MANDATORY REPORTING OF DOMESTIC VIOLENCE BY HEALTH CARE PROVIDERS: A POLICY PAPER[*]

PREPARED BY ARIELLA HYMAN, J.D.
FOR THE FAMILY VIOLENCE PREVENTION FUND
November 3, 1997 *(To be shortly updated)*

INTRODUCTION

With the increasing awareness about domestic violence as a health care issue, attention has turned to how healthcare providers can best intervene. Providers need to inquire routinely about domestic violence, provide sensitive and nonpunitive support, address patient safety, document the abuse, and provide information about options and resources. What is not clear, however, is whether providers should be required to bring cases of domestic violence to the attention of state authorities.

The goals potentially served by mandatory reporting include enhancing patient safety, improving health care providers' response to domestic violence, holding batterers accountable, and improving domestic violence data collection and documentation. Upon close examination, however, it becomes apparent that mandatory reporting will not necessarily accomplish these goals. Further, the implications of mandatory reporting for patient health and safety as well as ethical concerns raised by such a policy argues against its general application.

This paper discusses the risks posed to domestic violence survivors by laws mandating health care providers to report instances of domestic violence to the police or other governmental body. It gives an overview of state reporting laws throughout the country. It then sets forth policy recommendations in this area.

[*] This paper borrows generously from the following article by the same author: Hyman A, Schillinger D, Lo B. "Laws mandating reporting of domestic violence: Do they promote patient well-being?" *JAMA.1995*; 273:1781-1787.

Please contact the Family Violence Prevention Fund for reprint permission.

RISKS AND CONSEQUENCES OF MANDATORY REPORTING

Deterrent to Seeking Care

Donna, a client at a domestic violence agency in Gilroy was injured by her partner. She went to the hospital but was afraid to go inside because she was aware of the mandatory reporting law. She spent the night in her car in the hospital parking lot and did not receive necessary medical treatment for the injuries she sustained.[1]

Survivors of domestic violence often need medical care and information (assurances that they are not at fault for the battering); alternatives to returning home; an assessment of the dangers posed by their situation; and referrals for counseling, shelter, and legal services. Many survivors of domestic violence believe that calling the police is not a safe or preferred response to their situation. If they fear that reporting will place them and their children in greater danger, survivors may not seek needed medical care or may not tell their providers about the abuse. Undocumented immigrant battered women are made particularly vulnerable by mandatory reporting and may refrain from seeking care, fearing a call to the police will result in their deportation. The increased anxiety when seeking care and decreased candor with the provider may serve only to jeopardize further the health and safety of survivors and prevent them from obtaining necessary care and information. Furthermore, the goal of holding perpetrators accountable will not be met if survivors refrain from seeking care or being candid with their providers because of the law.

Risk of Retaliation

"I'm sorry, but if my doctor was to call the police and they went to my husband, my husband would have beat the shit out of me.... I don't know, but I don't think a doctor should go over your head, go to the police, it's dangerous..."

"She [the physician] wanted to call the police and I said, 'No, no he is the police'."

- ***Battered women in focus group study***[2]

Mandatory reporting can place survivors of domestic violence at risk of retaliation by the batterers. Violence typically escalates when survivors seek outside help or attempt to separate from the abusers. Moreover, a report to local law enforcement does not guarantee an appropriate response that meets the survivor's safety needs. As the patient knows most intimately, the kind of danger s/he is confronting, s/he should be an integral part of the decision-making process regarding steps to enhance her/his safety.

---

[1] Story appeared in *Mandatory Reporting Stories*, compiled by Ariella Hyman and Pam Wool at the San Francisco Neighborhood Legal Assistance Foundation, in collaboration with the California Alliance Against Domestic Violence.

[2] Mooney D, Rodriguez M. "California healthcare workers and mandatory reporting of intimate violence." *Hastings Women's Law Journal*. Winter 1996;7:85111. See also Rodriguez M, Quiroga S, Bauer H. "Breaking the silence." *Arch Fam Med*. 1996; 5:153158.

May Not Improve Provider Response

It is crucial to increase health care providers' identification and awareness of domestic violence. But is mandatory reporting an effective way to enlist more health care workers in the appropriate care of survivors?

It is doubtful that mandatory reporting enhances provider sensitivity to domestic violence.

Without an understanding of the dynamics of domestic violence and without the proper training on how to respond to the needs of survivors, health care providers may report and respond in ways that can result in increased danger to patients. Provider education about domestic violence is likely a more effective means of enhancing provider sensitivity toward and detection of domestic violence.

Furthermore, it is not the role of the health care system to invoke and foster criminal justice intervention. It would seem that health care providers should present a battered patient with the interventions and referral options available and support the patient in carrying out those s/he thinks are best.

Limited Response to Reports

A woman came into an Emergency Department in Los Angeles with facial injuries. A mandatory report was made to the police, resulting in her husband being arrested in the hospital waiting room. After the patient was finished being treated for her injuries, she went home thinking she was safe. However, her husband had already been released and was home waiting for her. She came back to the Emergency Department later that day "worse off" than she had been on the first visit as a result of her husband's retaliation.[2]

"Each time I have attempted to do this [make a report], the police officers (or sheriff) have gone out to the house and/or contacted the perpetrator resulting in heightened abuse."

- ***Physician in California survey***[3]

What will happen to a report, once made? If there is no effective or safe response system in place, mandatory reporting may create expectations of services and protection that cannot be met, decrease patient trust in the provider and system, and diminish patient safety.

---

[3] Transcripts from survey of physicians in California on mandatory reporting conducted by Dr. Michael Rodriguez, University of California -San Francisco, and Pacific Center for Violence Prevention, San Francisco: Rodriguez, M. "Mandatory Reporting of Domestic Violence: What do Patients and Physicians Think?". October 1997; prepared for the *1997 California Wellness Foundation/ University of California Wellness Lecture Series* under a grant from The California Wellness Foundation; and conversations with Dr. Rodriguez on survey results.

Data Collection

Collecting data to highlight the incidence and prevalence of domestic violence is an important goal. It is unclear, however, whether mandatory reporting by health care providers is an effective way to meet that goal.[4] Noncompliance with reporting requirements may be common, and there is likely a significant unevenness of reporting among individual providers and among health care settings. Accurate and useful statistics could be acquired through specialized studies and in ways that preserve the confidentiality and anonymity of survivors.

Documentation

Documentation of domestic violence is critical. Although mandatory reporting has the potential of achieving useful documentation, it is not a preferred means of accomplishing this goal. Documentation of abuse in the medical record serves the goal of documentation while better preserving privacy and confidentiality. In addition, it is a more reliable source of evidence for legal cases than a reporting form submitted to a state agency. A medical record can provide more thorough, detailed information on the abuse, and can include patient statements and provider observations regarding the abuse, body maps, and a history of the abuse. Additionally, a report to a third party is likely less readily available than a medical record and involves multiple levels of hearsay.

Bias in Reporting

Mandatory reporting of domestic violence may result in biased and inconsistent reporting to police. Studies in the child abuse reporting arena reveal that providers disproportionately report low-income families and persons of color. Racial and class bias in the identification of abuse by providers may also skew data collected through mandatory reporting.

[4] As an example, Connecticut had a statute with a five-year sunset provision, mandating health care providers to report domestic violence cases only for data collection purposes. This provision was allowed to lapse as it did not result in accurate data and was perceived to be serving no useful purpose. (Discussions with Anne Menard, who was the executive director of the CT Coalition Against Domestic Violence during the term in which this provision was in effect.)

ETHICAL ISSUES

In assessing the desirability of mandatory reporting, a number of ethical issues must be examined, including patient autonomy, confidentiality, and informed consent.

Patient Autonomy

Mandatory reporting does not respect the autonomy of survivors of domestic violence. In the medical model of health care delivery, competent and informed patients determine the course of action that is in their best interest. In domestic violence cases, patients are competent adults who should be granted the ability to make critical life decisions; if they believe calling the police will jeopardize their safety, then that opinion should be respected. These types of cases can be distinguished from child abuse cases, where the victim is a minor. Mandatory reporting not only impinges on the patient's self-determination, but in the process perpetuates harmful stereotypes of battered women as passive and helpless. By taking away patient autonomy, mandatory reporting revictimizes battered patients: their relationships with the batterers were ones in which the batterers controlled the decisions in their lives.

Confidentiality

> *"What made it difficult for me to confide was the fact that I feared for my life, you know. And I knew that if I was to tell them what actually happened, that they would call the police and I would have to file a report and they couldn't guarantee me that they would be there 24 hours to protect me from this maniac. So, therefore, I wasn't taking that chance on my life. ... What would make it easier for me would be....to be my choice....[I] f this happened to me but I don't want the police involved, can you please treat me and keep my confidentiality? There's supposed to be a law that they keep confidentiality between the patient and the physician."* - ***Battered woman in focus group study***[2]

Confidentiality and trust are vital to promoting candid discussion and successful intervention in domestic violence cases. Mandatory reporting interferes with the confidential nature of the provider-patient relationship, infringes on patient privacy, may limit the openness and candor of the patient, and undermine her/his trust in the provider. Though confidentiality and privacy rights must be balanced with public policy interests, the benefits derived from mandatory reporting are not sufficiently clear to justify infringements upon these rights.

Informed Consent

Informed consent is a principal tenet of medicine by which providers empower patients to make informed decisions. Mandatory reporting would require the provider to report domestic violence injuries even if the patient does not give his/her consent. Reporting without patient consent raises ethical issues and compromises the integrity of the provider's relationship with his/her patient. Some would argue that providers should put all patients on notice, prior to conducting an examination, that if a determination is made that the patient's injury resulted from domestic violence, the provider is required by law to make a report.

ATTITUDES ABOUT MANDATORY REPORTING

Survivors

It is difficult to measure the impact of mandatory reporting laws on survivors of domestic violence. How does one determine, for example, how many survivors are refraining from seeking care because of the law? There is evidence that at least some battered women find mandatory reporting laws troubling or are harmed by such laws. In 1993-1994, a study was conducted in San Francisco in which fifty-one women with histories of domestic violence, representing four ethnic groups (Caucasian, African American, Asian, and Latina), participated in eight focus groups. The participants were asked to talk about their personal experiences with the health care system and their feelings regarding seeking or avoiding help from medical providers. Many of the participants voiced serious concerns about mandatory reporting to the police and perceived it as an obstacle to care.[2] Additionally, anecdotes collected by the San Francisco Neighborhood Legal Assistance Foundation and the California Alliance Against Domestic Violence demonstrate risks to survivors posed by the California mandatory reporting law.[5] Though there may be survivors who are in favor of mandatory reporting, it is problematic to have a law that places even a few patients at increased risk.

Physicians

> *"Abused women hare had their autonomy taken away by their abusive partners. Forcing me to report her abuse again takes that autonomy and control away from her. She is a better judge than I of the consequences to her of reporting. Morally, it is wrong for me to take that decision away from her. Ethically, it is wrong of me to violate patient-doctor confidentiality. This is a bad law."*
>
> - ***Physician in California survey***[3]

In 1995-1996, California physicians were surveyed who practice in the areas of family medicine, general internal medicine, obstetrics/gynecology, and emergency medicine, on their attitudes and behaviors regarding mandatory reporting. 508 physicians responded to the survey. While recognizing some potential benefits of mandatory reporting, over two-thirds of the respondents believed that reporting domestic violence potentially harms patients and interferes with the patient-physician relationship. The majority of physicians surveyed said that if a patient whom they suspect is suffering from domestic violence related injuries asks them not to make a police report, they would not necessarily make a report in all situations.[3]

---

[5] See footnote 1. One entry involved a larger group of survivors and is worth noting here: Carole Burke, a licensed social worker and therapist in Contra Costa County, discussed the mandatory reporting law with a seventeen-member support group for battered women that she facilitates. The feedback from the group was overwhelmingly negative. They were very dismayed at being "treated as if they were infants and not able to make up their own minds whether to report to the police." They commenced that the mandatory reporting law puts them in jeopardy because all police officers react differently to domestic violence calls. All seventeen members of the group said their injuries would have to be life-threatening before they would go to a doctor again, because of the mandatory reporting law.

Please contact the Family Violence Prevention Fund for reprint permission.

OVERVIEW OF STATE STATUTES[6]

As advocates for domestic violence survivors, health care providers, and legislators attempt to forge a position on mandatory reporting of domestic violence, it is helpful to have a sense of the laws that presently exist around the country. This section provides an overview of state statutes that affect reporting in domestic violence cases. It first summarizes patterns that emerge from such an overview. It then reviews four categories:

1) states that require reporting of injuries caused by weapons;

2) states that mandate reports for injuries caused in violation of criminal laws, as a result of violence, or through nonaccidental means;

3) states that specifically address reporting in domestic violence or adult abuse cases; and

4) states for which our current research could find no relevant reporting statutes.

Summary Questions/Patterns

Upon examining reporting statutes throughout the country, a number of questions and patterns emerge:

***Who Is Required to Report?** Which health care providers are mandated reporters under the reporting laws varies widely from state to state. Some states require only physicians to report while others provide a long list of health care providers who are covered by the stature. A few states mandate "any person" to report in specified situations.[7]

***Who Receives the Report?** Almost all of the state statutes addressing mandatory reporting require that reports be made only to law enforcement, though a few exceptions exist in which reports must be made to a specified state agency, the district attorney, or other designated reportee.

---

[6] This overview does not discuss reporting laws and policies applicable in health facilities in the military, in the Veterans Administration, on Native American reservations, or in the territories. Also not included are laws requiring reporting of burns, poisoning, and suffocation, acts that may be common in domestic violence cases; and statutes relating only to child, elder or vulnerable adult abuse reporting.

[7] Whether health care providers fall within the scope of such statutes can only be assessed after an examination of the interactions between these provisions and the states' provider-patient privileges.

***What Happens to the Report?** Very few reporting statutes specify what is to be done with reports made by health care providers. However, providers who receive reports may be obligated to take certain actions based on other statutory sections or directives.

* **Penalties for Failure to Report and/or Immunity from Liability.** Almost all stares impose penalties for failure to comply with the reporting requirements, and most states provide health care providers with civil and/or criminal immunity from liability that might otherwise be incurred as a result of making a report.

***Provider-Patient Privilege.** Various statutes claim or have been interpreted to suggest that the physician-patient and other provider-patient privileges do not apply to the information required to be reported.

***Purpose of Reporting.** Finally, only a few of the reporting statutes specify what the state's purpose was in enacting the particular reporting requirement.

Deadly Weapons

At least 40 states and the District of Columbia mandate reporting by health care providers in specified instances where the patient has an injury that appears to have been caused by a gun, knife, firearm, or other deadly weapon. States vary as to which deadly weapons trigger the reporting requirement. In some states, the requirement to report deadly weapon injuries applies only if the injury appears intentionally inflicted, criminal in nature, is likely to result in death. [AK, AZ, AR, CA, CO, CT, DE, DC, FL, HI, ID, IL, IN, IA, KS, ME, MA, MI, MN, MS, MO, MT, NV, NH, NJ, NY, NC, ND, OH, OR, PA, RI, SD, TN, TX, UT, VT, VA, WV, WI]

Criminal Law Violation; Violence; Intentional Injuries; Gravity of Injury

At least eighteen states and Washington D.C. require reports when there is reason to believe the patient's injury may have resulted from an illegal act. Some of these states indicate that the reporting requirement applies only to illegal acts rising to certain levels. For example, they specify that the illegal act must have caused serious or grave bodily injury, that there must have been use of a weapon in addition to the illegal act, or that the illegal act must appear to be of a certain nature. [AZ, CA, CO, DC, ID, IL, IA, MA, MN, NE, NH, NC, ND, OH, OK, PA, UT, WV, WI]

At least seven states require health care providers to report injuries that they have reason to believe resulted from an act of violence, with some indicating that the injury must be grave or that the act appear illegal before the requirement to report would apply. [FL, HI, MI, NE, NC, OH, TN]

Finally, at least eight states require reports under circumstances in which the injury appears intentionally inflicted [AK, AR, CO, GA, HI, ID, NV, OR], and in nine states the gravity of the injury is of import to the decision to report. [AK, AZ, HI, IN, IA, KS, NY, NC, OH]

Domestic Violence or Abuse

At least six states have mandatory reporting laws that specifically address domestic violence or adult abuse. These provisions often appear in addition to deadly weapon or illegal act reporting requirements. Five of these states mandate reporting in certain instances of domestic violence, while one exempts victims of abuse from its general mandate to report certain injuries. [CA, CO, KY, NH, NM, RI] The following are examples of these statutes:[8]

CALIFORNIA: Health practitioners must report to the police if they provide medical services to a patient whom they know or reasonably suspect is suffering from a physical injury that was caused by a firearm or by "assaultive or abusive conduct" (defined to include twenty-four crimes). It is recommended that referrals to local services be given to domestic violence victims and that providers thoroughly document domestic violence in the medical record.

COLORADO: Physicians are required to report to law enforcement if they attend or treat an injury caused by a weapon or an injury they have reason to believe involves a criminal act "including injuries resulting from domestic violence."

KENTUCKY: Any person having reasonable cause to suspect that an adult has suffered abuse, neglect, or exploitation, shall report to the Cabinet for Human Resources. The Cabinet must notify police, initiate an investigation of the complaint, and make a written report of findings and recommendations. The Cabinet is allowed access to mental and physical health records of the adult if necessary to complete the investigation. The Cabinet can enter the private premises of the adult to investigate the need for protective services. If the adult does not consent, a search warrant may be issued upon a showing of probable cause of abuse. If a determination is made that protective services are necessary, the Cabinet shall provide such services except where the adult refuses them.

NEW HAMPSHIRE: A person treating or assisting another for a gunshot wound or any other injury believed to be caused by a criminal act is required to report, except if the injured person has been a victim of sexual assault or abuse, is over eighteen years of age, and objects to the release of this information to law enforcement. This exception does not apply if the person is also being treated for a gunshot wound or other serious bodily injury.

RHODE ISLAND: In addition to a deadly weapon reporting provision, the statute requires medical providers to report domestic violence related injuries only for data collection purposes. The reports are not to contain names or any identifying information. The domestic violence data is to be compiled and reported annually by the domestic violence training and monitoring unit of the court system.[9]

---

[8] These are brief, simplified summaries. The reader should see the full text of the statutes for complete information.

[9] The statute requires the unit to compile reports only for five years following October 1, 1988.

Voluntary Reporting

Though this paper reviews only mandates to report, note that a few states have voluntary reporting provisions where abuse is concerned. For example, a recently enacted Tennessee provision encourages health care providers voluntarily to report injuries due to domestic violence on a monthly basis to the Department of Health, Office of Health Statistics. The report is not to reveal the name or identification of the patient, in recognition of the importance of confidentiality, of safeguarding against retaliation, and of encouraging abuse survivors to seek care. Laws in Mississippi and Pennsylvania specify that any person may report abuse.

No Statutes Found

Our current research has not been able to locate reporting requirements for health care workers in the following five states: Alabama, Louisiana, South Carolina, Washington, and Wyoming.

POLICY DIRECTIONS: RECOMMENDATIONS FOR HEALTH CARE FACILITIES AND INSTITUTIONS

Minimizing Harms to Patient Under Current Laws

Health care providers and institutions must strive to minimize the harm to the abused patient under current mandatory reporting laws. Health care facilities should ensure that their domestic violence protocols and trainings address, at a minimum, the following issues regarding reporting:

1. Most important is the recognition that the critical intervention is not the report, but providing ongoing and supportive care, addressing safety issues, and guiding the patient through the available options. Providers need to understand that the legal report is only one small piece or a much larger intervention and should be carried out with the utmost caution.

2. Discussing with the patient the obligation to report. (Whether there is an ethical obligation to inform patients prior to taking a history or conducting an exam about the reporting law is an area that needs further exploration. Health care providers and institutions might consult with medical ethicists on this issue.)

3. Learning how authorities respond to reports and explaining this to patients so they know what to expect.

4. The need to address the potential risk of retaliation and precautionary measures, such as seeking shelter or obtaining restraining orders when the report is made.

5. How to work with the patient and the authorities to meet patient needs when reporting.

6. Maximizing the role of the patient's input regarding future action.

7. Working with community advocates for survivors of domestic violence and authorities to implement a process for responding to reports that enhances patient safety and autonomy, and to address problems that arise in response to reports.

Understanding Interactions with Other Protocols and Laws

Certain institutional protocols and state laws concerning domestic violence may interact with mandatory reporting in ways that have the potential to harm survivors of domestic violence. Health care institutions should be aware of these intersections so that they may consider steps to address problems that arise. Below are examples:

1. **Assessment:** Suppose a health care facility located in a state that mandates reporting of domestic violence injuries adopts a protocol requiring health care providers to assess for domestic violence. Once a survivor is detected through assessment, the reporting law may mandate a report to state authorities even without the patient's support. As the adoption of the assessment protocol may inadvertently facilitate enhanced reporting, it may have the unintended effect of scaring survivors away from the health facility. This may particularly be the case when the institution believes it has an ethical duty to inform patients subject to assessment of the existence of the reporting law.[10] The health care provider is also placed in an uncomfortable position: s/he may want to assess for domestic violence but may not want to have to breach confidentiality and act against a patient's will.

2. **Insurance discrimination:** A number of insurance companies have been denying health insurance coverage to patients who are or have been victims of domestic violence. Advocates for survivors have protested these policies, and a number of states now have laws forbidding such practices. If your state still has insurance laws or policies that discriminate against survivors of abuse, it is important to understand their implications for medical record documentation and reporting. Namely, the documentation that results from reporting a particular patient or noting the abuse in the patient's medical record may provide the insurance company with the basis for denying that patient coverage.

Engaging in Public Policy

Health care providers and institutions might engage in policy debates in their communities regarding mandatory reporting and challenge legislation that jeopardizes the well-being of their patients. Collaborating with and seeking input from advocates for survivors of domestic violence around policy issues is critical.

RECOMMENDATIONS FOR LEGISLATIVE ACTION

---

[10] "See remarks of Penny Ablin, M.D., in “Domestic violence reporting law: a hazard or a help to patients/victims?” *California Physician Magazine*. August 1996; 24—32 (Anecdotal evidence that publicity of hospital's screening protocols and the reporting law has resulted in fewer women disclosing abuse in the emergency room.)

Revising Your Mandatory Reporting Statute

For the reasons set forth in this paper, mandatory reporting by health care providers of survivors of domestic violence is a policy that should be avoided. Working toward legislative reform in this area is quite challenging, however, as in almost all states there is already some sort of reporting law in place. Depending on the nature of the existing law, different issues will need to be explored. These might include the following:

1. **If no current law:** If yours is one of the few states with no reporting requirements (other than child, elder, or vulnerable adult abuse reporting), it seems best to oppose the adoption of any new laws that would mandate reporting of adult survivors of domestic violence. Given the safety risks to survivors, the medical ethics considerations, and the fact that mandatory reporting laws are of unproven value, doing otherwise would seem unwise policy. This is especially the case for laws that require reports to include the identity of the patient.

2. **If deadly weapon law:** Although mandatory reporting in all cases is problematic, are there instances of such a grave nature in which reporting is warranted? For example, weapon injuries may indicate particular danger and therefore one might consider leaving unchanged an existing weapon reporting provision. On the other hand, it may be precisely in the most dangerous cases that a survivor's autonomy needs to be respected to best enhance her/his safety. Furthermore, unless "weapon" is limited, for example, to firearms, it may be interpreted so broadly as to subsume virtually all cases (i.e., some might define a fist as a weapon).

3. **If criminal/illegal act reporting:** If your state requires reports of injuries resulting from criminal acts, injuries due to domestic violence are clearly subject to the mandate. Some may feel uncomfortable exempting survivors from such a law, thereby treating domestic violence differently from other crimes. On the other hand, survivors do require particular advocacy and protection because of such factors as ongoing contact with the perpetrator, economic dependence on the perpetrator, and a higher risk of retaliatory violence.

   If your state requires reports of injuries due to criminal acts, you might consider several approaches. Each of these approaches can be made to apply either to all competent adults or only to domestic violence survivors:

   • Argue for the provision's repeal (for survivors of domestic violence or for all competent adults).
   • Maintain the mandate but insert a patient consent provision, such as, "injuries (due to domestic violence) shall not be reported unless the patient consents to a report being made."
   • Maintain the mandate to report unless the patient objects, such as, "injuries due to criminal acts shall be reported except if the patient (is a victim of domestic violence and) objects to a report being made. The health care provider must inform the patient of the right to object."

Although repealing a harmful provision may be the cleanest approach, maintaining the mandate may be, in some instances, more politically feasible. Additionally, the latter two approaches may indirectly help achieve another goal: encouraging providers to discuss with their patients the option of calling the police.

As in the deadly weapon context discussed above, the question arises as to whether the mandate should be maintained for certain injuries of a particularly grave nature. Can "grave" be defined in a way that does not subsume all cases, and that health providers will evenly apply? Should not the survivor's voice, especially in grave injury cases, be an integral part of the decision making in her case? For those considering a mandate in serious injury cases, it seems imperative to use a term such as "life-threatening" injury, which is both limited and conducive to more uniform application.

4. **Role of report recipient:** One might also amend the provision regarding who receives the report and what that party is obligated to do with it. For example, it may be specified that the agency receiving a report may, where safe, offer the patient information about options and assist the patient with pursuing those that are desirable, but that no measures will be imposed on the patient against her/his will. Training for agency employees on domestic violence and on how to contact the patient safely is a necessary part of such legislation.

5. **No identity of victim:** Another strategy is to require or allow anonymous reporting of survivors of domestic violence, with no provision of information being provided concerning the name or identification of the patient. Such reports might be used for surveillance by public health agencies for the purpose of improving intervention strategies. The information might also be used for data collection, but the experiences of Connecticut and Rhode Island with such statutes should first be reviewed.[4]

Policy Alternatives to Mandatory Reporting

It is clear that health care providers and institutions must play a role in the area of domestic violence. If reporting is not mandated, should any other legal interventions be considered? Educating health care providers about domestic violence is clearly the most important means of enhancing the health care system's response to domestic violence. Domestic violence education might be mandated in schools for health professionals or linked to licensure or funding eligibility. Other legislative proposals might include mandating health care facilities to implement domestic violence protocols regarding screening, safety assessment, documentation, and referrals. Requiring health care providers to offer patients referrals or certain options, including the option to call the police, might be considered. Whatever the approach, it is crucial that legislation be designed or amended with the utmost caution so as to avoid unintended and harmful consequences for survivors of domestic violence. Policy decisions should be informed by the views and experiences of survivors of domestic violence and their advocates. Legislative proposals should be examined to assess whether they enhance the quality of care offered survivors within the health care setting, respect the patient's autonomy and judgments about safety, and reduce the risk that the patient will refrain from seeking care.

Recommendations for Health Associations

Local, state, and national health associations can play a key role in effecting policy change. For example, they can pass resolutions in support of preferred policies relating to domestic violence and in opposition to policies that jeopardize the well-being of patients who are survivors. In this way, they can both enhance awareness among their membership and influence local, state, and federal legislation. A number of health associations have already adopted stances opposing mandatory reporting, including the American Medical Association, the American College of Emergency Physicians, the American Association of Women Emergency Physicians, the American College of Nurse-Midwives, and the California Medical Association.[11] Health associations can also distribute information to educate members on the risks of mandatory reporting and the importance of minimizing harms to the patient when complying with existing laws.

CONCLUSION

Mandatory reporting falls short of accomplishing the purported goals of enhancing patient safety and care, improving health care providers' response to domestic violence, holding perpetrators accountable, and increasing data collection and documentation. It also raises serious ethical concerns. The crisis of domestic violence requires a careful, well-conceived, effective response. Until further study demonstrates otherwise, there is ample reason to believe that mandatory reporting of all injuries due to domestic violence represents a threat to the health and safety of survivors of domestic violence. Health care providers and institutions need to strive to minimize harms to the patient under current laws. Advocates for survivors, health care providers, and others engaged in public policy should work together to consider legislative efforts to minimize risks to survivors posed by mandatory reporting laws. Education must be the focus of any attempt to combat domestic violence and must be the centerpiece of our efforts.

[11] The California Medical Association's resolution supports mandatory reporting except where the patient objects to a report being made.