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# SCREENING FOR VIOLENCE AND ABUSE THROUGH THE LENS OF MEDICAL ETHICS

*Stephanie A. Wolfson*<sup>\*</sup>

## INTRODUCTION

Mrs. Smith, an eighty-seven year-old widow, presents at the emergency room with a broken hip. Her son, who brought her in, tells you that he found her lying at the bottom of the stairs. During the exam you discover fresh bruising on her arm inconsistent with a fall. When her son leaves the room to make a phone call, you question Mrs. Smith about the accident. At first, she repeats the son's story. But, when she gets confused and cannot fill in the details, she admits that she did not fall down the stairs. Looking nervously toward the door, she explains that her son became frustrated with her and told her to go to her bedroom. He grabbed her arm and dragged her toward the room. When he pushed her into the bedroom she tripped on the carpet and fell. She acknowledges his increase in frustration lately, as she has become more forgetful. Before he returns, she begs you not to tell anyone. She explains that she needs her son and his wife to support her financially. She also enjoys being close to her grandchildren and fears being sent to a nursing home. As her physician, what do you do?

Physicians and other health care professionals often face difficult situations like that of Mrs. Smith. A physician faced with such a dilemma can look to her own personal morals, her understanding of biomedical ethics, the law, and — if it exists — hospital policy or a hospital ethics committee. However, further confusion arises when the physician discovers that these various sources of guidance give conflicting advice or directives.

This paper identifies and explores issues in biomedical ethics stemming from screening for and identification of violence and abuse across a patient's lifespan. The first section sets the background for the discussion of biomedical ethics and mandatory reporting statutes. The

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next section discusses the benefits of screening for abuse and neglect by health care professionals. Part three examines the opposition to screening and reporting from the perspective of patients, physicians, and victim advocates. The fourth part addresses the barriers that exist to successful screening and reporting by the medical community. Lastly, I distinguish ethical responsibilities from legal duties in screening for, intervening in, and reporting cases of violence and abuse.

## I. THE BACKDROP

The majority of professions, including those in health care, “contain, at least implicitly, a professional morality with standards of conduct that are generally acknowledged by those in the profession who are serious about their moral responsibilities.”<sup>1</sup> Within one profession, those standards can differ among cultures, change over time, or be altered through the acceptance of ethics policies or statutes. While professional morality in health care can include rules and principles of biomedical ethics, professional morality can also encompass virtues important to health professionals. Such virtues that may or may not overlap aspects of the widely accepted body of medical ethics include compassion, trustworthiness, integrity, conscientiousness, and the “ability to make judgments and reach decisions without being unduly influenced by extraneous considerations, fears, personal attachments, and the like.”<sup>2</sup>

Despite the importance of professional morality, the presence of morals personal to each individual physician and other health care professionals cannot be discounted. Each person’s own morals are developed throughout his or her lifetime, influenced by their unique experiences. These experiences include the distinctive combination of the effects of family, education, religion, and community. Personal morality can affect health care professionals by creating psychological and subconscious biases, which can impede successful screening or reporting of abuse and neglect.<sup>3</sup> For instance, health care professionals who feel that family violence is a private family matter are less likely to report, intervene, or even suspect serious abuse when presented with

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<sup>1</sup> Tom L. Beauchamp & James F. Childress, *Principles of Biomedical Ethics* 5 (5th ed., Oxford University Press 2001).

<sup>2</sup> *Id.* at 32, 34.

<sup>3</sup> Emalee G. Flaherty & Robert Sege, *Barriers to Physician Identification and Reporting of Child Abuse*, 34 *Pediatric Annals* 350 (2005).

the symptoms.<sup>4</sup> Health care professionals who are more tolerant of physical discipline are less likely to suspect that a particular injury is the result of abuse. Furthermore, twelve to fifteen percent of physicians have themselves witnessed domestic violence or experienced physical abuse by an intimate partner at some point in their lives.<sup>5</sup> This can make the subject too uncomfortable in a physician's own life to discuss with patients. Thus, professional morality does not necessarily override personal morality, even though it can sometimes be difficult to remember that professionals are people too.

Because physicians are merely human and professional morality does not compel physicians to abide by its norms, the contemporary biomedical ethics movement came into being in the early 1970s.<sup>6</sup> Modern breakthroughs in medical science and technology continually produce novel and controversial issues for biomedical ethics scholars to debate and attempt to resolve.

### A. Principlism

The leading school of thought in biomedical ethics in the United States surrounds four basic ethical principles: autonomy, beneficence, nonmaleficence, and justice.<sup>7</sup> While not the only approach to or theory behind biomedical ethics, principlism has the approval of influential governmental commissions on biomedical ethics.<sup>8</sup>

Autonomy is the obligation to respect the right that the patient has in decision-making.<sup>9</sup> For an action to be autonomous, it should be intentional, made with understanding by the patient, and free of manipulation or coercion.<sup>10</sup> Autonomy has replaced paternalism, the belief that the physician knows what is best for the patient, which was the traditional form of decision-making. Until the recent era of biomedical ethics, physicians could just about always decide what treatment was necessary and what information to divulge to patients.<sup>11</sup> Despite the definite shift to autonomy, paternalism still exists in some forms. At times, physicians may not realize that they are disguising

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<sup>4</sup> *Id.* at 352.

<sup>5</sup> Michael A. Rodriguez et al., *Screening and intervention for intimate partner abuse: practices and attitudes of primary care physicians*. 282 JAMA 468 (1999).

<sup>6</sup> Bonnie Steinbock et al., *Ethical Issues in Modern Medicine* 2 (6th ed. 2003).

<sup>7</sup> *Id.* at 36.

<sup>8</sup> *Id.*

<sup>9</sup> Beauchamp & Childress, *supra* note 1, at 59, 63.

<sup>10</sup> *Id.* at 59.

<sup>11</sup> *Id.* at 176.

paternalism under what they believe is mere guidance and respect for their patients' autonomy.

The beneficence principle instructs medical professionals to provide benefit and promote the welfare of patients.<sup>12</sup> With many factors to consider, the physician and patient must weigh this principle against the others when determining the best interests of the patient. Hence, the approach encompasses the notion of utility, weighing benefits against harms and costs to produce the highest net benefit.<sup>13</sup> Nonmaleficence can be considered the partner to beneficence. Nonmaleficence does not mandate benefit, but instead defines the obligation not to inflict harm.<sup>14</sup>

Last, but not least, is the justice principle. This concept of justice covers fairness in the allocation of health care resources.<sup>15</sup> Issues regarding setting priorities and rationing of medical supplies and limited physician time fall under this principle. A common conception of the justice principle is the notion of "tragic choices," such as prioritizing patients in an emergency room or those on an organ transplant wait list.<sup>16</sup> However, this principle also affects the average patient seeking preventative care, including the allocation of the flu vaccine or simply time.

One criticism of the principles approach is that answers to ethical questions are not easily answered due to the absence of an ordering of the four principles.<sup>17</sup> The creators of principlism deliberately did not give priority to one principle over another. They acknowledge that ethical dilemmas can only be resolved using the principles by a "subtle process of weighing and balancing" using the specific facts of the case in question.<sup>18</sup> Some feel that this approach is overly subjective, while others appreciate its adaptivity.<sup>19</sup>

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<sup>12</sup> *Id.* at 166.

<sup>13</sup> *Id.* at 165-66.

<sup>14</sup> *Id.* at 114-5.

<sup>15</sup> *Id.* at 250.

<sup>16</sup> *Id.* at 253.

<sup>17</sup> Steinbock, *supra* note 6, at 38.

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

<sup>19</sup> *Id.* at 38, 39.

## B. Abuse, Neglect, and Mandatory Reporting Statutes

Like the modern biomedical ethics movement, today's concerns regarding abuse and neglect are relatively new.<sup>20</sup> Family violence was once perceived as a family secret.<sup>21</sup> But now, the reality of family violence has become public. Child abuse, intimate partner violence, and elder abuse and neglect have been transformed into significant issues in public health, much like the development of concerns regarding alcoholism, sexually transmitted disease risks, and many other behaviors that were once seen as private and carried some amount of social stigma.<sup>22</sup>

Violence and neglect come in many forms, all of which are prevalent in society today. Elder abuse and neglect include physical and verbal abuse, medical neglect, and even financial exploitation. By 2002, child abuse became the fourth leading cause of death for children between the ages of one and four.<sup>23</sup> With eight to fourteen percent of primary care patients being victims of intimate partner violence,<sup>24</sup> it may not be surprising that the laws have evolved so that the arrest and conviction of abusers can occur without the assistance of a traumatized victim.<sup>25</sup>

Mandatory reporting statutes exist in every state, although the laws may differ greatly. Reporting of child abuse and neglect is required in every state. The same is true for elder abuse and neglect reporting, which can also cover broader adult protective services. Very few states have enacted laws requiring reports of intimate partner violence. Most laws give reporters, such as physicians, immunity from liability for making the report. Additionally, the legal requirement to report can override patient-physician confidentiality. The penalties for failing to report vary, from compelled continuing education to small fines to jail time.

Despite recent legislation, the modern biomedical ethics movement, and the few studies evaluating protocols for medical professionals' intervention, uncertainty and debate in this area remain.

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<sup>20</sup> Barbara Gerbert et al., *Domestic Violence Compared to Other Health Risks: A Survey of Physicians' Beliefs and Behaviors*, 23 *Am J Prev Med* 82, 87 (2002).

<sup>21</sup> *Id.*

<sup>22</sup> *Id.*

<sup>23</sup> Flaherty, *supra* note 3, at 350.

<sup>24</sup> Gerbert, *supra* note 20, at 82.

<sup>25</sup> Laura G. Iavicoli, *Mandatory Reporting of Domestic Violence: The Law, Friend or Foe?*, 72 *Mt Sinai J Med* 228, 229 (2005).

## II. THE BENEFITS OF SCREENING

As with many other crimes, the fact that abuse and neglect are illegal and carry a threat of imprisonment has not brought an end to its prevalence in society. With the recent increase in awareness and concern over various forms of violence and abuse, it is no surprise that medical and public health professionals have joined with law enforcement and other victim advocates in trying to reduce the problem and help survivors. Seemingly, health care professionals are a likely match for such intervention. This is due to the intimate relationship with their patients that gives health care providers a unique viewpoint that most, besides the victim or abuser, will not have.<sup>26</sup>

Both voluntary and mandatory screening for violence and abuse by health care professionals have benefits for society and the individual, such as increasing the number of instances in which there is intervention and arrest. This causes more perpetrators of abuse and neglect to be held accountable for their conduct.<sup>27</sup> There is also an increase in the prosecution of the perpetrators.<sup>28</sup> This increase in arrests and prosecution makes the threat more tangible and raises awareness by sending an unambiguous message to the public that society will no longer allow this behavior.<sup>29</sup>

Society also profits from the recent crackdown on screening by increasing the amount of information gathered.<sup>30</sup> This improved statistical collection and documentation can result in other benefits from the increase in comprehension and awareness. For instance, more information can lead to development and increased professional training in this area.<sup>31</sup> Thus, health care professionals, through increased education, can improve their identification and response<sup>32</sup> in addition to having enhanced treatment available for victims.<sup>33</sup> Much like the evolution of knowledge, intervention, and treatment for other

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<sup>26</sup> Mark S. Lachs, *Screening for Family Violence: What's an Evidence-Based Doctor To Do?*, 140 *Ann Intern Med* 399 (2004).

<sup>27</sup> Iavicoli, *supra* note 25, at 229.

<sup>28</sup> *Id.*; Michael A. Rodriguez et al., *Mandatory Reporting of Domestic Violence Injuries to the Police: What Do Emergency Department Patients Think?*, 286 *JAMA* 580 (2001).

<sup>29</sup> Iavicoli, *supra* note 25, at 229.

<sup>30</sup> Rodriguez, *supra* note 5, at 580, 582; Iavicoli, *supra* note 25, at 229.

<sup>31</sup> Iavicoli, *supra* note 25, at 229.

<sup>32</sup> Rodriguez, *supra* note 5, at 582.

<sup>33</sup> Iavicoli, *supra* note 25, at 229.

societal problems — such as alcoholism, substance abuse, and the spread of sexually transmitted diseases like the human immunodeficiency virus — violence and abuse should experience the same advancement now that it has become a focal point in public health.<sup>34</sup>

Individual patients can also benefit from health care providers screening for and intervening in cases of abuse and neglect. Assistance by health care professionals is even more important when considering that help for these patients may not be available elsewhere. Accordingly, there are many supporters of screening and even mandatory reporting, including victims. In one study, over half of abused female emergency room patients supported mandatory reporting for physicians.<sup>35</sup> In another study of female victims' opinions of mandatory reporting statutes, ninety-two percent thought the adoption of such laws would make assistance easier to obtain.<sup>36</sup> But not everyone entirely approves of the screening or reporting when it is mandated, more approve of policies and laws that take into account the victim's desired course of action.<sup>37</sup> For instance, if a policy allows a person other than the victim, such as a physician, to make the report, then the perpetrator can lay blame on the third-party reporter instead of the victim. Supporters of mandatory reporting statutes encourage liberation from having to make a police report.<sup>38</sup> One study reported that seventy-eight percent of abused women preferred having another person make a report.<sup>39</sup> Of these victims, eighty-one percent felt that they "would not resent someone having the power or control over when to call the police about the abuse."<sup>40</sup>

While there are varying opinions within the medical community about mandatory reporting statutes, eighty-six percent of primary care physicians agreed that intervening in cases of family violence is "an essential or nearly essential" responsibility.<sup>41</sup> Recognizing signs of abuse and neglect allow the physician to provide resources or options to patients. Except where required by law, physicians have the option of

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<sup>34</sup> Gerbert, *supra* note 20, at 88.

<sup>35</sup> Rodriguez, *supra* note 5, at 582.

<sup>36</sup> Ann T. Malecha et al., *Mandatory Reporting of Intimate Partner Violence: Safety or Retaliatory Abuse for Women?*, 9 J of Women's Health & Gender-Based Med. 75, 76 (2000).

<sup>37</sup> Rodriguez, *supra* note 5, at 582.

<sup>38</sup> *Id.*

<sup>39</sup> Malecha, *supra* note 36, at 77.

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

<sup>41</sup> Gerbert, *supra* note 20, at 86.



providing support without intervening directly, which gives the patient the choice when to utilize this support system. If a victim visits health care providers and they never screen or talk to the patient about the abuse, then it appears as if the physicians are colluding and furthering the victim's isolation.<sup>42</sup> Screening for and recognition of the symptoms also provides an avenue for the physician to document the information in the patient's medical records so that future health care providers can be aware of the problem and be a part of the patient's support system.

Many times, victims just need someone to talk to in order to realize how to break the cycle of violence and neglect without a physician having to seize control and report for the patient. Reporting is not the only method when "[d]irect asking in a nonjudgmental, compassionate manner could facilitate patient-physician communication about the abuse, create openings for future disclosure, and send the message to the public and to victims that violence is wrong and help is available."<sup>43</sup> Thus, screening, without reporting, can be a strong, helpful intervention in and of itself.<sup>44</sup> In the end, the hope is that increases in screening will lead to increases in patient safety.<sup>45</sup>

### III. THE OPPOSITION

While support for screening and intervention clearly exists, there is disagreement over the methods. Mandatory reporting statutes are especially controversial because the victim population consists mostly of consenting adults able to make their own decisions, medically or otherwise. The issue of mandatory reporting by physicians is divisive among victims, health care professionals and other advocates of violence prevention.<sup>46</sup> The American Medical Association, while advocating screening and intervention in cases of child and elder abuse and neglect, opposes mandatory reporting for competent adult victims of intimate partner violence.<sup>47</sup> The National Research Council, an organization within the National Academies, advocates a moratorium on mandatory reporting statutes pending

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<sup>42</sup> Suzanne Batchelor, *Better Treatment Sought for Domestic Violence Epidemic*, WENEWS, April 16, 2003, available at <http://www.feminist.com/news/news186.html>.

<sup>43</sup> Gerbert, *supra* note 20, at 88.

<sup>44</sup> *Id.* at 89.

<sup>45</sup> Iavicoli, *supra* note 25, at 229.

<sup>46</sup> Rodriguez, *supra* note 28, at 580.

<sup>47</sup> AMA Guidelines: E-2.02 Abuse of Spouses, Children, Elderly Persons, and Others at Risk, available at <http://www.ama-assn.org/ama/pub/category/8387/html> [last visited January 12, 2007].

further studies on the effects of these laws.<sup>48</sup> One study found that almost half of abused female emergency department patients did not agree with the laws mandating reporting by physicians.<sup>49</sup> However, the concern with this sample population is that it excludes victims who oppose the mandatory reporting and fear seeking help, underestimating the amount of opposition.<sup>50</sup>

A predominant concern of reporting violence and abuse is that the perpetrator will commit more acts of violence in retaliation. Retaliatory violence is also known as “secondary battering.”<sup>51</sup> While patients fear retaliation from reporting,<sup>52</sup> the physicians also fear for the patients’ safety, regardless of police intervention.<sup>53</sup> Most opponents of mandatory reporting statutes refer to retaliatory violence as a central reason for their resistance to the policy.<sup>54</sup> It is enough of a tragedy when the initial violence occurs; victims and their physicians do not want the violence to escalate during their attempts to stop it.

Consequently, the fear of mandatory reporting and retaliation by the abuser can deter victims from going to their physicians for help and other health care.<sup>55</sup> If victims do seek medical attention, then there is a decrease in the amount of abuse disclosure. One study showed that two-thirds of women surveyed feel that mandatory reporting statutes decrease the likelihood of patients revealing abuse to their physicians.<sup>56</sup> For these women, fear is a barrier to disclosure and seeking help, resulting in resentment of their physicians for reporting without their consent.<sup>57</sup> The fears do not focus solely on retaliatory violence. Victims lose even more control when a physician must report against their wishes.<sup>58</sup> Because mandatory reporting statutes require health care workers to act regardless of a patient’s requests, these laws can compromise important tenets of biomedical ethics. The policies force physicians to breach confidentiality and cause patients to lose

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<sup>48</sup> Rodriguez, *supra* note 28, at 580.

<sup>49</sup> *Id.* at 582.

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

<sup>51</sup> Evan Stark, *Reconsidering State Intervention in Domestic Violence Cases*, 5 SOC. POL’Y & SOC’Y 149 (2005).

<sup>52</sup> Batchelor, *supra* note 42; Rodriguez, *supra* note 28, at 582.

<sup>53</sup> Batchelor, *supra* note 42.

<sup>54</sup> Rodriguez, *supra* note 28, at 580.

<sup>55</sup> *Id.* at 580-81.

<sup>56</sup> Iavicoli, *supra* note 25, at 231.

<sup>57</sup> *Id.*

<sup>58</sup> Rodriguez, *supra* note 28, at 580.

autonomy.<sup>59</sup> Many victims do not want their families separated due to interventions.<sup>60</sup> Others doubt the efficacy of the legal system.<sup>61</sup> There can be further concerns for immigrant victims. Isolation for these immigrants can stem from their social status and language barriers in addition to the isolation created by their controlling intimate partner.<sup>62</sup> Deportation is always a concern when dealing with the authorities, even if there are laws protecting the victims, due to a mistrust of law enforcement.<sup>63</sup> Additionally, while screening and reporting allow increased documentation in the patient's chart and use in public health measures, the information produced may be misleading when taken without a patient's cooperation.<sup>64</sup>

A law professor, who has written often on the topic of intimate partner violence, has extreme opposition to the current mandatory reporting statutes. While she takes the standard views that the current policies cause retaliatory violence and undermine autonomy, she also feels that by not taking into account the diverse needs of victims, the current approaches produce a victim stereotype.<sup>65</sup> She believes that the stereotype not only paints every victim as helpless, but also has only one notion of what victims should do to escape the violence and abuse.<sup>66</sup> Due to her opposition, she not only sides with other opponents for repealing mandatory reporting statutes, but also feels that intimate partner violence should be decriminalized so that victims can instead seek counseling and mediation.<sup>67</sup> It is hard to believe that many concur with this extreme view and one critic believes evidence for her theories is deficient.<sup>68</sup> Nonetheless, it is true that victims' encounters with violence and abuse vary greatly, as do their desire for help. To the extent that ethics and the law allow, health care providers should take individual victim's circumstances into account when intervening in order to meet each patient's specific needs, just as the professional would do when confronted with any other ailment.

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<sup>59</sup> *Id.* at 582.

<sup>60</sup> *Id.* at 580, 582.

<sup>61</sup> *Id.* at 582.

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

<sup>63</sup> *Id.*

<sup>64</sup> Malecha, *supra* note 36, at 75.

<sup>65</sup> Stark, *supra* note 51, at 150.

<sup>66</sup> *Id.*

<sup>67</sup> *Id.*

<sup>68</sup> *Id.*

#### IV. THE BARRIERS

A large number of barriers exist that prevent health care professionals from both screening for and reporting abuse and neglect, or at least doing so properly. Some obstacles are universal, not specific to a type of abuse, such as the lack of a unanimously agreed upon case definition for family violence.<sup>69</sup> Similarly, interventions have not been generally accepted or proven successful, making family violence a disease without a cure.<sup>70</sup> Additionally, barriers are present that stem from the physician as well as those caused by the patient.

Despite the enactment of mandatory reporting statutes, there is a low level of compliance by physicians, specifically for intimate partner violence.<sup>71</sup> In one study, fifty-nine percent of emergency and primary care physicians surveyed admitted that they might not act in accordance with the mandatory reporting laws concerning intimate partner violence if their patients raised objections.<sup>72</sup> In fact, only ten percent of physicians even inquire about domestic abuse.<sup>73</sup> Not just symptoms, but even fatalities caused by child abuse are considerably under-recognized and consequently under-reported.<sup>74</sup>

Health care providers never get the chance to screen, let alone report, suspected abuse or neglect if they never have the opportunity to see the patients in the first place. Fear of screening and the abuser often prevent victims from obtaining medical care.<sup>75</sup> Thirty-nine percent of abused women in one study claimed that they would not divulge the abuse to a health care provider who was encumbered with mandatory reporting laws.<sup>76</sup> Over seventy percent of these women admitted that they lied or withheld information from their physicians.<sup>77</sup> For the physicians, it is as if their patients “have a full-blown, raging illness, the symptoms of which they might very well like to hide from the medical establishment.”<sup>78</sup> With patients failing to visit physicians or being deceptive during visits, the patients are hindering any possible

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<sup>69</sup> Lachs, *supra* note 26, at 399.

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

<sup>71</sup> Batchelor, *supra* note 42

<sup>72</sup> Malecha, *supra* note 36, at 77.

<sup>73</sup> Gerbert, *supra* note 20, at 83.

<sup>74</sup> Flaherty, *supra* note 3, at 350.

<sup>75</sup> Rodriguez, *supra* note 5, at 580-81; Iavicoli, *supra* note 25, at 231.

<sup>76</sup> Malecha, *supra* note 36, at 75.

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

<sup>78</sup> Lachs, *supra* note 26, at 399.

help from the medical community. Many victims may simply not be ready to accept help. One theory is that in order to accept intervention and understand that they are victims, they must be in an “open window phase.”<sup>79</sup> Victims must enter this phase to even be amenable to intervention and capable of undertaking the steps necessary to escape the violence and grapple with the consequences of mandatory reporting statutes.<sup>80</sup>

Deficiencies in time, training, resources, and policies greatly affect the ability of health care professionals to screen for and report abuse and neglect.<sup>81</sup> With patient appointments scheduled back-to-back in as little as fifteen-minute intervals or with the stressful setting of a hospital emergency room, it is no surprise that potential reporters do not often screen their patients. It takes a great deal of time to properly obtain a full history, examine the patient, and explain screening and reporting to the family if a child is involved.<sup>82</sup> Additionally, time is needed to actually create a report and physicians may be concerned with later commitments, such as testifying in court.<sup>83</sup> With few physicians that believe they have the knowledge and skills to screen or intervene, training in this area remains an impediment, as well.<sup>84</sup> Many physicians are just not familiar with the signs and symptoms of abuse and neglect, as demonstrated by the fact that almost one-third of Chicago-area physicians surveyed received no continuing medical education on child abuse and neglect for five years prior to the study.<sup>85</sup> The same report confirmed that physicians with at least some training were more likely to report all suspected cases of child abuse.<sup>86</sup> There is also a need for resources available to health care workers and their patients. One survey showed that few physicians had any referral resources available for patients.<sup>87</sup> Moreover, only one-third of managed care organizations actually had resources available for their physicians, including policies and guidelines.<sup>88</sup>

Many other reasons exist for physicians failing to screen or report abuse and neglect to the proper authority. With child abuse,

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<sup>79</sup> Malecha, *supra* note 36, at 77-78.

<sup>80</sup> *Id.*

<sup>81</sup> Gerbert, *supra* note 20, at 83.

<sup>82</sup> Flaherty, *supra* note 3, at 354-55.

<sup>83</sup> *Id.* at 355.

<sup>84</sup> Gerbert, *supra* note 20, at 83, 86.

<sup>85</sup> Flaherty, *supra* note 3, at 350.

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

<sup>87</sup> Gerbert, *supra* note 20, at 86.

<sup>88</sup> *Id.*

many people have difficulty accepting that a parent would intentionally injure a child.<sup>89</sup> Furthermore, if they do understand the frequency of abuse, physicians may believe that they can recognize abuse not from the symptoms, but by evaluating which parents are capable of such behavior.<sup>90</sup> Physicians may run into another psychological barrier if the family is like that of the physician, specifically the same socioeconomic class.<sup>91</sup> This furthers the struggle to accept the parent as an abuser. If the physician is close to the family, then disbelief can be coupled with discomfort in discussing child abuse and neglect.<sup>92</sup> This may be one reason why emergency room physicians are more likely to report abuse and neglect than family practitioners.<sup>93</sup> Another reason may be that emergency departments see injuries from family violence that are more severe than injuries seen by family physicians.<sup>94</sup> Unlike most emergency department physicians, a physician that sees the victim more than once may feel that the “situation had resolved itself” and not report the suspected abuse.<sup>95</sup> Unfortunately, racial and socioeconomic family characteristics have come into play. For instance, health care workers are more likely to mistake symptoms of abuse for accidental or other injuries if the family is white.<sup>96</sup> The same is true for families that are intact.<sup>97</sup> Moreover, physicians were seven times more likely to diagnose an injured black child from a lower socioeconomic class with abuse.<sup>98</sup>

Many health care workers have had such unpleasant or even shocking experiences with reporting suspected abuse that it affected their future reporting. If a physician had a bad experience with child protective services, for instance, then that physician may not report a future case, or at least not do so unless the symptoms are serious.<sup>99</sup> Many problems with screening and reporting can occur when a potential reporter misunderstands the role of or distrusts protective services or other investigators.<sup>100</sup> Some physicians hold off on

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<sup>89</sup> Flaherty, *supra* note 3, at 351.

<sup>90</sup> *Id.*

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

<sup>92</sup> *Id.*

<sup>93</sup> Batchelor, *supra* note 42, at 1.

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

<sup>95</sup> Flaherty, *supra* note 3, at 354.

<sup>96</sup> *Id.* at 351.

<sup>97</sup> *Id.*

<sup>98</sup> *Id.*

<sup>99</sup> *Id.* at 353, 354.

<sup>100</sup> *Id.* at 353-54.

reporting until a time when they are completely confident in their diagnosis of abuse instead of letting protective services do the investigating.<sup>101</sup> This may be due to a misinterpretation of the role of investigators or of the requirements of reporting. Many physicians believe that they need to, but are unable to, identify with certainty the “true” and “false” positive and negative results from screening.<sup>102</sup> Another problem within the area of mistrust of investigators and misinterpretation of reporting statutes arises with the variation in forms of abuse and neglect. If the child abuse is physical neglect, emotional abuse, or medical neglect, then approximately half of the physicians in one study reported their findings.<sup>103</sup> The same physicians reported over ninety percent of their suspected physical abuse cases.<sup>104</sup> Despite the mandatory reporting statutes, many physicians feel that particular forms of abuse should be reported while others need not be.<sup>105</sup> However, the statistics do vary by report. In a survey of Chicago area pediatricians, eight percent admitted to failing to report a case of suspected child abuse within the previous year.<sup>106</sup> When looking at a physician’s entire career, another study claimed that almost a third of physicians had not reported at least one suspected case of abuse.<sup>107</sup>

Aside from a mistrust of protective services or law enforcement, many other fears prevent health care workers from consistently reporting or even screening patients. Retaliatory violence is one main concern because they want to protect their patients from future harm.<sup>108</sup> Family physicians, who tend to be more familiar with their patients and the family, have more concerns about retaliation,<sup>109</sup> and injuring the relationship with the family.<sup>110</sup> The fear of offending a patient may also play a role in the decision to screen or report.<sup>111</sup> While retaliation is a possibility, without intervention the victim is undeniably left exposed to future abuse.<sup>112</sup> Conversely, there is also the concern that screening or reporting will cause the patient to avoid medical treatment

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<sup>101</sup> *Id.* at 354.

<sup>102</sup> Lachs, *supra* note 26, at 399.

<sup>103</sup> Flaherty, *supra* note 3, at 352.

<sup>104</sup> *Id.*

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

<sup>106</sup> *Id.* at 351-52.

<sup>107</sup> *Id.* at 352.

<sup>108</sup> *Id.* at 353.

<sup>109</sup> Batchelor, *supra* note 42, at 1-2.

<sup>110</sup> Flaherty & Sege, *supra* note 3, at 353.

<sup>111</sup> Gerbert et al., *supra* note 20, at 83.

<sup>112</sup> Batchelor, *supra* note 42, at 2.

in the future.<sup>113</sup> If a parent or other caretaker is in charge of medical care and is also the abuser, then the child or other victim may not return for necessary treatment or may fail to receive care in the future.<sup>114</sup>

Many health care providers are overworked and overexposed to violence and neglect, leaving them weary of the possibility of happy-endings. Screening and reporting decreases with the belief that a victim's situation will not change or that a physician has the inability to help remedy the problem.<sup>115</sup> Thus, many health care professionals feel helpless when confronted with violence and abuse. Many times victims of intimate partner violence put up with the abuse to keep a family together or elders remain in an abusive household because they rely on their caretaker for life's necessities. Physicians can always talk to a patient and explain that the abuse is wrong and not their fault, but the physician cannot force a victim of intimate partner violence to leave their abuser.<sup>116</sup> Conversely, some physicians may be confronted with a situation where they may feel that they can work with the patient and the abuser themselves. In these instances, physicians may feel that the use of the authorities is not warranted or that they can fix the problem better than protective services or the police.<sup>117</sup> Therefore, with myriad barriers and forms of opposition, "[c]an we realistically expect to prove that a choreographed "standard" intervention can thwart a heterogeneous problem that encompasses all of the complexities of human relationships. . . ?"<sup>118</sup> Perhaps the answer is no. Yet, many diseases leave a patient in need of individualized treatment and physicians currently screen for incurable diseases and provide experimental therapies with the hope of improving a patient's quality of life. Thus, as with many other ailments, health care professionals should continue to intervene in cases of violence and abuse despite the absence of a cure or standard case definition.

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<sup>113</sup> Rodriguez, *supra* note 28, at 580-81.

<sup>114</sup> Flaherty & Sege, *supra* note 3, at 353.

<sup>115</sup> Gerbert et al., *supra* note 20, at 83.

<sup>116</sup> Batchelor, *supra* note 42, at 2.

<sup>117</sup> Flaherty & Serge, *supra* note 3, at 353.

<sup>118</sup> Lachs, *supra* note 26, at 399.



#### IV. THE DILEMMA: BIOMEDICAL ETHICS VS. THE LAW

With the modern biomedical ethics movement now universally accepted in the United States and some form of mandatory reporting statutes enacted in every state, both ethics and the law govern every physician in the country simultaneously. These two bodies of principles and policies do not use the same justifications and they certainly do not consistently mandate the same behavior. Consequently, there is much confusion and debate when physicians look for guidance on how to screen and intervene in cases of child abuse and neglect, intimate partner violence, and elder abuse and neglect.

Should reporters disclose their legal obligation under mandatory reporting statutes to every patient? Should health care workers reveal the fact that they are screening even if a patient may then try to hide the abuse? A victim may not agree with what the government or a physician believes is in the victim's best interest. As a result, abiding by mandatory reporting statutes can often lead to violations of patients' rights.<sup>119</sup> For instance, mandatory reporting statutes compromise physician-patient confidentiality.<sup>120</sup> Although HIPAA, a federal statute, was enacted to protect patients' privacy rights, it does not preempt state laws.<sup>121</sup>

Patient rights change with the competency level of the patient. A patient can be deemed incompetent due to a physical or mental condition. If incompetent, a patient cannot give informed consent. For example, children need a parent or guardian to make medical decisions for them. The applicability of laws governing mandatory reporting also varies by the age and competency level of the victim. Patient autonomy is violated if competent patients are not allowed to make their own decisions. Yet, under the mandatory reporting statutes, health care workers must make a report without considering the wishes of the patient or guardians.

Reporting suspected abuse and neglect without the consent of competent patients is controversial, especially since many of the

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<sup>119</sup> Batchelor, *supra* note 42, at 2.

<sup>120</sup> Rodriguez, *supra* note 29, at 580.

<sup>121</sup> HIPAA stands for the Health Insurance Portability and Accountability Act of 1996. Doctors, hospitals, and other health care providers must follow the patient privacy rules in the statute.

patient-victims will inevitably be competent when dealing with elderly patients and victims of intimate partner violence. The controversy around mandatory reporting occurs predominantly with intimate partner violence, which has the largest proportion of competent victims. With caretakers or guardians, children and elders are more often deemed incompetent than the typical victim of intimate partner violence. Thus, mandatory reporting statutes are on the books in every state to protect children and elders, the two more vulnerable groups. A minority of states have passed laws requiring health care professionals to report intimate partner violence without the consent of the victim. Thus, it is the laws regarding intimate partner violence that are contentious. The American Medical Association, while supporting reports of suspected child maltreatment and elder abuse, opposes laws that force physicians to report for competent, non-elderly adult victims.<sup>122</sup> Absent legal requirements, their policy is that physicians should not report to state authorities without the consent of the patient.<sup>123</sup>

Why is there such a generalized separation between non-elderly and elderly adults regarding reporting of abuse? An elderly woman could still be the victim of spousal abuse. The need for a caretaker to help an elderly individual may only indicate physical decline, not mental incapacity. It seems that there is very little difference between the typical victim of intimate partner violence and a competent elder. If this is true, then there are two possible results: either mandatory reporting for elder abuse and neglect should be just as controversial as for intimate partner violence or laws requiring reports of intimate partner violence should be universal as are the statutes requiring elder abuse reporting. Moreover, separate laws exist that mandate the reporting of injuries resulting from deadly weapons or illegal acts.<sup>124</sup> An injury caused by intimate partner violence, for instance, may overlap with what is covered by this type of law. Yet, both types of laws are on the books in some states, and where there are no mandatory

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<sup>122</sup> AMA Policies: E-2.02 Abuse of Spouses, Children, Elderly Persons, and Others at Risk; H-515.965(5) Family and Intimate Partner Violence: "If and where mandatory reporting statutes dealing with competent adults are adopted, the AMA believes the laws must incorporate provisions that: (a) do not require the inclusion of victims' identities; (b) allow competent adult victims to opt out of the reporting system if identifiers are required; (c) provide that reports be made to public health agencies for surveillance purposes only; (d) contain a sunset mechanism; and (e) evaluate the efficacy of those laws."

<sup>123</sup> *Id.*

<sup>124</sup> Malecha et al., *supra* note 36, at 75.

reporting statutes for intimate partner violence, these deadly weapons statutes are rarely used to report family violence.

Mandatory reporting statutes weaken patient privacy and autonomy.<sup>125</sup> The fear is that reporting requirements could continue to expand until patient privacy is completely eroded and it seems that all physicians do is report without time for anything else. Patient privacy violations lead us down a slippery slope. Currently, one could go so far as to say that the government passing mandatory reporting legislation and physicians reporting suspected abuse is a return to the reign of paternalism. Although autonomy has replaced paternalism in the modern biomedical ethics movement, is paternalism always indefensible? The reasoning behind mandatory reporting statutes is that a duty to avoid further abuse or neglect can outweigh the duty to respect autonomy in certain situations. Another situation that illustrates this argument occurs when a patient is unable to act in his own best interest due to coercion or fear.<sup>126</sup> Here, a small amount of paternalism can possibly help the patient conquer his fear and sever his dependency on his abuser so that the patient can regain mental and physical health while in the care of his physician.<sup>127</sup> In the end, there is actually an increase in autonomous decision-making ability.

Under the principle of beneficence, some argue that intervention in cases of abuse and neglect would be required to truly promote patients' welfare.<sup>128</sup> Others argue that this principle affects health care professionals by limiting them to treating injuries and other symptoms of abuse while going no further.<sup>129</sup> Going further could cause retaliatory violence, for example, which would not benefit the patient. Thus, mandatory reporting could cause harm to the patient in particular circumstances in violation of the nonmaleficence principle.<sup>130</sup> Yet, diagnosing violence or neglect as the cause of an injury is important under this principle.<sup>131</sup> Without a proper diagnosis, there could be inappropriate or even harmful treatment.<sup>132</sup> Furthermore, ignoring the violence or neglect can cause the patient psychological harm by taking

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<sup>125</sup> Rodriguez, *supra* note 29, at 580.

<sup>126</sup> B.E. Paris et al., *Elder abuse and neglect: How to Recognize Warning Signs and Intervene*, 50 *Geriatrics* 47, 51 (1995).

<sup>127</sup> *Id.*

<sup>128</sup> AMA Council on Ethical and Judicial Affairs (CEJA), *Physicians and Domestic Violence: Ethical Considerations*, 267 *JAMA* 3190 (1992).

<sup>129</sup> *Id.*

<sup>130</sup> Iavicoli, *supra* note 25, at 230.

<sup>131</sup> CEJA, *supra* note 127, at 3190.

<sup>132</sup> *Id.*

part in the victim's isolation.<sup>133</sup> Not screening and intervening can lead to further health risks, just as a physician would not release a patient with another life-threatening ailment from an emergency room.<sup>134</sup>

The justice principle comes into play with violence and neglect, as well. With the ever-increasing list of topics for health care workers to cover during patient visits, time is an enormous restraint on proper screening and intervention. Depending on the age and competency-level of the patient, information is ascertained in addition to a basic medical history due to an influence by public health initiatives. The list of information includes: diet and exercise, alcohol abuse, smoking, safe sex, gun ownership, drug abuse, mental health, seatbelt use, and, hopefully, abuse and neglect. There is simply not enough time to do a medical exam, diagnose a problem, treat the patient, and get a full medical history that explores all possible areas of concern for every patient in a single visit. Physicians find themselves picking their battles and being unable to address more than a few of these issues.

Another concern arises when a patient is incompetent or is brought to the medical visit by a caretaker, family member, or intimate partner. Even if a patient consents to the person accompanying the patient and hearing private medical information, physicians should not make assumptions regarding the person's role in the patient's life. The person or caretaker may also be the perpetrator of the abuse or neglect. In such a case, patients may not be honest about their injuries in front of the person or, even worse, there may be retaliatory violence. If the person is the gatekeeper to medical care, then future visits may be prevented. Conversely, if the person is not the perpetrator, then he or she could benefit from the knowledge that abuse and neglect is taking place and help the patient.

But what happens when the patient is not the victim, but the perpetrator? Occasionally there may be disclosure by the perpetrator-patient of past or on-going abuse or neglect. In such a case, the health care worker must balance patient-physician privilege against protecting another person. Legal precedent exists for protecting third parties to the patient-physician relationship. Third parties should be protected from present and future violence even if it requires a physician to breach confidentiality.<sup>135</sup> For example, where a patient discloses future violence against a third party to a psychiatrist, the doctor has a duty to

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<sup>133</sup> *Id.* at 3191.

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

<sup>135</sup> *Tarasoff v. Regents of the Univ. of California*, 551 P.2d 334 (Cal. 1976).

somehow warn the third party.<sup>136</sup> Those who oppose this policy feel that it is not beneficial to interrupt treatment of the perpetrator-patient. Here, confidentiality is violated and all the benefits to the report fall on a third party to the care. If therapists disclose this hole in confidentiality and report abusers, treating the abusive behavior becomes difficult or even impossible. Nevertheless, the health care professional has a legal duty to report these threats of violence.

Duties of health care professionals come in many forms, including the required legal duties. Other duties are only recommended or newly proposed as further studies are completed on screening for violence and abuse. Proposed duties include requirements to gain knowledge about screening and have resources available to patients. Ethical duties may or may not be mandated by policy. With mandatory reporting statutes, the legal duty clearly overrides the ethical duty to maintain patient-physician privilege. Responsibilities that already exist in other medical contexts may be applied to violence and neglect scenarios. Personal biases and morals should not affect medical care; referrals to other physicians may be necessary where a personal history or experience with abuse makes screening or intervention too uncomfortable for the physician. Physicians also have a general duty to be educated about the causes of medical problems and ways to prevent them in order to competently diagnose and treat illness. Because violence and neglect can be the causes of medical conditions, it can be argued that this obligation encompasses health problems associated with abuse and neglect and ways to prevent or stop injuries to patients stemming from violence. Health care workers often make referrals when a patient needs to see a specialist. It follows from this that health care workers should be able to refer a victim of violence or neglect to a shelter or have other information and resources available. Just as medical professionals cannot harm patients under the principle of nonmaleficence, they should not themselves add to the abuse or neglect directly. For instance, one way that physicians could be an actual source of abuse or neglect for a patient is to not give a patient enough pain medication.<sup>137</sup>

The legal duty to report suspected abuse is not justified by biomedical ethics. In effect, the mandatory reporting statutes, which are authorized by the state's police power, put health care workers in

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

<sup>137</sup> Doctors can be a source of abuse. See Ben A. Rich, *Thinking the Unthinkable: The Clinician as Perpetrator of Elder Abuse of Patients in Pain*, 18J. Pain & Palliative Care Pharmacotherapy 63 (2004).

the role of law enforcement, albeit temporarily. Under these laws, health care professionals are, in essence, doing some of the detective work and supplying evidence for potential investigations, arrest warrants, or even criminal proceedings. Health care providers are in a good position to diagnose abuse and neglect and take part in some form of intervention, but there are other mechanisms that can be used to seek legal recourse against abusers. Does this relationship with law enforcement conflict with the purpose of the medical profession? From a medical perspective, health care professionals would never begin reporting as a result of motives stemming from medicine. Following the tenets of biomedical ethics, a physician might instead send a patient to a shelter or otherwise try to intervene. However, *interventions* by medical personnel are not required by law, while *reporting* is. Nevertheless, without national consensus on mandatory reporting statutes, the issues remain controversial and unresolved.

## CONCLUSION

Disputes continue to revolve around statistics, the proper scope of the law, morality, and ethics. Because many mandatory reporting statutes and public health measures are still so new, insufficient evidence and information exists on how to effectively screen for or intervene in cases of abuse and neglect. While some health care professionals may not agree with some of their legal or proposed duties, or have personal beliefs in conflict with their ethical or legal responsibilities, without education in this area they cannot appreciate the consequences of failing to conform to the policies. Whichever duties a medical professional chooses to follow, knowledge is needed to make informed decisions. Additionally, many questions will continue to remain unanswered regarding the responsibilities of health care professionals to screen for violence and abuse across the patient's lifespan. Morality, ethical theory, and the current state of policy do not allow for easy answers or a single solution to these problems.<sup>138</sup>

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<sup>138</sup> Beauchamp & Childress, *supra* note 1, at 21.

