Case Report

Mandatory Reporting of Intimate Partner Violence: An Ethical Dilemma for Forensic Nurses

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ABSTRACT

Nearly all states and provinces have laws mandating licensed healthcare professionals to report to law enforcement suspicions and allegations of the abuse of children, older adults, and disabled persons and all incidents of violence by a deadly weapon. However, a few states in the United States additionally mandate providers to report all injuries resultant from reported or suspected domestic/intimate partner violence. This can present a challenge to forensic nurses seeking to protect patient confidentiality and autonomy. This challenge becomes further compounded when a patient desiring to remain anonymous reports sexual assault by their partner, accompanied by bodily injury. This case report explores one such scenario that occurred in a rural Colorado Emergency Department, the issues this presents to forensic nurses, and possible responses.

KEY WORDS:

Anonymous; anonymous reporting; autonomy; confidentiality; domestic violence; DV; intimate partner sexual assault; intimate partner violence; IPSA; IPV; mandatory reporter; mandatory reporting

Most states and provinces in developed lands have laws mandating licensed healthcare professionals to report to law enforcement suspicions and allegations of the abuse of children, older adults, and disabled persons and all incidents of violence by a deadly weapon. However, some U.S. states additionally mandate providers to report to law enforcement all injuries suspected to be nonaccidental or resultant of a criminal act, regardless of patient age or wishes, and some of these (previously Colorado) specifically mandate providers to report all injuries resultant from reported or suspected domestic/intimate partner violence (IPV; Dubrow, Lizdas, O'Flaherty, & Marjavi, 2010). Healthcare encounters for injuries related to IPV may often be accompanied by a report of sexual violence, as over approximately half of sexual assault perpetrators are reported to be intimate partners (Centers for Disease Control and Prevention, 2012). Patients reporting sexual assault in the United States have the option of having a medical forensic examination with anonymous evidence collection as provided by the Violence Against Women Reauthorization Act of 2013 (U.S. Government Publishing Office, 2013). What happens then, in a mandatory reporting state, when a patient who desires to remain anonymous discloses sexual assault by an intimate partner and bodily injuries were also sustained? The following case report explores one such scenario that occurred in rural Colorado prior to May 2017 (Colorado General Assembly, 2017).

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Case Description

A 41-year-old woman presented to the emergency department (ED) one late afternoon with a chief complaint of a

head wound. She disclosed to the triage nurse that, on the previous evening, her husband hit her in the back of the head with an unknown object and threw her into the garage, where she lay unconscious until the morning. She reported that another family member found her early that morning in a "pool of blood." ED staff asked the patient if she wanted them to notify law enforcement, which the patient declined, stating that she did not wish to "press charges." The patient was evaluated by a certified physician's assistant. Through the provider's review of systems, the patient answered, when asked, that she was unsure whether she may have been sexually assaulted while unconscious. Once medically cleared, the physician's assistant offered the patient the option of a medical forensic examination by a sexual assault nurse examiner (SANE) for anonymous/unreported evidence collection, which she accepted.

Summary of Key Findings

After first contact, the SANE sought to obtain a social history. The patient disclosed that, 3 months prior, she had begun the process of filing criminal charges against her husband for a physical assault. However, because of scheduling and transportation difficulties in attending court sessions, the patient stopped cooperating with prosecution, and the case was dropped. The patient reported that, after filing charges, the abuse became more severe, causing her to separate from her spouse. However, shortly after the charges were dropped, her husband apologized for assaulting her, and the patient moved back in with him. The patient further described that, after moving back in, the physical abuse resumed and had been escalating, and the patient now feared for her life if she filed another report. Before the SANE's arrival, hospital social services had been consulted to assist with safety planning, and the patient planned to stay at her mother's house after discharge. After explanation of the medical forensic examination and reporting options, the patient wanted to proceed with the anonymous/unreported option for sexual assault evidence collection, understanding that, in Colorado, this evidence remains untested and is stored for up to 2 years pending the complainant's decision to make a report.

In the event history, the patient described to the SANE that her husband had a male guest, with whom she was not well acquainted, present at the time of the assault. She further reported that, after she awoke, she found large amounts of "dried leaves" inside her bra and underwear and an "overwhelming foul odor" from her genital area before showering. The patient expressed that these findings caused her to wonder whether her husband and/or the unidentified male friend had sexually assaulted her while unconscious. She denied past medical history. She denied current pregnancy and reported last menstrual period 4 weeks previous and last consensual intercourse over 1 week ago, unprotected with her husband. The only physical complaint at the time of the SANE's examination was a mild headache.

A head-to-toe medical forensic examination with photography was performed for injury documentation and evidence collection. The injuries that were identified and photographed are as follows: irregular contusions to the scalp, a 1.5-cm linear scabbed scalp laceration, 0.7-mm-wide round burns to the left side of the jaw, a 5 cm × 5 cm abrasion to the right flank, multiple contusions and abrasions to all four extremities, and a partially dislodged dermal finger piercing stud surrounded by dried blood. Anogenital assessment was negative for visible injury, with thick tan fluid present to the cervix. After vaginal/cervical swabbing, a urine pregnancy test was performed per facility policy to determine emergency contraception eligibility and returned positive.

Treatment

Before SANE arrival, the patient had been examined and medically cleared by the physician's assistant, including a computed tomography scan of the head, which was within normal limits. She was medicated with acetaminophen for headache. It was determined that the scalp laceration did not require closure. Cervical swabs for wet mount and cultures were collected during the SANE examination because of the presence of thick tan fluid. The patient was counseled as to her HIV and sexually transmitted infection risk. She was medicated for gonorrhea/chlamydia prophylaxis with ceftriaxone and azithromycin, which are Class B safe for pregnancy. The patient was given referrals to an ob-gyn for follow-up as well as to the nearest pregnancy center. A referral was also made to the local advocacy center (the patient had declined the presence of an advocate earlier). The patient requested removal of her dislodged finger piercing and a short-term prescription for anxiety medication before discharge. After the SANE examination, care of the patient was returned to ED staff.

After returning care of the patient to ED staff, the SANE called law enforcement to come to the SANE office adjacent to the ED for evidence handover. On the arrival of two law enforcement deputies, the SANE handed over custody of the evidence kit and gave a brief description of the patient having sustained a head injury, allegedly by her spouse. The deputies questioned the SANE as to the present location of the patient and why ED staff had not reported the physical assault. The SANE explained that, before her arrival, the patient had verbalized to ED staff not wanting to make a report of the incident, and the SANE was called in for anonymous/unreported sexual assault evidence collection as offered by the physician's assistant once medically cleared. The deputies expressed concern over compliance with the Colorado mandatory reporting law of IPV injuries and contacted their sergeant in charge. The sergeant shortly arrived on site at the hospital and confirmed the understanding that report of IPV

injuries was then mandatory in Colorado. Law enforcement indicated the need to know the patient's identity and to speak with her before her leaving the hospital. In compliance, ED staff then provided the patient's identity and current location. The SANE returned to the patient's bedside and explained the progression of events leading to the presence of three law enforcement officers on site to speak with her before discharge. The patient verbalized understanding. Law enforcement then had a brief discussion with the patient at bedside and left the hospital. The patient was then discharged by ED staff to her mother's house.

Discussion

It is essential that forensic nurses know and understand the applicable laws where they practice (Futures Without Violence [FWV], n.d.). Whereas some states mandate reporting of various injuries by all levels of healthcare workers (including unlicensed assistive personnel), others only require physicians and licensed midlevel providers (physician's assistants and nurse practitioners) to report (Dubrow et al., 2010). A report to law enforcement by a healthcare worker who is not mandated in the law code may be considered an unauthorized disclosure of protected health information and thus a violation of the Health Insurance Portability and Accountability Act Privacy Rule and subject to administrative and civil penalties (U.S. Department of Health and Human Services, 2003). The disclosure of protected health information to law enforcement as part of a report of an injury or a violent act is only permissible under the Health Insurance Portability and Accountability Act when the person making the report is defined as a mandatory reporter by state law or has been delegated by said mandatory reporter to make the report in their behalf.

Proponents of mandatory reporting of IPV argue that it is in the best interests of safety for victims and society to hold batterers accountable whether a victim desires bringing of charges (FWV, n.d.). Opponents argue that such reporting ethically violates patient autonomy and confidentiality, is a deterrent to victims to seek necessary medical care, and may jeopardize patient safety after discharge (Thomas, 2009).

Recognizing the danger that mandatory reporting of IPV can impose upon victims, many states/provinces have protocols to address the responsibilities of healthcare providers without requiring a report to law enforcement (Dubrow et al., 2010). For example, New York State's Family Protection and Domestic Violence Intervention Act of 1994 requires providers to document in the patient's medical file injuries suspected as resultant from IPV and to give a victim's rights notice containing referral information (New York State Office of Children and Family Services, 1995).

The Colorado Coalition Against Domestic Violence (2014) takes a stance against IPV mandatory reporting laws, recommending instead victim advocacy and referral without violation of autonomy and confidentiality, as does FWV (n.d.). However, healthcare providers have a legal obligation to comply with the laws in their practice areas; it is not for them to choose noncompliance based on their opinion of the law. Although violence is a criminal issue, it has medical consequences, and this often causes conflict between the two systems (Koziol-McLain & Campbell, 2001). Nurses wishing to uphold patient autonomy and maintain confidentiality are faced with this ethical dilemma when practicing in a locality with mandatory reporting of IPV injuries. Per the American Nurses Association (ANA) Code of Ethics for Nurses, the nurse's primary commitment is to the patient, and the nurse is to protect the rights of the patient, including the rights to confidentiality and autonomy (ANA, 2015). The forensic nurse must find a way to balance these ethical principles with the legal requirements of the state in which they practice.

Nurses, and the healthcare facilities where they practice, seek to provide a safe, nonthreatening space for victims of violence. Many facilities providing evidence collection after sexual assault have a practice of waiting until anonymous patients leave the premises before obtaining a case number and/or handing over evidence to law enforcement, as a means of assuring that the patient's identity cannot be uncovered on site. Some forensic examiners in mandatory reporting states report being able to make the bodily injury report separately and/or under a different case number than that used in the submission of an anonymous sexual assault evidence collection kit.

The author recommends that research be done regarding the risks and benefits of such laws and that other mandatory reporting states likewise accordingly consider amendments. Such research could be further informed by a mixed survivor/professional advisory council, where perhaps a roundtable could be formed to address the challenges presented by these laws.

Conclusions

Mandatory reporting of IPV, although at the initial face value may seem a just practice, presents several serious ethical concerns to healthcare providers and potential complications for patients. These issues become even more complex when accompanied by an anonymous disclosure of sexual assault, as may often be the case. Forensic nurses practicing in mandatory reporting states may be faced with the difficult task of balancing the protection of patient rights against compliance with reporting law. When these situations present, there is no universal "correct" course of action, as each patient scenario is different and each locality's response to report of IPV varies. For these reasons, whether a patient may be in greater danger due to such a report would vary on a case-by-case basis. When deciding how to proceed, forensic nurses do well to remember that, as nurses, their first

commitment is to their patients and their rights and welfare and thereby adapt and tailor their responses to facilitate the provision of the best possible care to each individual patient, within the confines of their local laws (ANA, 2015).

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