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Mandatory Reporting of Intimate Partner Violence to Police: Views of Physicians in California

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ABSTRACT

Objectives. This study examined physicians' perspectives on mandatory reporting of intimate partner violence to police.

Methods. We surveyed a stratified random sample of California physicians practicing emergency, family, and internal medicine and obstetrics/gynecology.

Results. An estimated 59% of California primary care and emergency physicians (n = 508, 71% response rate) reported that they might not comply with the reporting law if a patient objects. Primary care physicians reported lower compliance. Most physicians agreed that the legislation has potential risks, raises ethical concerns, and may provide benefits.

Conclusions. Physicians' stated noncompliance and perceived negative consequences raise the possibility that California's mandatory reporting law is problematic and ineffective. (*Am J Public Health.* 1999;89:575–578)

As intimate partner abuse gains visibility as a public health problem,[1,2] the medical community has worked to increase sensitivity to abused patients and to improve detection and assessment.[3–5] Because of the frequent use of medical services by abuse victims, health care providers are in a unique position to assist these patients.[6–8] Most states require health care providers to report injuries involving a weapon or criminal act; however, 6 states (California, Colorado, Kentucky, New Hampshire, New Mexico, and Rhode Island) have laws that specifically address reporting suspected cases of intimate partner violence. Whereas most of these states have provisions for protecting victim identity, obtaining informed consent, or reporting to social service agencies, California's law, effective January 1994,[9] requires reporting identifying information to police whether or not the patient consents.[10]

In general, these reporting laws differ from those pertaining to child or elder abuse because the victims are presumed to be competent, nondependent adults. While the California law has generated controversy and opposition,[9,11–14] few studies have evaluated the impact of this legislation on the health care community and victims of intimate partner violence.[15,16] We surveyed physicians in California to assess the law's potential impact on physician practice and to determine the factors that influence physicians' willingness to report to police.

Methods

From the California Medical Association database of licensed California physicians (members and nonmembers), we selected a stratified random sample of 1200 physicians. We drew 300 physicians each from emergency medicine, family medicine, general internal medicine, and obstetrics/gynecology. These specialties were selected because they serve as initial points of access to the health care system for most adult patients. To examine the effect of gender, women physicians were sampled at 1.5 times their proportion in each specialty. We excluded physicians who were retired, in training, practicing outside the state, who were primarily involved in administration, teaching, or research, or who lacked a valid California phone number or address. Recruitment started in July 1995 and involved 3 mailings of the coded questionnaire with telephone follow-up.

The questionnaire content included knowledge of and tendency to comply with the mandatory reporting law, attitudes about

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TABLE 1—Characteristics of Physician Participants (n = 508) and Their Experience with Intimate Partner Violence

Characteristic	Emergency Medicine (n = 108)	Family Medicine (n = 149)	Internal Medicine (n = 115)	Obstetrics and Gynecology (n = 136)	P[a]
Mean age, y (SD)	44.4 (7.4)	45.3 (10.1)	44.4 (10.8)	48.2 (10.1)	.005[b]
Women, %	23	40	41	44	.005
Ethnicity, %					.080
White	81	72	70	73	
Asian/Pacific Islander	7	16	23	17	
Hispanic/Black/other	12	12	7	10	
Practice setting, %					<.001
Hospital	55	1	1	2	
HMO	14	16	23	17	
Private clinic	7	58	50	68	
Other/mixed[c]	25	26	27	13	
Non-US training, %	4	24	12	22	<.001
Aware of law, %	86	67	65	61	<.001
Patient with abuse, %	99	90	74	80	<.001
Recent course on DV, %	45	30	19	24	<.001

Note. HMO = health maintenance organization; DV = domestic violence.
[a]*P* values were derived by Pearson χ^2 unless otherwise specified.
[b]Calculated by ANOVA comparison of means.
[c]Other settings included academic, community, and government/military clinics.

the law, and demographic data. To assess physicians' tendency to comply with the law, respondents were presented with 2 scenarios: "A patient asks me not to report, but I suspect that s/he is suffering from domestic violence–related injuries" and "A patient does not express a preference one way or the other for filing a police report, but I suspect s/he is suffering from domestic violence–related injuries." For each scenario, respondents were asked if they would report in all situations, some situations, or none. To measure attitudes about the law and circumstances appropriate for reporting, respondents were presented with multiple statements and asked to indicate their agreement on a 4-point scale.

Survey data were analyzed with SPSS statistical software.[17] Frequency data were stratified by medical specialty. For analysis of attitude questions, responses were dichotomized into agree vs disagree. Reported compliance with the law was dichotomized into reporting in all situations (compliance) vs reporting in some or no situations (noncompliance). Analysis of variance (ANOVA) was used for statistical comparison of means. For cross tabulations, statistical significance was determined by Pearson χ^2 and defined as $P < .05$. Physicians' reported noncompliance in the face of a patient's objection was chosen as the main outcome variable because this scenario encompasses the conflict between following a legal mandate and upholding ethical standards. To estimate reported noncompliance for the 4 sampled specialties in California, weighted proportions were calculated by the inverse of the sample fraction for each of the 8 gender/specialty strata. Logistic regression was used to estimate adjusted odds ratios for the variables associated with noncompliance.

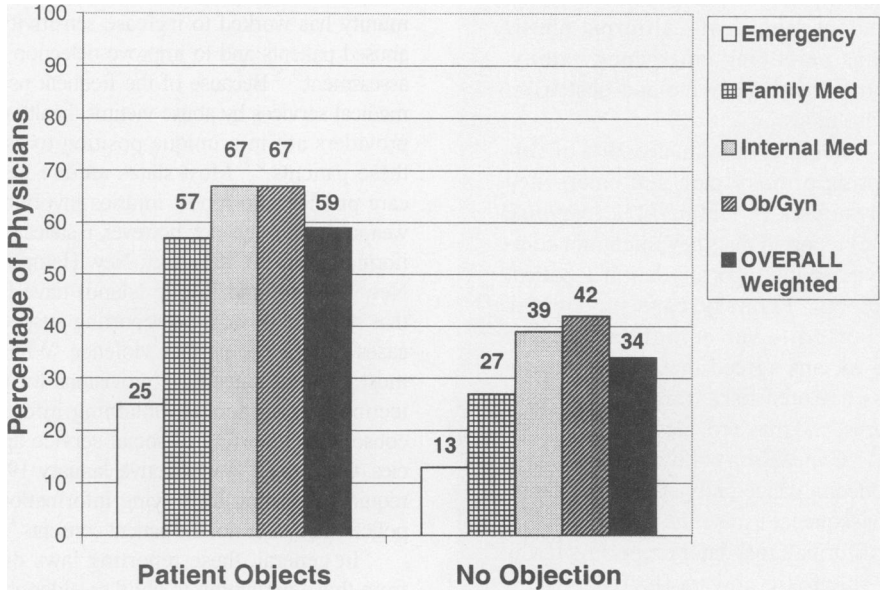

FIGURE 1—Proportion of physicians who would not report intimate partner violence to police in all cases, according to whether the patient objected.

Results

Of the original 1200 physicians sampled, 715 physicians were eligible for the study; of these, 508 (71%) completed the survey. Characteristics of the study population are presented in Table 1. The overall age range was 29 to 83 years. Compared with men, women physicians were younger (mean age, 41.8 years [SD = 7.3] vs 48.0 years [SD = 10.4]; $P < .001$). Most physicians in all 4 specialties had prior knowledge of mandatory reporting legislation (61%–86%) and had identified a patient experiencing partner violence (74%–99%); only 19% to 44% reported having taken a domestic violence

course within the previous 3 years. For each of these categories, emergency physicians showed significantly greater awareness and experience than physicians in other specialties ($P < .05$ for pairwise comparisons with each of the other 3 specialties for each category).

Overall, an estimated 59% (95% confidence interval = 55%, 63%) of California primary care and emergency physicians reported that they might not comply with the reporting law if a patient objected. Reported noncompliance with the mandatory reporting law varied significantly among the medical specialties depending on whether a patient objected ($P < .05$ within each specialty) (Figure 1). Compared with emergency physicians, primary care providers reported significantly higher rates of noncompliance when a patient objected ($P < .001$ for pairwise comparisons). Two percent of emergency physicians, 8% of family physicians, 13% of internists, and 17% of obstetrician/gynecologists responded that they would not report in any situation in which a patient objected.

Other factors associated with noncompliance included prior knowledge of the law, a recent course on domestic violence, and practice type (Table 2). Self-reported noncompliance did not differ by sex, age, ethnicity, country of training, or having identified an abuse victim in a clinical setting. On the basis of logistic regression analysis, primary care providers were 2.4 to 3.8 times less likely than emergency physicians to comply when a patient objected. Lack of prior awareness of the law also increased noncompliance.

Most physicians in all 4 specialties agreed that mandatory reporting legislation creates potential barriers to care (60%–79%), may escalate violence or abuse (53%–82%), and violates confidentiality (59%–85%) and autonomy (62%–75%) (Table 3). On the other hand, most physicians also agreed that the law improves the collection of useful statistics (77%–86%), the prosecution of perpetrators (72%–87%), and physician responsiveness (53%–73%). In addition, more than 90% of respondents in each specialty agreed that the following special circumstances require reporting to police regardless of the law: children or guns in the home, pregnancy, obvious injuries or repeated complaints of partner abuse, or immediate threats to a patient's safety (data not shown).

TABLE 2—Factors Associated With Physicians' Self-Reported Noncompliance With Mandatory Reporting of Intimate Partner Violence in Cases Where the Patient Objects

Characteristic	n	No. Non-compliant (%)	Unadjusted OR (95% CI)	Adjusted OR (95% CI)
Medical specialty				
Emergency medicine	106	26 (25)	1.00	1.00
Family medicine	145	83 (57)	4.12 (2.37, 7.15)	2.42 (1.16, 5.04)
Internal medicine	112	75 (67)	6.24 (3.45, 11.28)	3.82 (1.77, 8.22)
Obstetrics/gynecology	133	89 (67)	6.22 (3.52, 11.02)	3.71 (1.73, 7.97)
Awareness of law				
Aware	339	152 (45)	1.00	1.00
Unaware	156	121 (78)	4.25 (2.76, 6.65)	3.36 (2.09, 5.39)
Course on DV				
In previous 3 years	143	62 (43)	1.00	1.00
Not in 3 years	352	210 (60)	1.93 (1.30, 2.86)	1.29 (0.82, 2.04)
Medical practice type				
Hospital-based	61	12 (20)	1.00	1.00
HMO	86	37 (43)	3.08 (1.44, 6.61)	1.36 (0.52, 3.57)
Private	237	154 (65)	7.58 (3.82, 15.03)	2.06 (0.81, 5.22)
Gender				
Male	310	166 (54)	1.00	1.00
Female	186	107 (58)	1.18 (0.81, 1.70)	1.01 (0.66, 1.53)

Note. OR = odds ratio; CI = confidence interval; DV = domestic violence; HMO = health maintenance organization.

TABLE 3—Percentages of Responding Physicians Who Indicated Agreement With Potential Outcomes of Mandatory Reporting of Intimate Partner Violence

Potential Outcome	Emergency Medicine (n = 108)	Family Medicine (n = 149)	Internal Medicine (n = 115)	Obstetrics and Gynecology (n = 136)	P[a]
Potential risks					
Discourages help-seeking	60	75	79	76	.010
Escalates abuse/violence	53	65	82	74	<.001
Discourages physician's inquiry	17	33	35	45	<.001
Ethical violations					
Violates confidentiality	59	71	85	83	<.001
Violates autonomy	62	64	70	75	.110
Potential benefits					
Provides useful statistics	86	83	85	77	.219
Helps with prosecution	87	78	72	76	.054
Improves physician's response	73	63	53	58	.018

[a] *P* values were derived from Pearson χ^2 by use of dichotomous agree/disagree categories.

Discussion

Our results suggest that many physicians in California have mixed perceptions about the risks and benefits of mandatory reporting legislation and are ambivalent about reporting to police, particularly when a patient objects. Although most respondents agreed that the law may jeopardize patient safety and deter patients from seeking care, most also agreed that the law has potential benefits. In addition, almost all respondents agreed that the severity of abuse, immediate threats to the patient's safety, and involvement of children or guns are factors that increase the need for police involvement. The respondents' apparent contradictory opinions may reflect the complexity of addressing intimate partner violence in the clinical setting.[18] The decision to involve police often entails balancing patient safety, patient autonomy, legal requirements, and potential police protection. Achieving the optimal balance is inevitably difficult.

Reported noncompliance varied significantly among the medical specialties. Emergency physicians were most willing to comply even after adjusting for the confounding influences of practice type, greater awareness, and education. This result may partially reflect the increased severity of physical injuries encountered. Higher rates of noncompliance among the

primary care physicians sampled may reflect the greater continuity of the patient–provider relationships.

The physicians' concerns regarding the safety and ethical implications of the law accord with qualitative research on abused women.[15,19] Given the possibility of retaliation, many health care providers may believe that the law sometimes obligates them to act against the best interest of their patients. Most respondents agreed that the law requires physicians to violate patient confidentiality and autonomy. Furthermore, the fact that many physicians were less likely to report to police if the patient objected may reflect the high value placed on patient confidentiality and autonomy. By infringing on the patient–provider relationship, the law may inadvertently contribute to existing barriers[20–22] by discouraging patients from discussing abuse with their providers, thus precluding them from receiving referrals and support.

The results presented here were limited to California physicians in 4 specialties. As such, the findings do not necessarily reflect the perspectives of other health care professionals covered by the law. In addition, it is not known how accurately survey responses reflect actual behavior in clinical practice. Research is needed on the direct impact of the law on abuse victims to establish which, if any, of the potential risks or benefits have been realized. Furthermore, research is needed on the effectiveness of victim identification and interventions available to victims.[4,23]

The results of this study raise serious concerns about the impact and efficacy of California's mandatory reporting law from the point of view of physicians. As it currently stands, this law violates basic tenets of medical ethics, potentially creates barriers to care for victims, and is of unproven value. Mandatory reporting of cases involving weapons or serious injuries may be justified; however, most situations require greater flexibility. When health care providers can collaborate with patients in decisions to involve law enforcement, we may avoid situations where well-intentioned mandates do more harm than good. □

Contributors

M. A. Rodriguez, E. McLoughlin, and K. Grumbach conceived and designed the study. All 5 authors contributed to the analysis and interpretation of the data. M. A. Rodriguez and H. M. Bauer drafted the article, and E. McLoughlin, V. Paredes, and K. Grumbach revised it critically for intellectual content. All 5 authors approved the final version.

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This study was approved by the University of California at San Francisco Institutional Review Board, and informed consent was obtained from all participants.

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