Mandatory Reporting of Domestic Violence Injuries to the Police
What Do Emergency Department Patients Think?

Michael A. Rodríguez, MD, MPH
Elizabeth McLoughlin, ScD
Gregory Nah, MS
Jacquelyn C. Campbell, PhD, RN, FAAN

Most states require clinicians to report to police injuries due to violence, criminal acts, or deadly weapons. From 1991 to 1994, California, Colorado, Rhode Island, and Kentucky passed various forms of mandatory reporting laws requiring health care professionals to report intimate partner violence (IPV) to the police. Since 1994, California has required clinicians to report to police suspected IPV-related injuries, even if this is contrary to patient wishes. Noncomplying clinicians face penalties of fines up to $1000 and/or jail sentences of up to 6 months in California. The law does not specify how police should respond, local jurisdictions vary in response, and the degree of enforcement is unknown.

Mandatory reporting is controversial among clinicians, patients, and domestic violence prevention advocates. Supporters of the policy argue that it will facilitate the prosecution of batterers, encourage health care clinicians to identify domestic violence, and improve data collection. Opponents believe it may increase violence by the perpetrators, diminish patients’ autonomy, and compromise patient-clinician confidentiality. Mandatory reporting laws are not affected by the new Federal Medical Privacy Protections for Victims of Domestic Violence because they fall under the provision relating to disclosures required by law. The National Resource Council has recommended a moratorium on such laws until more research is conducted on the advantages and disadvantages of mandatory reporting policies for domestic violence.

While patients frequently look to police for help during acute episodes of violence, clinician reporting to police may raise fears of increased violence, loss of control, and family separation, all of which may lead some abused patients to avoid seeking help from health care providers. The efficacy of mandatory reporting of domestic violence to police should be further assessed, and policymakers should consider options that include consent of patients before wider implementation.
care clinicians. Two recent studies have found that some women may be supportive of mandatory reporting policies. However, another study reports that a majority of abused patients are opposed to mandatory reporting of IPV to police. A Colorado study found that 9% of female patient respondents were less likely to seek medical care as a result of mandatory reporting. Limitations of these studies include low response rates, small sample sizes, or samples primarily from states where specific domestic violence mandatory reporting laws do not exist. An evaluation of an emergency department intervention to improve the health system response to abused patients permitted us to survey a large random sample of female patients in California and Pennsylvania about mandatory reporting. Unlike California, Pennsylvania does not have a specific law that mandates clinicians to report IPV to police.

**METHODS**

The patient survey was part of an emergency department IPV intervention study and involved 12 emergency departments, randomly drawn from all midsized hospitals (20,000–40,000 patient visits annually) within 160 km of San Francisco, Calif, and Pittsburgh, Pa. In contrast to previous published analyses of 3 waves of data collection for 11 of these 12 emergency departments, this study used only the third wave of patient surveys from all 12 emergency departments. Response rates had improved for that wave and the questions on mandatory reporting had been revised to allow for better assessment of patient preferences. We attempted to survey 1672 patients during 8-hour and 12-hour evening shifts between Friday and Tuesday to obtain representation from weekday and weekend shifts. We excluded patients too ill to respond to questions and those never left alone by accompanying persons. The institutional review boards at the coordinating institutions in Pennsylvania and California approved the study. Signed consent forms were waived by the institutional review boards and oral consent was obtained. The patients were informed that the questionnaire was anonymous and voluntary, had no impact on the care they would receive, and would not be seen by the clinicians treating them that day.

We analyzed the data using univariate and logistic regression analysis. For cross-tabulation, mandatory reporting attitudinal responses were dichotomized into “report always” (support vs “report never” or “only with patient consent” (oppose). Predictor variables included age, race, primary language spoken at home, total family income per month, relationship status, and partner violence in the past year. Statistical significance was determined by Pearson χ² statistical test with a 2-tailed P value of less than .05. We generated adjusted odds ratios (ORs) and 95% confidence intervals (CIs) for factors independently associated with opposition to mandatory reporting. All statistical analyses were conducted using SAS version 8 software (SAS Institute Inc, Cary, NC).

**RESULTS**

A total of 1218 eligible emergency department patients responded to the Patient Satisfaction and Safety Survey (response rate, 72.8%). Overall, the response rates for respondents who answered the question on mandatory reporting and completed information on each characteristic ranged from 67.3% to 70.2%. There were no significant state-specific differences in response to the survey attitudinal questions, including support for or opposition to mandatory reporting laws. Overall, 12.0% of respondents (n = 140) reported being physically abused or forced to have sexual activities in the previous year.

Among the abused respondents, 44.3% (n = 62) opposed mandatory reporting of domestic violence to police (36.4% [n = 51] supported reporting but only with patient consent; 7.9% [n = 11] thought that physicians should never report to police), while 55.7% (n = 78) supported mandatory reporting. Of nonabused respondents 70.7% (n = 728) reported higher levels of support for the policy, while 29.3% (n = 301) opposed the law (25.7% [n = 264] favored reporting with consent; 3.6% [n = 37] preferred physicians never to report, P < .001).

Women who opposed the mandatory reporting policy tended to be young (34.3% of 18–39 years old vs 28.3% of those > 40 years old, P = .03); nonwhite (35.9% of nonwhite patients vs 29.0% of white patients, P = .02); non-English speakers at home (41.7% of non-English speakers vs 30.3% of primary English speakers, P = .04); and abused (44.3% of those reporting abuse in the past year vs 29.2% of those reporting no abuse, P = .001) (TABLE). Opposition to the policy did not differ significantly by relationship status, total family income per month, or state (California vs Pennsylvania).

Based on regression analysis, the following factors were independently pre-
dective of favoring nonreporting when a patient objects: (1) physical abuse in the last year (adjusted OR, 2.2; 95% CI, 1.6-2.9); (2) non-English spoken at home (adjusted OR, 2.1; 95% CI, 1.4-3.0); and (3) currently seeing/living with a partner (adjusted OR, 1.5; 95% CI, 1.1-2.0).

**COMMENT**

In this study, 44.3% of recently abused female emergency department patients do not support mandatory reporting of domestic violence to police. Possible reasons for such opposition include fear of retaliation by the abuser, fear of family separation, mistrust of the legal system, and preference for confidentiality and autonomy in the patient-clinician relationship. Yet, our study also demonstrated that a higher percentage (55.7%) of recently abused female emergency department patients do support mandatory reporting. This may be due to desires for enhanced safety and relief from the onus of making a police report.

Many patients supported IPV reporting policies that take into consideration patients’ preferences. For example, of the 44.3% of women with recent histories of abuse who opposed mandatory reporting, the very women who would potentially be reported to police, the majority selected the response indicating support for reporting to police unless the patient objects. Further research with abused women is needed to distinguish their preferences among several options: (1) a law requiring reporting unless the patient objects; (2) a reporting law that requires patient consent; or (3) no reporting laws but physician responsiveness to IPV and assistance with criminal justice interventions when desired.

Similar to the women with recent histories of abuse, 41.7% of women who were primarily non-English speakers were opposed to mandatory reporting. These findings are consistent with previous qualitative research in which abused women expressed the belief that they should control the decisions to involve the police. Another study has explored sociopolitical factors that hinder abused immigrant women from seeking help, including social isolation, language barriers, and fear of deportation. Because the impact of police involvement in immigrant women’s lives may be different than for US-born women, changes in welfare and immigration laws may interact with this policy, resulting in further disempowerment of the female patient. Given the attitudes expressed by the respondents in these studies, it is unclear whether mandatory reporting will help recent IPV survivors or put them at risk for further violence. One clinical alternative is to encourage the assessment of danger that can help women and clinicians assess safety, yet leave the final decision as to whether to call the police with the patient.

Physicians’ attitudes regarding mandatory reporting have varied. In a previous survey of physicians in California, 53% to 85% responded that such policies could prevent women from seeking medical care, provoke retaliation, or compromise confidentiality and autonomy. In the same survey, 53% to 86% believed that these policies can increase recognition and responsiveness to domestic violence, as well as improve and increase documentation and collection of statistics.

One limitation of our study is that we only surveyed patients seeking care at emergency departments. Therefore, we missed IPV survivors who may have been deferred from seeking help for reasons that include fear they may be reported to the police. This limitation would have the impact of underestimating the degree of opposition among abused women to laws that mandate reporting IPV to police.

Further research on mandatory reporting is needed to address the preferences of those in abusive relationships. Research should also track patient and clinician outcomes in other states that require reporting IPV to pol-

---

**Table.** Characteristics of Respondents and Factors Associated With Opposition to and Support for Mandatory Reporting of Intimate Partner Violence to Police (N = 1218)*

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Opposed to Mandatory Reporting</th>
<th>Support for Mandatory Reporting</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age group, y (n = 1158)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-39</td>
<td>536</td>
<td>12.4% (0.02)</td>
<td>34.3% (0.04)</td>
</tr>
<tr>
<td>≥40</td>
<td>622</td>
<td>17.7% (0.03)</td>
<td>28.3% (0.03)</td>
</tr>
<tr>
<td>Race (n = 1170)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>825</td>
<td>15.9% (0.03)</td>
<td>29.0% (0.03)</td>
</tr>
<tr>
<td>Nonwhite</td>
<td>345</td>
<td>9.4% (0.03)</td>
<td>35.9% (0.04)</td>
</tr>
<tr>
<td>Primary language spoken at home (n = 1174)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>English</td>
<td>1102</td>
<td>11.8% (0.02)</td>
<td>30.3% (0.03)</td>
</tr>
<tr>
<td>Non-English</td>
<td>72</td>
<td>7.7% (0.02)</td>
<td>41.7% (0.05)</td>
</tr>
<tr>
<td>Total family income per month (n = 1126)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;$1000</td>
<td>456</td>
<td>17.8% (0.02)</td>
<td>33.1% (0.04)</td>
</tr>
<tr>
<td>≥$1000</td>
<td>670</td>
<td>15.6% (0.03)</td>
<td>29.5% (0.03)</td>
</tr>
<tr>
<td>Relationship status (n = 1140)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>With partner</td>
<td>711</td>
<td>12.4% (0.02)</td>
<td>32.8% (0.03)</td>
</tr>
<tr>
<td>Without partner</td>
<td>429</td>
<td>9.8% (0.03)</td>
<td>27.5% (0.04)</td>
</tr>
<tr>
<td>Past year physical or sexual abuse (n = 1169)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>140</td>
<td>12.0% (0.03)</td>
<td>44.3% (0.06)</td>
</tr>
<tr>
<td>No</td>
<td>1029</td>
<td>8.8% (0.01)</td>
<td>29.3% (0.03)</td>
</tr>
<tr>
<td>State (n = 1174)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>California</td>
<td>592</td>
<td>10.2% (0.02)</td>
<td>31.6% (0.03)</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>582</td>
<td>9.6% (0.02)</td>
<td>30.4% (0.03)</td>
</tr>
</tbody>
</table>

*The number of respondents who answered the question on mandatory reporting and completed information on each characteristic ranged from 1126 to 1174 (67.3%-70.2%).

©2001 American Medical Association. All rights reserved.
lice. Lacking answers to these concerns, our research suggests that policymakers should consider development of IPV reporting policy options that combine respect for patient autonomy with the greatest potential for protection from abuse.

Author Contributions: Study concept and design: Rodriguez, McLoughlin, Nah, Campbell.
Analysis and interpretation of data: Rodriguez, McLoughlin, Nah, Campbell.
Drafting of the manuscript: Rodriguez, McLoughlin.
Critical revision of the manuscript for important intellectual content: Rodriguez, McLoughlin, Nah, Campbell.
Statistical expertise: Nah.
Obtained funding: McLoughlin, Campbell.
Administrative, technical, or material support: Rodriguez, McLoughlin.
Study supervision: Rodriguez, McLoughlin, Campbell.
Funding/Support: This work was supported by the American Academy of Family Physicians Advanced Research Training Program, grant R49 CCR 903697.11 from the San Francisco Centers for Disease Control Injury Center, Picker-Commonwealth Scholars Program (Commonwealth Fund, New York, NY), and grant R49 CCR 310553 from the Centers for Disease Control and Prevention National Center for Injury Prevention and Control.

Acknowledgment: We are indebted to the patients from emergency departments in California and Pennsylvania who generously shared their experiences and opinions. We also acknowledge Karen Goodrich, MD, and Nancy Glass, RN, M PH, PhD, for manuscript assistance.

REFERENCES

Hot lead can be almost as effective coming from a lithotype as from a firearm.
—John O’Hara (1905-1970)