

Virtual Mentor

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JOURNAL DISCUSSION

Against the Mandatory Reporting of Intimate Partner Violence

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Iavicoli LG. Mandatory reporting of domestic violence: the law, friend or foe? *Mt Sinai J Med.* 2005;72(4):228-231.

For many victims of intimate partner violence (IPV), a visit to the doctor may be the only opportunity for professional intervention. It is therefore incumbent upon health care practitioners to recognize this form of violence and act in the best interest of the patient. The physical and psychological sequelae of intimate partner abuse are profound. Beyond traumatic injuries, battered women suffer from chronic pain, frequent headaches, stomach ulcers, spastic colon, stammering, and other neurological and gastrointestinal disorders [1]. They experience a significantly higher prevalence of major depression and PTSD, along with more anxiety, insomnia, and social dysfunction than those not abused [2, 3]. The 40 to 45 percent of battered women who experience both physical and sexual abuse are at an even higher risk for a host of gynecological problems, including sexually transmitted infections, vaginal bleeding, chronic pelvic pain, and urinary-tract infections [3].

The U.S. Department of Justice found in a national survey that 25 percent of women were raped, physically assaulted, or both by a current or former spouse, cohabiting partner, or date in their lifetime, 1.5 percent of them within the year. This translates to an estimated 1.5 million women being raped or physically assaulted by an intimate partner annually. Men, too, are victims, though to a lesser degree. The same survey estimates some 834,700 men are raped, physically assaulted, or both by an intimate partner each year in the United States [4]. In response to what Surgeon General C. Everett Koop once declared a national epidemic, policy makers in six states—California, Colorado, Kentucky, New Hampshire, New Mexico, and Rhode Island—have mandated that physicians report their suspicion of intimate partner abuse to a law-enforcement agency, even over the protests of the victim involved.

Many in the medical community oppose such a mandate, arguing that reporting might not always be in the best interest of the patient, and, when mandated to act against his or her clinical judgment, the physician might end up causing more harm than good. In “Mandatory Reporting of Domestic Violence: The Law, Friend or Foe?” Laura Iavicoli, MD, summarizes the arguments and evidence for and against mandatory reporting and concludes that more research is needed on the impact of existing laws on survivors of abuse before the debate can be resolved [5]. To date, anecdotal evidence abounds on both sides, the relatively limited data are

inconsistent, and no clear consensus has been reached. In lieu of more data, a thorough analysis of the argument seems warranted.

In general, victims of intimate partner abuse in a health care setting can be grouped into one of three categories:

- Those seeking legal intervention.
- Those seeking professional advice short of legal intervention.
- Those seeking medical care only.

Victims in the first category would seem to benefit from mandatory reporting. As proponents of mandatory reporting have argued, medical documentation of injuries would strengthen the legal case against the perpetrator, aid law-enforcement officials in the prosecution of the perpetrator, and remove the responsibility of contacting law enforcement from the victim [6]. For those seeking legal intervention, these benefits can be had without instituting a policy of mandatory reporting. As Iavicoli points out, the American Medical Association proposed that mandatory reporting statutes include an opt-out clause for competent adults, thus allowing clinicians to facilitate all of the above benefits for willing patients without having to betray the wishes and confidentiality of those who do not want their cases reported.

Proponents of mandatory reporting argue, however, that it permits collection of incidence and prevalence data, improves health care providers' response to and identification of abuse, and makes clear that intimate partner violence will not be condoned [6]. While important to society, these and other benefits must not obscure the physician's duty to the health and safety of the victims. Certainly, mandatory reporting infringes on the autonomy of the victim, can strain the patient-doctor relationship, and, in some instances, can place the victim in danger of retaliatory violence from the perpetrator. Above all, mandatory reporting might result in fewer victims admitting to abuse, perhaps even fewer seeking medical care.

It can be reasonably assumed that victims in the latter two categories, those seeking professional advice short of legal intervention and those seeking medical care only, would be less inclined to admit to IPV (or even seek medical care) if mandatory reporting laws required physicians to pursue legal intervention. Particularly problematic are those who would benefit greatly from professional advice and social support services, but would nonetheless be deterred by an inflexible mandate. Ultimately, mandatory reporting might result in lost opportunities for medical intervention, if victims were to avoid disclosing abuse for fear that it might place them in an intractable situation.

Iavicoli cites a study that supports this conclusion. Gielen et al. found that, of the 202 abused and 240 nonabused women they interviewed, two-thirds felt that mandatory reporting would decrease women's likelihood of disclosing their abuse to their health care provider [7]. Of the abused women who did not disclose their abuse, 71 percent felt they would be less likely to do so under a policy of mandatory reporting.

Saliently, 74.5 percent of the abused women who did disclose IPV to their medical caregiver found it was either somewhat or entirely helpful.

Thus, the unintended tragedy of mandatory reporting may be that, instead of facilitating intervention for victims of intimate partner violence, this policy might drive victims away from those who could help. As many have noted, the medical professional is often the last resort for victims, and a victim can gain a great deal of assistance and professional counsel from this source. Education, counseling, referrals to shelters and legal services, even law enforcement, are levels of intervention that a physician can facilitate—but only if a patient is willing to disclose IPV, and the physician is flexible enough to act on sound clinical judgment. On these grounds, reports of IPV to legal authorities should only be made with the victim's consent. Preserving the chance for any level of intervention is surely better than risking no intervention at all.

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