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MANDATORY REPORTING OF DOMESTIC VIOLENCE: AN INAPPROPRIATE RESPONSE FOR NEW YORK HEALTH CARE PROFESSIONALS

Mia M. McFarlane*

INTRODUCTION

For the past three years, the New York State Assembly has considered a bill that would require certain persons, including physicians, to file reports of domestic violence.[1] While the New York State Legislature should be commended for recognizing the seriousness of domestic violence and for promoting efforts to curtail this problem, this current initiative must be given careful consideration. At first glance, mandatory reporting laws appear to benefit battered women,[2] but the government should beware of

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[1] The bill was first introduced by New York State Assembly Member Felix Ortiz in 1996. *See* A.B. 9721, 219th Ann. Leg. Sess. (NY 1996). The bill was introduced again in 1997 and was referred to the Assembly Committee on Social Services. *See* A.B. 4586, 220th Ann. Leg. Sess. (NY 1997). Assembly Bill 4586 was again referred to the Social Services Committee on January 7, 1998. No further action was taken on this bill before the close of the 221st Annual Legislative Session. The same bill was again introduced by Assembly Member Ortiz on March 1, 1999. *See* A.B. 5788, 222nd Ann. Leg. Sess. (NY 1999).

[2] Because the majority of domestic violence victims are women, terms referring to the female gender will be used throughout this article. *See, e.g.*, AM. MED. ASS'N, Board of Trustees Report 11-A-97, at 1 (1997)(stating that studies have found that 95% of domestic violence victims are women); U.S. DEP'T OF JUSTICE, NATIONAL CRIME VICTIMIZATION SURVEY, 1992-1996, *reprinted in* U.S. DEP'T OF JUSTICE, BUREAU OF JUSTICE STATISTICS FACTBOOK, VIOLENCE BY INTIMATES: ANALYSIS OF DATA ON CRIMES BY CURRENT OR FORMER

seeking a quick fix without examining the impact of its actions. The benefits of this proposed legislation may be far outweighed by its harmful effects on battered women.

Domestic violence is definitely an underreported crime.[3] Given the large numbers of battered women who may not call the police but who do seek medical attention, health care providers can play a significant role in the fight against domestic violence. A number of initiatives in New York State have improved health care providers' response to victims of domestic violence.[4] Physicians should be trained not only to identify and treat domestic violence, but also to provide information and make referrals.[5] If physicians act in a supportive and nonjudgmental way, they can empower women to seek help when they are ready and when their safety can be ensured. However, physicians should not be required to report domestic violence when such action may be contrary to the wishes of the patient and may, in fact, jeopardize her safety.

This article will argue that the mandatory reporting of domestic violence should be vehemently opposed. Part I of this article provides background information on domestic violence, including a historical overview of this pervasive problem. The prevalence of domestic violence, the dynamics of the battering relationship, women's help-seeking measures, and society's response to the problem are discussed. Domestic violence and its

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SPOUSES, BOYFRIENDS, AND GIRLFRIENDS 1 (March 1998)(stating that more than 960,000 incidents of intimate violence occur each year and that approximately 85% of the victims are women).

[3] *See* U.S DEP'T OF JUSTICE, BUREAU OF JUSTICE STATISTICS FACTBOOK, VIOLENCE BY INTIMATES: ANALYSIS OF DATA ON CRIMES BY CURRENT OR FORMER SPOUSES, BOYFRIENDS, AND GIRLFRIENDS, at V (1998)(stating that only half of all domestic violence incidents perpetrated against women are reported to the police).

[4] Domestic violence protocols have been developed by the New York State Department of Health, the New York State Office for the Prevention of Domestic Violence, and area hospitals. *See infra* Part III.

[5] *See infra* Part III.

interface with the health care system is also examined. Part II analyzes the mandatory reporting laws that have been enacted in some states[6] and discusses the proposed legislation in New York State.[7] Arguments supporting the mandatory reporting of domestic violence, and the stronger opposing arguments are examined. Part III explores alternatives to mandatory reporting. This section will focus on current initiatives in New York State which have the potential to provide an effective medical response to domestic violence.

I. BACKGROUND ON DOMESTIC VIOLENCE

A. Historical Overview

In order to understand the pervasiveness of domestic violence, it is helpful to examine the history of society's acceptance and tolerance of violence towards women. Although a complete history of domestic violence is beyond the scope of this article, a brief historical overview will be provided.[8]

The sanctioning of wife abuse can be found in the law as early as 753 B.C. under the Roman Laws of Chastisement.[9] Under these laws, women were treated as possessions of their husbands rather than separate individuals. Husbands could be held liable for

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[6] For example, California, Kentucky, New Hampshire, New Mexico, and Rhode Island have mandatory reporting laws that specifically address domestic violence. *See* CAL. PENAL CODE §§ 11160-11163.2 (West 1994); KY. REV. STAT. ANN. §§ 209.010-.990 (Michie 1995); N.H. REV. STAT. ANN. § 631:6 (Michie 1997); N.M. STAT. ANN. §§ 27-7-14 to 31 (Michie 1997); R.I. GEN. LAWS § 12-29-9 (1994).

[7] *See supra* note 1.

[8] For a more complete overview of the historical background, and domestic violence generally, *see* DOMESTIC VIOLENCE LAW: A COMPREHENSIVE OVERVIEW OF CASES AND SOURCES (Nancy K. D. Lemon ed., 1996).

[9] Cheryl Ward Smith, *"The Rule of Thumb," A Historic Perspective?*, *in* DOMESTIC VIOLENCE LAW 34 (Nancy K. D. Lemon ed., 1996).

any crimes committed by their wives, and therefore, a husband could punish his wife to control her behavior.[10] The church, as well as the state, approved of the head of the household "disciplining" his wife.[11] The right of a husband to chastise his wife continued under English common law, limited only by the "Rule of Thumb."[12]

The common law tradition was followed in America. In 1824, *Bradley v. State*[13] upheld the right of a husband to chastise his wife. This case also made clear that family conflicts are private matters that should not be aired in the courts.[14] The decision in *Bradley* remained good law in Mississippi for the next 70 years,

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[10] *Id.*

[11] One example of the views of the Christian church can be found in the *Rules of Marriage* published by Friar Cherubino in the 15th century. The following passage is often quoted in the literature: "When you see your wife commit an offense, don't rush at her with insults and violent blows . . . . Scold her sharply, bully and terrify her. And if this doesn't work...take up a stick and beat her soundly, for it is better to punish the body and correct the soul...Readily beat her, not in rage but out of charity . . . for her soul, so that the beating will rebound to your merit and her good." *Id.*

[12] This rule permitted a man to beat his wife so long as the rod or switch used did not exceed the circumference of his right thumb. *Id. See also* Beirne Stedman, *Right of Husband to Chastise Wife, in* DOMESTIC VIOLENCE LAW 30 (Nancy K. D. Lemon ed., 1996)(commenting on the arbitrariness of this rule: "A light blow, or many light blows, with a stick larger than the thumb, might produce no injury; but a switch half the size might be so used as to produce death"). *But see* Henry Ansgar Kelly, *Rule of Thumb and the Folklaw of the Husband's Stick*, 44 J. LEGAL EDUC. 341 (1994) (stating that the phrase "rule of thumb" did not originate in the context of domestic violence).

[13] 2 Miss. (1 Walker) 156 (1824).

[14] The unwillingness of the courts to interfere with family privacy is also exemplified in State v. Rhodes, 61 N.C. 453, 459 (Phil.Law 1868) ("It will be observed that the ground upon which we have put this decision, is not that the husband has the right to whip his wife much or little; but that we will not interfere with family government in trifling cases . . . . We will not inflict upon society the greater evil of raising the curtain upon domestic privacy, to punish the lesser evil of trifling violence.").

until it was rejected in *Harris v. State*.[15] In 1882, Maryland became the first state to criminalize wife abuse.[16] Eventually, the other states followed suit. However, domestic violence remained largely a private matter, and batterers continued to beat their partners without fear of reprisal. It was not until the women's liberation movement in the late 1960's and 1970's that the problem of domestic violence began to receive adequate attention.[17]

B. Extent and Nature of the Problem

It has been estimated that there are between 2 million to 4 million annual cases of domestic violence involving female victims.[18] Between 1992 and 1996, there was an average of over 960,000 violent incidents[19] per year against women ages 12 and older committed by a current or former spouse, boyfriend, or girlfriend.[20] During that same time period, approximately 8 in 1,000 women were victims of a violent act perpetrated by an

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[15] 71 Miss. 462 (1894).

[16] Barbara J. Hart, *The Legal Road to Freedom*, *in* BATTERING AND FAMILY THERAPY: A FEMINIST PERSPECTIVE 13, 14 (Marsali Hansen & Michele Harway eds., 1993).

[17] *Id.* at 15.

[18] *See* AM. MED. ASS'N, DIAGNOSTIC AND TREATMENT GUIDELINES ON MENTAL HEALTH EFFECTS OF FAMILY VIOLENCE 6 (1995). *See also* U.S. DEP'T OF JUSTICE, BUREAU OF JUSTICE STATISTICS SPECIAL REPORT, VIOLENCE-RELATED INJURIES TREATED IN HOSPITAL EMERGENCY DEPARTMENTS 1 (1997) ("During 1994 U.S. hospital emergency department (ED) personnel treated an estimated 1.4 million people for injuries from confirmed or suspected interpersonal violence").

[19] Violent incidents include murder, rape, sexual assault, robbery, aggravated assault, and simple assault. U.S. DEP'T OF JUSTICE, VIOLENCE BY INTIMATES, *supra* note 3, at 3.

[20] *Id.*

intimate partner.[21] In 1996, domestic violence resulted in 1,800 murders, 75% of which had a female victim.[22]

Domestic violence is a pattern of behavior used to maintain power and control over an intimate partner.[23] Domestic violence includes physical abuse, sexual abuse, emotional abuse, economic abuse, threats and intimidation, isolation, the use of male privilege, and control tactics using the children as pawns.[24]

Lenore Walker developed the cycle theory of violence in which she delineated three phases of the domestic violence relationship: (1) tension building, (2) the acute battering incident, and (3) loving contrition.[25] This theory describes domestic violence occurring in continuous cycles in which tension escalates until there is a violent episode which is followed by apologies and loving behavior.[26] At least in the beginning of the relationship, this third phase may reinforce the woman's hope that her partner will change.[27]

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[21] *Id.*

[22] *Id.* at V.

[23] *See* Commission in Domestic Violence Fatalities, Report to the Governor, State of New York, October 1997, at 6 (defining domestic violence). *See also* Martha R. Mahoney, *Legal Images of Battered Women: Redefining the Issue of Separation*, 90 MICH. L. REV. 1, 5 (1991) (stating that power and control are the core of the battering process).

[24] *See* Power and Control Wheel, Domestic Abuse Intervention Project, Duluth, Minnesota (depicting the many tactics used by batterers to maintain power and control over their victims). The Duluth project also developed the "Equality Wheel" which illustrates the components of a nonviolent relationship which include respect, trust and support, honesty and accountability, responsible parenting, shared responsibility, economic partnership, negotiation and fairness, and non-threatening behavior. *Reprinted in* SHERRI L. SCHORNSTEIN, DOMESTIC VIOLENCE AND HEALTH CARE: WHAT EVERY PROFESSIONAL NEEDS TO KNOW 50 fig. 3.2 (1997).

[25] LENORE E. WALKER, THE BATTERED WOMAN SYNDROME 95 (1984).

[26] *Id.* at 95-96.

[27] *Id.* at 96.

However, the cycle theory of domestic violence has been criticized for failing to adequately depict the experiences of many battered women. For instance, Ellen Pence facilitated several women's groups in Duluth, Minnesota and found that most of the women did not identify a "honeymoon phase" as a reason for staying in an abusive relationship.[28] Women described the abuse as a constant presence rather than waxing and waning in a cycle.[29] Although there may be a period of time between physical assaults, batterers use other forms of abuse, such as economic and emotional abuse, during this time to reinforce their power.[30] Over 200 women participating in 30 educational sessions sponsored by the Duluth battered women's shelter developed the *Power and Control Wheel*[31] to more accurately portray the abuse as a pattern of behavior rather than a cyclical process.[32]

In addition to the cycle theory of domestic violence, Lenore Walker was also the first to develop the theory of learned helplessness as applied to battered women.[33] Learned helplessness evolved as a concept to help explain why battered women do not leave abusive relationships. In a domestic violence situation, a woman is battered regardless of what she does. After repeated beatings, the victim begins to feel that she has no control over her situation, and she eventually becomes passive or helpless.[34] The

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[28] Tineke Ritmeester & Ellen Pence, *A Cynical Twist of Fate: How Processes of Ruling in the Criminal Justice System and the Social Sciences Impede Justice for Battered Women*, 2 S. CAL. REV. L. & WOMEN'S STUD. 255, 288-290 (1992).

[29] Ellen Pence & Michael Paymar, The Duluth Domestic Abuse Intervention Project *in* Domestic Violence Information Manual, W.I.S.E. — Women's Issues & Social Empowerment (last modified Feb. 16, 1998) <http://www.infoxchange.net.au/wise>.

[30] *Id.*

[31] SCHORNSTEIN, *supra* note 24, at 50.

[32] *Id.*

[33] WALKER, *supra* note 25, at 86-94.

[34] *Id.*

learned helplessness theory is one component of the Battered Woman Syndrome also developed by Lenore Walker.[35]

However, the learned helplessness theory offers an incomplete portrayal of battered women.[36] This theory discounts the active efforts of battered women to seek help — help which the community cannot always provide. Many victims of domestic violence simply lack the support and resources necessary to obtain self-sufficiency.[37] It is often difficult for those who have not experienced domestic violence to understand the decisions of a battered woman, especially decisions to stay in the relationship. However, given a battered woman's options and circumstances, she acts in very rational ways.

Edward Gondolf and Ellen Fisher propose the survivor theory as an alternative to the learned helplessness theory.[38] Under this theory, victims of domestic violence are portrayed as survivors who use active coping and help-seeking strategies, but who are

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[35] *See generally*, WALKER, *supra* note 25 (describing research on the characteristics of battered women and the effects of repeated abuse on victims). Expert testimony on battered woman syndrome is often used in self-defense cases in which battered women have killed their abusers. *See, e.g.*, Mahoney, *supra* note 23, at 34-35. Such testimony, including a description of learned helplessness and Walker's cycle theory of violence, helps to explain the battered woman's experience to the trier of fact. *Id.*

[36] *See* Mahoney, *supra* note 23, at 40-43 for a discussion of criticisms of the learned helplessness theory. The learned helplessness concept can be misleading because the term "helplessness" would seem to ignore the active efforts of battered women to seek help, efforts that are often met with frustration. *See id.* at 41. Mahoney acknowledges the usefulness of expert testimony on battered woman syndrome and learned helplessness, but she cautions that "[A]s long as explanation emphasizes 'helplessness' in the psychology of individual women, it runs into the danger of contributing to stereotyping." *Id.* at 42.

[37] *See* EDWARD GONDOLF AND ELLEN FISHER, BATTERED WOMEN AS SURVIVORS: AN ALTERNATIVE TO LEARNED HELPLESSNESS 11 (1988).

[38] *Id.* at 11-25.

often trapped in an abusive relationship due to a lack of resources and inadequate community services.[39]

. Many people blame battered women for staying in abusive relationships.[40] The myth that women will be safe once they leave the relationship fails to take into account the batterers' absolute need for control over their partners. Challenges to the batterer's control are met with increased violence. Separation is the ultimate challenge to the batterer's power and usually leads to retaliation.[41] Therefore, the most dangerous time for battered women is when they attempt to leave the batterer.[42] Martha Mahoney was the first to name "the particular assault on a woman's body and volition that seeks to block her from leaving, retaliate for her departure, or forcibly end the separation" as "separation assault."[43]

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[39] *Id.* Gondolf and Fisher suggest that "battered women remain in abusive situations not because they are passive but because they have tried to escape with no avail." *Id.* at 17.

[40] Mahoney, *supra* note 23, at 6 ("[A] woman's 'failure' to permanently separate from a violent relationship is still widely held to be mysterious and in need of explanation, an indicator of her pathology rather than her batterer's").

[41] *See* Hart, *supra* note 16, at 16 (citing that up to 75% of domestic assaults reported to the police may occur after the couple has separated; that 73% of battered women seeking emergency room care had been beaten after leaving the batterer; and that women are most likely to be murdered when they attempt to report the abuse or leave the batterer). *See also* Jody Raphael, *Prisoners of Abuse: Policy Implications of the Relationship Between Domestic Violence and Welfare Receipt*, CLEARINGHOUSE REVIEW, Special Issue 1996, at 187 (emphasizing that abuse does not end with separation. Divorced and separated women constitute 10% of the female population in this country, but they account for 75% of all battered women. Additionally, divorced and separated women report that they are physically beaten fourteen times as often as women who are living with the batterers).

[42] Mahoney, *supra* note 23, at 5-6 (stating that separation or attempted separation is the most violent and potentially deadly time in a domestic violence relationship).

[43] *Id.* at 6.

C. Domestic Violence and Health Care

Recognizing domestic violence as a public health issue has been a crucial first step to the medical community's efforts in recent years to develop an effective response to the problem. Former Surgeon General Everett Koop named domestic violence the number one health problem for women in the United States.[44] According to the American Medical Association, violence against women is a "public health problem that has reached epidemic proportions."[45] Domestic violence accounts for more injuries to women than rapes, muggings, and car accidents combined.[46] Injuries caused by domestic violence are significantly more severe than those resulting from assaults by strangers.[47] In 1989, the Attorney General's Family Violence Task Force found that domestic violence injuries were just as serious or more serious as the injuries sustained in 90% of all violent felonies.[48]

The health care costs attributable to domestic violence are staggering. For female victims of domestic violence, medical expenses, damaged and lost property, and lost pay total approximately $150 million per year.[49] Approximately 57,500 female domestic violence victims incur $61 million in medical expenses each year.[50] In addition to treatment for physical injuries, a substantial amount of health care expenses are related to the many indirect effects of domestic violence.[51] The secondary

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[44] *See* Hart, *supra* note 16, at 18.

[45] AM. MED. ASS'N, DIAGNOSTIC AND TREATMENT GUIDELINES ON DOMESTIC VIOLENCE 4 (1994) (stating that 8-12 million women in the United States are at risk for domestic abuse).

[46] Hart, *supra* note 16, at 18.

[47] *Id.*

[48] *Id.*

[49] U.S. DEP'T OF JUSTICE, *supra* note 3, at 21.

[50] *Id.* (stating that these figures may be substantially underestimated).

[51] For example, domestic violence may be associated with 50% of all female alcoholism. The mental health costs of domestic violence are also exorbitant.

outcomes of domestic violence such as post-traumatic stress disorder, depression, and substance abuse often require mental health intervention.[52]

According to a U.S. Department of Justice study, 37% of all women treated in hospital emergency rooms for violence-related injuries in 1994 were harmed by their former or current partners.[53] This study found that approximately 243,000 people sought treatment at hospital emergency departments for injuries caused by domestic violence.[54] This number is four times greater than estimates of domestic violence found in the Bureau of Justice Statistic's National Crime Victimization Survey.[55] Given the large numbers of battered women who seek medical attention, the health care system is a logical place for domestic violence intervention.[56]

Health care providers can use their contact with a battered woman in a way that helps and empowers her or, conversely, in a way that contributes to her victimization.[57] The Domestic Violence

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Battered women are more than 15 times more likely than other women to seriously consider suicide. Of all women suffering from chronic pain, 53% were victims of domestic violence before their condition began. Women who are beaten during pregnancy are more than twice as likely to have a miscarriage, and they are more likely than other women to have a baby with a birth defect. *See* Joan Zorza, *Women Battering: High Costs and the State of the Law*, CLEARINGHOUSE REVIEW, Special Issue 1994, 383, 383-384.

[52] *See* SCHORNSTEIN, *supra* note 24, at 62-68.

[53] U.S. DEP'T OF JUSTICE, *supra* note 18, at 5.

[54] *Id.* at 2.

[55] *Id.* at 1.

[56] The identification of domestic violence cases is one reason proponents give in support for mandatory reporting laws. *See, e.g.*, James T. R. Jones, *Battered Spouses' Damage Actions Against Non-Reporting Physicians*, 45 DEPAUL L. REV. 191, 223-24 (stating that proponents support mandatory reporting because they believe that such reporting will help detect crime, identify domestic violence victims, and assist data collection efforts). Part III, *infra*, will discuss the ways in which health care providers can identify and assist battered women without mandatory reporting laws.

[57] SCHORNSTEIN, *supra* note 24, at 70.

Project, Inc. of Kenosha, Wisconsin has developed a model to illustrate the ways in which the medical profession can either (1)increase the danger and entrapment experienced by battered women, or (2)empower women.[58] This model includes the "Medical Power and Control Wheel"[59] and the "Advocacy Wheel"[60] which have been adapted from the Duluth Model's "Power and Control" and "Equality" wheels.[61]

The "Medical Power and Control Wheel" depicts the many ways that physicians can become a part of the problem by violating confidentiality, trivializing and minimizing the abuse, blaming the victim, not respecting her autonomy, ignoring her need for safety, and normalizing victimization.[62] In contrast, the "Advocacy Wheel" illustrates the ways in which health care providers can become part of the solution by respecting confidentiality, believing and validating the victim, acknowledging the injustice, respecting the battered woman's autonomy, helping her develop a safety plan, and promoting access to community services.[63] The "Advocacy Wheel" reflects physicians' ethical responsibilities as promulgated by the American Medical Association's Council on Ethical and Judicial Affairs.[64]

Because the medical community has frequent contact with domestic violence victims, the health care arena is a critical focal point for intervention. Health care providers should become involved in identifying and assisting victims of domestic violence,

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[58] *Id.*

[59] A. Cosgrove, Domestic Violence Project, Inc., Medical Power and Control Wheel (1992), *reprinted in* SCHORNSTEIN, *supra* note 24, at 71 fig. 4.1.

[60] A. Cosgrove, Domestic Violence Project, Inc., Advocacy Wheel (1992), *reprinted in* SCHORNSTEIN, *supra* note 24, at 72 fig. 4.2.

[61] *See supra* note 24 and accompanying text.

[62] A. Cosgrove, *supra* note 59.

[63] A. Cosgrove, *supra* note 60.

[64] SCHORNSTEIN, *supra* note 24, at 70-71. As will be discussed in Part III, *infra*, mandatory reporting laws directly conflict with medical ethics, forcing physicians to ignore confidentiality and patient autonomy.

but as will be discussed in Part II, mandatory reporting laws are not the answer.

II. MANDATORY REPORTING LAWS

A. Mandatory Reporting Laws in Other States

Almost all states require physicians to make a report when a patient is injured by a gun, knife, or other deadly weapon;[65] but only some states have mandatory reporting laws that specifically address domestic violence. These states include California, Kentucky, New Mexico, New Hampshire, Rhode Island, and Colorado.[66]

California's mandatory reporting requirement was signed into law by Governor Pete Wilson on September 19, 1994.[67] The legislation was drafted by Democratic Assemblywoman Jacqueline Speier partly in response to concerns voiced by members of the Northeastern California Perinatal Outreach Program and others

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[65] *See, e.g.*, MO. ANN. STAT. § 578.350 (Vernon's 1995) (requiring physicians, nurses, and therapists to report any person treated for a gunshot wound to local law enforcement officials); VA. CODE ANN. § 54.1-2967 (Michie 1998) (requiring physicians and any other person giving medical aid to report wounds inflicted by a weapon); D.C. CODE ANN. § 2-1361 (1998)(mandating physicians to report injuries caused by firearms or other dangerous weapons).

[66] *See supra* note 6. For an overview of the different types of state reporting statutes, see Ariella Hyman, *Mandatory Reporting of Domestic Violence by Health Care Providers: A Policy Paper*, *in* CAROLE WARSHAW & ANNE L. GANLEY, IMPROVING THE HEALTH CARE RESPONSE TO DOMESTIC VIOLENCE: A RESOURCE MANUAL FOR HEALTH CARE PROVIDERS, Appendix N (Debbie Lee et al. eds., 2d ed. 1998). This manual was produced by the Family Violence Prevention Fund in collaboration with the Pennsylvania Coalition Against Domestic Violence.

[67] *See Domestic Violence Law May be Backfiring, Say California Health Organizations*, West's Legal News, December 27, 1996, 1996 WL 735716.

who sought to intervene in domestic violence cases.[68] The law requires health practitioners to report to a local law enforcement agency when they "know[] or reasonably suspect[]"[69] that the patient is "suffering from any wound or other physical injury inflicted upon the person where the injury is the result of assaultive or abusive conduct."[70] The California Medical Association opposed the enactment of this legislation,[71] but the law had extensive backing by law enforcement groups.[72]

In Kentucky, health care providers report to the Cabinet for Human Resources if they have reasonable cause to suspect that a person has been abused, and then the Cabinet notifies the police.[73] This provision for physician reporting is part of the broader Kentucky Adult Protection Act[74] which requires "[a]ny person, including, but not limited to, physician, law enforcement officer,

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[68] *See* Donna R. Mooney & Michael Rodriguez, M.D., *California Healthcare Workers and Mandatory Reporting of Intimate Violence*, 7 HASTINGS WOMEN'S L.J. 85, 88-90 (1996). In a 1994 speech, Assemblywoman Speier stated: "In part, legislation came out of concern expressed by OB/Nursery managers of the Northeastern California Perinatal Outreach Program and others who, concerned about preventing domestic violence and intervening in the cycle of abuse to protect the woman and the unborn child of those 25-45% of battered women who are battered during pregnancy, wanted to expand our mandatory reporting laws past the obligation for physicians, surgeons, hospitals and pharmacies [to report injuries resulting from a knife, gun, pistol or other deadly weapon] while at the same time providing immunity from prosecution."
Id. at n. 29.

[69] CAL. PENAL CODE § 11160 (West 1994). See also § 11161 detailing the information that should be included in the report.

[70] *Id.*

[71] *See* Mooney & Rodriguez, *supra* note 68, at 92. The California Medical Association opposed the legislation for several reasons, including insufficient protections from liability for mandated reporters and the "unprecedented" amount of information that physicians would be required to document in patients' medical records. *Id.*

[72] *See* West's Legal News, *supra* note 67.

[73] *See* KY. REV. STAT. ANN. § 209.030 (Michie 1995).

[74] KY. REV. STAT. ANN. § 209.080 (Michie 1995).

nurse, social worker, cabinet 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 . . . ."[75] Once a report is made to the Cabinet, the Cabinet notifies the appropriate law enforcement agency, investigates the complaint, and prepares a written report of findings and recommendations.[76] If the Cabinet recommends that services be provided, the domestic violence victim has the right to refuse those services.[77] New Mexico has a similar statutory scheme in which reports are made to the Children, Youth and Families Department.[78]

New Hampshire law mandates reporting of injuries believed to be caused by a criminal act.[79] However, if the victim of abuse or sexual assault is 18 years of age or older and objects to such reporting, a report does not need to be made unless the victim is "being treated for a gunshot wound or other serious bodily injury."[80] Rhode Island only requires reports for data collection purposes; the identity of the victim is not revealed.[81]

In Colorado, physicians must report to the police any injuries caused by a firearm, knife, or other sharp instrument or "any other injury which the physician has reason to believe

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[75] KY. REV. STAT. ANN. § 209.030 (2) (Michie 1995) For the purposes of this law, "adult" is defined as "a person eighteen (18) years of age or older or a married person without regard to age, who because of mental or physical dysfunctioning, or who is the victim of abuse or neglect inflicted by a spouse, is unable to manage his own resources, carry out the activities of daily living, or protect himself from neglect, hazardous or abusive situations without assistance from others and may be in need of protective services." KY. REV. STAT. ANN. § 209.020(4) (Michie 1995).

[76] KY. REV. STAT. ANN. § 209.030 (4) (Michie 1995).

[77] KY. REV. STAT. ANN. § 209.030 (7) (Michie 1995).

[78] N.M. STAT. ANN. §§ 27-7-14 to 31 (Michie 1997).

[79] *See* N.H. REV. STAT. ANN. § 631:6 (Michie 1997).

[80] *Id.*

[81] R.I. GEN. LAWS § 12-29-9 (1994).

involves a criminal act, including injuries resulting from *domestic violence*."[82] Ohio physicians are mandated to report to the police any "serious physical harm" which the physician "knows or has reasonable cause to believe resulted from an offense of violence."[83] Although domestic violence is not explicitly mentioned in the body of the statute, it is named in the title: "Reporting felony; Medical personnel to report gunshot, stabbing, and burn injuries and suspected *domestic violence*."[84]

Other states have reporting statutes that do not explicitly mention domestic violence, but these statutes can be interpreted to encompass such violence. For example, Georgia requires medical personnel to report to local law enforcement when a physician has "cause to believe that a patient has had physical injury or injuries inflicted upon him other than by accidental means."[85] Because domestic violence is a crime, it would be included under the Nebraska reporting statute which mandates all medical personnel to report to local law enforcement officials each case in which "a wound or injury of violence . . . appears to have been received in connection with the commission of a criminal offense . . . ."[86] Similarly, in North Dakota, health care providers must report to the sheriff or state's attorney when they treat "any person suffering from any wound, injury, or other physical trauma inflicted by his own act or by the act of another by means of a knife, gun, or pistol, or which [they have] reasonable cause to suspect was inflicted in violation of any criminal law . . . ."[87]

Since these mandatory reporting laws have been enacted, there has been little follow-up to determine the effectiveness of

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[82] COLO. REV. STAT. § 12-36-135 (West 1996) (emphasis added).
[83] OHIO REV. CODE ANN. § 2921.22 (Baldwin 1996 & Supp. 1996).
[84] *Id.* (emphasis added).
[85] GA. CODE ANN. § 31-7-9 (1996).
[86] NEB. REV. STAT. § 28-902 (1995).
[87] N.D. CENT. CODE § 43-17-41 (1993).

these laws, and no formal research has been conducted.[88] In California, however, a mail survey conducted by Dr. Michael Rodriguez found ambivalence among California physicians with respect to reporting requirements, and some physicians indicated that they would not always comply with the statutory mandates.[89] Dr. Rodriguez also conducted a qualitative study of battered women in California and found that some women were reluctant to seek medical treatment with the reporting law in place.[90] The women participating in the study expressed concern that a report to the police might further jeopardize their safety.[91]

Several California medical associations and organizations assisting battered women have voiced their opposition to the mandatory reporting law. They have supported a proposed amendment to the law which would require physicians to obtain the victim's permission before filing a report.[92]

In Kentucky, there has been a mixed response to the mandatory reporting. Some advocates and physicians have actively supported the mandatory reporting law, and many proponents of

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[88] *See* AM. MED. ASS'N, *supra* note 2, at 4.

[89] *Id.*

[90] Michael A. Rodriguez et al., *Breaking the Silence: Battered Women's Perspectives on Medical Care,* ARCHIVES OF FAMILY MED., Mar. 1996, at 156.

[91] *Id.*

[92] California Assemblywoman Sheila Kuehl introduced Assembly Bill 714 on February 26, 1997 and an amended version on April 3, 1997. *See* A.B. 714, California 1997-1998 Reg. Sess. Supporters of the bill included the American Association of Women Emergency Physicians, the California Academy of Family Physicians, the California Alliance Against Domestic Violence, the California Association of HMOs, Inc., the California Chapter of the American College of Emergency Physicians, the El Dorado Women's Center, the Family Violence Prevention Fund of San Francisco, the Nursing Network on Violence Against Women International, Physicians for a Violence Free Society, Services for Battered Women and their Children, Sor Juana Ines Shelter, and the Family Violence Project, Panorama City. *See Hearing on A.B. 714 (Keul) Before California Assembly Committee on Public Safety,* 1997-98 Regular Session (Cal. Apr. 1, 1997).

the law contend that it has contributed to a well funded shelter system in that state.[93] However, other advocates and physicians are opposed to the law because of safety and confidentiality concerns.[94] The degree of receptiveness to the law in Kentucky may be affected by the fact that reports are made to social service agencies, rather than to the police, and those agencies have allowed victims to refuse assistance.[95]

B. Proposed Legislation in New York

Assembly Bill 4586 was introduced by Assembly Member Felix Ortiz on February 20, 1997.[96] The bill was multi-sponsored by Assembly Members Richard Anderson, Republican, and Keith Wright, Democrat.[97] On the same day that the bill was introduced, it was referred to the Committee on Social Services.[98] The bill

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[93] *See* AM. MED. ASS'N, *supra* note 2, at 4; *see also* Travis A Fritsch & Kathy W. Frederich, *Mandatory Reporting of Domestic Violence and Coordination with Child Protective Services*, DOMESTIC VIOLENCE REP., Apr/May 1998, at 51-52 (stressing the benefits of Kentucky's mandatory reporting law, including early identification and the provision of services and support for domestic violence victims).

[94] *See* AM. MED. ASS'N, *supra* note 2, at 4; *see also* Sherry Currens, *Kentucky Coalition's Concerns about Mandatory Reporting*, DOMESTIC VIOLENCE REP., Apr./May 1998, at 49-50 (expressing the Kentucky Domestic Violence Association's concerns with Kentucky's mandatory reporting law, including infringement of the victims' rights and safety issues).

[95] AM. MED. ASS'N, *supra* note 2, at 4. However, the law does include a provision for the Cabinet for Human Resources to "[n]otify the appropriate law enforcement agency." *See* KY. REV. STAT. ANN. § 209.030(4) (Michie 1995).

[96] *See* A.B. 4586, 220th Ann. Leg. Sess. (NY 1997). The text of this bill is identical to 1996 bill also sponsored by Assembly Member Ortiz. *See* A.B. 9721, 219th Ann. Leg. Sess. (NY 1996).

[97] *Id.*

[98] The 1997 bill was carried over into the 221st legislative session and referred again to the Committee on Social Services on January 7, 1998. It should be noted that the Social Services Committee took no action on this bill before the close of the legislative session in June of 1998.

sought to amend the Social Services Law by requiring physicians and other professionals[99] to report domestic violence to the Commissioner of Social Services "when they have reasonable cause to suspect that an individual coming before them in their professional or official capacity is a victim of domestic violence."[100] The Commissioner, in turn, would refer victims to various programs for services.[101] The bill would have granted immunity, from any civil or criminal liability arising from a report, to mandated reporters who made the report in good faith.[102]

The memorandum accompanying the original draft of this Assembly bill included the following justification for this legislation: "This bill would ensure that those suffering from domestic violence would not be ignored. . . . Domestic violence is a very serious problem, which in many cases, could and has lead to loss of life. Any steps that can be taken to reduce the number of

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[99] In addition to physicians, Assembly Bill 4586 would have made the following persons mandated reporters: "registered physician assistant; surgeon; medical examiner; coroner; dentist; dental hygienist; osteopath; optometrist; chiropractor; podiatrist; resident; intern; psychologist; registered nurse; hospital personnel engaged in the admission, examination, care or treatment of persons; a Christian Science practitioner; social services worker; mental health professional; substance abuse counselor; alcoholism counselor; peace officer; police officer; district attorney or assistant district attorney; investigator employed in the office of a district attorney; or other law enforcement official." A.B. 4586, 220th Ann. Leg. Sess. (NY 1997).

[100] *See* A.B. 4586, 220th Ann. Leg. Sess. (NY 1997).

[101] *Id.* The bill would have required the Commissioner to make referrals to programs under sections 459-b or 459-c of the Social Services Law. N.Y. Soc. Serv. § 459-b provides for emergency shelter and other residential services for victims of domestic violence. N.Y. Soc. Serv. § 459-c provides non-residential services, including, but not limited to "information and referral services, advocacy, counseling, community education and outreach activities, and hotline services."

[102] *See* A.B. 4586

cases of domestic violence, to promote awareness, and to educate people should be taken."[103]

Although no action was taken on Assembly Bill 4586 before the close of the 221st legislative session in June 1998, a similar bill was introduced by Assembly Member Ortiz on March, 1 1999.[104] While the New York State Legislature should be commended for its efforts to reduce the incidence of domestic violence and to raise awareness, the Legislature should not act until the effects of its action have been carefully considered.[105] On its face, mandatory reporting legislation may appear to help domestic violence victims, but as will be discussed below, mandatory reporting laws may do more harm than good.

C. Arguments in Opposition to Mandatory Reporting

Many domestic violence organizations opposed Assembly Bill 4586 and sent position papers to the Governor and the Legislature voicing their concerns.[106] These groups oppose the

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[103] Memorandum in Support of A.B. 4586, 220th Ann. Leg. Sess. (N.Y. 1997).

[104] *See* A.B. 5788, 222nd Ann. Leg. Sess. (NY 1999). The only change to the text of the bill reflects the name change of the Commissioner of Social Services to the Commissioner of the Office of Children and Family Services. *Id.*

[105] One possible method of analyzing this type of legislation may be through a framework conceptualized by David B. Wexler and Bruce J. Winick, which is called therapeutic jurisprudence. "Therapeutic jurisprudence seeks to apply social science to examine [the] law's impact on the mental and physical health of the people it affects." *See* Bruce J. Winick, *The Jurisprudence of Therapeutic Jurisprudence*, 3 PSYCHOL. PUB. POL'Y & L. 184, 187 (1997) (reprinted in slightly different form in LAW IN A THERAPEUTIC KEY: DEVELOPMENTS IN THERAPEUTIC JURISPRUDENCE (David B. Wexler & Bruce J. Winick eds., 1996)).

[106] *See, e.g.*, *Mandatory Reporting of Domestic Violence by Health Care Providers*, A Position of The New York State Coalition Against Domestic Violence, September 9, 1997. (Hereinafter NYSCADV position paper). The bill's sponsor, Assembly Member Felix Ortiz, also received opposition letters

proposed mandatory reporting law for several well founded reasons: the law cannot guarantee women's safety, it fails to recognize that women are autonomous adults capable of making their own decisions, and it violates ethical considerations in the medical profession.[107] These arguments apply not only to the New York bill but to mandatory reporting laws in general. Therefore, this section will focus both on the proposed New York legislation as well as the arguments for and against mandatory reporting in a broader context -- including other states and national arenas.

One factor which is likely to have a powerful affect on current and proposed mandatory reporting laws is the official position of the American Medical Association, which in 1997 announced its opposition to such legislation.[108] While the American Medical Association identified valid arguments on both sides of the mandatory reporting issue, it underscored the fact that in the absence of formal research on the benefits or harm of a mandatory reporting policy, these arguments are mostly conjectural and stem from the ideological beliefs of the supporters and opponents.[109] Consequently, the American Medical Association based its position on the fact that mandatory reporting laws conflict with the profession's ethical tenets regarding patients' rights and physicians' responsibilities.[110] The position officially adopted in 1997 was as follows: "The American Medical Association opposes the adoption of mandatory reporting laws for

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from Child & Family Services/Haven House (Buffalo), the Coalition of Battered Women's Advocates, and the New York State Chapter of the National Women's Political Caucus. (On file with author). It should be noted that while A.B. 4586 would have mandated reports to the Commissioner of Social Services, some reporting laws in other states mandate reports to the police. Since similar bills could be drafted in New York, many of these domestic violence groups addressed opposition to reporting to the police as well.

[107] *Id.*

[108] *See* AM. MED. ASS'N, Board of Trustees Report, *supra* note 2.

[109] *Id.*, at 4.

[110] *Id.*, at 6.

physicians treating competent adult victims of domestic violence if the required reports identify victims. Such laws violate basic tenets of medical ethics and are of unproven value."[111] The ethical considerations of the medical profession and other concerns with mandatory reporting laws are addressed below.

1. Safety Concerns

When a victim of domestic violence tries to leave an abusive relationship, the batterer fears that he is losing power and control. Consequently, the violence usually escalates.[112] When a woman makes a police report or seeks an order of protection, plans must be put in place to ensure her safety. Only the battered women fully understands her own particular situation, knows when and how she can be safe, and can decide when it is the right time to leave the relationship.[113]

Although the criminal justice system has improved its response to domestic violence, it has failed to protect battered women in the past. Many victims have been seriously injured or killed after police reports have been made or orders of protection have been sought.[114] These dangerous circumstances dictate that

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[111] *Id.*

[112] *See supra* notes 40-43 and accompanying text.

[113] *See, e.g.*, California Assembly Committee on Public Safety, Hearing, Apr. 1, 1997 (In support of amending California's mandatory reporting law to allow reports only with the victim's permission, the agency Services for Battered Women and their Children argued that due to safety concerns, victims should be given information on available options and assistance in order to make decisions in their best interest).

[114] *See* Ariella Hyman et al., *Laws Mandating Reporting of Domestic Violence: Do they Promote Patient Well-Being?*, 273 JAMA 1781, 1783 (stating that as many as half of all batterers threaten retaliation, and more than 30% actually do retaliate with further violence during prosecution). The New York State Commission on Domestic Violence Fatalities reviewed 57 domestic violence homicide cases occurring between 1990 and 1997. In 21 of the 57 cases, there was at least one current order of protection, and in 17 of these 21 cases, a

only the woman should be able to decide when a report should be made.

The inability of the system to protect domestic violence victims from retaliation by their abusers is one reason for opposing mandatory reporting. If a doctor reports domestic violence, the report does not guarantee that the woman will be safe when she leaves the emergency room. When batterers are arrested, they are often only in custody for a short time. In fact, they may even return to the home before the battered woman has returned from the hospital.[115] Batterers are not always held without bail, and the criminal justice system cannot ensure around-the-clock protection.[116] In these instances, instead of helping victims of domestic violence, the reporting law inadvertently places women in greater danger.

In addition to retaliation issues, a woman's health may be further jeopardized if the batterer denies a victim access to health care or if the woman does not seek medical attention for fear of reprisals.[117] Because batterers attempt to control all aspects of their partner's lives, they also seek to control access to health care.[118] If the batterer knows that he will be reported if abuse is detected by a health care provider, then he is likely to bar the woman from seeking medical attention.[119] Even in instances where the abuser

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current order of protection had been violated prior to the homicide. *See* Commission on Domestic Violence Fatalities, *supra* note 23, at 7.

[115] *See* NYSCADV position paper, *supra* note 106.

[116] *See* Commission on Domestic Violence Fatalities, *supra* note 23, at 32. *See also* Rodriguez et al., *supra* note 90, at 156 (In response to a question regarding problems with seeking medical care under mandatory reporting laws, a woman in a battered women's focus group study responded "...they couldn't guarantee me that they would be there 24 hours to protect me from this maniac. So, therefore, I wasn't taking a chance on my life....").

[117] *See* Commission on Domestic Violence Fatalities, *supra* note 23; Hyman et al., *supra* note 114, at 1784.

[118] *See* NYSCADV position paper, *supra* note 106, at 2.

[119] *Id.*

does not expressly forbid medical care, the battered woman may not risk seeing a physician for fear that a report will be made.[120] Mandatory reporting laws pose particular concerns for immigrants who fear that a report could lead to their deportation.[121]

Ariella Hyman, a San Francisco attorney who specializes in domestic violence, has written much on the subject of mandatory reporting, and she has compiled anecdotes about the effects of the mandatory reporting law in California.[122] Several stories have been reported to Hyman of women seeking medical assistance from battered women's shelters, rather than hospitals, in order to avoid mandated reporting by a physician.[123] In these cases, the women had suffered serious injuries and were in need of hospital care: one woman's husband burned her face by holding it against a hot grill; another woman's husband banged her head against the floor and a wall causing serious head injuries.[124]

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[120] Battered women participating in a qualitative study in California expressed concerns about mandatory reporting, and some participants revealed that they failed to seek medical attention because they feared the consequences of reporting to the police. *See* Rodriguez et al., *supra* note 90, at 156. Transcripts from the same study indicate that even when domestic violence victims seek medical care, they may not be forthcoming with information that would assist in their medical treatment. For example, one participant stated: "I think it would make people less apt to tell the doctor what they need to tell him for the[ir] own health. They're thinking of all the repercussions." Mooney & Rodriguez, *supra* note 68, at 95.

[121] *See* NYSCADV position paper, *supra* note 106, at 2. *See also* Leni Marin, *A Very Private Pain: Violence in the Filipino Immigrant Home*, *in* DOMESTIC VIOLENCE LAW 132, 134 (NANCY K.D. LEMON ED., 1996) ("Fear of revealing their legal status in the U.S is another major reason why immigrant women stay in battering relationships").

[122] Shari Roan, *Law Against Domestic Abuse May Be Backfiring Crime: Health professionals are required to report suspected cases. But the rule may be stopping victims, fearful of revenge, from getting help*, L.A. Times, Dec. 25, 1996, at E1.

[123] *Id.*

[124] *Id.*

Although many of the arguments involving safety issues are based on mandating reports to law enforcement agencies, similar arguments can be made in opposition to laws mandating reports to social service agencies.[125] In Kentucky, health care providers are required to report domestic violence to the Department for Social Services (DSS) which investigates the allegation of abuse by contacting the victim by phone, letter, or a home visit.[126] The Kentucky Domestic Violence Association argues that "[t]his contact can be dangerous when dealing with an abuser who jealously guards his spouse or partner's every move."[127] Furthermore, state social service agencies are overburdened, underfunded, and are not always sensitive to the needs of domestic violence victims.[128]

2. Violations of Autonomy

One of the main arguments cited in opposition to mandatory reporting laws for domestic violence is that women are

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[125] Unlike some mandatory reporting laws in other states, the proposed legislation in New York would require reports to the Commissioner of Social Services rather than to the police.

[126] *See* Currens, *supra* note 94, at 49.

[127] *Id.* The Kentucky Domestic Violence Association further asserts that mandatory reporting is an unnecessary risk given that DSS only opens a few cases each year even though thousands of reports are investigated. *Id.*

[128] *See* Hyman et al., *supra* note 114, at 1284 and Ariella Hyman & Ronald Chez, *Mandatory Reporting of Domestic Violence by Health Care Providers: A Misguided Approach*, WOMEN'S HEALTH ISSUES, Winter 1995, at 209 (stating that social service agencies dealing with child and elder abuse are already overwhelmed and may engage in practices that conflict with the needs of battered women). *Cf. Mandatory Reporting of Domestic Violence to Law Enforcement and Criminal Justice Agencies*, ANNALS OF EMERGENCY MED., Oct. 1997, at 561 (stating that the American College of Emergency Physicians is opposed to the mandatory reporting of domestic violence to law enforcement agencies but encourages reporting to social service and other helping agencies that can provide confidential counseling and assistance if the victim so desires).

autonomous, competent, rational adults capable of making their own decisions.[129] Concepts such as the battered women's syndrome and learned helplessness often lead people to believe that women are unable to make appropriate decisions in order to help themselves.[130] This thinking often justifies paternalism and serves as an excuse to usurp the battered woman's right to make decisions affecting her own life. Given their situations and vulnerability, battered women often act in rational ways,[131] and they are likely to be well aware of the consequences that will result from particular courses of action. Mandatory reporting laws, such as those currently proposed in New York State, deny women the right to make decisions that have serious consequences for their lives.

Many mandatory reporting laws for domestic violence are based on similar laws for child abuse and elder abuse. Part of the New York State Assembly's justification for bill 4586 is that "[t]here are laws to protect children in this state who are abused. There should also be laws to protect adults from physical harm."[132] Opponents of the mandatory reporting laws argue that these laws perpetuate the stereotypes of battered women as being "helpless" and "childlike."[133] Furthermore, mandatory reporting laws replicate the power and control dynamic that occurs in an abusive relationship, only here the state and physicians are the ones taking power away from the woman and making decisions for her.[134]

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[129] *See, e.g.,* NYSCADV position paper, *supra* note 106, at 3; Hyman et al., *supra* note 114, at 1785.

[130] *See* Mooney & Rodriguez, *supra* note 68, at 104 ("The assumption of a woman's helplessness as a justification for mandatory intervention by healthcare workers and law enforcement is faulty based on the lack of definitive research and the diversity of situations healthcare workers would encounter").

[131] *See* Hyman et al., *supra* note 114, at 1785.

[132] Memorandum in Support of A.B. 4586, *supra* note 103.

[133] *See* Jones, *supra* note 56, at 228.

[134] *See* Hyman & Chez, *supra* note 128, at 211. For similar arguments, *see also* NYSCADV position paper, *supra* note 106, at 3 (arguing that just because the

Mandatory reporting laws in other states demonstrate a blatant disregard for a woman's autonomy. The portrayal of victims as helpless is evident in the legislative intent of some of these state statutes. For instance, the legislative findings and purpose of the New Mexico reporting statute indicate that the "legislature recognizes that many adults in the state are unable to manage their own affairs or protect themselves from exploitation, abuse or neglect."[135] Almost identical language is found in the legislative intent of Kentucky's reporting statute: "The General Assembly of the Commonwealth of Kentucky recognizes that some adults of the Commonwealth are unable to manage their own affairs or to protect themselves from abuse, neglect, or exploitation."[136]

Physicians should help battered women regain a sense of control by providing information, offering choices, and letting women decide when a report should be made. "Although tempting, practitioners should avoid the pitfall of 'rescuing' their patients."[137] Some doctors have gone on record supporting such a stance. For instance, Dr. Howard Holtz testified:

> I don't think that competent women who have experienced violence, who go to their doctors and depend on that trust and confidentiality, should have the specter of mandatory reporting to some adult protective service agency. This isn't the model of child abuse. We're not dealing with developmentally or cognitively incompetent patients, and after thinking about it long and hard, I am very much against any kind of mandatory

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criminal justice system is coercive by its nature does not mean that the health care system has to be coercive as well).

[135] N.M. STAT. ANN. § 27-7-15 (Michie 1978).

[136] KY. REV. STAT. ANN. § 209.090 (Banks-Baldwin 1995).

[137] Hyman et al., *supra* note 114, at 1785.

> reporting other than for statistical purposes, on an anonymous basis, about domestic violence in clinical situations.[138]

Similar sentiments have been voiced by other professionals. Regina Podhorin, former Supervisor of the Office on Prevention of Violence Against Women, Division on Women, testified:

> I would prefer to look at that--to mandate them [physicians] to record, to put in the medical record, their suspicions, so that there is documentation of it, but not that it be a reporting to officials, because I still also believe that women have the right to not have that reported to officials until they are ready. One of the most critical things about following through and making sure that women are able to be empowered and freed--It needs to be at their pace; it needs to be at their time. The danger level of doing it before that may help us to feel better, that we have done our part, but may put her in more danger. I don't know that is a good place for all of us to be. It almost feels like a salve. Instead of something that is helping that woman, it is something that is taking us off the hook by saying, "Well, we reported it." That is not necessarily helping her.[139]

Many doctors are frustrated by domestic violence and are eager to do something about the problem, but mandatory reporting laws are not the answer. Reporting domestic violence may help health care

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[138] Caroline W. Jacobus, *Legislative Responses to Discrimination in Women's Health Care: A Report Prepared for the Commission to Study Sex Discrimination in the Statutes*, 16 WOMEN'S RTS. L. REP. 153, 216.
[139] *Id.*

providers feel that they have done their part, but there are safer and more effective ways for physicians to assist battered women.

3. Ethical Concerns

Another concern regarding mandatory reporting laws is that such requirements breach confidentiality between doctors and their patients. Some mandatory reporting laws in other states actually contradict the express policies of the American Medical Association which provide that "[f]or competent adult victims, physicians must not disclose an abuse diagnosis to caregivers, spouses or any other third party without the consent of the patient."[140] "Similarly, the Council on Ethical and Judicial Affairs (CEJA) opinion 2.02 (Current Ethical Opinions) tells physicians to routinely screen patients for physical, sexual and psychological abuse, but not to disclose the diagnosis for an adult patient to anyone without the patient's consent."[141] These medical ethics present a conflict for physicians who are mandated in certain states to report domestic violence.[142] If New York adopts mandatory reporting legislation, the state will be placing all physicians in an ethical dilemma. In July of 1997, the AMA House of Delegates officially adopted the position that it opposed mandatory reporting of domestic violence.[143]

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[140] The Am. Med. Ass'n Policy Compendium 515.983(6) (1991). *See The AMA Opposes Mandatory Medical Reporting*, DOMESTIC VIOLENCE REPORT, Oct./Nov.1997, at 1.

[141] *Id.*

[142] 1996 American College of Emergency Physicians President, Dr. Larry Bedard, stated a desire to make domestic violence prevention a top priority but expressed the following in regards to mandatory reporting: "I feel a lot of trepidation when I am faced with a situation where a woman says, 'Please don't report, because if you do, my husband will kill me'" *See* Doug Levy, *Doctors Study Fitness of Spouse-Abuse Laws*, USA TODAY, September 9, 1996, at 1D.

[143] *See* Am. Med. Ass'n, Board of Trustees Report, *supra* note 2.

When a person receives medical care, she is already in a vulnerable situation. Many people feel nervous during a physical examination; this situation is exacerbated when the patient does not trust the health care provider. Battered women, in particular, have experienced relationships with others in which their trust in that person has been shattered. They many not readily confide in other people, including doctors.[144] Physicians may have to gain a battered woman's trust, and this trust would be destroyed if confidentiality is breached.[145]

In order for a battered woman to receive the proper medical treatment, she must feel safe enough to completely disclose the abuse, including information on specific symptoms and injuries. If a woman fears that the abuse will be reported, she may not be forthcoming with her physician. Inadequate information available to a physician could lead to inadequate medical treatment.[146]

In addition to confidentiality concerns, other professionals have used the medical concepts of nonmaleficence and beneficence to argue against reporting laws.[147] The doctrine of nonmaleficence states that above all else, the doctor should do no harm; the doctor should not risk engaging in any practice which would leave the patient worse off than before he or she intervened.[148] Under this argument, physicians should not report domestic violence because there is no guarantee that the patient will not be harmed.[149] A

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[144] *See* Schornstein, *supra* note 24, at 72 (stating that battered women may distrust anyone, including health care providers, who inquire about their abuse).

[145] *See id.* (explaining that the first step for intervention by a health care provider should be to develop trust). *See also* Rodriguez et al., *supra* note 90, at 156 (finding that battered women identified trust, compassion, support, and confidentiality as essential components of a good doctor-patient relationship).

[146] *See* NYSCADV position paper, *supra* note 106. *See also* note 120, *supra*.

[147] *See* Hyman et al., *supra* note 114, at 1284-85.

[148] *Id.*

[149] On the other hand, nonmalefeasance does not mean that physicians should do nothing. *See* Schornstein, *supra* note 24, at 39 (stating that the failure to diagnose domestic violence or to determine the cause of the symptoms can be

similar argument could be made under the beneficence doctrine which requires physicians to help their patients. The best way for a physician to help is to provide a safe and supportive environment in which the battered woman is free to discuss her abuse without repercussions. Health care providers should provide information, make referrals, and document the abuse so that it can be used in the future if the victim decides to prosecute.[150] Effective assistance can be better achieved without the mandatory reporting requirements.

4. Other Concerns

A significant concern with the mandatory reporting of domestic violence is that criminal justice and social service systems already have difficulty serving the woman that come forward on their own. Many argue that mandatory reporting will detect many more cases, but these women will be at greater risks of danger if the system is so overburdened that it cannot protect them all. For example, "in San Francisco, four out of five women are turned away from shelters due to lack of space."[151] Other commentators have also voiced concerns regarding cases in which the batterer is a police officer.[152]

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harmful. For example, physicians frequently prescribe sedatives and painkillers to battered women who may be at risk for suicide or substance abuse).

[150] *See* SCHORNSTEIN, *supra* note 24, at 70-97. *See also* EVAN STARK & ANNE FLITCRAFT, WOMEN AT RISK: DOMESTIC VIOLENCE AND WOMEN'S HEALTH 201-10 (1996).

[151] Hyman et al., *supra* note 114, at 1784. *See also* Jenny Rivera, *Domestic Violence Against Latinas by Latino Males: An Analysis of Race, National Origin, and Gender Differentials*, 14 B.C. Third World L.J. 231, 252 (1994) (stating that only one out of six women seeking shelter find an available space, ninety-five percent of shelters do not accept women with children, and many Latina women have difficulty finding shelter space because of the language barrier).

[152] *See e.g.*, NYSCADV position paper, *supra* note 106, at 2.

An additional concern with the imposition of mandatory reporting is that of skewed data collection. Many supporters of mandatory reporting laws assume that the laws will lead to improved data on domestic violence. However, this assumption rests on the notion that doctors will always identify and report domestic violence. In reality, incomplete documentation and reporting may lead to skewed data.[153] The American Medical Association has stated that domestic violence reporting may encounter problems similar to those found in the area of child abuse where reporting has been inconsistent and has reflected the cultural biases of physicians.[154] Even the best-intentioned laws can have implementation problems. If physicians fail to report domestic violence,[155] then the incidence of domestic violence would be underestimated, which in turn is likely to affect future policies and funding for domestic violence programs.[156]

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[153] *Id. at 4.*

[154] *See* AM. MED. ASS'N, *supra* note 2, at 3.

[155] Physicians' reluctance to report domestic violence in all cases has been noted in California. *See supra* note 89 and accompanying text. The El Dorado Women's Center in California has observed that "providers' reluctance to comply with mandatory reporting requirements discourages some health care providers from asking patients about injuries that may have been a result of domestic violence. Consequently, many domestic violence victims are not receiving necessary information about domestic violence and referrals to appropriate agencies." *See* California Assembly Committee on Public Safety, Hearing on 1997 Assembly Bill 714, Apr. 1, 1997. *See also* Carolyn J. Sachs et al., *Failure of the Mandatory Domestic Violence Reporting Law to Increase Medical Facility Referral to Police,* ANNALS OF EMERGENCY MED., Apr. 1998, at 488 (finding that the number of reports from health care providers to the Los Angeles Sheriff's Department did not increase during the two years following the enactment of the mandatory reporting law in California).

[156] *See* AM. MED. ASS'N, Board of Trustees Report, *supra* note 2, at 3.

D. Arguments in Support of Mandatory Reporting

The arguments presented so far have been in opposition to mandatory reporting, but, as many commentators point out, when mandatory reporting laws are examined, both the pros and cons must be weighed.[157] Among the arguments in favor of mandatory reporting is the public interest in prosecuting criminals. Proponents of mandatory reporting laws argue that the laws help law enforcement in two ways.[158] First, because domestic violence is an underreported crime, mandatory reporting would help identify batterers who would otherwise remain undetected and elude prosecution.[159] Secondly, mandatory reporting would require complete documentation of domestic violence-related injuries in the victim's medical record which could later be used as evidence in prosecuting the batterer.[160] Supporters further argue that mandatory reporting would improve the identification and treatment of injuries caused by domestic violence.[161]

Mandatory reporting laws may assist law enforcement officials in the detection of more batterers, but this increased detection should not be sought at the expense of the victim's safety. Unless the criminal justice system is improved and shelter

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[157] *See e.g.,* Jones, *supra* note 56, at 223 ("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. What one values more, as well as how one assesses the results of reporting, can determine how one feels about obligatory reporting"); AM. MED. ASS'N, Board of Trustees Report, *supra* note 2, at 2 (1997) ("Mandatory reporting laws are typically justified when the state's need to intervene, outweighs an individual's right to privacy, most often when the need is to detect a crime or to protect the public health").

[158] *See* AM. MED. ASS'N, Board of Trustees Report, *supra* note 2, at 3.

[159] *Id.*

[160] *Id.*

[161] *Id.* at 2. For similar arguments supporting mandatory reporting laws *see* Jones, *supra* note 56, at 223-224.

systems are expanded, women's lives will be placed in jeopardy. Often 24-hour protection, which cannot be provided by the current system, is the only solution to protecting a woman from retaliation from her abuser.

With respect to the improved identification argument, physicians can, and should, be trained to identify domestic violence and assist victims. However, this can be achieved without mandatory reporting laws. Many hospitals have implemented domestic violence protocols which will be discussed in Part III.

Before proceeding to the alternatives to mandatory reporting, it should be noted that the New York State Commission on Domestic Violence Fatalities has recommended a limited reporting law in New York which would mandate health care providers to report domestic violence when the victim has suffered life-threatening or serious physical injury.[162] The Commission argues that "[m]andatory medical reporting is consistent with both the New York policy of mandatory arrest of domestic violence offenders, and the public interest in seeing that those who commit violent crimes are arrested and prosecuted."[163] The Commission further argues that the medical profession could help identify domestic violence cases that would otherwise never be reported.[164]

Arguments against this limited version of the mandatory reporting law are the same as for other mandatory reporting requirements. Three members of the Commission on Domestic Violence Fatalities dissented from the above recommendation and

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[162] *See*, Commission on Domestic Violence Fatalities, *supra* note 23, at 34. The Commission argues that this limited type of reporting law would simply extend reporting requirements that already exist for gunshot and stab wounds. *See* N.Y. PENAL LAW § 265.25 (McKinney 1997) (requiring physicians to report to the police "[e]very case of a bullet wound, powder burn or any other injury arising from or caused by the discharge of a gun or firearm, and every case of a wound which is likely to or may result in death and is actually or apparently inflicted by a knife, icepick or other sharp or pointed instrument...").

[163] *Id.*, at 33.

[164] *Id., at 36.*

opposed all forms of mandatory reporting.[165] The dissenters believed that the harm that would result from even limited mandatory reporting, such as retaliation by batterers and obstacles to receiving medical treatment, would outweigh the benefits.[166]

III. ALTERNATIVES TO MANDATORY REPORTING

Although mandatory reporting is not a safe solution for victims of domestic violence, that does not mean that physicians should not play a critical role in addressing the problem of domestic violence. Because physicians, especially emergency room personnel, have such significant contact with victims, the medical community should have an ethical duty to identify and effectively assist battered women and men. This section will discuss current initiatives and protocols that have been developed in medical communities, with particular emphasis on hospitals in Western New York.

Effective medical protocols include training physicians about domestic violence so that they can identify it and assist the victims.[167] Physicians can help battered women by offering nonjudgmental support; addressing the violence by asking direct questions; documenting the violence completely in the patients' medical records including photographs, injury location charts, and any physical evidence; educating victims about domestic violence; providing information about available resources and making referrals to support services; making danger or lethality assessments; developing safety plans; and conducting follow-ups.[168]

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[165] *Id.*

[166] *Id.*

[167] *See* AM. MED. ASS'N, Board of Trustees Report, *supra* note 2, at 2-3 (stating that health care providers often fail to identify domestic violence).

[168] Schornstein, *supra* note 24, at 72-95.

In 1992, the American Medical Association issued the *Diagnostic and Treatment Guidelines on Domestic Violence* which included facts about domestic violence, diagnostic and clinical findings, barriers to identification, and guidelines to assist physicians in the interview process, documentation, and interventions.[169]

In addition to the American Medical Association guidelines, New York State has developed its own protocols. In 1990, the New York State Department of Health issued a protocol entitled *Identifying and Treating Adult Victims of Domestic Violence.*[170] This guideline defines the roles and responsibilities of all emergency room staff including security, intake, and triage staff.[171] The protocol also outlines specific procedures such as conveying respect and assuring confidentiality, interviewing the victim in private, preserving physical evidence and taking photographs, providing referral information, and offering to call the police.[172]

The Family Protection and Domestic Violence Intervention Act of 1994 also improved the medical response to domestic violence in New York.[173] The act requires all health care staff in hospitals and diagnostic and treatment facilities to give a victim's rights notice to a suspected or confirmed victim of domestic violence.[174] Among other items, the notice contains referral information.[175] The act also requires health care providers to

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[169] *See* AM. MED. ASS'N, *Diagnostic and Treatment Guidelines on Domestic Violence* (1992) (*reprinted in* 1994).

[170] N.Y. ST. DEP'T OF HEALTH, Office of Health Systems Management. Division of Health Care Standards and Surveillance, in Collaboration with New York State Office for the Prevention of Domestic Violence, *Identifying and Treating Adult Victims of Domestic Violence* (1990).

[171] *Id.*, at 11.

[172] *Id.*, at 3-17.

[173] *See* Commission on Domestic Violence Fatalities, *supra* note 23, at 29.

[174] *Id.*

[175] *Id.*

document domestic violence or suspicion of domestic violence in the patient's medical record.[176]

Even more elaborate guidelines for medical staff are contained in the Model Domestic Violence Policy for Counties prepared by the New York State Office for the Prevention of Domestic Violence.[177] This policy indicates that health care providers are often the first professionals with whom domestic violence victims have contact.[178] Despite this opportunity for intervention, health care providers frequently fail to identify domestic violence.[179] The Model Domestic Violence Policy for Counties builds upon the American Medical Association and the New York State Department of Health protocols, and emphasizes the importance of victim safety and self-determination. The policy stresses that reports to the police should only be made in cases mandated by the penal law which include gunshot and stab wounds and life-threatening injuries.[180] Health care providers should not make any other reports to the police without the victim's consent.[181]

Individual hospitals have implemented additional procedures to assist victims of domestic violence. Sisters Hospital of Buffalo was the first in Erie County to develop its own domestic

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[176] *Id.*

[177] *New York State Office for the Prevention of Domestic Violence, Model Domestic Violence Policy for Counties, State of New York (Jan. 1998).*

[178] *Id.*

[179] *Id.* The Model Domestic Violence Policy for Counties lists symptoms, complaints, and injury patterns associated with domestic violence including, but not limited to: headaches, migraines, chronic pain, fatigue, insomnia, palpitations and hyperventilation, gastrointestinal disorders, eating disorders, sexually transmitted diseases, substance abuse, depression, suicidal ideation, injuries during pregnancy, bilateral injuries, multiple injuries in different stages of healing, patterned injuries, defensive injuries,.and nose and eye fractures. *Id.*

[180] *Id.*

[181] *Id.* Despite these guidelines and the absence of a mandatory reporting law in New York, some health care providers have been reporting domestic violence to the police without their patients' consent.

violence program, the Safe Passage Program, in 1994.[182] In partnership with Crisis Services and Haven House (a shelter for battered women), the Safe Passage Program was designed to offer 24-hour advocacy and support to victims of domestic violence.[183] The program also operates a two-family transitional living home for women and their children.[184] According to Kathleen Slammon, the Coordinator of the Domestic Violence Program at Sisters Hospital, the training of health care providers is a critical component to the effective implementation of the domestic violence protocol at the hospital.[185] Helping medical professionals to recognize that domestic violence is a health care issue has been a major accomplishment.[186] At Sisters, routine screening for domestic violence is incorporated in the nurses' assessment forms, and all hospital staff dealing with patients are required to receive domestic violence training each year.[187] The number of domestic violence victims identified has increased over the years since the domestic violence protocol and intensive training have been in place.[188]

Also in Buffalo, Millard Fillmore Hospital has social workers or domestic violence counselors available to assist victims 24 hours a day.[189] Patients are not required to accept the counselor's services, but the counselor may offer referral information, notice of victim's rights, and assistance in developing

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[182] Interview with Kathleen Slammon, Domestic Violence Program Director; Expressly for Women, Sisters Hospital in Buffalo, NY (Apr. 7, 1998).

[183] Social workers and domestic violence advocates conduct assessments, offer counseling, make referrals to services, and assist with safety planning. *Id.*

[184] Safe Passage Program brochure, Sisters Healthcare, Expressly for Women.

[185] Interview with Kathleen Slammon, supra note 182.

[186] *Id.*

[187] *Id.*

[188] Currently, the hospital identifies approximately 10-25 domestic violence cases per month. *Id.*

[189] *See* Commission on Domestic Violence Fatalities, *supra* note 23, at 26.

a safety plan prior to discharge.[190] At the Commission on Domestic Violence Fatalities' public hearing in Buffalo, Dr. Margo Krasnoff of Millard Fillmore Hospital testified on the domestic violence protocol implemented at this facility:

> . . . about 35% of victims have initiated contact through the hotline more than once; 26% have obtained and utilized orders of protection; 25% have linked successfully with other community domestic violence providers regarding such issues as jobs and housing; 33% have participated actively in counseling, either individually, in groups or by phone; and 36% have developed action plans to protect themselves and their children in the event of future violence.[191]

Not only have hospitals in Erie County developed individual protocols for domestic violence, but in October of 1995, area hospitals joined with other community service providers to form the Healthcare Emergency Response Violence Intervention Project (HERVIP) in order to establish a county-wide standard of care for domestic violence victims.[192] HERVIP issued its *Domestic*

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[190] *Id.*, at 27.

[191] *Id.*

[192] HERVIP includes Bertrand Chaffee Hospital, Buffalo General Hospital, Children's Hospital of Buffalo, Columbus Hospital, Erie County Medical Center, Kenmore Mercy Hospital, Mercy Hospital of Buffalo, Millard Fillmore Gates Circle Hospital, Millard Fillmore Suburban Hospital, Our Lady of Victory Hospital, St. Joseph Hospital, Sheehan Memorial Hospital, Sisters of Charity Hospital, Crisis Services, Erie County Coordinating Council on Children and Families, Erie County Department of Social Services, Erie County District Attorney's Office, Erie County Sheriff's Department, Haven House, Hispanics United, Northern Erie Clinical Services, Rural/Metro Ambulance, Twin City Ambulance, University of Buffalo School of Law - Family Violence Clinic, United Way of Buffalo and Erie County, and Western New York Health Care Association. The Safe Passage Program of Sisters Hospital, the Domestic

Violence Policy and Procedure for Hospitals in 1997.[193] This document includes guidelines for health care provider intervention, preservation of evidence, safety assessments and planning, documentation, medical photography, and provisions for hospital security.[194] Some hospitals already had a similar protocol in place, and other hospitals are still in the process of approving and adopting the HERVIP protocol.[195]

Although domestic violence protocols in the health care arena are relatively new, there have been some initial efforts to evaluate their effectiveness. One example of this type of research is being conducted at Erie County Medical Center in Buffalo, New York. Erie County Medical Center (ECMC) has a domestic violence protocol in effect for its emergency department. ECMC has received a three year grant from the Department of Health to study the effectiveness of the hospital's domestic violence protocol which includes screening, intervention, and follow-up.[196] Every female patient, ages 18-65, seen in the emergency room is supposed to be asked three questions in order to screen for

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Violence Community Coordinator, and former Legislator Len Lenihan played and instrumental role in HERVIP's formation.

[193] Health Care Emergency Response Violence Intervention Project, *Domestic Violence Policy and Procedure for Hospitals* (1997).

[194] *Id.*

[195] Some smaller, rural hospitals expressed concern about meeting all of the requirements of the protocol. For example, some hospitals may only have one social worker and may not have a security department to meet security needs. Kathleen Slammon of Sisters Hospital stated that each hospital may modify the HERVIP protocol to meet its needs. Interview, *supra* note 182. To date, all hospitals involved with HERVIP, with one exception, have adopted the protocol. The one hospital that has not yet adopted the protocol has agreed to adopt it.

[196] This research is being conducted by Getty Bailey, the Domestic Violence Coordinator at Erie County Medical Center. Interview with Getty Bailey, Domestic Violence Coordinator; Erie County Medical Center in Buffalo, NY (Apr. 20, 1998).

domestic violence.[197] Data is also collected from a number of particular fields in the patient's medical records.[198] Retrospective data from 1996 was used for a baseline.[199] Data collection began in July of 1997 and will continue until the year 2000.[200] The hypothesis to be tested by the study is that with increased training and sensitivity to domestic violence, more domestic violence cases will be identified.[201]

The protocols and initiatives mentioned above are some examples of what the medical profession can offer for victims of domestic violence without the need for mandatory reporting. When implemented properly, these efforts insure that domestic violence is identified, that evidence is documented for future use, and that victims get the help that they need without jeopardizing their safety.

CONCLUSION

Although mandatory reporting laws have been implemented in some states, there is no empirical evidence to support their benefits. In fact, anecdotal evidence suggests that the risk of harm to victims under those laws may outweigh their advantages. Because mandatory reporting laws cannot guarantee women's safety, because they fail to recognize women as autonomous adults, and because they violate the ethical tenets of the medical profession, New York should decline to follow the minority of states that have enacted mandatory reporting statutes. As initiatives in Western New York indicate, the medical profession can become actively involved in eliminating domestic violence without the need for mandatory reporting requirements.

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[197] *Id.*
[198] *Id.*
[199] *Id.*
[200] Interview with Getty Baily, in Buffalo, NY (Apr. 20, 1998).
[201] *Id.*