

## CONCEPTS

## Ethics

# Mandatory and permissive reporting laws: obligations, challenges, moral dilemmas, and opportunities

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## Abstract

The duty to report certain conditions to public health or law enforcement authorities is one that falls on all physicians and other health care workers as part of their duty to protect the public from harm. In an open society, others, such as teachers, clergy, police officers, or simply neighbors, share the responsibility of protecting individuals at risk, often by reporting them to authorities. The emergency physician and others in the emergency department are uniquely positioned to identify people at risk or who pose a risk, and to report them as required or allowed under the law. In some circumstances, these duties may conflict with ethical duties such as respect for patient autonomy or to protect confidentiality. This article will examine mandatory and permissive reporting laws in various states from an ethical perspective. It will also explore emerging issues such as the reporting of suspected human trafficking.

## KEYWORDS

ethics, public health, reporting

## 1 | INTRODUCTION

In the United States, medical practice is generally regulated by the states. Some federal agencies also have reporting requirements. The United States Food and Drug Administration (FDA) Adverse Event Reporting System is a computerized information database designed to support the FDA's post-marketing safety surveillance program for approved drugs and therapeutic biologic products.<sup>1</sup>

Mandatory and permissive reporting laws that affect medical providers vary from state to state. Many states have similar laws but some diverge significantly. Mandatory reporting laws require medical professionals and others to report certain conditions to government authorities or even to specific individuals, while permissive laws allow reporting without fear of civil liability but do not require reporting. In this article, we will compare and contrast these state laws and discuss the ethical and legal differences between mandatory and permissive laws. We will discuss the relevant ethical issues that underpin

these laws and related controversies. We will review current pertinent policies of emergency medicine (EM) organizations. Finally, we propose that reporting of suspected human sex trafficking should be permissive and practitioners should be protected from civil liability if they report a suspicion of trafficking or seek to engage other parties including law enforcement and social service agencies in good faith to protect and assist a potential victim.

### 1.1 | What are mandatory reporting laws and why are they necessary?

Mandatory reporting laws are deemed necessary for both individual and societal purposes. Some reasons for enacting such laws are: (a) gathering information for either epidemiological or statistical purposes; (b) protecting members of the public from harm from a communicable disease; (c) protecting members of the public from

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harm from a violent/criminal act (eg, reporting of gunshot wounds) or accidental injury by another party; (d) protecting an individual patient from further harm caused by a perpetrator; or (e) assisting law enforcement in solving crimes or preventing future acts.

Mandatory reporting laws raise important ethical questions, because they prioritize public and patient welfare and set aside both patient autonomy and the physician's duty to protect confidentiality; that is, to not disclose what a patient reveals during their encounter with their physician. Reporting is required by the government and it is not necessary legally to seek the patient's permission to disclose personal health information for these purposes. Many ethical codes on confidentiality carve out an exception for situations where there is a higher duty or "to obey the law," but reporting may nevertheless create moral distress on the part of the provider in certain circumstances. Reporting laws seek to prevent harm from coming to the index patient or other patients (non-maleficence) or to directly benefit patients (beneficence) by protecting them from specific harms. Alternatively, reporting that overrides patient autonomy may cause the patient either to distrust the provider or facility or to avoid care altogether.

## 1.2 | Mandatory versus permissive reporting laws

Mandatory reporting laws are mandated by law and leave no room for judgment on the part of the provider. Failure to follow these laws could lead to civil liability, fines, or other penalties and problems on the part of the physician (eg, with a state medical board).<sup>2</sup>

Permissive reporting laws allow, but do not compel, physicians to report certain conditions. For example, the use of alcohol or drugs during a serious motor vehicle accident may be allowed but not mandated. California's "mandatory" reporting law for lapse of consciousness law has a permissive clause that illustrates its weakness:

*103900. (a) Every physician and surgeon shall report immediately to the local health officer in writing, the name, date of birth, and address of every patient at least 14 years of age or older whom the physician and surgeon has diagnosed as having a case of a disorder characterized by lapses of consciousness. However, if a physician and surgeon reasonably and in good faith believes that the reporting of a patient will serve the public interest, he or she may report a patient's condition even if it may not be required under the department's definition of disorders characterized by lapses of consciousness...*

This particular law has the feature of allowing judgment but is also so ambiguous that its practical application is limited.

Permissive reporting laws raise ethical concerns. Implicit (or subconscious) bias may lead an individual to be more suspicious of someone who appears, acts, or speaks in a certain manner. When individuals can pick and choose when and whom to report, they may be more

likely to choose members of one sex, socioeconomic or cultural group, or religion over another. Even mandatory laws are subject to these concerns, because only suspicions must be reported and there may be a bias regarding of whom one is suspicious. Even when the law prescribes permissive reporting, physicians have an ethical responsibility to report behavior that may endanger others and may be found liable for failure to report in certain cases.<sup>3</sup>

Reporting laws have been reviewed elsewhere and were divided into those that are "less" and "more" controversial.<sup>2</sup> In this article, we propose dividing these laws into those that are intended to protect the public and those that are intended to protect the individual.

## 1.3 | Reporting laws that are intended to protect the public

### 1.3.1 | Causes of death

The cause of death is usually routinely publicly reported on death certificates without the consent or permission of the deceased or their next of kin or loved ones. There are few ethical objections to such reporting, as long as it does not include the release of post-mortem photographs or salacious or sensitive information. In general, the dead have more limited rights to privacy than the living but should still be treated respectfully.

### 1.3.2 | Injuries

In many states and counties, reportable conditions include traffic accidents, gunshot wounds and other penetrating trauma, animal bites, falls, residential fires, occupational injuries, poisoning, overdose, sexual assault, suicides, and drowning. Reporting is aimed at either preventing future injuries, enforcing statutes designed to protect the public, or solving crimes. This reporting is intended to protect the public and is usually not controversial.

### 1.3.3 | Infectious diseases

The control and prevention of infectious diseases has been a primary mandate for government health authorities since the later part of the nineteenth century. In 1874, the State Board of Health of Massachusetts initiated a plan for the weekly voluntary reporting of prevalent diseases by physicians by postcard. In 1883, Michigan mandated the reporting of specific infectious diseases. By 1901, all states required notification of certain communicable diseases to state or local health authorities.

Federally, the Quarantine Act of 1878 authorized the US Public Health Service to collect morbidity data to implement quarantine measures against yellow fever, smallpox, and cholera. The Quarantine Act of 1893 authorized the US Public Health Service to collect morbidity

information each week from state and local public health authorities throughout the United States and its territories. Such data is helpful annually, for instance, in knowing when widespread influenza appears, peaks, and then wanes.

The poliomyelitis epidemic in 1916 and the influenza pandemic of 1918 heightened interest in reporting requirements, resulting in the participation of all states in national morbidity reporting by 1925. Beginning in 1961, the Centers for Disease Control (CDC) in Atlanta has operated the National Notifiable Diseases Surveillance System for the purpose of tabulating and disseminating summary morbidity data. Today, all states participate in a national morbidity reporting system and regularly report data for infectious diseases including antibiotic resistance data to the CDC.

Variation among states exists as to which conditions and diseases need to be reported, time frames for reporting, agencies designated to receive reports, and persons or entities required to report. In many states, health care providers are required to report certain diseases and injuries directly to local health departments charged with rendering epidemiologic services rather than to the state health department. This often includes conditions such as tuberculosis, HIV infection, anthrax, botulism, meningococemia, measles, and rubella. In some circumstances, reporting is required within an hour of diagnosis and in others, within the first business day that follows. Providers should be familiar with state laws, and institutions should have systems in place for timely reporting as required by law.

Reporting of most infectious diseases is generally not controversial, although there have been exceptions. In the early days of HIV infection, the associated stigma caused some hesitance to report the illness. Some state laws penalized doctors and hospitals for reporting and required test results to be concealed. Reporting was avoided because of the very real fear of discrimination, both economically and socially, even when the disease was contracted via routes such as blood transfusion or needlesticks. Public relations campaigns were launched against these attitudes, including by the US Surgeon General, C. Everett Koop, MD. More recently, public attitudes and legislatures have changed, and in recent years, they have required physicians or health facilities to report HIV to try to help alleviate the spread of the virus. There are important implications for accurate reporting as society allocates funding for research for diseases that are most prevalent in the population, inclusion in government-backed insurance and disability programs, and supportive services. The reporting of HIV, once shunned, is now commonly required by law and well accepted and in fact, lessens the stigma associated with the infection or with homosexuality, which is now much more well accepted in society.

The outbreak of the Ebola virus in 2014 and subsequent cases reported in the United States engendered controversy regarding the quarantine of patients, health care workers, and volunteers in non-government organizations who were known to be exposed. Future emerging infections may cause similar controversies. Emergency department (ED) personnel are likely to be affected by these issues as they are often on the front lines of emerging disease detection and treatment.

## 1.4 | Reporting laws intended to protect individuals

### 1.4.1 | Suspected child abuse

According to the Children's National Alliance, in 2015 there were 3.4 million referrals for suspected child abuse with  $\approx 2/3$  of these resulting in investigations by a child protective services agency. Approximately four out of five of the abusers were the children's parents. All 50 states and the District of Columbia have laws requiring the reporting of suspected or confirmed child abuse. Forty-six states have criminal penalties for failure to comply with these laws. These laws are generally not controversial.

Children are particularly vulnerable, and in many cases, are not free to express their own free will or capable of protecting or defending themselves or changing their own circumstances. In these instances, it is morally acceptable for the physician to set aside "autonomy" (that does not really exist in such cases) and act in loco parentis (in the place of a parent), that is, "paternalistically" (or maternalistically), and perform the duties society would expect of a responsible parent, a moral imperative, in terms of the deontological ethics of Kant.

Nevertheless, reporting of suspected child abuse is not without its problems in individual cases. Parents who are reported may complain to hospital administrators, department chairs, insurance companies, or agencies, or threaten lawsuits. However, there generally are immunity laws that shield physicians and others for reporting suspected abuse or neglect in good faith.

Regardless of the aforementioned immunity from litigation, when suspected child abuse is reported, parents should be informed. Most parents or guardians will be appreciative if physicians express their concerns for the wellbeing of the child and explain their duty to report. This may also serve to diminish hard feelings toward the physician or hospital if the investigation clears the parents. Specific circumstances, including immediate or obvious danger, may merit emergency intervention that may include notifying authorities without the notification of the parent or guardian.

### 1.4.2 | Duty to warn or protect—"Tarasoff" laws

In *Tarasoff v Regents of California* (1974 and 1976), the California Supreme Court ruled that a mental health professional has the duty to warn a particular person if a patient has confided in them their intentions to harm a third party (note that there were two opinions issued in this case, one more expansive than the other as the result of an appeal). As a result, the duty of mental health professionals to warn or protect a person from imminent or severe violence became enshrined in California law and elsewhere.

The Tarasoff case arose out a relationship between Prosenjit Poddar, a student at the University of California, Berkeley, and Tatiana Tarasoff, another student at the same school. Poddar had become enamored with Tatiana after a few dates. When Tarasoff declined his advances, Poddar underwent a severe emotional crisis and

subsequently confided to his therapist, an employee of the University of California, his intentions to kill Tatiana, although she had left the country to study abroad. After her return, Poddar eventually murdered Tatiana Tarasoff. Neither she nor had parents had been warned by the therapist or the school, which formed the basis of the legal action.

Following the Tarasoff rulings, other states adopted "Tarasoff" reporting laws that are either mandatory or permissive (or nonexistent at all). It is hard to be exact owing to different reports,<sup>4,5</sup> but at last accounting, between 27 and 33 states have mandatory laws on the duty to warn, 9 to 11 have permissive statutes, and 6 to 13 have no statutes.<sup>6</sup> At first blush, it is hard to understand, from a moral standpoint, how what could be considered immoral in one state can be deemed moral or ambiguous in other states. The best answer is that there are good arguments on all sides, with some states favoring confidentiality and the necessity of patients to trust their therapist in disclosing their feelings, other states favoring patient autonomy to decide for themselves and report if they choose, and some states citing societal interests and requiring that providers report in all cases.

Therapists worry about several issues, some owing to differences in state laws. In most states with mandatory laws, for the duty to be triggered, the requirement is that the threat must be imminent and that a potential victim is identifiable. A few states require not that the threat be imminent, but that it must be serious. Thus, much is left to the interpretation and judgment of the therapist.

Permissive states present different challenges. While permissive laws may shield therapists from liability for reporting, not doing so may still result in liability. For example, in *Almonte v New York College*, a private practice psychiatrist in Manhattan and Connecticut settled a lawsuit brought by Denny Almonte, who served a prison term for his own sexual assault. A federal district court jury found that the psychiatrist was negligent for failing to report the pedophilic ideation of his patient, Joseph DeMasi, MD (a psychiatry resident himself undergoing psychoanalysis), who later sexually assaulted Almonte. Almonte claimed that his own subsequent assaults were the result of this lack of reporting by Dr. DeMasi's psychiatrist. The defendant in the case, the psychiatrist, settled the suit for an undisclosed amount prior to the penalty phase of the trial.

It is important to note that most "Tarasoff" laws apply to mental health workers but not emergency personnel. However, a few states do have duty-to-warn laws that apply to all physicians and others. Physicians and other providers should be familiar with the laws in their states. If uncertain, they should consult with the psychiatry service, the hospital's legal counsel, or both to relieve themselves of their own liability.

### 1.4.3 | Elder abuse and neglect

As of 2019, 43 states have elder abuse and neglect reporting laws, and the majority of them have accompanying legislation that legally shields those who report it. Similar to child abuse laws, elder abuse laws carry criminal penalties for failure to comply (although they are rarely enforced). The true incidence of elder abuse is difficult to ascertain,

estimated with a wide range of estimates, from 700,000 to 1.2 million annually. Some estimates are that 10% of older adults will suffer from some sort of abuse.<sup>7,8</sup> State statistics vary widely as there is no uniform reporting system, and national data are not collected. For example, in Massachusetts, elder abuse includes physical, sexual, and emotional abuse, caretaker neglect, financial exploitation, and self-neglect.<sup>9</sup>

Adding to the uncertainty, definitions of elder abuse vary in the literature. Elder abuse has arisen as a category under which negligence suits can be filed against facilities and individuals who care for the elderly. Therefore, disputes can arise as to whether certain acts of commission or omission constitute elder abuse, with financial consequences as a result of how the claim is resolved. Whatever the true current incidence, as the population gets older, the number of people at risk and the incidence of elder abuse are expected to rise.

Proponents of mandatory elder abuse reporting argue that the elderly constitute a vulnerable population that is either unable (due to incapacity) or unwilling (because of the fear of retribution or shame) to report abuse or neglect independently. Aside from protecting the index case for their own protection, there is an argument for societal benefit if the reporting leads to exposing facilities or individuals who are abusing or neglecting others under their care.

Opponents of routine mandatory reporting are concerned that reporting of competent patients who could otherwise act on their own behalf violates their autonomy and confidentiality. Consequently, these patients may place less trust in their physicians. Some individuals may fear retribution by the accused following reporting. Under such circumstances, patients may avoid the ED for their care. Other barriers to mandatory reporting include lack of time and knowledge, vague definitions, fear of offending patients, families or private physicians, uncertainty, and the reluctance to be drawn into civil lawsuits.

Elder abuse is among a number of conditions whose mandatory reporting is opposed under a policy statement on domestic violence of the American College of Emergency Physicians (ACEP). Instead, ACEP "encourages partnering with and reporting...to local social services, victim's services, the criminal justice system, or any other appropriate resource agency (in order) to provide confidential counseling and assistance, in accordance with the patient's wishes."<sup>10</sup>

### 1.4.4 | Interpersonal violence

Interpersonal violence, also referred to as domestic or intimate partner violence, battering, or spousal abuse, all refer to the victimization of a person with whom the abuser has had an intimate relationship.<sup>11</sup> According to the American Medical Association (AMA), interpersonal violence may take the form of physical, sexual, or psychological abuse and often escalates over time. Although much of the published domestic interpersonal violence literature assumes that women are the usual victims, men may be victimized as well.

The legal duty to report some cases of interpersonal violence is implicit and may be encompassed in laws that require the reporting of crimes committed with guns, knives, or other deadly weapons, or laws that require the reporting of suspected sexual assault. A few states

have laws that mandate the reporting to law enforcement of all suspected cases of interpersonal violence. Such laws have engendered heated debate.

Proponents of these laws cite the duty to protect vulnerable victims who may be reluctant to report on their own behalf out of shame or fear of reprisal. Further, they argue that the ED offers an opportune and even unique setting to address this problem for several reasons. Compared to other settings, underserved patients are seen disproportionately in the ED and this may offer a unique opportunity to screen for domestic violence; in addition, the long times patients experience waiting to be seen affords an opportunity to be screened without causing unnecessary burden. Theoretically, some patients may also feel more comfortable disclosing abuse in the secure setting offered by the ED to strangers with whom they have no relationship.

Opponents of laws requiring the reporting of all interpersonal violence to law enforcement authorities point to the fact that there is little evidence that such reporting uniformly contributes to the safety of victims or facilitates access to appropriate resources.<sup>12</sup> Further, if there is no effective response to reporting, the presence of a mandatory reporting law may produce disappointment and distrust with the system or a false sense of security on the part of the patient, once reporting has occurred. In fact, it is argued that mandatory reporting may paradoxically put abused patients at increased risk by deterring them from telling their providers about the abuse or from seeking care at all. Some individuals oppose reporting for fear of retribution, financial consequences, homelessness, or future plans to salvage or maintain a relationship.

Routine reporting to law enforcement may produce other unwanted consequences including loss of a job for the alleged abuser, imprisonment, family separation, deportation, or other circumstances that may be less acceptable than solutions that could be achieved without police or court involvement. The issue of deportation could especially impact the willingness of undocumented foreign nationals to seek care in the ED where much of their care is commonly provided. Avoiding the ED when life- or limb-threatening conditions are present could lead to devastating consequences.

Setting aside the issue of mandatory reporting, physicians and other providers have an affirmative moral duty to be familiar with interpersonal violence, reasonably screen for it, detect it, treat it, and provide appropriate referrals to shelters and other resources. Physicians must have adequate education and training in recognizing and dealing with these issues, and hospitals should provide adequate resources such as social work support and referral processes.

Interpersonal violence is among several conditions whose mandatory reporting is opposed under a policy statement of the ACEP. Instead, ACEP favors a permissive approach and “encourages reporting...to local social services, victim’s services, the criminal justice system, or any other appropriate resource agency (in order) to provide confidential counseling and assistance, in accordance with the patient’s wishes.”<sup>13</sup> AMA takes a more ambiguous position on mandatory reporting of interpersonal violence.<sup>14</sup> It recommends: (a) physicians comply with the law in jurisdictions where reporting is mandatory; (b) physicians within these jurisdictions should advocate

to change the law if evidence suggests that reporting laws are not in the best interest of the patients (note: this hard-to-prove threshold shifts the burden of proof to physicians and physician organizations by requiring evidence that these laws cause harm, rather than leaving it to lawmakers to show they have benefit); and (c) in jurisdictions without reporting laws, reporting requires the consent of the patient. The fact that in the absence of reporting laws, the policy recommends obtaining consent makes clear that from an ethical rather than legal point of view, patients should be informed and consent to reporting, before it occurs.

#### 1.4.5 | Perinatal substance use

Unfortunately, drug and alcohol use during pregnancy is relatively common. It has been reported that 15% of pregnant women use alcohol and 5% of pregnant women use illicit drugs.<sup>15,16</sup> Perinatal alcohol exposure results in significant fetal harm, including fetal alcohol syndrome, congenital anomalies, fetal demise, low birth weight, and others. Perinatal drug exposure also may result in significant fetal harm, including congenital anomalies, opiate dependence, preterm labor, prematurity, low birth weight, fetal demise, stillbirth, and others.<sup>17</sup> Some states require or permit providers to report perinatal substance abuse.<sup>18,19</sup> Women who use alcohol or drugs while pregnant may be subject to criminal or civil penalties (eg, incarceration, loss of custody of children, or other penalties).

#### 1.4.6 | Seizures and other lapses of consciousness

Seizures, lapses of consciousness, or impaired cognition may affect an individual’s ability to safely operate a vehicle, including a personal car, boat, or commercial vehicle.<sup>20</sup> Mandatory reporting of cognitive or medical impairment is required in six states (as of 2019). In addition, 25 states encourage or allow reporting.<sup>21</sup> In some states, the laws are drawn more broadly (eg, California), where the law requires the reporting to the Department of Motor Vehicles of all conditions “characterized by a lapse of consciousness,” including seizures. A survey of physicians in California found that of 14 possible conditions that could cause a lapse of consciousness, only seizures were consistently reported; the others were rarely or never reported. Part of this may be because it is unclear when an event is isolated and when it becomes a condition. For instance, if a patient has a first-time episode of syncope and it is felt to most likely be vasovagal, this may be interpreted as an episode rather than a condition. Similarly, what to do about a patient who experiences a transient ischemic attack? Existing guidelines are vague. Oregon has a broadly written law requiring the reporting to the Department of Motor Vehicles of “functional and cognitive impairments” that are “severe and uncontrollable,” widely interpreted to include seizures as well as alcohol or drug use if their use results in a motor vehicle accident.

Patients whose seizure disorder is reported against their will may be subject to suspension of their driver’s license and require medical

follow-up, supervision, monitoring, and a release to be able to return to driving. Overriding the patient's desire to keep their episode or illness confidential frequently results in dissatisfaction or anger toward the physician who files the report. This may be minimized in some cases by taking the time to address the patient, empathize with them, and stress that they are being reported, in part, to prevent future harm to them or someone else and to comply with the law. In fact, physicians are morally obligated to be truthful and tell patients who have decisional capacity that their condition will be reported.

Opponents of mandatory reporting of seizures argue that reporting compromises patient confidentiality and trust with little gain. They argue that the risk of a patient with seizures being involved in a vehicular accident is barely greater than for those without seizures, and the loss of driving privileges can have severe consequences on a patient's life such as compromised ability to work and provide for self and family, loss of independence, limited participation within the community, social isolation, and decreased quality of life. Another concern is that patients with seizures will withhold crucial information about themselves from doctors at routine visits and potentially not receive optimal treatment or volunteer for clinical trials.

The ACEP policy on reporting of potentially impaired drivers states that reporting should be individualized to the patient's clinical condition and the risk posed to the patient and public by continued driving. ACEP opposes mandatory reporting of entire classes of patients or diagnoses unless compelling evidence exists for a public health benefit for such reporting.<sup>22</sup> The AMA has a similar policy.<sup>23</sup>

### 1.4.7 | Impaired physicians

Health conditions that affect a physician's ability to practice medicine can interfere with a physician's ability to undertake professional activities and may result in significant risk to patients. Physicians have a duty to intervene if impairment is recognized. Appropriate interventions may include reporting to ensure cease of practicing and appropriate assistance from a physician health program. According to AMA policy:<sup>24</sup>

To protect patient interests and ensure that their colleagues receive appropriate care and assistance, physicians individually have an ethical obligation to:

- a. intervene in a timely manner to ensure that impaired colleagues cease practicing and receive appropriate assistance from a physician health program;
- b. report impaired colleagues in keeping with ethics guidance and applicable law; and
- c. assist recovered colleagues when they resume patient care.

Collectively, physicians have an obligation to ensure that their colleagues are able to provide safe and effective care. This obligation is discharged by:

- a. promoting health and wellness among physicians;

- b. establishing mechanisms to ensure that impaired physicians promptly cease practice;
- c. supporting peers in identifying physicians in need of help; and
- d. establishing or supporting physician health programs that provide a supportive environment to maintain and restore health and wellness.

## 1.5 | Other opportunities

### 1.5.1 | Human trafficking

The awareness of the crime of human trafficking and its terrible toll has increased in recent years.<sup>25</sup> Human trafficking includes both sex and labor trafficking. It is reported that 28–88% of survivors of trafficking were seen by a health care provider at least once during the time they were trafficked. According to the 1974 Child Abuse Prevention and Treatment Act, and its 2015 amendment, victims of child abuse and neglect include victims of sex trafficking.<sup>26</sup> Many states have incorporated trafficking into existing child abuse reporting laws. A recent review found that 14 states have reporting laws that include trafficking. However, these laws apply only to minors and may overlap with existing laws on reporting child abuse.<sup>27,28</sup> A growing number of states have enacted safe harbor laws that recognize victims in need of health care and support services, rather than as criminals or prostitutes.<sup>29</sup>

Identification of victims of trafficking is an opportunity in emergency medicine, where victims may commonly seek medical attention for injuries, infections, or other conditions. For adult victims, arguments against mandatory reporting are similar to those against mandatory reporting of domestic abuse: they may deter patients from seeking medical care or being brought there by another individual, they may result in further physical or other harm to the patient, and they may not achieve what they are intended to do because of failures of agencies and bureaucracies.<sup>30</sup>

Currently, strategies for combatting trafficking and helping victims of trafficking include identification of victims, surreptitiously providing them with referrals to agencies and organizations (such as the Coalition to Abolish Slavery and Human Trafficking-CAST) or unlabeled phone numbers such as the National Human Trafficking Hotline (NHTRC) or the BeFree text option (text HELP to BEFREE [233733]), and reporting to the appropriate agency as identified by the state.

There are currently few direct reporting options that protect providers who may want to report suspicion of a patient being the victim of sex trafficking. The authors believe permissive reporting laws should be enacted that shield providers who report suspicions of trafficking in good faith from civil liability but do not require them to do so.

### 1.6 | Mandatory reporting laws and civil disobedience: conscience over law

Just as confidentiality is not inviolate, neither is there an absolute duty to mandatorily report a condition or demographic information about

a patient. A physician's professional duty is primarily to the patient. A moral hazard is created when a physician becomes an agent of the state and places that agency ahead of the patient's interests. To do otherwise violates the first tenet of professionalism.

From 1933 to 1945 in Germany, during the Nazi era, physicians were integral to carrying out key Nazi policies, all of which were "legal" under the regime of the Third Reich. These included: (a) the Nuremberg race laws (physicians headed up racial offices and conducted examinations to determine "Aryan" racial purity required under the Marital Health Law); (b) the Sterilization Act expected physicians to report patients suspected of carrying "genetic defects" as candidates for sterilization (360,000 sterilizations of non-Jews and Jews were performed on patients by cooperating physicians); and (c) the "Operation T-4" euthanasia program that initially required physicians and midwives to register any child born with congenital deformities to be euthanized at one of 28 institutions, including some of the most venerable hospitals in Germany. Further, the T-4 program was eventually expanded to include children with acquired diseases, and later to undesirable adults, and helped perfect the prototype of the gas chambers used to exterminate millions.<sup>31</sup> All of the aforementioned laws had a "mandatory reporting" component. In addition, physicians had a very direct role in the "final solution," resulting in the mass imprisonment and/or genocide of Jews, political prisoners, homosexuals, Romani, and others. Physicians served on the ramp at the rail stations at the death camps, separating those who were deemed healthy enough to be useful to the Reich and those who were not and would go straight to a certain death in gas chambers. Physicians also conducted unethical experiments on forced subjects in the concentration camps and chose some of them directly from the railway platform in the cold and darkness of the night with dogs keeping order by their sides. It is safe to say that the full scope of the atrocities that transpired during the Holocaust could not have been carried out had physicians in large numbers not been co-opted as agents of the state and had they resisted the "laws" of the day. Physicians in large numbers did anything but resist. Rather, physicians joined the Nazi party at a higher rate than any other profession, upward of 60%, often for personal gain. This is a permanent stain on the medical profession and serves as a reminder as to the primary duties of doctors to provide for the welfare other human beings rather than for their self-enrichment or advancement.

In California, in 1994, voters by a wide margin passed Proposition 187, a statewide ballot initiative allegedly designed to deter illegal immigration into the United States via its southern border. In part, the measure required medical personnel to report anyone "reasonably suspected" of being an illegal alien to state and federal agencies. Left to individual discretion, "reasonable suspicion" might be based on a patient's skin color, appearance, surname, or spoken language. Proposition 187 created backlash and was challenged in the courts, ruled unconstitutional, and never implemented. Had it been implemented, in the opinion of the authors, physicians would have been morally obligated to commit civil disobedience and not follow it, because following it likely would have deterred some patients from coming to the ED and resulted in harm to them for lack of health care. Again, the physician's first duty is to the patient.

## 2 | CONCLUSIONS

Reporting laws that currently exist in the United States are written to protect individuals and the public. Because the ED is a sanctuary, or a protected place for patients, emergency physicians should be adept at the recognition and reporting of conditions as required or permitted by law if they are moral. We believe that mandatory reporting is appropriate for causes of death, infectious diseases, cause of injuries, abuse, neglect (especially of disabled or senior adults), and trafficking of minors. However, for adults with decisional capacity, the ethical principles of beneficence, non-maleficence, and respect for autonomy should be weighed, and shared decision making should be considered in the reporting of other conditions.

### CONFLICTS OF INTEREST

The authors have no conflicts of interest to report.

### AUTHOR CONTRIBUTIONS

JG and CM authored the manuscript.

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