicians will fulfill their responsibilities both because it is the right thing to do and because they fear the possible consequences if they do not. Other governmental agencies should be liable under the same legal theories as the police should they shirk their duty to deal appropriately with domestic violence reports.<sup>266</sup>

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261. See *supra* notes 40-44 and accompanying text (discussing Kentucky's basically successful experience with mandatory reporting of domestic violence).

262. It also seems unlikely that with a problem as pervasive yet hidden as domestic violence the authorities will already know about the vast majority of cases which physicians report to them. If that is true, why does government not act to stop the abuse?

263. See *supra* note 53 (demonstrating that in Kentucky over 75% of mandatory spouse abuse reports are substantiated by state investigators).

264. See, e.g., sources cited *supra* note 9.

265. See Jones, *Battered Spouses' State Law Damage Actions*, *supra* note 1, at 13-14 n.34-38 (listing various law enforcement liability decisions).

266. See *supra* note 86 (noting that the school, social worker, and related governmental defendants already called to task for failure to report child abuse). Social workers and others are also held both civilly and criminally responsible for failing adequately to investigate the reports of child abuse and related problems they receive or to follow-up properly on their investigations. See, e.g., *Mammo v. State*, 675 P.2d 1347, 1350 (Ariz. Ct. App. 1983) (holding that a state agency had a duty to act with reasonable care when it received information from a non-custodial parent concerning a threatened child); *Turner v. District of Colom.*, 532 A.2d 662, 675 (D.C. 1987)

There will, moreover, be other forces driving government agencies to act. As the enormity of wife battering increasingly has become apparent, there have been escalating political pressures which force agencies to address the problem. Politicians already have enacted various valuable domestic violence legislation, both state and federal,<sup>267</sup> and more undoubtedly will follow. At a time when groups like the AMA have thrown their efforts into the fight against wife battering,<sup>268</sup> government has done the same. It is understandable, but erroneous, to assume that because government's reaction to spouse abuse once was woefully inadequate it will continue to be the same. Rather than oppose mandatory reporting, perhaps its critics should focus their considerable political skills on insuring that government continues working to address domestic violence so that there is no question that abuse reports promptly and competently will be processed and acted upon.

Concern over the impact of reporting on both the police and other officials<sup>269</sup> may be at least somewhat explainable as well, but it does not outweigh the benefits of reporting. Police economic and safety concerns in domestic violence cases do not justify blocking report-

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(holding that a special relationship is created between abused and neglected children and the Child Protective Services division so that action can be taken against the District of Columbia for breach of this duty); Florida Dep't of Health & Rehabilitative Servs. v. Yamuni, 529 So. 2d 258, 261 (Fla. 1988) (holding that the Department of Health and Rehabilitative Services has a statutory duty to prevent further harm to children when reports of child abuse are received); Brodie v. Summit County Children Servs. Bd., 554 N.E.2d 1301, 1308 (Ohio 1990) (holding that the county children services board has a duty to take affirmative action when it receives a report that child abuse or child neglect is suspected); Jensen v. Anderson County Dep't of Social Servs., 403 S.E.2d 615, 620 (S.C. 1991) (concluding that a cause of action may be brought against a social worker for failing properly to investigate a report of child abuse); Susan L. Abbott, Note, *Liability of the State and Its Employees for the Negligent Investigation of Child Abuse Reports*, 10 ALASKA L. REV. 401 (1993) (arguing that liability should be imposed on the state, rather than on the individual social workers, for the negligent investigation of child abuse reports); Kim Boyer, Comment, *County Welfare Department Liability for Handling Reports of Child Abuse*, 30 SAN DIEGO L. REV. 187 (1993) (analyzing contexts which trigger a special relationship with a county welfare department); Laura Huber Martin, Comment, *Caseworker Liability for the Negligent Handling of Child Abuse Reports*, 60 U. CIN. L. REV. 191 (1991) (arguing that the state, rather than the caseworkers, should be liable if a negligence claim in the handling of child abuse reports can be proven).

267. See Jones, *Battered Spouses' State Law Damage Actions*, *supra* note 1, at 24-26 nn.97-98 (listing the numerous state laws which address domestic violence, including the many order of protection statutes in place across the nation). On the federal front, perhaps the best example of legislative concern is the recently enacted Violence Against Women Act of 1994, Pub. L. No. 103-322, § 40001, 108 Stat. 1902 (1994).

268. See *supra* note 38 and accompanying text (discussing the AMA's commitment to domestic violence).

269. See *supra* notes 210-12 and accompanying text (noting that reporting affects law enforcement officials both physically and financially).

ing,<sup>270</sup> nor do those of attorneys, judges, or others in the legal system. That mandated reporting will force people to do their jobs is not a basis for rejecting it even if it means increased workloads. As for psychic damage to those discouraged by the lack of response to reports,<sup>271</sup> to the extent this occurs it should be remedied by officials who respond appropriately to reports, not by eliminating the reports. Once all see government respond enthusiastically to stopping domestic violence, any disillusionment should end.<sup>272</sup>

With regards to the interests of the reporting physician,<sup>273</sup> while mandatory reporting definitely will entail economic costs they should not be excessive for most reporters (each of whom presumably do not have vast numbers of battered patients), and often only may entail a telephone call. They certainly should not be any greater comparatively than those expenses physicians already incur in dealing with patient insurance; working with governmental health (e.g., Medicare, Medicaid) or benefits (e.g., Social Security) or workers' compensation programs; testifying about patients' medical condition in civil and/or criminal trials; and handling other administrative matters involving their patients, such as the school immunization and examination reports pediatricians fill out on their small charges. If physicians can handle, or pass on directly or indirectly, the costs of these efforts, they can do the same with that of reporting spouse abuse.

When the issue focuses on possibly rupturing the relationship between the physician and the patient who did not want her abuse reported, once again the explanation that reporting is mandatory should help avoid, or repair, the schism. Indeed, there is some indication that mandatory reporting does not drive a wedge between patient and physician, and even that it actually may strengthen the relationship between the patient and her physician who, after all, actually took her

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270. See Jones, *Battered Spouses' State Law Damage Actions*, *supra* note 1, at 3-4 n.8 (addressing the motives which underlie police hesitation and inaction in domestic violence situations). Forcing them to exercise the good judgment they are being paid to develop and use is also not a justification. (Should the police be protected from difficult events which are out of the ordinary lest they have to overtax their faculties? Should the police abolish SWAT teams, or maybe ban requests for their use, because if called upon their members must use extraordinarily good sense in dangerous and tricky situations? The notion is ridiculous, and insulting of the capabilities of the dedicated professionals in law enforcement.)

271. See *supra* notes 213-14 and accompanying text (listing those groups who would be disheartened by a mandatory reporting system's failure to respond to reports of abuse).

272. Manifestly, the way to deal with a problem like spouse abuse is *not* essentially to ignore it and hope it goes away on its own—it is to address it and resolve it. Once this is done, all the secondary issues like discouragement over a lack of response will take care of themselves.

273. See *supra* notes 215-19 and accompanying text (discussing the economic and non-economic costs to the reporting physician).

situation seriously enough to report it.<sup>274</sup> When possible lawsuits by the patient against the reporting physician for breach of confidentiality, invasion of privacy, or the like are stated as the issue, they are red herrings. While such causes of action can be extremely viable in the appropriate situation, a mandatory reporting scenario ordinarily would not fit the bill. That is because of a well-established qualified privilege to report in good faith, albeit erroneously, on matters in which there is a compelling public interest which extends to available tort actions for wrongful disclosure.<sup>275</sup> This privilege has been codified in some reporting situations such as the aforementioned spouse abuse reporting statutes in several states,<sup>276</sup> the universal child abuse reporting legislation,<sup>277</sup> the elder abuse reporting provisions,<sup>278</sup> and some communicable disease reporting laws.<sup>279</sup> Additionally, commentators generally agree that the privilege for good faith reporting

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274. See, e.g., Bell & Toomer, *supra* note 28, at 345 (arguing that mandatory reporting promotes trust in the patient-therapist relationship); Brooks et al., *supra* note 92, at 56 (arguing that although the therapeutic bond between patient and physician may be injured by reporting, research shows that the relationship may actually improve over time); Levine, *supra* note 13, at 734-35 (arguing that there are benefits to physician reporting of abuse in that reporting strengthens the therapeutic alliance between patient and therapist and it helps the patient focus on previously avoided abuse issues).

275. See, e.g., Arnett v. Baskous, 856 P.2d 790, 791 (Alaska 1993) (holding that a physician could not be held liable for breach of patient confidence when he released a patient's medical records pursuant to a court order); Bryson v. Tillinghast, 749 P.2d 110, 113 (Okla. 1988) (holding that a doctor's act of providing police with patient information, which ultimately led to a conviction, did not violate the physician-patient privilege and benefitted the public at large); GUTHEIL & APPELBAUM, *supra* note 144, at 13 (indicating that the obligation to report represents a legislative decision that public knowledge is more important than confidentiality); DIANE H. SCHETKY & ELISSA P. BENEDEK, CLINICAL HANDBOOK OF CHILD PSYCHIATRY AND THE LAW 81-82, 122 (1992); Besharov, *Failing to Report*, *supra* note 58, at 70-71; Paulsen, *Abused Children*, *supra* note 161, at 173-74 (indicating that liability will not be imposed on a physician for breach of confidence if he or she reports in good faith).

276. See *supra* notes 40-53 and accompanying text (commenting on the operation of spouse abuse reporting statutes in Kentucky, California and New Mexico).

277. See, e.g., Hope v. Landau, 486 N.E.2d 89, 91-92 (Mass. 1985) (holding that a writer of a child abuse report required by statute is immune from liability regardless of correctness of belief); Besharov, *Child Abuse and Neglect*, *supra* note 14, at 477-78 (discussing the importance of abrogation of privileged communication in child abuse cases); Fraser, *supra* note 14, at 664 (discussing the abrogation of privileged communications in child abuse cases); see generally Robert F. Danelen, *Statutory Immunity Under the Child Abuse and Neglect Reporting Act: From First Impression to Present Day*, 12 J. JUV. L. 16 (1991) (discussing absolute immunity for mandatory reporters under the California Child Abuse and Neglect Reporting Act); Craig S. Steinberg, *Reporting of Child Abuse: Is Absolute Immunity Too Much to Offer?*, 14 J. JUV. L. 167 (1993) (arguing that absolute immunity is an unnecessary protection for child abuse reporters).

278. See, e.g., Gilbert, *supra* note 128, at 53 (discussing mandatory reporting of elder abuse by nurses and immunity from liability if reports are made in good faith).

279. See *Simonsen v. Swenson*, 177 N.W. 831, 832 (Neb. 1920) (holding that a physician is not liable to his patient for disclosing a contagious disease when the physician acts in good faith, even if the physician made a mistaken diagnosis).



exists whether or not specifically provided for by statute.<sup>280</sup> Thus, physicians need not worry about such litigation so long as they act in good faith when they report,<sup>281</sup> and certainly ought not to use it as a rationale for not reporting.<sup>282</sup> Finally, arguments about creating a sense of disempowerment and conflict of interest for the physician may be worrisome, but should be alleviated when the physician sees a positive governmental response to abuse reports.

A final observation should be voiced. Physicians have proposed many reasons why forcing them to report the abuse of their patients is a bad idea,<sup>283</sup> some more valid than others. All these objections lose sight of a large point, first made nearly thirty years ago in the context of child abuse reporting, which is equally valid today in the domestic violence arena—whether or not to have mandatory reporting is a matter of *social policy*, not merely a medical matter to be left in the hands of physicians.<sup>284</sup> It is for the courts and legislatures to determine after weighing all the issues, medical and otherwise, and considering the gravity of the problem.<sup>285</sup> After doing so, legislatures have decided to require reporting of child and elder abuse, and several progressive

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280. See, e.g., BESHAROV, *THE VULNERABLE SOCIAL WORKER*, *supra* note 57, at 38-39 (illustrating with cases the immunity from liability for those who report in good faith and asserting that all states grant this immunity); Besharov, *Child Abuse and Neglect*, *supra* note 14, at 475 (indicating that all states grant mandatory reporters immunity from civil and criminal liability for good faith reports, and forty states extend this to voluntary good faith reporters); Fraser, *supra* note 14, at 664 (discussing the abrogation of privileged communications in child abuse cases); Maidment, *supra* note 104, at 163-64 (arguing that in child abuse cases, the truth of the report is irrelevant as long as it was made in good faith); Paulsen, *Abused Children*, *supra* note 160, at 173-74 (arguing that liability to the physician may arise from state statute or judicial consideration of the ethical concepts underlying the practice of medicine); Sussman, *supra* note 14, at 294 (indicating that good faith is available as a defense for a reporter).

281. If suit is brought against a reporter, it should be summarily dismissed absent tangible allegations of bad faith reporting. BESHAROV, *THE VULNERABLE SOCIAL WORKER*, *supra* note 57, at 39-42. See *supra* note 46 (discussing the California statute which reimburses reporters for attorneys' fees they incur while opposing litigation brought against them for good faith reporting).

282. Another, practical consideration generally precludes such litigation—"the normal course of a suit would probably result in *additional* release of very private information." Smith, *Privileges and Confidentiality*, *supra* note 43, at 484 (emphasis added). Licensure sanctions against disclosing physicians similarly should not pose any real problem. *Id.*

283. See, e.g., *supra* notes 215-19 (discussing the practical concerns of the physician, such as costs, time and damage to the physician-patient relationship).

284. See, e.g., Daly, *supra* note 154, at 305-06; Paulsen, *Abused Children*, *supra* note 160, at 162; Paulsen, *Child Abuse Reporting Laws*, *supra* note 87, at 8; Sussman, *supra* note 14, at 271-72.

285. And as a recent analogous Missouri failure to warn about child abuse case determined: [W]hen the cost of imposing this duty and the economic burden upon the actor are balanced against the magnitude of preventable injury suffered, the outcome overwhelmingly weighs in favor of imposing a duty. The execution of the duty . . . only requires a simple telephone call to . . . appropriate authorities. The burden imposed on

bodies like those in California and Kentucky have extended the rule into the lives of battered women.<sup>286</sup> For the reasons discussed above and the safety of the abused, courts should consider this the appropriate result in all cases, and therefore conclude that public policy dictates that physicians have a duty to report whether or not a statute requires them to do so. In so doing, tribunals will further what one author has described as "an almost universal assumption throughout the English-speaking world . . . that . . . abuse reporting laws are a necessary and integral part of a protective . . . abuse legislative program."<sup>287</sup>

### b. Statutory Negligence

Regardless of how courts feel about proclaiming a common law duty for physicians to report domestic violence, they should not hesitate to declare a reporting obligation in any of the many jurisdictions which have some version of statutorily mandated reporting. This should be accomplished pursuant to the well-established statutory negligence doctrine, which generates a special relationship, and hence a duty, where there otherwise might not be one.<sup>288</sup> As noted, mandatory physician reporting of domestic violence exists, in some form, in a number of jurisdictions.<sup>289</sup> These include states like Kentucky and California with well-developed spouse abuse reporting requirements,<sup>290</sup> as well as others with more general reporting laws. Typical are those (1) requiring physicians to report injuries caused by firearms, knives, or other sources attributable to criminal acts or else face criminal sanction and, (2) immunizing them from liability for their reports.<sup>291</sup> Given the inherent nature of domestic violence, these

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an individual in fulfilling this duty is greatly outweighed by the potential or actual harm suffered as a result of failure to fulfill this duty.

Bradley v. Ray, 904 S.W.2d 302, 310 (Mo. Ct. App. 1995).

286. See *supra* notes 40-48 and accompanying text (discussing the Kentucky and California statutes which require that physicians report suspected abuse).

287. Maidment, *supra* note 104, at 150-51.

288. See *supra* notes 80-83 and accompanying text (explaining the doctrine of statutory negligence).

289. See Hyman et al., *Reporting of Domestic Violence*, *supra* note 37, at 1781 (providing a comprehensive, recent overview of the area, including an extensive collection of statutory citations). Forty-five states now have some sort of domestic violence reporting law. *Id.*

290. See *supra* notes 40-49 and accompanying text (evaluating the operation of spouse abuse statutes in Kentucky and California).

291. COLO. REV. STAT. § 12-36-135 (1991) is representative, and provides in pertinent part:

(1) It shall be the duty of every physician who attends or treats a bullet wound, a gunshot wound, a powder burn, or any other injury arising from the discharge of a firearm, or an injury caused by a knife, an ice pick, or any other sharp or pointed instrument which he believes to have been intentionally inflicted upon a person, or any

laws mandate reporting in many spouse abuse cases, whether they are seen in hospital emergency rooms, physicians' offices, or elsewhere. The laws are enacted for various purposes, including the protection of victims, the detection of crime, and the collection of crime data (including domestic violence information).<sup>292</sup> As previously noted, even the AMA agrees that physicians should report violent acts committed against their patients when a statute mandates that they do so.<sup>293</sup> The statutory negligence doctrine should generate the basis for holding them negligent if they do not.

The reasons for and prerequisites of statutory negligence are clear. According to the leading commentator, courts impose it "to further the ultimate policy for the protection of individuals which they find underlying the statute [in question], and which they believe the legislature must have had in mind."<sup>294</sup> The authors of the *Restatement (Second) of Torts* define when courts should apply the statutory negligence doctrine as follows:

The court may adopt as the standard of conduct of a reasonable man the requirements of a legislative enactment or an administrative regulation whose purpose is found to be exclusively or in part

- (a) to protect a class of persons which includes the one whose interest is invaded, and
- (b) to protect the particular interest which is invaded, and
- (c) to protect that interest against the kind of harm which has resulted, and

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other injury which he has reason to believe involves a criminal act to report such injury at once to the police of the city, town, or city and county or the sheriff of the county in which the physician is located. Any physician who fails to make a report as required by this section commits a class 2 petty offense . . . and, upon conviction thereof, shall be punished by a fine of not more than three hundred dollars, or by imprisonment in the county jail for not more than ninety days, or both by such fine and imprisonment.

(2) Any physician who, in good faith, makes a report pursuant to subsection (1) of this section shall have immunity from any liability, civil or criminal, that might otherwise be incurred or imposed with respect to the making of such report, and shall have the same immunity with respect to participation in any judicial proceeding resulting from such report.

For analogous statutes in other states, see, e.g., ARIZ. REV. STAT. ANN. § 13-3806 (1989); IND. CODE ANN. § 35-47-7-1 (Burns 1994); MASS. ANN. LAWS ANN. ch. 112, § 12A (West 1991); NEB. REV. STAT. § 28-902 (1989); N.C. GEN. STAT. § 90-21.20 (1994); N.D. CENT. CODE § 43-17-41 (1993); N.Y. PENAL LAW § 265.25 (McKinney 1989); TENN. CODE ANN. § 38-1-101 (1991); UTAH CODE ANN. §§ 26-23a-2, -3 (1995); WIS. STAT. ANN. § 146.995 (West 1989 & Supp. 1994).

292. Hyman et al., *Reporting of Domestic Violence*, *supra* note 37, at 1781.

293. *Physicians and Domestic Violence*, *supra* note 1, at 3192; see *supra* note 39 and accompanying text (discussing the limitations on the AMA mandate that physicians report domestic abuse).

294. KEETON ET AL., *supra* note 63, § 36, at 222.

(d) to protect that interest against the particular hazard from which the harm results.<sup>295</sup>

Numerous courts have employed this basic test when determining whether they should declare the provision in question begets a duty.<sup>296</sup> On the other hand, a court may conclude the enactor of a statutory provision did not intend for it to give rise to a statutory negligence claim/duty. The *Restatement (Second) of Torts* further states that:

The court will not adopt as the standard of conduct of a reasonable man the requirements of a legislative enactment or an administrative regulation whose purpose is found to be exclusively

(a) to protect the interests of the state or any subdivision of it as such, or

(b) to secure to individuals the enjoyment of rights or privileges to which they are entitled only as members of the public, or

(c) to impose upon the actor the performance of a service which the state or any subdivision of it undertakes to give the public, or

(d) to protect a class of persons other than the one whose interests are invaded, or

(e) to protect another interest than the one invaded, or

(f) to protect against other harm than that which has resulted, or

(g) to protect against any other hazards than that from which the harm has resulted.<sup>297</sup>

Courts can reject statutory negligence claims on the basis of the various tenets of this provision's search for legislative intent.<sup>298</sup>

295. RESTATEMENT (SECOND) OF TORTS § 286 (1965). See, e.g., *Freehauf v. School Bd.*, 623 So. 2d 761, 763 (Fla. Dist. Ct. App. 1993) (recognizing that whether a statute generates statutory negligence turns on considerations set out in the *Restatement (Second) of Torts*).

296. See, e.g., *Crown v. Raymond*, 764 P.2d 1146 (Ariz. Ct. App. 1988) (holding that a gun shop owner's sale of a handgun to a minor who later committed suicide was negligent per se); *Sanchez v. Galey*, 733 P.2d 1234 (Idaho 1986) (explaining the criteria that must be met for a finding of negligence per se, particularly that the plaintiff injured is a member of the class of persons the statute was designed to protect); *Martin v. Herzog*, 126 N.E. 814 (N.Y. 1920) (holding that the failure to display lights on a vehicle, as required by statute, constituted negligence); KEETON ET AL., *supra* note 63, § 36 (noting that violation of a statute designed to protect a certain class of persons constitutes negligence per se).

297. RESTATEMENT (SECOND) OF TORTS § 288 (1965).

298. See, e.g., *Freehauf*, 623 So. 2d at 762-64 (Fla. Dist. Ct. App. 1993) (refusing to create statutory negligence for breach of a child reporting statute without a clear legislative mandate); *Borne ex rel. Borne v. Northwest Allen County Sch. Corp.*, 532 N.E.2d 1196, 1202-03 (Ind. Ct. App. 1989) (holding that it was not the intent of the legislature to generate statutory negligence for breach of a duty to report child abuse); *Kansas State Bank & Trust Co. v. Specialized Transp. Servs.*, 819 P.2d 587, 602-04 (Kan. 1991) (recognizing that the legislature did not intend to generate statutory negligence for violation of mandatory child abuse reporting statutes).

The obvious question is whether mandatory reporting laws are the types of provisions courts should enforce through statutory negligence. As noted,<sup>299</sup> several courts have applied the doctrine in analogous child abuse reporting situations. While one did so in the context of a specific child abuse reporting law, which included an express civil liability provision, rather than one of the more general statutes mandating the reporting of criminal acts,<sup>300</sup> *Landeros* utilized statutory negligence both pursuant to California's specific child abuse reporting law and its general criminal acts reporting one.<sup>301</sup> Both believed that statutory negligence furthers the legislative purpose to guard abused children from further abuse which gave rise to the original protective legislation. Numerous commentators on child abuse reporting have agreed that those who do not report should be liable for statutory negligence.<sup>302</sup> Several have cited to various early decisions, which held physicians statutorily negligent when they do not obey laws requiring them to report certain infectious diseases suffered by their patients and harm results to the patients or others due to the failure to report, as a basis for imposing statutory negligence liability here.<sup>303</sup>

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299. See *supra* notes 103, 118 and accompanying text (discussing the *Landeros* decision, which held a physician who did not report child abuse liable under statutory negligence).

300. *Williams v. Coleman*, 488 N.W.2d 464, 466-67, 471-72 (Mich. Ct. App. 1992).

301. *Landeros v. Flood*, 551 P.2d 389, 397 (Cal. 1976).

302. See, e.g., Aaron, *supra* note 11, at 195-200 (discussing the statutory duty to report); Besharov, *Failing to Report*, *supra* note 58, at 68 (discussing fact that a violation of a reporting statute may be negligence per se); Clymer, *supra* note 87, at 547-51 (discussing the statutory liability theory in child abuse cases); Isaacson, *supra* note 87, at 747-65 (discussing the origins of the statutory liability approach, and applying it to the conduct of a non-reporting doctor in a child abuse case); Lehto, *supra* note 12, at 149-58 (discussing statutory negligence for the failure to report child abuse); McDonald, *supra* note 58, at 489-90 (discussing the negligence per se theory in child abuse cases, which imposes a duty to report on a defendant). A practitioner's guide has summarized the statutory negligence analysis in failure to report child abuse cases:

The basic elements of this theory are that:

- (1) the physician, by failing to report a suspected case of child abuse, violated his statutory duty;
- (2) as a proximate result of that violation, the child suffered subsequent injuries;
- (3) the child was a member of the class of persons which the statute was designed to protect;
- and (4) the subsequent injuries were the result of acts that the statute was designed to prevent.

Jimmie E. Tinsley, *Failure to Report Suspected Case of Child Abuse*, 6 PROOF OF FACTS 2D 345, 356 (1975).

303. See, e.g., *Medlin v. Bloom*, 119 N.E. 773, 775 (Mass. 1918) (holding that a physician could be liable for statutory negligence for failure promptly to report infant patient's eye infection as required by law when infant lost vision as a result); *Jones v. Stanko*, 160 N.E. 456 (Ohio 1928) (holding that a physician could be liable for statutory negligence for failure to report patient's black smallpox as required by law when neighbor contracted disease and died as a result); *Dietsch v. Mayberry*, 47 N.E.2d 404 (Ohio Ct. App. 1942) (holding that a physician could be liable for statutory negligence for failure to report infant patient's eye infection as required by law when infant lost vision in one eye as a result); Clymer, *supra* note 87, at 547-48 (discussing early medical malpractice cases based on negligence per se for violation of mandatory reporting

But what about the various child abuse rulings to the contrary?<sup>304</sup> These decisions concur that reporting violations do not fit the parameters of statutory negligence because the legislature did not intend it,<sup>305</sup> and present a real roadblock for the attorney representing a battered spouse in her claim against a non-reporting physician. They reflect a narrowing view of when statutory negligence is appropriate,<sup>306</sup> far outnumber the decisions in favor of statutory negligence,<sup>307</sup> and include several very recent opinions.<sup>308</sup> They hold that being in the protected class (by being a child abuse victim) does not suffice to generate statutory negligence coverage, that the victim must "demonstrate[ ] a clear legislative intention to provide for civil remedies"<sup>309</sup> and that reporting laws are intended to protect the general public rather than a specific class of individuals.<sup>310</sup>

Regardless of these cases, courts should exercise their considerable discretion and extend statutory negligence to violations of child abuse reporting laws. They certainly were enacted to help protect children from abuse (even if there were other rationales also), and under the terms of the *Restatement* qualify for statutory negligence.<sup>311</sup> Because of their focus on abused children they do not protect merely the state

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statutes); Isaacson, *supra* note 87, at 759-61 (reviewing cases which dealt with a doctor's negligent non-compliance).

304. See *supra* notes 119-23 and accompanying text (discussing decisions which have refused to extend statutory negligence to violations of child abuse reporting statutes).

305. See *supra* notes 121-23 and accompanying text (discussing the reasoning of the courts which have refused to extend statutory negligence to child abuse reporting statutes).

306. See, e.g., Fischer v. Metcalf, 543 So. 2d 785, 789 (Fla. Dist. Ct. App. 1989) (listing factors to determine when legislation qualifies for statutory negligence); Bradley v. Ray, 904 S.W.2d 302, 312-14 (Mo. Ct. App. 1995) (holding that a statute which required psychologists to report sexual abuse was not intended by the legislature to create a statutory negligence action).

307. Compare notes 102, 117, *supra* with note 119, *supra* (evaluating those cases which endorse statutory negligence in comparison to those cases which do not recognize a statutory negligence action).

308. See, e.g., Iseley v. Capuchin Province, 880 F. Supp. 1138, 1147-48 (E.D. Mich. 1995) (holding that a reporting statute which requires school administrators to report injuries or other forms of child abuse did not generate a statutory negligence action); Letlow v. Evans, 857 F. Supp. 676, 678 (W.D. Mo. 1994) (holding that there was no statutory negligence for a violation of a child abuse reporting statute); J.A.W. v. Roberts, 627 N.E.2d 802, 813 (Ind. Ct. App. 1994) (holding that absent codification, extending a civil remedy to an abuse victim against all persons who know of child abuse and fail to report is not sound public policy); Bradley v. Ray, 904 S.W.2d 302, 312-14 (Mo. Ct. App. 1995) (holding that a statute which required a psychologist to report sexual abuse did not support a statutory negligence claim).

309. Bradley, 904 S.W.2d at 314.

310. Freehauf v. School Bd., 623 So. 2d 761, 764 (Fla. Dist. Ct. App. 1993); see also Doe "A" v. Special Sch. Dist., 637 F. Supp. 1138, 1148 (E.D. Mo. 1986), *aff'd*, 901 F.2d 642 (8th Cir. 1990) (refusing to recognize a statutory negligence action for violation of a child abuse reporting statute because the statute created a duty owed to the general public, rather than to individuals).

311. See *supra* note 288 and accompanying text (indicating when the statutory negligence doctrine is applicable).

at large, thereby transgressing the *Restatement*.<sup>312</sup> Employing statutory negligence will help motivate reporters to take actions which will facilitate protection for child abuse victims, certainly a legislative purpose which meets any statutory negligence test. These laws are analogous to the order of protection statutes in domestic violence cases, which various courts have indicated qualify for statutory negligence treatment.<sup>313</sup> Those provisions also arguably benefit the general public, but in addition they more specifically help protect an unfortunately large group of individuals from injury attributable to domestic violence. If, as these courts have found, battered spouses merit statutory negligence treatment due to the presence of order of protection laws, so should they and child abuse victims covered by a mandatory reporting law.

The recent child abuse precedents could be particularly worrisome when statutory negligence for a failure to report domestic violence is the issue. All those cases involved specific child abuse reporting laws, which thus were focused relatively narrowly. On the other hand, in all but a few states the only reporting laws which apply to spouse abuse are general ones which extend to crimes across the board. They accordingly are even more vulnerable to attack than the child abuse provisions because at least the child abuse laws applied only to children.<sup>314</sup> The laws in Kentucky or California fit the mold of specific child abuse reporting statutes, leaving even them subject to attack as in the number of states which decline to impose statutory negligence for child abuse reporting violations. Still, as *Landeros* and this discussion have demonstrated, the doctrine ought to apply whether the statute in question is a specific spouse abuse reporting law or a general crime reporting one. Both fit the letter and spirit of the *Restatement's* classic statutory negligence-generating provision. The public policy which favors mandatory reporting as a major weapon in the fight against domestic violence equally favors courts using the statutory negligence approach as a means for making reporting an even more effective tool. The judiciary ought freely to use it regardless of narrow decisions to the contrary.

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312. See *supra* note 290 and accompanying text (discussing legislative intent).

313. See, e.g., *Raucci v. Town of Rotterdam*, 902 F.2d 1050, 1055-56 (2d Cir. 1990); *Sorichetti v. City of N.Y.*, 482 N.E.2d 70, 76 (N.Y. 1985); *Jones, Battered Spouses' State Law Damage Actions*, *supra* note 1, at 23-29, 37-38.

314. Or, if they applied more broadly, they were roundly attacked as not constituting suitable foundations for statutory negligence. See *Fischer v. Metcalf*, 543 So. 2d 785, 790 (Fla. Dist. Ct. App. 1989) (holding that a psychiatrist's failure to report the abuse of the child of one of his patients did not provide that child with a statutory negligence action).

### C. Remaining Steps In Negligence Analysis

Once a battered spouse demonstrates the non-reporting physician owed her a duty via the common law and/or statutory negligence methods for establishing one, she still must show that the physician breached that duty and that the breach was the cause in fact *and* the proximate cause of the injuries she suffered. Although the spouse may encounter difficulties in doing so—particularly when the physician contests causation—she should be able successfully to advance through the breach and causation stages.<sup>315</sup> Physicians who do not report abuse will have breached their duty and accordingly face negligence liability like anyone else who violates the standard of care. Courts will be setting the duty, so obdurate physicians will not be able to block it by arguing it is the custom in their community not to report so they did not violate the standard of care by their inaction.<sup>316</sup>

After the spouse abuse victim reaches this stage in her suit against the physician who did not report her condition to the proper authorities, she still may have to cope with such defenses to negligence which the physician may raise as contributory negligence, assumption of the risk, and/or comparative fault.<sup>317</sup> Courts are unlikely to permit the physician successfully to proffer such defenses for policy reasons, since one reason states enact reporting and domestic violence legislation is to help those unable or unwilling to help themselves. It makes no sense to recognize that this is the condition of many battered spouses and then penalize them, through negligence defenses, for not taking care of themselves.<sup>318</sup> Still, although defenses ought not to apply to domestic violence suits, claimants should be ready to fend off any attempts to raise them.<sup>319</sup>

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315. See *supra* note 65 and accompanying text (discussing proximate cause).

316. See, e.g., *Helling v. Carey*, 519 P.2d 981, 983 (Wash. 1974) (holding ophthalmologist negligent in failing to give glaucoma test, despite expert testimony that it was the standard in the profession not to administer that test); RESTATEMENT (SECOND) OF TORTS § 285 (1965) (stating that the standard by which the actor's conduct is compared is fixed by judicial decisions); KEETON ET AL., *supra* note 63, § 33 (discussing the application of the standard of reasonable conduct).

317. Jones, *Battered Spouses' State Law Damage Actions*, *supra* note 1, at 40.

318. For arguments that helplessness is part of the cycle of abuse, see *id.* at 40-41; *supra* note 230 and accompanying text.

319. Jones, *Battered Spouses' State Law Damage Actions*, *supra* note 1, at 41. Such a defense might arise in the following situation: A domestic violence victim consults her physician for treatment of injuries her spouse inflicted upon her. The physician duly notes the injuries and realizes their source, but fails to report them to the authorities although he has a duty to do so. The spouse subsequently severely beats the patient, causing serious permanent injuries. She sues the physician (her abuser is now incarcerated and penniless) for negligent non-reporting, and he counters with a comparative fault/assumption of the risk defense. He charges that the patient should not have stayed with her abuser and that any recovery she gets from him should be



Several special issues might come up in statutory negligence situations. Many courts have let defendants in such cases raise the typical negligence defenses.<sup>320</sup> However, given the particular reporting laws at issue here, it is unlikely that courts would treat domestic violence cases grounded upon them like ordinary negligence ones. A number of tribunals absolutely forbid defendants who violate special safety or other laws from raising any of the ordinary defenses to negligence on the basis that the defendants ignored essentially strict liability provisions requiring them to safeguard certain people from foreseeable harm.<sup>321</sup> To do otherwise would undermine the legislature's clear intentions by allowing those defendants, partially or completely, to escape accountability solely on the basis of a protected person's own, often predictable, error.<sup>322</sup> Although such laws are not typical, numerous courts have treated a wide variety of specific laws as immune from statutory negligence defenses.<sup>323</sup>

Reporting requirements should be considered part of this small category of protective laws. Legislatures pass them, at least in part, because they believe domestic violence must be reported and that its victims cannot bear the burden of reporting it themselves.<sup>324</sup> Allowing physicians to raise negligence defenses in such cases would undercut the very rationale underlying mandatory reporting statutes. Thus, battered spouses ought not to lose their damage claims against non-reporting physicians, or even see them partially reduced, because of their own actions.<sup>325</sup>

In conclusion, when a battered spouse can prove that a physician's failure to report her abuse to the authorities contributed to her subse-

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reduced in recognition of her own role in the domestic violence scenario. If these defenses get to a jury, they could have serious negative ramifications for the patient's suit.

320. See *id.* at 41 (citing *Valentine v. United States*, 706 F. Supp. 77, 82-83 (D.D.C. 1989); *King v. Magnolia Homeowners Ass'n*, 253 Cal. Rptr. 140, 143 (Cal. Ct. App. 1988); *Brady v. Ralph M. Parsons Co.*, 572 A.2d 1115, 1122 n.4 (Md. Ct. Spec. App. 1965)).

321. Jones, *Battered Spouses' State Law Damage Actions*, *supra* note 1, at 41.

322. *Id.* at 42.

323. See *id.* at 42 (citing *Wren v. Sullivan Elec., Inc.*, 797 F.2d 323, 326-27 (6th Cir. 1986) (holding that a subcontractor which violated state and federal safety statutes by not installing adequate temporary lighting at construction site could not assert assumption of risk or contributory negligence defenses against injured construction worker); *Tamiami Gun Shop v. Klein*, 116 So. 2d 421, 422-24 (Fla. 1959) (concluding that a store that sold a rifle to a minor in violation of both a state statute and a municipal ordinance could not assert contributory negligence nor comparative fault defenses against the minor); *Lomayestewa v. Our Lady of Mercy Hosp.*, 589 S.W.2d 885, 887 (Ky. 1979) (deciding that a hospital that violated a state regulation by failing to erect a detention screen to prevent a mental patient from falling or jumping out of the window could not assert the contributory negligence defense against the injured patient)).

324. Jones, *Battered Spouses' State Law Damage Actions*, *supra* note 1, at 42-43.

325. See *id.*

quent harm, she should be able to recover from him under common law negligence for his negligent failure to report. Moreover, if her jurisdiction has some form of statutory reporting requirement, she also should be able to recover from the physician on a statutory negligence theory. Negligence defenses should not partially or completely derail her claim due to its inherent nature. This approach has borne fruit in the analogous child abuse reporting violation area,<sup>326</sup> and should do so for domestic violence victims as well. Negligence law should offer the battered spouse her principal source of redress from the non-reporting physician.

## II. BATTERED SPOUSES' STATE COMMON LAW STATUTORY TORT SUITS

Some abused spouses may raise another tort against physicians, a common law statutory tort claim.<sup>327</sup> For centuries<sup>328</sup> courts have im-

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326. See, e.g., *Landeros v. Flood*, 551 P.2d 389 (Cal. 1976) (en banc) (stating that physician and hospital could be held liable for injuries sustained by abused child if they negligently failed to diagnose and report battered child syndrome); *J.A.W. v. Roberts*, 627 N.E.2d 802 (Ind. Ct. App. 1994).

327. This author has discussed the implied statutory tort in detail elsewhere. See Jones, *Battered Spouses' State Law Damage Actions*, *supra* note 1, at 43-50. For overviews of the law concerning implied state (and sometimes also federal) rights of action, see, e.g., John H. Bauman, Note, *Implied Causes of Action in the State Courts*, 30 *STANFORD L. REV.* 1243 (1978) (examining federal and state court analyses for deciding whether to imply a private right of action); Caroline Forell, *The Statutory Duty Action in Tort: A Statutory/Common Law Hybrid*, 23 *IND. L. REV.* 781, 787 (1990) [hereinafter Forell, *The Statutory Duty Action*] (examining the sources and different kinds of statutory duty actions and proposing analysis for "judges to apply when presented with statutory duties"); Caroline Forell, *The Interrelationship of Statutes and Tort Actions*, 66 *OR. L. REV.* 219 (1987) [hereinafter Forell, *Interrelationship*] (urging courts to replace the vague notion of negligence per se with a more "principled examination of the interrelationship of statutes and tort actions."); H. Miles Foy, III, *Some Reflections on Legislation, Adjudication, and Implied Private Actions in the State and Federal Courts*, 71 *CORNELL L. REV.* 501 (1986) (discussing the history of implied private actions); Gordon Gamm & Howard Eisberg, *The Implied Rights Doctrine*, 41 *UMKC L. REV.* 292 (1972) (discussing the theoretical basis of the implied rights doctrine, its application by the federal and Missouri courts, and the reasons that Missouri should expand its present application of the doctrine); Note, *The Use of Criminal Statutes in the Creation of New Torts*, 48 *COLUM. L. REV.* 456 (1948) [hereinafter *New Torts*] (examining the doctrine of implied actions and the soundness of its underlying rationale); cf., e.g., R. A. Buckley, *Liability in Tort for Breach of Statutory Duty*, 100 *LAW Q. REV.* 204 (1984) (examining the implication of civil remedies for statutory violations in the United Kingdom); G.H.L. Friedman, *Civil Liability for Criminal Conduct*, 16 *OTTAWA L. REV.* 34 (1984) (examining the implication of civil remedies for statutory violations in Canada); see also, e.g., Ezra Ripley Thayer, *Public Wrong and Private Action*, 27 *HARV. L. REV.* 317 (1914) (providing an influential early discussion of this area).

328. In 1986, Professor H. Miles Foy, III wrote an exhaustive and fascinating article in which he traced English and American implied private actions back as far as the fifteenth century. Foy, *supra* note 327, at 524-28; see also Thomas J. André, Jr., *The Implied Remedies Doctrine and the Statute of Westminster II*, 54 *TUL. L. REV.* 589 (1980) (analyzing the origins of the implied remedies doctrine); Graham L. Fricke, *The Juridical Nature of the Action Upon the Statute*, 76 *LAW Q.*

plied private civil actions against those who violate legislation which protects specific people.<sup>329</sup> They do so in order to uphold legislative

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REV. 240, 240-41 (1960) (stating that the second statute of Westminster has received little attention from historians and has remained largely unnoticed, despite its provision of a private remedy available to those aggrieved by the neglect of statutory duties). In the process, Professor Foy discussed very early cases where courts upheld such suits based upon violations of penal statutes. *See, e.g.*, Lord Cromwell's Case, 4 Co. Rep. 12 b, 76 Eng. Rep. 877 (K.B. 1578) (holding that a statute which outlawed false statements about leading nobles and/or great "men" of realm gave rise to implied civil action although statute did not provide for one); Prior of Bruton v. Ede, Y.B. Pasch. 10 Edw. 4 (Q.B. 1470), *reprinted in* 47 SELDEN SOCIETY 31 (N. Neilson, Ph.D. ed. 1931) (providing that a statute which outlawed forcible entry of premises of another gave rise to implied civil action although statute did not provide for one); Foy, *supra* note 327, at 527 n.86 (citing additional English cases from 1422, 1470, and 1605 which held statutory violations generated implied civil actions although statutes in question did not provide for them); *see also* André, *supra*, at 605-07, 610-12 (citing numerous early English statutes and cases which held statutory violations generated implied civil actions although statutes in question did not explicitly provide for them). He further noted the statement of Sir Edward Coke, the celebrated English late sixteenth and early seventeenth century barrister, jurist, politician, and scholar, to the effect that one who violated a criminal provision would be civilly liable for commission of a statutory tort as well. Foy, *supra* note 327, at 524, 603-04 ("[E]very Act of parliament made against any injury, mischief [sic], or grievance doth either expressly, or impliedly give a remedy to the party wronged, or grieved . . .") (quoting EDWARD COKE, THE SECOND PART OF THE INSTITUTES OF THE LAWS OF ENGLAND 55 (1642)) (emphasis added). This viewpoint continued in England into the nineteenth century. *Id. supra*, at 530-32. It crossed the Atlantic to the United States. *But see* Note, *supra* note 327, at 457 ("There is no evidence that this [implied right of action] doctrine existed in Anglo-American law before 1854 . . ."). It is reflected in cases like Bullard v. Bell, 4 F. Cas. 624, 639 (C.C.N.H. 1817) (No. 2,121) (adopting the English approach of implying civil actions for violations of criminal statutes although statutes did not provide for them), or the celebrated Marbury v. Madison, 5 U.S. 137, 154-73 (1803) (indicating agreement with precedents implying civil actions for violations of criminal statutes although statutes did not provide for them). Foy, *supra* note 327, at 533-35. Notwithstanding a few detours, *id.* at 536-48, including the rise of the law of negligence and the use of statutes to generate negligence duties rather than independent implied private tort actions, *id.* at 540-46; *see also supra* notes 80-83, 279-305 and accompanying text; implied actions have survived, and flourished, up to the present. *See* Foy, *supra*, at 548-69 (evaluating the theories of recovery in the modern period); Karen Majcher Art, Note, *A New Tort for Violation of a Statutory Duty: Nearing v. Weaver*, 20 WILLAMETTE L. REV. 579, 584-85 (1984) (analyzing the general concept of statutory tort and its place within the development of tort law).

329. *See, e.g.*, Transamerica Fin. Corp. v. Superior Court, 761 P.2d 1019 (Ariz. 1988) (en banc) (holding that lender which violated Consumer Loan Act had implied tort liability for its failure to comply with law); Castillo v. Friedman, 243 Cal. Rptr. 206 (Cal. Ct. App. 1987) (finding that landlord who violated rent stabilization ordinance had implied tort liability for his failure to comply with law); Kelsay v. Motorola, Inc., 384 N.E.2d 353 (Ill. 1978) (holding that an employer, which violated Workmen's Compensation Act, had implied tort liability for its failure to comply with law); Bortz v. Rammel, 376 A.2d 1261 (N.J. Super. Ct. App. Div.), *cert. denied*, 384 A.2d 518 (N.J. 1977) (finding that construction contractor which violated Construction Safety Act had implied tort liability because of its failure to comply with law); County of Broome v. State, 507 N.Y.S.2d 320 (N.Y. App. Div. 1986) (holding that a state, which violated a statute requiring it to reimburse counties for the legal fees incurred in defending against Native Americans' challenges to land titles, had implied tort liability for its failure to comply with law); *cf.* Merrill Lynch, Pierce, Fenner & Smith, Inc. v. Curran, 456 U.S. 353 (1982) (holding that brokers and others who violated Commodity Exchange Act had implied federal tort liability to private plaintiffs for their failure to comply with law); Transamerica Mortgage Advisors, Inc. v. Lewis, 444 U.S. 11 (1979)

intent.<sup>330</sup> In evaluating this aim, courts consider laws' relative specificity, the adequacy of existing remedies, the impact of upholding a statutory tort action upon them, the significance of the legislative purpose at issue, how drastically recognizing new implied private torts will affect current law, and the burden they will inflict on the judicial system.<sup>331</sup> Once claimants persuade tribunals that they should imply statutory torts, they then must convince the tribunals that they belong to the groups for whose benefit the legislature enacted the provisions and that the harm they suffered is the type the legislature wanted erased.<sup>332</sup>

An implied statutory tort action differs markedly from a statutory negligence suit. There, a court merely employs a law in connection with traditional, and preexisting, negligence principles; the plaintiff still must show all the elements of, and fend off the various defenses to, negligence. In an implied private civil action case, on the other

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(holding that investment adviser which violated Investment Advisers Act of 1940 had implied federal tort liability for its failure to comply with law).

330. The *Restatement* expresses the essence of the cause of action very well:

When a legislative provision protects a class of persons by proscribing or requiring certain conduct but does not provide a civil remedy for the violation, the court may, if it determines that the remedy is appropriate in furtherance of the purpose of the legislation and needed to assure the effectiveness of the provision, accord to an injured member of the class a right of action, using a suitable existing tort action or a new cause of action analogous to an existing tort action.

RESTATEMENT (SECOND) OF TORTS § 874A (1979).

331. See, e.g., *Credit Managers Ass'n v. Kennesaw Life & Accident Ins. Co.*, 809 F.2d 617, 624 (9th Cir. 1987) (denying the plaintiff's claim of a cause of action under California Insurance Code Section 803, since Section 803 aimed to protect a class of persons and not insurers); *Lally v. Copygraphics*, 413 A.2d 960, 963 (N.J. Super. Ct. App. Div. 1980), *aff'd*, 428 A.2d 1317 (N.J. 1981) (holding that an employee had a judicially cognizable cause of action against his employer for violation of the statute); *CPC Int'l, Inc. v. McKesson Corp.*, 514 N.E.2d 116, 119 (N.Y. 1987) (noting that whether a statutory negligence action is granted should depend on legislative intent and the purposes underlying the applicable legislative scheme); RESTATEMENT (SECOND) OF TORTS § 874A cmt. h (1979) (providing the factors courts should evaluate in determining whether to provide a tort remedy).

332. See, e.g., *Scroggins v. Allstate Ins. Co.*, 393 N.E.2d 718 (Ill. App. Ct. 1979) (denying plaintiffs' claims against insurance company due to failure to establish that they fell within the class of persons whom the statute was designed to protect); *State v. Kansas City Firefighters Local No. 42*, 672 S.W.2d 99, 110 (Mo. Ct. App. 1984) (noting the legislature's intent to benefit the public employer or employee, but not to benefit a third party); *County of Broome v. State*, 494 N.Y.S.2d 638, 640 (N.Y. Ct. Cl. 1985), *aff'd*, 507 N.Y.S.2d 320 (N.Y. App. Div. 1986) (stating that whether a statutory negligence action for damages was intended should depend first on whether the claimants are members of the class for whose benefit the statute was enacted); RESTATEMENT (SECOND) OF TORTS § 874A cmt. i (1979) (setting forth tort liability for violation of a legislative provision).

For more on the mechanics of qualifying for a common law statutory tort claim, see Forell, *The Statutory Duty Action*, *supra* note 327; Forell, *Interrelationship*, *supra* note 327; Bauman, *supra* note 327, at 1253-61. For more of the various cases where courts have upheld such claims, see *supra* note 320.

hand, the tribunal crafts the legislation into a totally new tort claim in which, for example, negligence defenses should play no role.<sup>333</sup> Thus,

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333. Courts in statutory tort cases could handle negligence defenses like contributory negligence, assumption of the risk, or comparative fault as they are treated in statutory negligence ones. See *supra* notes 311-14 and accompanying text. On the other hand, tribunals might refuse even to recognize some or all of those defenses, or even decide invariably to uphold them. Unfortunately, very few authorities have discussed the way defenses operate under state implied statutory tort law. But see Art, *supra* note 328, at 583-84 (discussing statutes as a source of civil liability); Jennifer Friesen, *Recovering Damages for State Bills of Rights Claims*, 63 TEX. L. REV. 1269, 1282-83 (1985) (discussing liability under section 874A of the Restatement of Torts); cf. David S. Ruder & Neil S. Cross, *Limitations on Civil Liability Under Rule 10b-5*, 1972 DUKE L.J. 1125; Note, *Implying Civil Remedies From Federal Regulatory Statutes*, 77 HARV. L. REV. 285, 296-97 (1964) (stating that a court which recognizes a private remedy from a federal regulatory statute must also place limitations on the remedy in terms of available defenses, statute of limitations and venue requirements). Luckily, it is fairly clear how they ought to work there.

*Restatement (Second) of Torts* § 874A cmt. j (1979) states that a court which must decide what defenses apply in an implied statutory tort action should look at the legislation from which the claim arises for guidance. It further directs the court to apply "all the recognized defenses existing for the established tort that the court has adapted to cover this situation . . ." *Id.* Comment f to Section 874A also speaks of assimilating an implied statutory negligence action "to the most similar common law tort." *Id.* cmt. f. In the case of the statutory tort asserted by a battered spouse, the analogous common law tort obviously is a suit for statutory negligence. As discussed *supra* note 320 and accompanying text, defendants in many statutory negligence cases are free to assert defenses like contributory negligence, assumption of the risk, or comparative negligence there. "If they successfully prove a defense, they may be able to prevent those suing them from recovering anything." Jones, *Battered Spouses' State Law Damage Actions*, *supra* note 1, at n.197. At the least, they perhaps can limit the plaintiffs' damages through an offset for the portion of their injuries attributable to their own fault. *Id.*

Fortunately for battered spouses, however, a different rule applies in a few statutory negligence suits. See *supra* notes 321-22 and accompanying text (discussing the unavailability of negligence defenses when defendants violate special safety laws). There, negligence defenses are unavailable when the quasi-absolute liability statute in question reflects the legislature's clear desire to protect those who cannot guard themselves regardless of their own actions. *Id.* "Courts ought to deem protective domestic violence reporting laws to be of this type." *Id.*; see *supra* note 316 and accompanying text (arguing that physicians who do not report suspicions of domestic violence should not be permitted to raise negligence defenses since such defenses would undercut the very rationale underlying mandatory reporting statutes).

Various state law courts seem to have followed Section 874A by carrying over to the statutory tort realm the rule which outlaws all negligence defenses to statutory negligence claims which are derived from violations of focused protective legislation. For example, in *Nearing v. Weaver*, 670 P.2d 137 (Or. 1983) (en banc), the Oregon Supreme Court apparently held that when a battered spouse sued the police for violating a provision which required that they arrest certain designated spouse abusers, the statute in question qualified for special status under statutory negligence law. Hence, no negligence defenses were available under either that law or the analogous implied private action which would be assimilated to it. *Nearing*, 670 P.2d at 141-42, 143-44. But see *Cain v. Rijken*, 717 P.2d 140, 147 (Or. 1986) (en banc) (stating that because a statute merely provided that a mental health provider "may" (as opposed to "shall") take a person into custody, the statute did not create a *Nearing v. Weaver* statutory tort). As a result, the only defenses the law enforcement defendants in *Nearing* could assert were those which were defenses to violations of the underlying law itself. *Nearing*, 670 P.2d at 141-42, 143-44.

A number of other tribunals in appropriate statutory tort and related cases have rejected traditional negligence defenses. See H. WOODS, *COMPARATIVE FAULT* §§ 10:1-5 (2d ed. 1987 & Supp. 1994) (discussing violations of statutes which bar defenses or are silent on their applicabil-

the court acts much more dramatically when it generates a completely original tort than when it merely further refines a well-established one.<sup>334</sup> Such judicial behavior can rate both praise and criticism.<sup>335</sup>

In 1983, the implied statutory tort entered the domestic violence arena when the Oregon Supreme Court implied a private civil action when law enforcement officers ignored Oregon statutes mandating the arrest of certain spouse abusers.<sup>336</sup> The court held that when the po-

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ity). A New York statute requires contractors and building owners to erect scaffolding, ladders, ropes, and other similar safety devices to protect construction workers from harm. N.Y. LABOR LAW § 240(1) (McKinney 1986). Many New York courts evidently have implied a statutory tort for violations of this provision. Furthermore, they have banned the negligence defenses defendants have tried to advance against it as if in a statutory negligence case and imposed absolute liability because of the nature of the law and the legislature's intent when it enacted it. *See, e.g.*, *Berndt v. Aquavello*, 527 N.Y.S.2d 910 (N.Y. App. Div. 1988) (holding that contributory negligence and assumption of risk were not defenses to imposition of absolute liability under the statute); *Spouse v. Ragu Foods, Inc.*, 508 N.Y.S.2d 810 (N.Y. App. Div. 1986) (concluding that comparative negligence was no defense to a worker's cause of action under a statute imposing absolute liability where the injuries resulted from the failure to provide equipment for protection of employees); *Zimmer v. Chemung County Performing Arts, Inc.*, 482 N.E.2d 898 (N.Y. App. Div. 1985) (holding that an owner or contractor who failed to provide any safety devices for workers was absolutely liable in damages for injuries sustained by workers). New York law goes even further and directly imposes liability on those whose failure to obey federal, state, or local regulations causes harm to firemen who are hurt or killed in the line of duty. N.Y. GEN. MUN. LAW § 205-a (McKinney 1986). In *Johnson v. Riggio Realty Corp.*, 544 N.Y.S.2d 589 (N.Y. App. Div.), *appeal dismissed*, 549 N.E.2d 481 (N.Y. 1989), the court construed this law and concluded that contributory or comparative negligence are not defenses to its infringement.

Some tribunals have upheld negligence defenses in statutory tort situations. *See, e.g.*, *Sage v. Johnson*, 437 N.W.2d 582 (Iowa 1989) (holding that two defendants who served alcohol to minor, who was subsequently injured in a drunk diving accident, in violation of state alcohol regulatory statute, could be sued in statutory tort action, but made the claim subject to the comparative fault defense). However, the holdings of these courts can be explained. As in the statutory negligence setting, the statutes construed in such cases simply were not the special type which merit absolute liability status.

In sum, despite the relative lack of authority on the point, it seems clear that battered spouses who contend physicians committed either a statutory tort or statutory negligence when they did not help the spouses by reporting the spouses' situation are in almost the identical position when the physicians try to use negligence defenses against them. In either event, the spouses can argue forcefully that the statutes in question implicitly impose near absolute liability so that the negligence defenses simply do not apply. Non-negligence defenses could still create difficulties in some cases. *See Nearing*, 670 P.2d at 141-42, 143-44 (stating that liability was not absolute since these defenses might be asserted). However, the most worrisome excuses—contributory negligence, comparative negligence, or assumption of the risk—should not trouble them.

334. For more on the difference between statutory forms of negligence and new causes of action implied from legislation, see RESTATEMENT (SECOND) OF TORTS § 874A cmt. e (1979); Forell, *The Statutory Duty Action*, *supra* note 327, at 782, 789 & n.41; Forell, *Interrelationship*, *supra* note 327, at 220-21; Friesen, *supra* note 333, at 1282-83; Gamm & Eisberg, *supra* note 329, at 296-97.

335. *See, e.g.*, Gamm & Eisberg, *supra* note 327, at 297-301 (discussing some of the pros and cons of implying new tort causes of action from statutes).

336. *Nearing*, 670 P.2d 137. For commentary on *Nearing*, see Ruth Gundle, *Civil Liability for Police Failure to Arrest: Nearing v. Weaver*, 9 WOMEN'S RTS. L. REP. 259 (1986); Forell, *Interre-*

lice violated the mandatory terms of the arrest statute their actions gave rise to a statutory tort.<sup>337</sup> The decision was important because it established the principle that some domestic violence statutes are sufficiently focused and definite that their violation creates implied tort actions.<sup>338</sup>

At least some mandatory spouse abuse reporting laws should rate similar treatment. The focused ones of jurisdictions like California and Kentucky<sup>339</sup> demonstrate clear legislative intent to require reporting by physicians to help victims in domestic violence cases which should support statutory tort liability. The more general crime reporting laws of the various states seem less designed for such a purpose but still might qualify for a private implied cause of action as well; the key issue may be whether courts decide those laws were enacted to protect specific crime victims like battered spouses or for some broader societal purpose. Presumably, the less definitively a legislature expresses its purpose, the less likely courts will be to imply private tort actions arising out of protective legislation.

While a statutory tort action might present a battered spouse with the only practical chance to recover, it also may offer no real advantage over one sounding in statutory negligence; defendants may be unable to use negligence defenses in either action.<sup>340</sup> Nevertheless, state implied private actions may transform some abused spouses, doomed to be unsuccessful under a negligence theory, into winners. Counsel representing battered spouses should remember that the implied statutory tort action theory may be open to them and may prove extremely useful in some cases.

### III. BATTERED SPOUSES' STATUTORY LIABILITY CLAIMS

Domestic violence victims could have another source of remedy against physicians who do not report their abuse. This depends on provisions like those in some child<sup>341</sup> and elder<sup>342</sup> abuse reporting

*lationship*, *supra* note 327, at 255-59; M.B., Case Note, 22 J. FAM. L. 767 (1983-84); Art, *supra* note 328.

337. *Nearing*, 670 P.2d at 142, 143; Jones, *Battered Spouses' State Law Damage Actions*, *supra* note 1, at 49.

338. See Jones, *Battered Spouses' State Law Damage Actions*, *supra* note 1, at 49 (analyzing the significance of the *Nearing* decision).

339. See *supra* notes 40-48 and accompanying text (reviewing some particular state statutes which govern a physician's duty to report suspected domestic violence).

340. See *supra* notes 317-19 and accompanying text (arguing that domestic violence cases ought to be included among those where negligence defenses are not available to those who violate mandatory reporting statutes).

341. See *supra* notes 124-26 and accompanying text.

342. See *supra* note 134 and accompanying text.

laws mandating civil liability against non-reporters. To date, no state has adopted such a law for non-reporters of spouse abuse. If one does, it will provide a greatly simplified means for the compensation of battered women, and happily eliminate the need for most of the discussion herein.

#### IV. CONCLUSION

Spouse abuse continues to be a major American, and international, scandal about which something fundamental must be done. Society must find new ways to identify battered women so it can intervene appropriately on their behalf. Because many domestic violence victims seek medical treatment, physicians and other healthcare personnel can be an excellent source for identifying the battered. But many physicians refuse to come forward voluntarily, raising numerous objections to reporting. The clear alternative is mandatory reporting—taking this issue out of physicians' discretion. Since some physicians will not report even when required by reporting laws to do so, something is needed to engender obedience to required reporting. The main ways to do that are criminal and/or civil penalties. These can convince physicians that beyond the safety of their patients, their own interest demands that they report. Unfortunately, criminal penalties have proved ineffective in making them report either child, elder, or spouse abuse, so civil liability is the preferable means for compliance. It provides a strong incentive for non-reporting physicians to report, for if they do not they may suffer severe adverse financial consequences which could prove far more certain than what are, at best, misdemeanor criminal sanctions.

Civil liability is possible under several different theories. The most likely is negligence, either common law or statutory. Common law negligence has the advantage of being available in all jurisdictions so long as the courts there are willing to find that physicians have a negligence duty to report spouse abuse inflicted upon their patients. This may be a somewhat controversial point, but when all factors are considered courts should find public policy dictates such a duty. Statutory negligence ought to be obtainable in all jurisdictions with either domestic violence statutes which include physician reporting provisions, general physician crime reporting laws, or both. In such places, it provides an even more solid remedy than common law negligence.

Some battered spouses also may profit from a second, albeit far less used, cause of action—the implied statutory tort claim. While this claim is similar in many ways to one for statutory negligence, it still can be of great help to claimants who are, for some reason, foreclosed



from negligence recoveries. Under statutory tort claims, plaintiffs need only convince a court that they are the beneficiaries of focused pieces of legislation which impose a duty upon physicians, the violation of which is impliedly a tort. This can be done through the various reporting laws already on the books in many states.

Finally, domestic violence victims can employ express civil liability laws which impose liability on non-reporting physicians once states start passing such legislation to correspond to the civil liability provisions which already exist in some child or elder abuse statutes. Such statutes will be an appropriate expression of legislative concern over the non-reporting physician problem.

In conclusion, domestic violence victims can pursue various avenues both to encourage physicians to report abuse of their patients to the authorities so government can intervene and help the battered and to compensate the victims for the injuries which timely reporting would have averted. Battered spouses should derive significant benefits under these approaches. When physicians are convinced to report past abuse, protective service and law enforcement professionals will be able to prevent more and more future battering from ever occurring. That facilitates the real goal, which ultimately is *not* to make physicians pay damages to patients whose subsequent injuries are attributable to non-reporting; the *real* goal is to reduce, and eventually eliminate, domestic violence so that reporting no longer is needed. Physician civil liability for non-reporting is a necessary and invaluable component in bringing about that ultimate result.