

INTIMATE PARTNER VIOLENCE DURING PREGNANCY: EXPLORING THE EFFICACY OF A MANDATORY REPORTING STATUTE

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I. INTRODUCTION

“[M]ale spousal violence against pregnant women has been iden-

tified as one of the most unaddressed sources of fetal abuse.”¹ Homicide is the second leading cause of death for pregnant women in the United States,² accounting for thirty-one percent of all pregnancy-associated injury deaths.³ Substantial evidence indicates that “a significant proportion of all female homicide victims are killed by their intimate partners.”⁴ Despite the fact that intimate partner violence (IPV) is “more common for pregnant women than gestational diabetes or preeclampsia—conditions for which pregnant women are routinely screened,”⁵ health care professionals are by and large not required to screen pregnant patients for IPV nor mandated to report suspected or confirmed incidents of IPV against their pregnant patients. Although “there is consensus regarding the continued role of healthcare institutions, medical providers, researchers, and policy makers in improving the medical response to abused patients,”⁶ there appears to be no nationwide consensus in the way states approach reporting IPV against pregnant women or competent adult victims.

A handful of states have instituted mandatory reporting statutes of varying configurations in an attempt to address the IPV epidemic against competent adult victims. For example, California’s mandatory reporting law originated as a response to a letter written by a group of prenatal nurses to San Francisco Bay Area assemblywoman Jacqueline Speier.⁷ In this letter, the nurses voiced their disapproval

¹ Constance MacIntosh, *Conceiving Fetal Abuse*, 15 CAN. J. FAM. L. 178, 187 (1998) (citation omitted).

² Jeani Chang et al., *Homicide: A Leading Cause of Injury Deaths Among Pregnant and Postpartum Women in the United States, 1991-1999*, 95 AM. J. PUB. HEALTH 3, 471, 474 (2005).

³ *Id.* at 472.

⁴ FAMILY VIOLENCE PREVENTION FUND, THE FACTS ON HEALTH CARE AND DOMESTIC VIOLENCE 2, <http://www.endabuse.org/resources/facts/HealthCare.pdf> (last visited Dec. 12, 2008) (citation omitted) [hereinafter DOMESTIC VIOLENCE FACT SHEET].

⁵ *Id.* at 2.

⁶ Heidi M. Bauer et al., *Culture and Medicine: California’s Mandatory Reporting of Domestic Violence Injuries: Does the Law Go Too Far or Not Far Enough?*, 171 W. J. MED. 118, 123 (1999); see also Stephanie A. Wolfson, *Screening Through the Lens of Medical Ethics*, 11 DEPAUL J. HEALTH CARE L. 5, 7 (2007) (reporting that eighty-six percent of primary physicians surveyed agreed that intervening in family violence situations is their responsibility).

⁷ Donna R. Mooney & Michael A. Rodriguez, *California Healthcare Workers and Mandatory Re-*

of the insufficient legislative protections for pregnant patients and their unborn fetuses as victims of IPV.⁸ While well-intentioned, most of these mandatory reporting statutes are constructed in a manner that further harms the victims that the laws were designed to protect. Such statutes offend the autonomy of competent adult victims through re-victimization, violate patient medical privacy rights, and jeopardize patient safety by increasing the risk of retaliatory violence and driving IPV victims away from essential medical care. These issues, of significant importance to any competent adult IPV victim, are even more critical for pregnant victims and their unborn children—whose access to prenatal health care is crucial.

This Comment will explore: (1) the prevalence and magnitude of the harm caused by IPV against pregnant women, (2) the current legal protections for pregnant IPV victims, (3) the HIPAA privacy rule and the manner in which it affects state reporting statutes for incidents of IPV, (4) the effectiveness of the three current models of reporting statutes that offer some protection to either pregnant IPV victims or their unborn children, and finally (5) this Comment's recommendation that states consider the possibility of adopting a mandatory reporting statute to protect pregnant victims of IPV.

Based on the state's interests in maternal and fetal health, as well as the mother's interest in reproductive self-determination, states may consider the possibility of adopting a reporting statute that requires all health care providers to report to the local government department of social services when they reasonably suspect IPV against a pregnant woman. Upon obtaining the victim's consent, this department would extend resources, aid, and protective services when needed, subject to budgetary limitations. Additionally, either to supplement or to act as a substitute for the reporting statute, states should, at a minimum, require hospitals to institute policies mandating across-the-board: (1) screening for IPV for all pregnant patients who present with physical injuries consistent with IPV, (2) documentation of the victim's injuries, and (3) dispersement of a victim's

porting of Intimate Violence, 7 HASTINGS WOMEN'S L.J. 85, 90 (1996).

⁸ *Id.* (quoting that the letter read "[w]e all are interested in preventing domestic violence and intervening in the cycle of abuse to protect the woman and the unborn fetus").

rights notice to all victims providing information about the impact of domestic violence as well as the victim's legal and community or government shelter options. Furthermore, additional training and education is needed for law enforcement, social workers, and health care providers to increase sensitivity and the ability to effectively screen and identify victims of IPV. This educational advancement can be accomplished by attaching liability to these professionals for failure to report under the mandatory reporting statute or by separate implementation of educational programs by the states.

II. INTIMATE PARTNER VIOLENCE DURING PREGNANCY

A. The Facts

Intimate partner violence (IPV) consists of the use or threat of use of physical, emotional, verbal, or sexual abuse by a current or former partner or spouse with the intent of instilling fear, intimidating, and controlling behavior.⁹ Many scholars have characterized IPV as a pattern or cycle of behavior based on the batterer's control and domination of the victim through abuse or threats, which prevents the victim from making autonomous decisions about her education, employment, family planning, health care, and even daily activities.¹⁰ This continuing pattern of abuse and control provides a wider window for IPV detection, and consequently, statistics regarding the prevalence

⁹ See Michelle Rice, Nat'l Ctr. for Posttraumatic Stress Disorder, Domestic Violence Fact Sheet (2007), http://www.ncptsd.va.gov/nmain/ncdocs/fact_shts/fs_domestic_violence.html#Anchor-Harway-46919 (last visited Dec. 12, 2008); see also Ctr. for Disease Control & Prevention (CDC), Intimate Partner Violence Prevention Scientific Information: Definitions, <http://cdc.gov/ncipc/dvp/IPV/ipv-definitions.htm> (last visited Sept. 5, 2009) (providing uniform definitions for physical, sexual, psychological, and threats of violence).

¹⁰ See Tamara L. Kuennen, *Analyzing the Impact of Coercion on Domestic Violence Victims: How Much is Too Much?*, 22 BERKELEY J. GENDER L. & JUST. 2, 8-10 (2007) (describing characterization of battery as a "pattern of coercive control" through physical and sexual violence, forced isolation, controlled access to food, protection, and outside relationships). Refer to discussion notes 28, 129, *infra*, and accompanying text.

of IPV against women in general are now ubiquitous.¹¹

However, the availability of data on the number of pregnant IPV victims is still limited, and the studies that do exist “cannot be generalized or projected to all pregnant women” as a result of several barriers to accurate data collection.¹² First, currently available national estimates of the number of pregnant IPV victims are not nationally representative of the true number of victims as the studies upon which they are based often: use self-reported data; “do not employ random samples;” are “disproportionately weighted toward specific demographic or socioeconomic populations”; and differ widely in their methodologies.¹³ Second, the transient nature of pregnancy provides only a nine-month window for the detection of pregnancy IPV within a larger pattern of abuse.¹⁴ Third, inconsistent screening practices, stringent patient confidentiality laws and policies, and the control that abusers have over their victims’ ability and willingness to report their abuse hampers data collection.¹⁵

¹¹ See Adele M. Morrison, *Queering Domestic Violence To “Straighten Out” Criminal Law: What Might Happen When Queer Theory and Practice Meet Criminal Law’s Conventional Responses to Domestic Violence*, 13 S. CAL. REV. L. & WOMEN’S STUD. 81, 113 (2003) (“Today, local law enforcement, county and state agencies and federal government offices keep specific domestic violence statistics.”) (citations omitted).

¹² GENERAL ACCOUNTING OFFICE (GAO), REPORT TO THE HONORABLE ELEANOR HOLMES NORTON, HOUSE OF REPRESENTATIVES, VIOLENCE AGAINST WOMEN: DATA ON PREGNANT VICTIMS AND EFFECTIVENESS OF PREVENTION STRATEGIES ARE LIMITED 4, 7 (2002), <http://www.gao.gov/new.items/d02530.pdf> [hereinafter GAO].

¹³ The variations in methodology include “differences in how violence is defined, the time period used to measure violence, and the method used to collect the data.” *Id.* at 7.

¹⁴ Kuennen, *supra* note 10, at 8 (citing Elizabeth M. Schneider, *Battered Women & Feminist Lawmaking* 21-22 (2000) (“Physical abuse [is] a particular ‘moment’ in a larger continuum of ‘doing power,’ which might include emotional abuse, sexual abuse and rape, and other maneuvers to control, isolate, threaten, intimidate, or stalk.”)). This struggle of identifying and documenting instances of IPV in a wide pattern of abusive conduct for female IPV victims is even more difficult for those who are battered during pregnancy – an even narrower temporal window in which to catch the incidents of physical violence.

¹⁵ Michael A. Rodriguez et al., *Screening and Intervention for Intimate Partner Abuse*, 282 J. AM. MED. ASS’N 468 (1999) (finding that primary care physicians are missing opportunities to screen patients for IPV in a variety of clinical situations); See MacIntosh, *supra* note 1, at 190 (suggesting that statistics of pregnant IPV victims might be low because battered women are frequently prevented from seeking medical care during pregnancy by their abusive partners, and the limited medical attention they receive is rendered in the presence of the

Despite these difficulties, the CDC's Pregnancy Risk Assessment Monitoring System (PRAMS) has produced estimates that in 1998 between 2.4 and 6.6 percent of women whose pregnancies resulted in live births had experienced violence during their pregnancies.¹⁶ Roughly translated, of the 3.9 million women in the U.S. who gave birth to live infants in 1998, researchers estimate that "between 152,000 and 324,000 women experienced violence during their pregnancies that year."¹⁷ While the precise number of pregnant IPV victims is unknown, the results of studies based on data from the Pregnancy Mortality Surveillance System (PMSS) conclude that homicide is the second leading cause of injury-related death among pregnant and postpartum women.¹⁸ Results also indicate that homicide claims a greater proportion of pregnant women than non-pregnant women.¹⁹ Although these statistics do not isolate IPV from other possible sources of pregnancy violence, "in the vast majority of cases, violence against pregnant women is perpetrated by an intimate [partner]."²⁰

abuser). The primary source of patient health information protection is the Health Insurance Portability and Accountability Act Privacy Rule codified in 45 C.F.R. §§ 160, 164. See discussion *infra* pp. 13-19.

¹⁶ GAO, *supra* note 12, at 6 (stating that such data was collected only from only 15 participating states in 1998). PRAMS is an "ongoing population-based surveillance system that generates state specific data on a number of maternal behaviors [. . .] and experiences – including physical abuse – before, during and immediately following a woman's pregnancy." *Id.*

¹⁷ Julie A. Gazmararian, et al., *Violence and Reproductive Health: Current Knowledge and Future Research Directions*, 4 MATERNAL & CHILD HEALTH J. 2, 80 (2000) (featuring results of a meta-analysis of thirteen studies regarding the incidence of violence during pregnancy). Furthermore, these studies are under-inclusive of the true problem of IPV during pregnancy as they cannot identify pregnant victims that do not give birth to live children nor those who do not report the violence they experienced. *Id.*

¹⁸ Chang et al., *supra* note 2, at 472. These studies collect data on all reported deaths that occur during or within one year of pregnancy through death certificate information. *Id.*

¹⁹ *Id.* at 474-75 (citing Isabelle L. Horton & Diana Cheng, *Enhanced Surveillance for Pregnancy-Associated Mortality, Maryland, 1993-1998*, 285 JAMA 1455 (2001)(reporting the result that after controlling for race and age, "homicide is still responsible for a greater proportion of deaths among pregnant and postpartum women (20.2%) than among women who ha[d] not been pregnant in the year preceding death (11.2%).").

²⁰ *Id.* at 476 (internal citations omitted) (stating that in 2002, the FBI found that "approximately one-third (32.1%) of female homicide victims [. . .] died at the hands of a husband, ex-husband, or boyfriend"); Deborah Tuerkheimer, *Conceptualizing Violence Against Pregnant Women*, 81 IND. L.J. 667, 672 (2006) (internal citations omitted) (stating that 88 % of cases in-

Medical professionals have proposed several theories to explain the occurrence of violence during pregnancy, including: the abuser's feelings of jealousy or hostility given competition posed by the fetus for the mother's attentions; the stress that accompanies pregnancy, particularly unwanted pregnancy; disputes regarding paternity; and the pregnancy battering as merely a continuation of an abusive relationship that existed prior to the victim's pregnancy.²¹ Although it is uncertain why battering during pregnancy occurs and whether IPV initiates or increases during pregnancy, the harm that results from such abuse to both the pregnant woman and her unborn child is undisputed.²²

B. The Impact of IPV on Pregnant Women and the Unborn Child

IPV during pregnancy has been shown to harm the general health of both the pregnant mother and her unborn child. Women who are abused either during pregnancy or in the preceding year are "40 to 60 percent more likely than non-abused women to report high-blood pressure, vaginal bleeding, severe nausea, kidney or urinary tract infections, and hospitalization during pregnancy, and are 37 percent more likely to deliver preterm."²³ Likewise, for the unborn child, "[m]any adverse fetal outcomes, including miscarriage, still-born birth, preterm labor and delivery, direct fetal injury, fetal hemorrhage, and placental abruption are directly attributable to [the] physical trauma" that stems from violence perpetrated against the

volving trauma during pregnancy resulted from "domestic discord").

²¹ Linda L. Bellig, *Domestic Violence Pregnancy*, 21 INT'L J. CHILDBIRTH EDUC. 2, 19, <http://www.icea.org/images/articles/DOMVIOL.pdf> (last visited October 30, 2008) (internal citations omitted); see also Tuerkheimer, *supra* note 20, at n. 65 (internal citations omitted) (recognizing theories of the non-pregnant partner's "sense of competition with the child for the woman's attention").

²² GAO, *supra* note 12, at 2 (noting that the CDC studies indicate that for most abused women, physical abuse does not initiate or increase during pregnancy).

²³ FAMILY VIOLENCE PREVENTION FUND, THE FACTS ON REPRODUCTIVE HEALTH AND VIOLENCE AGAINST WOMEN 2 (2008), http://endabuse.org/resources/facts/Repro_FINAL_2008.doc (internal citations omitted) [hereinafter VIOLENCE AGAINST WOMEN FACT SHEET].

mother.²⁴

In addition to the physical harm that results to both the pregnant victim and her unborn child, pregnant IPV victims suffer different and, as some suggest, more powerful emotional trauma than non-pregnant victims due to the “unique vulnerability that derives from the status of pregnancy.”²⁵ The controlling and dominating effect that IPV has on a pregnant victim is magnified by her pregnancy, which “itself becomes [a] further mechanism of subordination: a victim’s stake in the pregnancy heightens her vulnerability, intensifying the power differential between herself and the batterer.”²⁶ The deprivation of autonomy that results from such abuse includes not only the loss of personal freedom from harm, but also the compromise of her interests in “reproductive self-determination” and “in developing and maintaining a connection to [her] growing fetus.”²⁷ The loss of control that results from IPV victimization complicates the limited legal efforts taken to prevent or end violence against pregnant women, because any attempts at mandatory intervention, even if benevolent in nature, further increase the loss of control that IPV victims already experience at the hand of their abusers regarding access to education, employment, family and friends, and healthcare. Although legal remedies and protections do exist for pregnant victims of IPV, most are deficient in their conceptualization, intent, design, or implementation and, thus, merit closer scrutiny and evaluation than they have been given in either social scientific or legal discourse.

²⁴ Tuerkheimer, *supra* note 20, at 672.

²⁵ *Id.* at 674, n.35 (citing MacIntosh, *supra* note 1, at 194 (reporting findings by Canadian researchers that pregnant IPV victims “were far less likely than non-abused pregnant women to feel they had any personal control over the well-being of their pregnancy” but instead “expressed a sense of powerlessness over their own lives which extended to their pregnancies, and left them believing that health and well-being were matters of chance which they could not effectively influence”)).

²⁶ See Kuennen, *supra* note 10, at 8-10; Tuerkheimer, *supra* note 20, at 708.

²⁷ Tuerkheimer, *supra* note 20, at 700.

III. CURRENT LEGAL PROTECTIONS TARGETING PREGNANT VICTIMS OF INTIMATE PARTNER VIOLENCE

A. Criminal Protections: Traditional and Modern Responses

Scholars have noted that incidences of IPV against pregnant women seem to have fallen into the “fissures of appellate decisions” —where the courts mention such battering during pregnancy only (1) “while detailing a ‘prior history’ of abuse or simply to complete the event narrative,” or (2) in cases where the “pregnancy is relevant to the charge or charges, most often because a ‘fetal victim’ has been injured.”²⁸ This dichotomy in the focus of appellate decisions that involve pregnant IPV victims parallels the split in the legal protections for pregnant women—those focused on the rights of the pregnant mother and those directed toward the interests of the unborn child.²⁹

1. *The Pregnant Mother*

The first group of legal protections offered to pregnant women and their unborn children focuses on the prosecution of acts perpetrated against the pregnant mother through domestic violence criminal prosecutions³⁰ and the enforcement of civil protective orders.³¹

²⁸ *Id.* at 675-76.

²⁹ *See id.* at 687-94 (describing generally the problem with the focus of laws aimed at ending pregnancy battery on the unborn child).

³⁰ In cases where the pregnant status of the victim is merely a factual footnote in the prosecution of harm perpetrated against the pregnant mother it becomes apparent that the laws used to prosecute in such instances are characterized by a “narrow temporal lens,” where the prosecuted episode of abuse is merely part of a pattern of violent and controlling conduct. *Id.* at 678-79 (internal citations omitted). Such prosecutions also feature “an exclusive focus on physical injury as the sole cognizable harm,” even though the harm extends to the invocation of fear and loss of autonomy manifested in learned helplessness, in which victims respond to abuse through the adaptation of passive behavior as a mechanism to control the threat and incidence of further abuse but lose their autonomy in the process. *Id.*

³¹ All states grant civil protection orders for victims of domestic violence, but the scope of protection (requiring the abuser to stay an explicit distance away, not abuse, or not contact the victim) and the duration of the order (whether it be emergency, temporary, or permanent) varies based upon the provisions of state law. AM. BAR ASS'N, STANDARDS OF PRACTICE FOR

Traditionally, the private nature of IPV prevented criminal prosecution of IPV abusers and provided few legal remedies for the protection of IPV victims because such incidents of abuse went unreported or were inconsistently investigated.³² As private domestic abuse became a public health concern,³³ current criminal laws were applied to prosecute intimate partner abusers for the assault, battery,³⁴ sexual assault, rape, or criminalized stalking of their intimate victims.³⁵ State policies such as warrantless arrest,³⁶ mandatory arrest,³⁷ and “no-drop” prosecution³⁸ have influenced domestic violence prosecutions,³⁹ though the efficacy of such policies is still disputed.⁴⁰

As a precursor to, a result of, or in lieu of criminal charges, IPV

LAWYERS REPRESENTING VICTIMS OF DOMESTIC VIOLENCE, SEXUAL ASSAULT AND STALKING IN CIVIL PROTECTION ORDER CASES 2-3 (2007), <http://www.abanet.org/domviol/docs/StandardsBlackLetter.pdf>.

- ³² Tonya McCormick, *Convicting Domestic Violence Abusers When the Victim Remains Silent*, 13 BYU J. PUB. L. 427, 435 (1999) (describing in brief the legalized history of spousal abuse).
- ³³ Wolfson, *supra* note 6, at 5 (internal citations omitted).
- ³⁴ Morrison, *supra* note 11, at 93 (stating that laws against attempting and/or committing assault, battery, kidnapping, rape and homicide have not always been but are now frequently used in the domestic violence prosecutions).
- ³⁵ Lauren M. Hayter & Victor Voronov (ed.), *Eighth Annual Review of Gender and Sexuality Law: Criminal Law Chapter: Domestic Violence and the State*, 8 GEO. J. GENDER & L. 273, 275-78 (2007) (detailing the statutory organization of domestic violence crimes).
- ³⁶ All states currently permit warrantless arrests “where the arresting officer has probable cause to believe that the batterer has violated a restraining order or committed a criminal act against an intimate partner.” Hayter, *supra* note 35, at 284 (internal citations omitted).
- ³⁷ Several states have laws that require law enforcement to arrest offenders in all domestic violence cases as well as instances of protective order violations, which can even include the IPV victim if there is evidence of self-defense. *Id.* at 286 (internal citations omitted).
- ³⁸ In states with “no-drop” policies, prosecutors are not given discretion to forego charges against an IPV offender, even if the victim requests it. *Id.* at 289 (internal citations omitted).
- ³⁹ Since the bulk of domestic violence offenses are prosecuted by the state, the statistics for such prosecutions vary based on the policies of the state toward law enforcement and prosecution. *See id.* at 282-84; *see also* Myrna S. Raeder, *Domestic Violence in Federal Court: Abused Women as Victims, Survivors, and Offenders*, 19 FED. SENT. R. 91, 1 (2006).
- ⁴⁰ *See id.* at 282-89 (detailing further information including debate regarding the policy and practical reasons for each of these approaches); *see also* Gena L. Durham, *The Domestic Violence Dilemma: How Ineffective and Varied Responses Our Conflicted Views of the Problem*, 71 S. CAL. L. REV. 641 (1998).

victims in all states⁴¹ can obtain civil protection orders⁴² and, in some states, mandatory criminal no-contact orders carried out by law enforcement.⁴³ A civil protection order is a “binding order proscribing a person who has threatened, emotionally abused or injured an intimate partner or family member from having further contact with that intimate partner or family member, or from visiting specific locations such as the victim’s school or workplace.”⁴⁴ The violation of such civil protection orders can be punished by civil contempt or criminal punishment, ranging from criminal contempt to a misdemeanor or felony conviction, particularly if the abuser has previously violated a protection order.⁴⁵ Although obtaining such protection orders can be a crucial step in securing the safety of the IPV victim through the use of modern GPS tracking technologies, the obvious limitations on the availability of such technology and new limitations on police liability for lack of enforcement gut the protection that these orders promise.⁴⁶ In 2005, the United States Supreme Court ruled in *Town of Castle Rock v. Gonzales*, that due to a lack of explicit state statutory direction for the enforcement of protection orders, which required only the use of “every reasonable means of enforcement,” police officers are immune from legal action for failure to enforce a valid protection order, even if such refusal results in the victim’s injury or death.⁴⁷ Many fear

⁴¹ Hayter, *supra* note 35, at 294.

⁴² *Id.* at 294-95 (internal citations omitted).

⁴³ A criminal no-contact order is a purely criminal remedy granted by a judge that “prohibits the defendant from having contact with the victim,” usually as a “conditio[n] of pre-trial release or of sentencing in domestic violence cases.” *Id.* at 291 (internal citations omitted).

⁴⁴ *Id.* at 294-95 (internal citations omitted).

⁴⁵ *Id.* at 279-80 (internal citations omitted).

⁴⁶ Leah Satine, *Conversation: GPS Monitoring of Domestic Violence Offenders: Maximal Safety, Minimal Intrusion: Monitoring Civil Protection Orders Without Implicating Privacy*, 43 HARV. C.R.-C.L. L. REV. 267, 267- 69 (2008) (proposing the feasibility of GPS technology adaptation for supplemental enforcement of protection orders by two viable methods to protect privacy while reporting all violations of the order).

⁴⁷ Hayter, *supra* note 35, at 302-03 (citing 545 U.S. 748 (2005)); see generally Nicole M. Quester, *Refusing to Remove an Obstacle to the Remedy: The Supreme Court's Decision in Town of Castle Rock v. Gonzales Continues to Deny Domestic Violence Victims Meaningful Recourse*, 40 AKRON L. REV. 391 (2007) (describing the ruling’s implications for the enforcement of civil protection orders).

that as a result of this decision, batterers will be encouraged to ignore civil protection orders with the knowledge that the authorities have discretion not to enforce them.⁴⁸

2. *The Fetus*

The second group of legal protections offered to pregnant women and their unborn children focuses on (1) the prosecution of criminal conduct that results in harm to the unborn child under the federal Unborn Victims of Violence Act of 2004 (UVVA)⁴⁹ or state fetal homicide laws⁵⁰ and on (2) laws which criminalize or mandate state intervention in cases of substance abuse by pregnant women.

By recognizing the unborn as separate, distinct victims of prenatal substance abuse or other violent crimes, these laws create a dangerous dichotomy. At best, the UVVA and state fetal homicide laws corrode the fundamental rights of pregnant women by viewing them as mere “vessels” for development of the individual unborn and ignoring their rights and legal interests as individuals.⁵¹ At worst, these laws criminalize or force state intervention in cases where the preg-

⁴⁸ Hayter, *supra* note 35, at 302-03 (citing 545 U.S. 748 (2005)).

⁴⁹ Unborn Victims of Violence Act, 18 U.S.C. § 1841 (West 2004). The UVVA acknowledges unborn children as legal victims of previously codified federal violent crimes by use of transferred intent to the fetus by an attack upon the pregnant mother, regardless of the perpetrator’s knowledge that the victim is pregnant. Tara Kole & Laura Kadetsky, *Recent Developments: The Unborn Victims of Violence Act*, 39 HARV. J. ON LEGIS. 218-19 (2002). However, the statute still delineates the harm to the fetus as a separate offense similarly to the state fetal homicide laws.

⁵⁰ NATIONAL CONFERENCE OF STATE LEGISLATURES, FETAL HOMICIDE, <http://www.ncsl.org/programs/health/fethom.htm> (last visited October 2009). These state fetal homicide laws explicitly criminalize the killing of a fetus, outside the exercise of a woman’s right to choose a legal abortion procedure. *Id.* (reporting that at least thirty-six states have fetal homicide laws, nineteen of which apply to the earliest stages of pregnancy such as fertilization or “any state of gestation”).

⁵¹ Tuerkheimer, *supra* note 20, at 688-89 (internal citations omitted); see also Stacey L. Best, *Wyoming Division: Comment: Fetal Equality?: The Equality State’s Response to the Challenge of Protecting Unborn Children*, 32 LAND & WATER L. REV. 193, 201 note 51 (1997) (internal citations omitted) (describing the philosophical roots behind the conception of women as “vessels” for the developing fetus); Jean R. Schroedel et al., *Women’s Rights and Fetal Personhood in Criminal Law*, 7 DUKE J. GENDER L. & POL. 89, 117 (2000) (“Every expansion in fetal rights has resulted in a commensurate decline in the fundamental rights of pregnant women.”).

nant woman engages in “high risk” behavior, such as the consumption of dangerous substances harmful to the unborn child, and by doing so treat pregnant women as a suspect source of unborn child abuse.⁵² Such laws foster “maternal-fetal conflict” of interests and tighten government control of pregnant women by authorizing criminal sanctions, civil contempt, and forced medical treatment.⁵³ In this division of protection, such laws ignore the interest of the pregnant mother in making reproductive decisions free from third party influence through abuse as well as the interest of the unborn child in freedom from such abuse.⁵⁴ Because no criminal laws adequately protect pregnant IPV victims and their unborn children, this Comment considers a possible reporting statute with the purpose of unifying the interests of both the pregnant woman and her unborn child – through the recognition of their mutual (instead of divided) interests in freedom from IPV and its harmful effects.⁵⁵

B. Reporting Statutes Impacting IPV Victims & The HIPAA Privacy Rule

Reporting statutes generally impose either criminal or civil liabil-

⁵² Tuerkheimer, *supra* note 20, at 689-90.

⁵³ *Id.* at 688-90 (citing Dorothy E. Roberts, *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty* 40 (1997) (“Feminists use the term ‘maternal-fetal conflict’ to describe the way in which law, social policies, and medical practice sometimes treat a pregnant woman’s interests in opposition to those of the fetus she is carrying”)); *see also* Lynn M. Paltrow et al., *Governmental Responses to Pregnant Women Who Use Alcohol or Other Drugs* 1-10 (2000), www.advocatesforpregnantwomen.org/articles/gov_response_review.pdf (describing federal and state reactions to the threat of maternal substance abuse and the assumptions upon which governmental interference in the maternal-fetal relationship is based) (last visited October 2009).

⁵⁴ Though fetal homicide laws protect the interest of the unborn child in not dying prior to birth, these laws do not protect against any prenatal harm that does not result in death, the consequences of which remain uncertain until after the child is born alive.

⁵⁵ Rather than controverting female autonomy by granting separate status and protection to the unborn fetus from violence during pregnancy and forcing the “virtual disappearance of the pregnant woman” and her interests, the courts and legislatures should consider conceptualization of a pregnant woman’s interest as “multiplicitous, not unitary” rather than “counter-autonomous” to include her interests in “reproductive self-determination” and in her “growing connection to the developing fetus.” Tuerkheimer, *supra* note 20, at 693-94, 706-07.

ity on physicians and members of law enforcement who fail to report incidents of violence against a statutorily protected group to the specified authorities.⁵⁶ The legal duty to report overrides patient-physician confidentiality by giving good faith reporters immunity from liability for any reports made pursuant to the particular reporting statute.⁵⁷ All states have mandatory or voluntary reporting statutes that impact IPV victims either directly or remotely, but the provisions of such state laws vary widely.⁵⁸ Although the vast majority of states provide for mandatory reporting of suspected child or dependent adult abuse, only a limited number of states have laws requiring the reporting of abuse for competent adult victims or unborn children.⁵⁹ There are four predominate state approaches to the reporting of IPV for competent adult victims: (1) explicitly requiring the reporting of IPV or competent adult abuse; (2) requiring the reporting of certain types of injuries caused by weapons; (3) mandating the reporting of injuries resulting from violent or non-accidental criminal conduct; and (4) not requiring or authorizing the reporting of IPV by health care professionals.⁶⁰ In states with reporting statutes, individuals and entities obligated to report under such statutes must comply with the federal Health Insurance Portability and Account-

⁵⁶ The penalties imposed for failure to report to the specified authorities (usually either a social services agency or local law enforcement) can range from required continuing education regarding domestic violence to the imposition of fines or jail time. Wolfson, *supra* note 6, at 5; ARIELLA HYMAN, FAMILY VIOLENCE PREVENTION FUND, MANDATORY REPORTING OF DOMESTIC VIOLENCE BY HEALTH CARE PROVIDERS: A POLICY PAPER 7 (1997), <http://endabuse.org/health/mandatoryreporting/policypaper.pdf>.

⁵⁷ Mandatory reporting laws are one of the well-established exceptions to the duty of doctor-patient confidentiality, and without such statutes any disclosure of confidential patient information, of benign or beneficent intent, would be an impermissible violation of the physician's duty to his or her patient. Michelle Oberman, *Mothers and Doctors' Orders: Unmasking the Doctor's Fiduciary Role in Maternal-Fetal Conflicts*, 94 NW. U.L. REV. 451, 462-63 (2000); Wolfson, *supra* note 6, at 5.

⁵⁸ TERESA P. SCALZO, REPORTING REQUIREMENTS FOR COMPETENT ADULT VICTIMS OF DOMESTIC VIOLENCE 2 (2006), <http://www.usmc-mccs.org/famadv/restrictedreporting/Natioinal%20Domestic%20Violence%20Reporting%20Requirements.pdf> (describing several types of reporting laws that directly or indirectly impact the reporting of instances of IPV); Wolfson, *supra* note 6, at 5.

⁵⁹ Wolfson, *supra* note 6, at 5.

⁶⁰ HYMAN, *supra* note 56, at 7.

ability Act (HIPAA privacy rule).⁶¹

The HIPAA privacy rule provides a set of standards for the disclosure of protected health information (PHI) predicated upon the protection of patients' rights to privacy and confidentiality in physician-patient communications.⁶² PHI includes past, present, and future patient medical health information that reveals, or reasonably could reveal, the patient's identity.⁶³ Although the HIPAA privacy rule protects patients' privacy rights, its provisions only preempt state laws that are "contrary to" the requirements and standards set out in HIPAA's administrative simplification provisions.⁶⁴ HIPAA standards do not preempt state law provisions regarding the disclosure of PHI for victims of domestic violence if such provisions either (1) are "more stringent" in the protection of PHI, or (2) "provid[e] for the reporting of disease or injury, child abuse, or death, or for the conduct of public health surveillance, investigation, or intervention."⁶⁵ Accordingly, this non-preemption provision could apply to state laws that tangentially impact competent adult victims of IPV by mandating the reporting of specific types of injuries and wounds, like those from deadly weapons, that an IPV victim could receive from her abuser.⁶⁶ While these laws can impact IPV victims by authorizing PHI disclosure of those who present to health care professionals with the

⁶¹ 45 C.F.R. §§ 160, 164 (West 2008).

⁶² 45 C.F.R. § 160.103 (West 2006); Wolfson, *supra* note 6, at 16.

⁶³ 45 C.F.R. § 160.103; US DEP'T OF HEALTH & HUMAN SERV., SUMMARY OF THE HIPAA PRIVACY RULE 4 (2003), <http://www.hhs.gov/ocr/privacysummary.pdf> [hereinafter SUMMARY].

⁶⁴ "Contrary" provisions of state law are those which make it "impossible for a covered entity to comply with both the state and federal requirements" or that are "obstacle[s] to accomplishing the full purposes and objectives of the Administrative Simplification provisions of HIPAA." SUMMARY, *supra* note 63, at 17; Tamela J. White & Charlotte A. Hoffman, *Privacy Standards under the Health Insurance Portability and Accountability Act: A Practical Guide to Promote Order and Avoid Potential Chaos*, 106 W. VA. L. REV. 709, 716 (2004) (HIPAA does not preempt consistent or more stringent state laws).

⁶⁵ 45 C.F.R. § 160.203(b)-(c) (West 2008).

⁶⁶ Michigan is one such state that requires specific types of injuries be reported. MICH. COMP. LAWS ANN. § 750.411 (West 2001)(requiring the reporting of any individual suffering from a wound or injury inflicted by a knife, firearm, other deadly weapon or other means of violence to law enforcement); See SCALZO, *supra* note 55, at 2 (survey of all state laws potentially impacting IPV victims by reporting injuries to law enforcement).

type of wounds targeted by statute for reporting, the HIPAA privacy rule has specific provisions that authorize the disclosure of PHI of competent adult IPV victims.⁶⁷

Unlike the free authorization of all state mandatory child abuse reporting statutes, the HIPAA privacy rule authorizes the disclosure of PHI of competent adult IPV victims in limited situations.⁶⁸ First, health care providers may report the PHI of an individual that the entity “reasonably believes to be a victim of abuse, neglect or domestic violence” to a government authority including any “social service or protective services agency” authorized to receive such reports if the report is required by law and the instant report complies with and is limited to the requirements of that law.⁶⁹ This provision of HIPAA has made possible mandatory reporting statutes like that of Kentucky’s Adult Protection Act, which requires the reporting of spousal abuse of a competent adult victim to the state’s protective services department, with notification to law enforcement, for the rendering of services to the victim upon consent.⁷⁰ New Mexico has a similar statute that requires the reporting of IPV of “incapacitated adults” and implicitly allows the reporting of abuse of “protected adults,” competent adult victims who consent to protective services or placement, to its Children, Youth, and Families Department.⁷¹ Furthermore, Colorado and California have also enacted laws that require mandatory reporting of criminal acts, including explicitly those that produce injuries consistent with domestic abuse or violence, for all competent adult victims regardless of marital or relationship status.⁷²

⁶⁷ 45 C.F.R. §§ 164.512(c), 164.512(f) (West 2008).

⁶⁸ *Id.*; 45 C.F.R. § 164.512(b)(1)(ii) (allowing for mandatory reporting of child abuse); 45 C.F.R. § 160.203(c) (not preempting state laws for the reporting of child abuse).

⁶⁹ 45 C.F.R. § 164.512(c)(1)(i).

⁷⁰ KY. REV. STAT. ANN. § 209A.010 (West 2008).

⁷¹ N.M. STAT. ANN. § 27-7-14 to 21 (West 2008).

⁷² COLO. REV. STAT. ANN. § 12-36-135 (West 2008) (mandating the reporting to local law enforcement of “any other injury that [medical] licensee has reason to believe involves a criminal act, including injuries resulting from domestic violence”); CAL. PENAL CODE § 11160 (West 2008) (requiring the reporting to local law enforcement of “any person suffering from any wound or physical injury inflicted upon a person where the injury is the result of assaultive or abusive conduct”).

Second, a disclosure of adult IPV victim PHI, if not required by law, can also be possible on a voluntary basis under the HIPAA privacy rule through the consent of the individual.⁷³ Third, such PHI disclosures can be made by health care providers if “expressly authorized by statute or regulation” and the provider “believes the disclosure is necessary to prevent serious harm to the individual or other potential victims.”⁷⁴ Wisconsin appears to use this voluntary reporting provision of the HIPAA privacy rule to justify federal non-preemption of its much more controversial reporting statute.⁷⁵ The Wisconsin statute authorizes medical personnel to voluntarily report suspected abuse of an unborn child as a result of prenatal substance abuse.⁷⁶ Few other states seem to have voluntary reporting provisions for competent adult IPV victims, and those that do typically only do so anonymously for statistical data collection purposes.⁷⁷

Under either a mandatory or voluntary reporting statute, health care providers must provide prompt notice to the individual about whom the report is made unless the provider “in the exercise of professional judgment, believes informing the individual would place the individual at risk of serious harm” or the provider “would be in-

⁷³ 45 C.F.R. § 164.512(c)(1)(ii)(West 2008).

⁷⁴ 45 C.F.R. § 164.512(c)(1)(iii)(A).

⁷⁵ WIS. STAT. ANN. § 48.981 (West 2008). Passed prior to the promulgation of the HHS’s HIPAA standards, the Wisconsin law was not invalidated by the Privacy Rule’s standards. 45 C.F.R. § 160.203 (West 2008).

⁷⁶ In its preemption analysis, the HIPAA Collaborative of Wisconsin justifies the state’s unborn child abuse reporting statute by citation to 45 C.F.R. § 164.512(c), which states the general standards for reporting IPV of adult victims, as well as 45 C.F.R. § 160.203(c), the provision for non-preemption of state laws for the reporting of child abuse. HIPAA COLLABORATIVE OF WISCONSIN, CHAPTER 51.30: HIPAA PRIVACY STANDARDS MATRIX 31 (2003), <http://www.hipaacow.org/docs/PrivacyGrid/51.30%20analysis%20072103.pdf>. However, the validity of such justification is somewhat unclear. Little legal discussion has been made of the Wisconsin statute’s relationship with the federal HIPAA Privacy Rule, and, as such, merits further research. The more controversial and controlling provisions of Wisconsin’s reporting statute will be addressed at length in later sections of this comment.

⁷⁷ This paper primarily focuses on mandatory rather than voluntary reporting statutes for victims of IPV. See HYMAN, *supra* note 56, at 7 (explaining briefly that Mississippi and Pennsylvania allow any person to voluntarily report abuse and that Tennessee health care providers may report anonymous information about incidents to its state Department of Health of IPV for data collection purposes).

forming a personal representative” like a spouse and the provider “believes the personal representative is responsible for the abuse.”⁷⁸ If the individual is unable to consent to the report’s disclosure of PHI due to incapacity, a voluntary report may also be made if law enforcement or a social services agent authorized to receive such a report “represents that [1] the protected health information for which disclosure is sought is not intended to be used against the individual and that [2] an immediate enforcement activity that depends on the disclosure would be materially and adversely affected by waiting until the individual is able to agree to the disclosure.”⁷⁹ These provisions cover all voluntary and mandatory reports entailing the PHI disclosure of adults reasonably believed to be victims of abuse to government authorities—including law enforcement, social services, or protective services agencies—except for reports made for law enforcement purposes such as warrants, grand jury subpoenas, to report the death of an individual, or to report a crime on the reporter’s premises.⁸⁰

Thus, to construct a valid statute that explicitly provides for the reporting of suspected IPV of a pregnant woman and her unborn child to a government protective or social services agency and that would not be preempted by HIPAA, the reporting duty would have to conform to one of the following schemes: (1) mandatory reporting of all suspected instances of IPV against a pregnant woman; (2) reporting with the consent of the pregnant woman; or (3) reporting on a voluntary basis [A] upon the professional belief by reporters that the report is necessary to prevent serious harm to the pregnant wom-

⁷⁸ 45 C.F.R. § 164.512(c)(2).

⁷⁹ 45 C.F.R. § 164.512(c)(1)(iii)(B) (West 2008).

⁸⁰ Under a separate provision, the disclosure of a suspected IPV victim’s PHI may be made for general law enforcement purposes such as warrants, grand jury subpoenas, civil investigations, to report the death of the victim for investigation, to report suspected IPV on the reporters’ premises, or to identify and locate a suspect, fugitive, material witness or missing person. 45 C.F.R. § 164.512(f)(1)(ii), (2), (4), (5). This disclosure provision likely serves to authorize law enforcement or prosecutorial efforts on behalf of a non-consenting adult victim of IPV. The remainder of the provisions including those requiring reporting of physical wounds, reporting the victims of crimes, and crimes in emergencies explicitly direct all regulations requiring or authorizing disclosure of PHI of IPV victims to the standards previously discussed and set out in 45 C.F.R. § 164.512(c). 45 C.F.R. § 164.512(f)(1)(i), (3), (6).

an and her unborn child, or [B] if the pregnant woman cannot consent due to incapacity and an immediate enforcement activity would be materially and adversely impacted by waiting for her consent, but only where the information would not be used against her legally.⁸¹

Furthermore, notice of the making of any voluntary or mandatory report would have to be given to the pregnant woman unless (1) it would place her at a risk of serious harm or (2) to inform her that a report was made would also be to inform her abuser, the person believed to be the cause of her injuries.⁸² With these HIPAA privacy rule standards for the disclosure of IPV victims' PHI in mind, this Comment will explore in greater detail the Wisconsin, California, Colorado, New Mexico, and Kentucky reporting statutes to assess what, if any, implications these statutory schemes may have upon whether or how a reporting statute should be designed to protect the interests of both pregnant IPV victims and their unborn children.

IV. A CLOSER LOOK AT THE AVAILABLE MODELS FOR REPORTING OF IPV AGAINST PREGNANT WOMEN

Wisconsin, California, Colorado, New Mexico, and Kentucky are among the small minority of states that have extended a duty to or provided an opportunity for health care providers to report suspected abuse of a competent adult or an unborn child. These five states present three reporting models that extend varying degrees and quality of protection to pregnant IPV victims—(1) voluntary reporting of unborn child abuse perpetrated by the pregnant woman, (2) mandatory reporting of IPV of competent adults to law enforcement, and (3) mandatory reporting of IPV of competent adults to so-

⁸¹ 45 C.F.R. § 164.512(c)(1). Legal interpretation of this HIPAA administrative simplification provision has not yet determined what constitutes a use of information against the woman legally—specifically whether this would preclude consideration of abuse in custody determinations. This would likely depend on the state's custody determination procedures. This Comment does not explore the custody ramifications of reporting statutes, but this area does merit further research. Most research and legal discussion surrounding reporting statutes of competent adults only mention HIPAA Privacy Rule standards for IPV victims under 45 C.F.R. § 164.512(c) in passing rather than in a detailed discussion.

⁸² 45 C.F.R. § 164.512(c)(2).

cial services with law enforcement notification and victim veto power for services rendered.

A. Targeting the Pregnant Woman While Protecting the Unborn: Wisconsin's Voluntary Unborn Child Abuse Reporting Statute

In 1997, Wisconsin passed Act 292, amending the state's children's code to authorize the voluntary reporting of suspected instances of unborn child abuse, defined narrowly in terms of the harm caused to the fetus by the pregnant woman's excessive consumption of alcohol or controlled substances. In doing so, the Wisconsin legislature opened the door to allow "any person, including an attorney, who has reason to suspect that an unborn child has been abused or has reason to believe that an unborn child is at substantial risk of abuse" to file a report detailing "the facts and circumstances contributing to a suspicion [. . .] of unborn child abuse" to either the state Department of Children and Families, a licensed child welfare agency, or local law enforcement.⁸³

Although all reports are forwarded to the Department of Children and Families for timely investigation, reporters may also request an immediate investigation by law enforcement "if the [reporter] has reason to suspect that the health or safety of [. . .] an unborn child is in immediate danger" of harm from prenatal substance abuse.⁸⁴ Upon such a request, law enforcement must "immediately investigate to determine if there is reason to believe that the health or safety of the [. . .] unborn child is in immediate danger and take any necessary action to protect the [. . .] unborn chil[d]."⁸⁵

While several other states have adopted sister reporting statutes similarly targeting the pregnant woman as the sole source of unborn child abuse, this Comment analyzes only Wisconsin's reporting statute as representative of the unborn child abuse reporting model.⁸⁶ Al-

⁸³ WIS. STAT. ANN. § 48.981(2)(d) (West 2008); WIS. STAT. ANN. § 48.981(3)(a)(1).

⁸⁴ WIS. STAT. ANN. § 48.981(3)(b)(1).

⁸⁵ WIS. STAT. ANN. § 48.981(3)(b)(1)(2); WIS. STAT. ANN. § 48.981 (a)(4).

⁸⁶ See GUTTMACHER INSTITUTE, STATE POLICIES IN BRIEF: SUBSTANCE ABUSE DURING PREGNANCY

though perhaps well-intentioned, this unborn child abuse reporting model is inherently flawed in the protections that it fails to offer pregnant IPV victims and their unborn children.

The first deficiency of the unborn child abuse reporting model is the limited protection offered by the statute to unborn children due to its narrow definition of unborn child abuse. The Wisconsin statute recognizes that the courts and agencies responsible for child welfare under the state children's code "should assist parents and expectant mothers of unborn children in changing any circumstances in the home which might harm the child or unborn child."⁸⁷ Despite this recognition, the Wisconsin legislature explicitly chose to create the new opportunity to report only for the purpose of "ensur[ing] that unborn children are protected against the harmful effects" of prenatal alcohol and substance abuse.⁸⁸ By authorizing reports only upon belief that the unborn child is suffering as a result of "the habitual lack of self-control of their expectant mothers in the use of alcohol beverages, controlled substances or controlled substance analogs, exhibited to a severe degree," this narrow definition of abuse in the unborn child abuse reporting model entirely ignores the equally significant harm to which an unborn child is exposed as a result of IPV against its expectant mother.⁸⁹ Because the unborn child abuse reporting model does not authorize or mandate reporting of suspected IPV against the pregnant woman as it threatens fetal health, this model fails to protect the unborn child from the harmful effects of IPV.

Second, the unborn child abuse reporting model, like the fetal homicide laws similarly geared toward protection of the unborn child rather than both the pregnant woman and her fetus, dehumanizes the pregnant woman by reducing her status under the law "by statutory terms to an 'environment' for a fetus" rather than recognizing her as an individual with reproductive liberty and other autono-

1 (2008), http://www.gutmacher.org/statecenter/spibs/spib_SADP.pdf (last visited Dec. 12, 2008) ("14 states require health care professionals to report suspected prenatal drug abuse, and 4 states require them to test for prenatal drug exposure if they suspect abuse.").

⁸⁷ WIS. STAT. ANN. § 48.01(1)(a).

⁸⁸ WIS. STAT. ANN. § 48.01(1)(bm).

⁸⁹ WIS. STAT. ANN. § 48.02(1)(am); WIS. STAT. ANN. § 48.01(1)(bm) (West 2008).

mous interests.⁹⁰ This debasement of the pregnant woman simplifies the alienation of her individual liberty interests in the more extreme, interventionist provisions of the Wisconsin reporting statute. Such measures allow the state to take a pregnant woman into custody upon reasonable grounds to believe and detain her based on a judicial determination that her habitual lack of self-control in the consumption of alcohol or controlled substances poses a “substantial risk to the physical health of the unborn child.”⁹¹ Further provisions complete the dehumanization of the pregnant woman by allowing the state to detain her until she submits to their attempt to “fix” the negative environment she offers the fetus through mandated alcohol or drug abuse treatment.⁹²

Third, the unborn child abuse reporting model not only fails to recognize and protect the interests of both the pregnant IPV victim and her unborn child, but also fosters “maternal-fetal conflict” of interests by presuming the existence of such conflict before a court even determines that such prenatal substance abuse exists. The statute specifically does so through the automatic mandated appointment of a guardian ad litem to represent the unborn child in all cases of suspected substance abuse by the pregnant woman.⁹³ This provision is based on a series of harmful assumptions, including that pregnant “women who use drugs could simply stop, and failure to do so indicates disregard for the future child’s well-being,”⁹⁴ which fails to consider the complicated nature of addiction. This provision also presumes that “a woman’s use of drugs while pregnant indicates that she would be unable to care for the child once born.”⁹⁵ Furthermore,

⁹⁰ WIS. STAT. ANN. § 48.235(3)(b)(1) (West 2008) (describing the duties of the guardian ad litem who is mandatorily appointed to determine and represent the best interests of the unborn child through an assessment of the “appropriateness and safety of the environment” of the child at every stage of the process); Paltrow, *supra* note 53, at 9-10.

⁹¹ See WIS. STAT. ANN. § 48.193(1)(c)-(d) (West 2008).

⁹² WIS. STAT. ANN. § 48.205(1m) (West 2008).

⁹³ WIS. STAT. ANN. § 48.235(3)(b) (generally describing the responsibilities and duties of the guardian ad litem).

⁹⁴ Paltrow et al., *supra* note 53, at 5.

⁹⁵ *Id.* at 6.

the provision also presumes that no false positive reports ever occur—despite the fact that reports may be filed by “any person, including an attorney,” who may lack both personal knowledge of the circumstances as well as the expert knowledge necessary to diagnose substance abuse.⁹⁶

Fourth, the provisions of the unborn child abuse reporting model significantly encroach upon patient privacy and usurp the autonomy of pregnant women in their medical and life decisions.⁹⁷ Although all reporting statutes are offensive to patient privacy, the unborn child abuse reporting model in particular reveals not only general PHI of the pregnant woman but, specifically, information regarding the frequency of her alcohol and controlled substance consumption, regardless of her consent. Furthermore, this model effectively revokes the autonomy of a legally competent adult pregnant woman to make her own medical decisions by at best subjecting her to a court’s fact-finding of her ability to care for her own child and at worst holding her against her will until she submits to a good faith effort to participate in court-ordered medical treatment for substance abuse.⁹⁸

For the purposes of this Comment, the unborn child abuse reporting model embodied by the Wisconsin reporting statute is relevant because of what the model fails to provide, the protection of pregnant IPV victims and their unborn children, and what it does provide—the usurpation of the autonomy of pregnant women and the encouragement of maternal-fetal conflict. Two conclusions emerge from the analysis of this model. First, the reporting model does take an affirmative step toward protecting the interest of the pregnant woman’s unborn child in survival and development.⁹⁹ However, the model does so at the cost of oversimplifying and ignoring the important individual interests of the pregnant mother. Sec-

⁹⁶ WIS. STAT. ANN. § 48.981(2)(d) (West 2008).

⁹⁷ See WIS. STAT. ANN. § 48.205(1m) (West 2008).

⁹⁸ *Id.*

⁹⁹ Though placed in the context of preventing an unborn child’s exposure to substance abuse, the Wisconsin statute does recognize an unborn child’s interest in satisfying its basic needs “including the need to develop physically to their potential and the need to be free from physical harm.” WIS. STAT. ANN. § 48.01(am) (West 2008).

ond, this Comment concludes that instead of exclusively considering the interests of the unborn child in freedom from the harm of prenatal substance abuse, states should authorize or mandate reporting of IPV against pregnant women to recognize, protect, and unify the significant interests of the unborn child in being free from the harmful effects of IPV and of the pregnant victim in her reproductive liberty.

B. Re-victimization of Pregnant IPV Victims: Mandatory Reporting of IPV for Competent Adult Victims to Law Enforcement

A second reporting model that offers protection to pregnant victims of IPV is mandatory reporting to law enforcement for competent adult victims. Colorado and California have substantively similar IPV reporting statutes, which require health care providers to report to local law enforcement injuries of competent adult patients that are the “result of assaultive or abusive conduct” or “any other injury that the [reporter] has reason to believe involves a criminal act, including injuries resulting from domestic violence.”¹⁰⁰ Although there are strong arguments made both in favor and against the mandatory reporting to law enforcement model, the predominant voice that emerges from states like California and Colorado is one that initially rejects the current model in favor of more research on the impact of current mandatory reporting laws that extends beyond anecdotal evidence and instead encompasses “large-scale, multi-center trials” that assess the “risks and benefits of mandatory reporting.”¹⁰¹

¹⁰⁰ CAL. PENAL CODE § 11160 (West 2008) (including subsection (d) which defines “assaultive or abusive conduct” to include, attempted or actual battery, torture, assault, spousal rape, or abuse of a spouse or cohabitant); COLO. STAT. ANN. § 12-36-135 (West 2008) (defining domestic violence as “an act upon a person with whom the actor is or has been involved in an intimate relationship” including any crime “when used as a method of coercion, control, punishment, intimidation, or revenge directed against a person with whom the actor is or has been involved in an intimate relationship”).

¹⁰¹ Laura G. Iavicoli, *Mandatory Reporting of Domestic Violence*, 72 MOUNT SINAI J. MED. 228, 231 (2005), available at http://www.mssm.edu/msjournal/72/72_4_pages_228_231.pdf.

1. *Arguments in Favor of the Mandatory Reporting to Law Enforcement Model*

Proponents of the mandatory reporting to law enforcement model advance a variety of arguments in support of mandatory reporting for all instances of IPV, regardless of the victim's status as a competent adult, including that such statutes: (1) increase the commitment of health care providers to providing protocols and additional training to better screen for, treat, and document the injuries that result from IPV; (2) hold the perpetrator responsible by publicly labeling the behavior as unacceptable and by prosecuting individual batterers; (3) enhance patient safety by providing an opportunity for intervention at the earliest point possible; (4) encourage IPV victim education about their legal options and opportunities for support and shelter; and (5) give health care providers an opportunity to respond ethically and professionally to IPV without overburdening them.

First, physicians in California "have seen a dramatic increase in the commitment made by healthcare institutions to address domestic violence" since the adoption of the state's mandatory reporting model.¹⁰² This heightened commitment can be seen in the increased adoption of domestic violence policies and protocols by emergency departments, resulting in the proliferation of "standardized injury forms, information packets for patients, cameras for documenting injuries, and social service workers poised to intervene."¹⁰³ Similarly, these California physicians argue that the state's mandatory reporting model has also increased training and education on domestic violence issues "necessary for effective intervention and even screening practices" as a result of physician recognition of their legal liability for reporting.¹⁰⁴ "Without question, mandatory reporting has improved the identification and treatment" of IPV victims, because those victims seeking medical care are increasingly encountering physicians now "familiar with the 'red flags' of domestic violence" who are trained to "demonstrate concern, ask critical questions, and

¹⁰² Bauer et al., *supra* note 6, at 119.

¹⁰³ *Id.* at 119-20.

¹⁰⁴ *Id.* at 123.

create an environment where patients feel safe.”¹⁰⁵ Physicians also argue that in conjunction with increased detection, this model has encouraged better documentation of IPV by requiring specificity in reporting of the cause of injury and the perpetrator’s name, which can later be used by victims “in criminal prosecution, divorce, child custody, and civil cases.”¹⁰⁶

However, some physicians argue that the actual impact of California’s mandatory reporting law is unknown due to the enactment of amendments to the state’s Joint Commission on the Accreditation of Health Care Organization requirements, obligating “hospitals and medical directors to establish written policies and protocols for screening patients for spousal and partner abuse.”¹⁰⁷ While it is impossible to know which legislative enactment caused the increase in protocols and detection, it is clear that this complementary enactment of laws has made a significant impact on the problem of detecting and treating IPV victims in California.

Second, proponents of the mandatory reporting to law enforcement model argue that the model holds individual perpetrators responsible for their acts of abuse and violence while also sending “a clear message to the victim and to society that domestic violence is a crime and will not be tolerated.”¹⁰⁸ Given that the “strongest deterrent to continued violence is the threat of incarceration,” not reporting IPV is arguably “tantamount to aiding and abetting a batterer and deprives the victim of the opportunity for the criminal justice system to work.”¹⁰⁹ Not requiring the reporting and investigation of suspected IPV, as with any other crime, reinforces traditional views of

¹⁰⁵ *Id.* at 119-20.

¹⁰⁶ *Id.* at 120. The California statute in particular also recommends, but does not require, health care providers to include “a map of the injured person’s body showing and identifying injuries and bruises at the time of the health care” in their report. CAL. PENAL CODE § 11161(b)(2) (West 2008).

¹⁰⁷ *Id.* at 123 (citing CAL. HEALTH & SAFETY CODE §§ 1233.5, 1259.5 (West 1999)) (attributing the increase in number of emergency department protocols for adult victims of IPV from 43% in 1992 to 79% in 1997 to these legislative changes rather than the mandatory reporting statute).

¹⁰⁸ Bauer et al., *supra* note 6, at 120.

¹⁰⁹ *Id.* at 119-20.

IPV that negatively impact its victims: "that the matter is a purely private dispute and that the harm is less serious than violence by a stranger."¹¹⁰ Similarly, physicians in California analogize mandatory reporting of IPV for competent adult victims to the now widespread mandatory reporting of sexual assault crimes, which over a decade ago was "harshly criticized for its paternalism."¹¹¹

Third, this mandatory reporting model is purported to enhance the safety of IPV victims by providing a window of opportunity for intervention.¹¹² Opponents argue, as developed later in this Comment, that the model jeopardizes victim safety because it increases the risk of retaliatory violence by the abuser against the victim as a result of mandatory law enforcement involvement through investigation and, often, the arrest of the abuser.¹¹³ Although the health care provider is responsible for the report, the abuser blames the victim for revealing the abuse to the authorities.¹¹⁴ Proponents of the mandatory reporting model argue that the "victim-in-charge" approach leaves the IPV victim without any protection by law enforcement when and if the victim does choose to leave her abuser—a period during which the victim is at an even greater risk of being seriously injured or killed.¹¹⁵ For many victims, intimate partner violence is "a prelude to murder,"¹¹⁶ which cannot be detected or stopped unless the victim finds a way to reach out to her physician, the community, or to law enforcement. Although the "victim-in-charge" approach is supposed to "'empower' the victim and allow her to rebuild her family, if she wishes, or 'give' her the self-esteem to leave the violent relationship," it fails to give her the tools to do so; instead this approach sends a message of "systemic indifference to the problem, couched in

¹¹⁰ Durham, *supra* note 40, at 655.

¹¹¹ Bauer et al., *supra* note 6, at 120.

¹¹² *Id.*

¹¹³ See discussion *infra* Part IV.B.2.

¹¹⁴ *Id.*

¹¹⁵ See Durham, *supra* note 40, at 654-56 (criticizing the "victim-in-charge" approach for its systematic indifference).

¹¹⁶ Bauer et al., *supra* note 6, at 120.

terms of ‘empowering’ the victim.”¹¹⁷

Fourth, the mandatory reporting model fosters education of IPV victims regarding their legal options and opportunities for support and shelter from government social services or within the community.¹¹⁸ California physicians also specifically argue that “through emotional support and honest discussions, patients can be persuaded to cooperate with law enforcement,”¹¹⁹ which can further ensure their safety. Fifth, health care providers under this model are able to respond ethically “to avoid causing harm, to prevent serious injury and to act for the benefit of the patient”¹²⁰ without being overburdened with additional obligations to thoroughly counsel all IPV victims, personally educate them about the risks of IPV, develop safety plans, and conduct follow-ups with patients as opponents of the mandatory reporting to law enforcement model advocate.¹²¹ This may be an appropriate approach for some health care providers who have a practice more conducive to extensive patient counseling. However, consigning the entire burden to all health care providers, irrespective of the time constraints and demands this will place on different providers, is not wise when the burden instead could be shared by social service agencies who would substitute for or supplement law enforcement intervention. Furthermore, mandatory reporting in general gives a clear protocol for health care providers to follow, which leaves less room for abuse of discretion in reporting.

2. Arguments Against the Mandatory Reporting to Law Enforcement Model

Although its provisions are not as nefarious as those of the Wisconsin unborn child abuse reporting model, the mandatory reporting to law enforcement model does result in an equally objectionable en-

¹¹⁷ Durham, *supra* note 40, at 654-55.

¹¹⁸ Bauer et al., *supra* note 6, at 120.

¹¹⁹ *Id.*

¹²⁰ See Bauer et. al., *supra* note 6, at 121.

¹²¹ Mia M. McFarlane, *Mandatory Reporting of Domestic Violence: An Inappropriate Response for New York Health Care Professionals*, 17 BUFF. PUB. INT. L.J. 1, 35 (1998/1999).

croachment upon the individual liberty of competent adult IPV victims by eliminating the requirement of patient consent for reporting. Similarly, the mandatory reporting to law enforcement model raises a host of practical concerns that bear on the efficacy of enforcing such mandates, whether it is instituted for all competent adult victims of IPV or pregnant victims specifically. The central arguments against the mandatory reporting to law enforcement model are that these laws: (1) fail to acknowledge and respect IPV victims as autonomous adults capable of independent decision-making, thus reinforcing harmful stereotypes of IPV victims as helpless; (2) compromise the confidentiality and trust of the doctor-patient relationship and act as potential deterrents to IPV victims receiving proper medical care; (3) jeopardize the safety of IPV victims by posing a risk of retaliatory violence; and (4) produce uncertain results in the quality of patient care due to inconsistencies in reporting and lack of effective enforcement.¹²²

While passed with the intention of aiding IPV victims, the California mandatory reporting statute and its Colorado counterpart are, first and foremost, "mismatched against [. . .] battered wom[e]n's autonomy and against the problem of domestic violence generally."¹²³ The primary problem is the set of assumptions upon which such laws are premised – (1) that all IPV victims are helpless or otherwise incapable of calling for police assistance or extricating themselves from their abusive relationship, and (2) that every missed opportunity to contact law enforcement is a failure of the community's relationship and duty to the IPV victim.¹²⁴ This oversimplifies the complex problem of IPV and as a result forcibly removes from the victim the important decision of when to leave her abuser.¹²⁵ In doing so, manda-

¹²² See Bauer et al., *supra* note 6, at 121-23; Mooney & Rodriguez, *supra* note 7, at 101-9; COLORADO COALITION AGAINST DOMESTIC VIOLENCE, MANDATORY REPORTING BY HEALTH CARE PROFESSIONALS 3, <http://www.ccadv.org/publications/CCADV-MandatoryReportingIssueBrief.pdf> (last visited Dec. 12, 2008) [hereinafter COLORADO COALITION].

¹²³ Mooney & Rodriguez, *supra* note 7, at 111.

¹²⁴ *Id.* at 103.

¹²⁵ *Id.*; HYMAN, *supra* note 56, at 5.

tory reporting to law enforcement “not only impinges on the patient’s self-determination, but in the process perpetuates harmful stereotypes of battered women as passive and helpless” and “re-[v]ictimizes battered patients” whose life decisions are already controlled by their batterers.¹²⁶

At the root of the mandatory reporting to law enforcement model is a statutory usurpation of patient freedom in medical and personal decision-making that the IPV victim would otherwise have as any other patient based on the doctrine of informed consent.¹²⁷ This loss of self-determination reinforces the dangerous presumption that all IPV victims are incapable of autonomous, informed decision-making due to their state of learned helplessness.¹²⁸ This assumption is faulty not only due to the dearth of definitive research into the consistency of the psychological effect of IPV on all victims, but also due to the diversity of situations from which IPV victims emerge to seek medical assistance.¹²⁹ Although not all IPV victims suffer from learned helplessness, all victims of abuse do experience a loss of control at the hands of their abusers, which is difficult to regain when mandatory reporting statutes serve to further deny them their most significant independent decisions—namely, the decision of when and how to report abusive partners to the authorities based on the victim’s own assessment of timing and degree of personal risk.¹³⁰ Opponents to the mandatory reporting model prefer a “victim-in-charge” approach instead because the model blocks the attempts of “survivors of abuse to [heal and] reclaim their own sense of control and to

¹²⁶ *Id.*

¹²⁷ See HYMAN, *supra* note 56, at 5 (“Informed consent is a principal tenet of medicine by which providers empower patients to make informed medical decisions. Mandatory reporting would require the provider to report [IPV] injuries even if the patient does not give his/her consent”). Under the doctrine of informed consent, “competent informed adults should be given the freedom to act in accordance with their values and goals.” Bauer et al., *supra* note 6, at 122.

¹²⁸ See Bauer et al., *supra* note 6, at 122 (critiquing mandatory reporting statutes for characterizing all IPV victims as passive and helpless)

¹²⁹ See Mooney & Rodriguez, *supra* note 7, at 104.

¹³⁰ See Bauer et al., *supra* note 6, at 122 (commenting that mandatory reporting statutes may revictimize IPV victims rather than help them control their lives)

be empowered to make decisions in their best interest."¹³¹

Second, some health care providers in California criticize the mandatory reporting to law enforcement model for disturbing the doctor-patient relationship by violating the doctrine of nonmaleficence and undermining the confidentiality and any trust IPV victims have in the healthcare system.¹³² While stifling patient autonomy, this model "removes the ability of healthcare providers to decide," in their professional discretion, what is "in the best interests" of their IPV patients, to whom they owe a duty to do no harm, and secures providers very little control over the "level of protection their patients subsequently receive."¹³³ Furthermore, the violation of confidentiality and trust associated with the forced disclosure of IPV victims' PHI undermines the doctor-patient relationship by deterring IPV victims from confiding in their providers about their abusive relationships or from seeking medical care entirely for fear of such information being reported to law enforcement.¹³⁴ IPV victims withhold information from doctors because the lost trust between the doctor and patient is amplified by the lost trust between the victim and her intimate abuser.¹³⁵ Even if the patients themselves are not deterred from seeking medical care, their abusers "may also prohibit their current or former partners' access to health care when it is suspected that reports are being made" or may attend the medical con-

¹³¹ *Id.* at 122.

¹³² *Id.* at 122-23.

¹³³ *Id.* at 122.

¹³⁴ *Id.* at 121-23. One focus group participant states that she thought mandatory reporting statutes "would make people less apt to tell the doctor what they needed to tell him for the[ir] own health." Mooney & Rodriguez, *supra* note 7, at 95 (citing Michael Rodriguez et al., Battered Women Focus Group Study (1993-94) (unpublished transcript) (quoting a comment made by one participant during an interview as part of the Battered Women Focus Group Study of eight focus groups separated into four ethnic groups comprising a total of 51 women to determine barriers to and how to improve healthcare for battered women) [hereinafter Battered Women Focus Group Study]).

¹³⁵ Mooney & Rodriguez, *supra* note 7, at 98 (citing Battered Women Focus Group Study, *supra* note 134 (detailing the description of one focus group participant regarding the difficulty in trusting others that results from abuse by someone that the victim originally trusted)).

sultations with their victims to prevent such IPV reports,¹³⁶ impairing the proper diagnosis and treatment of IPV injuries.

Third, the mandatory reporting to law enforcement model places the IPV victim at risk of harm from retaliatory violence by their intimate abusers because “batterers often escalate the violence if their partners seek outside help or attempt to leave the relationship;” after all, “separation is the ultimate challenge to the batterer’s power.”¹³⁷ Despite the fact that the legal and practical responsibility of filing the report is placed on the health care provider, the abuser may blame the victim “for revealing the source of their injury,” as one participant in a battered women focus group study revealed that she also feared.¹³⁸ Given the risk of retaliatory violence and the cyclical or patterned nature of IPV, mandatory reporting to law enforcement in particular can be dangerous if law enforcement attempts to intervene when the victim refuses to leave because she is not yet prepared to leave the home practically or end the relationship emotionally.¹³⁹ Furthermore, because law enforcement cannot feasibly provide twenty-four hour protection for every IPV victim about whom a report is made, victims who do leave fear that the police will be unable to protect them and, consequently, tend to view police involvement as

¹³⁶ Bauer et al., *supra* note 6, at 121-22; Bellig, *supra* note 21, at 19 (recognizing that batterers may accompany the victim and insist on being present for any interview or examination of the victim, which may appear “as loving concern or attachment to the pregnancy; however it is done to maintain control over the victim and to hide any sign of abuse”).

¹³⁷ *Id.* at 121 (up to 75% of IPV assaults reported to law enforcement occur after the couple has separated and 73% of emergency room IPV victims had been abused after leaving the batterer); McFarlane, *supra* note 121, at 7-9.

¹³⁸ Bauer et al., *supra* note 6, at 121; Mooney & Rodriguez, *supra* note 7, at 106 (citing Battered Women Focus Group Study, *supra* note 134, at 29)).

¹³⁹ Regardless the view of IPV as a cycle of violent physical abuse that escalates to a peak then reconciles the victim and the abuser or a constant pattern of abuse, including physical violence, that dominates the victim into submission, the ultimate conclusion remains that the IPV victim’s situation can vary from victim to victim and at different points in time. See McFarlane, *supra* note 121, at 6-9. One focus group participant describes that “the [victim] has to be ready to take the steps that are necessary for her to be safe [. . .] [a]nd if it’s not at that point, it’s going to put her into a lot more jeopardy.” Mooney & Rodriguez, *supra* note 7, at 96 (citing Battered Women Focus Group Study, *supra* note 134, at 22-24).

dangerous.¹⁴⁰

Finally, the impact of the mandatory reporting to law enforcement statutes currently in existence on the quality of patient care for IPV victims is uncertain, given: (1) the need for additional training and education for health care providers to more effectively screen and identify victims of IPV; (2) the failure of many providers to mandatorily report victims of IPV in accordance with the law; and (3) the existence of inconsistency and bias in the reporting that does occur.¹⁴¹ Lack of training to detect IPV is a widely known complaint concerning the effectiveness of mandatory reporting, but one that is frequently overlooked.¹⁴² In Colorado, one study revealed that only four in ten physicians of the 684 surveyed reported IPV injuries to law enforcement in accordance with their statutory duty to report.¹⁴³ Low levels of compliance with reporting laws can be attributed to any number of factors, including "lack of awareness of laws, failure of providers to identify cases, opposition to mandatory reporting, and concern the police will not adequately respond."¹⁴⁴ As with any reporting statute, there will be a risk of both intentional and unintentional differences in IPV reporting, which may fall disproportionately on "low income and minority patients [. . .] thus perpetuating harmful stereotypes," similar to how child abuse reporting statutes have impacted these same groups as a result of racial discrimination and the confusion of the symptoms of poverty with those of abuse.¹⁴⁵ As with the training needed for proper screening, the risk of abuse in reporting should also be considered and minimized in the construction of any reporting statute. However, this problem may be an unavoidable evil in light of the harm that the reporting model could prevent.

¹⁴⁰ Mooney & Rodriguez, *supra* note 7, at 106 (citing Battered Women Focus Group Study, *supra* note 134, at 17, 22); *see also* McFarlane, *supra* note 121, 22-23 (noting the inability of law enforcement to provide around-the-clock protection).

¹⁴¹ *See* Bauer et al., *supra* note 6, at 122.

¹⁴² *Id.* at 122, 124 (describing California's need for further education, training and protocols to improve the effectiveness and sensitivity of reporters).

¹⁴³ *See* COLORADO COALITION, *supra* note 122, at 3.

¹⁴⁴ Bauer et al., *supra* note 6, at 122.

¹⁴⁵ *Id.* at 122.

3. *Mixed Patient Response to the Mandatory Reporting to Law Enforcement Model*

Proponents and opponents alike cite to statistical and anecdotal patient approval and disapproval of the mandatory reporting to law enforcement model. Proponents refer to statistical studies in California that indicate approval of mandatory reporting laws and conclude that such laws do not deter patients from seeking care. One California study found that “a higher percentage (55.7%) of recently abused female emergency department patients do support mandatory reporting,” as opposed to 44.3% who disapproved of the current model due to “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.”¹⁴⁶ Two additional studies have concluded that the mandatory reporting model “do[es] not deter patients from seeking care and that [IPV] survivors don’t believe [the] laws put them at greater risk for future violence.”¹⁴⁷ The model’s opponents, however, cite to a great deal of anecdotal evidence of IPV survivors who disapprove of the model due to negative experiences and to surveys of physicians, which indicate that over two-thirds of physician respondents believe that the model potentially harms patients and interferes with the patient-physician relationship.¹⁴⁸ Opponents also frequently reference the disapproval of the mandatory reporting to law enforcement model by local domestic violence organizations in states that have adopted it and the American Medical Association’s disapproval of any mandatory reporting statute that fails to provide for patient privacy protection and an opt-out provision for non-consenting competent adults.¹⁴⁹ Further re-

¹⁴⁶ Michael A. Rodriguez, et al., *Mandatory Reporting of Domestic Violence Injuries to the Police: What do Emergency Department Patients Think?*, 286 JAMA 580, 582 (2001).

¹⁴⁷ Iavicoli, *supra* note 101, at 230.

¹⁴⁸ HYMAN, *supra* note 56, at 6 (referring to anecdotal evidence collected by the San Francisco Neighborhood Legal Assistance Foundation and the California Alliance Against Domestic Violence and citing transcripts from a survey of physicians in California, conducted by Michael Rodriguez, University of California-San Francisco, and Pacific Center for Violence Prevention).

¹⁴⁹ See McFarlane, *supra* note 121, at 20-21, 35.

search “on the experiences and perspectives of battered patients, particularly those who have been reported by a healthcare provider,” is needed to properly assess the efficacy of the mandatory reporting to law enforcement model.¹⁵⁰

4. Conclusions Drawn from the Mandatory Reporting to Law Enforcement Model

Several conclusions relevant to the possibility of a reporting statute for pregnant IPV victims and their unborn children can be drawn from this model. First, a mandatory reporting statute could result in increased detection and effective reporting of IPV against pregnant women, if enacted in combination with a law requiring hospitals to establish written policies and standards for the detection and treatment of intimate partner violence in pregnant women like in California. Second, more studies are needed regarding the effect of this mandatory reporting model on patients, specifically in terms of the rate of retaliation and patient thoughts regarding medical care avoidance for fear of reporting. These results should then be compared to results of similar research regarding the two other models discussed herein to consider the mandatory reporting to law enforcement model's effectiveness in protecting victims of IPV and their unborn children before such a strong policy is adopted. Third, in light of the model's re-victimization effect and its violation of IPV victim autonomy, some form of patient opt-out or override should be provided to competent adult pregnant IPV victims if a mandatory reporting statute is implemented. This patient opt-out or override function could be achieved by allowing the patient to control whether a report is made under non-emergency circumstances or whether the report is made to law enforcement directly or to social services. Fourth, to ensure consistency in reporting, even in the mandatory reporting model, further training for IPV detection should be funded and stiff penalties imposed for failure to report or reporting in bad faith.

C. Mandatory Reporting to Social Services with Notification to Law Enforcement & Victim Veto for Services Offered: A

¹⁵⁰ Bauer et al., *supra* note 6, at 123-2.

Helping Hand to Pregnant Victims of IPV

The final reporting model mandates reporting of IPV against competent adult victims to social services first with notification to law enforcement thereafter, but allows the victim to reject the offer of protective services. The Kentucky¹⁵¹ and New Mexico¹⁵² IPV reporting statutes each embody this model, which appears to present the most viable reporting statute scheme of those that currently exist. Generally, this model offers protective intervention to pregnant IPV victims while still allowing them to retain control over their decision to involve law enforcement or to leave their abusive partners.¹⁵³ Since the Kentucky and New Mexico statutes are substantively similar, except that Kentucky's statute applies only to reporting of spousal abuse, this Comment will analyze the Kentucky statute as a model for mandatory reporting to social services with victim veto for services offered.¹⁵⁴

Kentucky's Adult Protection Act, as currently constructed in Chapter 209A of the Kentucky Code Title on Economic Security and Public Welfare, requires the reporting of suspected spousal abuse for the purpose of "identify[ing] victims of domestic violence, abuse, or neglect inflicted by a spouse, and [providing] for the protection of adults who choose to access those services."¹⁵⁵ Kentucky mandates that individuals report when they have "reasonable cause to suspect that an adult has suffered abuse or neglect."¹⁵⁶ The person making the oral or written report is required to provide the following PHI, if known, including: name, address, and age of the adult; "nature and extent of the abuse or neglect, including any evidence of previous

¹⁵¹ KY. REV. STAT. ANN. § 209A.010-.080 (West 2008).

¹⁵² N.M. STAT. ANN. §§ 27-7-14 to 31 (West 2008).

¹⁵³ *See id.*; *see also* KY. REV. STAT. ANN. § 209A.010-.080 (West 2008).

¹⁵⁴ *See* KY. REV. STAT. ANN. § 209A.010.

¹⁵⁵ KY. REV. STAT. ANN. § 209A.010.

¹⁵⁶ KY. REV. STAT. ANN. § 209A.030(2) ("Any person, including but not limited to physician, law enforcement officer, nurse, social worker, cabinet personnel, coroner, medical examiner, mental health professional, alternate care facility employee, or caretaker" is required to report").

abuse or neglect"; "the identity of the perpetrator, if known"; and "the identity of the complainant, if possible."¹⁵⁷ Once the report is received, the Kentucky Cabinet for Health and Family Services is required to: "notify the appropriate law enforcement agency"; investigate the complaint; and "make a written report of the initial findings together with a recommendation for further action, if indicated."¹⁵⁸

Although the statute requires notification to law enforcement, "this does not mean that a police authority follows up on each notification," particularly given that the Kentucky reporting statute contains no provision mandating law enforcement investigation of such reports.¹⁵⁹ In the course of the cabinet investigation, any representative can access the PHI included in the adult's mental and physical health records and may, only with permission of the adult, enter "any private premises where any adult alleged to be abused or neglected is found."¹⁶⁰ If protective services are found to be necessary during the investigation, the cabinet provides, upon consent of the adult, protective "social services aimed at preventing and remedying abuse or neglect."¹⁶¹

1. Analyzing the Model for Mandatory Reporting to Social Services With Notification to Law Enforcement and Victim Veto Power for Services Offered

Many of the benefits of the mandatory reporting to law enforcement model are similarly derived from the mandatory reporting to social services model.¹⁶² The mandatory reporting to social services model secures the majority of the principal benefits as it: (1) provides legal liability as an incentive for health care providers to train and

¹⁵⁷ KY. REV. STAT. ANN. § 209A.030(3)-(4) (West 2008).

¹⁵⁸ KY. REV. STAT. ANN. § 209A.030(5).

¹⁵⁹ Karen P. West et al., *The Mandatory Reporting of Adult Victims of Violence: Perspectives from the Field*, 90 KY. L.J. 1071, 1074 (2001-2002); see generally, KY. REV. STAT. ANN. §§ 209A.010-.080. The statute only requires investigation by the Cabinet for Health and Family Services rather than law enforcement. See KY. REV. STAT. ANN. § 209A.030(5).

¹⁶⁰ KY. REV. STAT. ANN. § 209A.030(7)-(8).

¹⁶¹ KY. REV. STAT. ANN. § 209A.030(9), (5).

¹⁶² See discussion *supra* pp. 48-54.

educate themselves to effectively intervene by identifying, treating, and reporting IPV against competent adult victims; (2) holds the batterer accountable for his criminal conduct; and (3) sends a clear message to society that IPV is just as harmful and unacceptable as other violent criminal conduct against strangers.¹⁶³ However unlike the mandatory to law enforcement reporting model, the mandatory to social services reporting model provides a system of passive intervention that allows the victim to maintain control over when and if she leaves the abusive relationship by allowing her to: (1) physically exclude social services from entering the home or other private premises, and (2) reject any offer of protective or other social services made by the government.¹⁶⁴

Although the predominant criticism of mandatory reporting statutes for IPV victims centers upon the mandatory reporting to law enforcement model, many of the same arguments are reiterated in critique of the model for mandatory reporting to social services with notification to law enforcement and victim veto power for services offered. This Comment will analyze the manner in which the mandatory reporting to social services model measures up to the three main concerns at the root of the arguments made by opponents to all mandatory reporting models: (1) patient autonomy, (2) patient safety, and (3) patient care.

a. Patient Autonomy

Under the umbrella of patient autonomy, opponents argue that the mandatory reporting to social services model's paternalistic na-

¹⁶³ *Id.*

¹⁶⁴ KY. REV. STAT. ANN. § 209A.030(8)-(9) (West 2008). At worst, even if the victim chooses not to accept protective services, this mandated contact with a social worker, while intrusive, gives the IPV victim a file and a contact to whom she may turn whenever, if ever, she is prepared and chooses to leave the relationship. However, it is important to note that any investigation could impact the current home situation by entailing the removal of a child born alive that is either being abused or is imminent risk of abuse. Furthermore, it is still uncertain what role protective services or law enforcement might play once the unborn child is born alive if the pregnant woman chooses not to leave the abusive relationship. Each of these areas are important and should be explored by further legal research and discourse.

ture reinforces the negative stereotype that all female victims of IPV are “helpless” and “childlike,” rather than “autonomous, competent, rational adults capable of making their own decisions.”¹⁶⁵ Opponents also argue that the model re-victimizes IPV victims by “replicat[ing] the power and control dynamic that occurs in an abusive relationship, only here the state and physicians are the ones taking power away from the woman and making decisions for her.”¹⁶⁶

Although still interventionist, the model for mandatory reporting to social services allows for a victim to determine at her own pace if, when, and how she receives outside help through several distinct protections for IPV victim autonomy that are absent from the mandatory reporting to law enforcement model (and even from its sister statute in New Mexico). First, the Kentucky reporting statute was, like the New Mexico statute,¹⁶⁷ originally enacted to require the reporting of adult IPV victims regardless of competency, categorizing all IPV victims as those individuals “unable to manage their own affairs or protect themselves from abuse, neglect or exploitation.”¹⁶⁸ However, in 2005 Kentucky recognized the clear distinction between competent and incompetent IPV victims when it amended its reporting statute to codify the duty to report IPV against competent adult victims in an entirely separate chapter from the duty to report incompetent victims.¹⁶⁹ Second, apart from the mandatory nature of the duty to report, the practical measures of the Kentucky statute are very deferen-

¹⁶⁵ Mooney & Rodriguez, *supra* note 7, at 104 (attacking the faulty presumption that all female IPV victims are helpless, which is perpetuated by the concepts of battered woman’s syndrome and learned helplessness); McFarlane, *supra* note 121, at 35.

¹⁶⁶ McFarlane, *supra* note 121 at 26.

¹⁶⁷ The New Mexico statute was similarly enacted in recognition that “many adults in this state are unable to manage their own affairs or protect themselves from abuse, neglect or exploitation.” N.M. STAT. ANN. § 27-7-15 (West 2008).

¹⁶⁸ McFarlane, *supra* note 121, at 35 (citing KY. REV. STAT. ANN. 209.090 (Banks-Baldwin 1995) (statute now codified separately in chapter 209A.010-.080)).

¹⁶⁹ DIVISION OF CHILD ABUSE & DOMESTIC VIOLENCE SERVICES, DEPARTMENT FOR HUMAN SUPPORT SERVICES, CABINET FOR HEALTH & FAMILY SERVICES, MANDATORY REPORTING OF CHILD AND SPOUSE ABUSE, <http://chfs.ky.gov/NR/rdonlyres/FF4ED4C7-574C-4CB1-8F7B-66C1E36A2EA7/0/MandatoryReportingofChildandSpouseAbuse.htm> (last visited Oct. 25, 2008) (later revised by Chapter 132 HB 298 on March 18, 2005; Ky. Legis. 132); *see also* KY. REV. STAT. ANN. § 209A.010 (West 2008).

tial to IPV victim autonomy because: (1) during its investigation, cabinet members may not enter any “private premises” where the adult IPV victim might be found without the victim’s consent; and (2) when offered support or protective services by the cabinet, IPV patients can decline all offers of assistance.¹⁷⁰ The construct of this model, which stipulates that the report goes directly to social services with only secondary notification to law enforcement, could easily be modified to mandate that reports only be submitted to law enforcement at the discretion of the social worker, in case of emergency, or upon the victim’s consent.¹⁷¹ This temporary intrusion upon victim autonomy by a small dose of paternalism, even less than under the mandatory reporting to law enforcement model, could be mitigated by the model’s effect of empowering pregnant IPV victims with the resources and protective shelter necessary to end the abuse.¹⁷²

b. Patient Safety

The concern for patient safety due to mandatory reporting is based primarily on the threat of retaliation upon the victim by the abuser, which is exacerbated by: the underfunding and overburdening of protective shelters, the inability of law enforcement to provide around-the-clock protection, and state social service agencies not being sensitive enough to the precarious and unstable position of IPV victims.¹⁷³ The problem of retaliatory violence, though unquestioned, is a less significant threat under the model for mandatory reporting to social services because the statute based upon this model (1) has improved the state shelter system in Kentucky (unlike the struggling California shelter system) and (2) involves passive intervention rather than assertive law enforcement involvement, which can inflame the abuser, particularly in states with mandatory arrest policies.

In California, IPV victims are at greater risk of danger since the

¹⁷⁰ KY. REV. STAT. ANN. § 209A.030(8), (9) (West 2008).

¹⁷¹ KY. REV. STAT. ANN. § 209A.030(3), (5).

¹⁷² Wolfson, *supra* note 6, at 18 (“In the end [with mandatory reporting statutes for competent adult victims], there is actually an increase in autonomous decision-making ability.”).

¹⁷³ McFarlane, *supra* note 121, at 22-25.

“system is so overburdened that it cannot protect them all;” in fact, more victims are turned away than accepted into shelters as a result of lack of space.¹⁷⁴ In Kentucky, however, supporters of the state’s model advocate that it has “contributed to a well funded [state] shelter system,” despite the fact that the offer of protective services to victims is statutorily “subject to budgetary limitations.”¹⁷⁵ As a result, IPV victims under the mandatory reporting to social services model in Kentucky who are offered help have a well-funded shelter upon which they can rely when they decide it is safe to leave. In contrast, IPV victims in California are forced to accept law enforcement intervention, which frequently alerts the batterer that a report has been made (due to mandatory interrogation or arrest of the batterer) and thereafter exposes the victim to a greater need for twenty-four hour personal protection that cannot be consistently provided.¹⁷⁶

Furthermore, the mandatory reporting to social services model provides passive intervention that defers to the judgment of those much more sensitive to the precarious situation of IPV victims—the individual victim and the social worker assigned to investigate the report. First, current restrictions on the behavior of investigators and the provision of protective services under this model forcibly encourage sensitivity.¹⁷⁷ Second, unlike law enforcement, whose authority and purpose it is to confront and arrest abusers, social workers are much better trained at careful investigation and passive intervention in tenuous family violence situations.¹⁷⁸ Finally, if necessary, increased funding for training and the establishment of additional clear protocols for investigation can be implemented to aid social workers in protecting victim safety.

¹⁷⁴ *Id.* at 31, 34-35.

¹⁷⁵ *Id.* at 18; KY. REV. STAT. ANN. § 209A.030(9) (West 2008) (stating explicitly that the subsection is subject to “budgetary limitations”).

¹⁷⁶ McFarlane, *supra* note 121, at 23.

¹⁷⁷ KY. REV. STAT. ANN. § 209A.030(8)-(9).

¹⁷⁸ See McMullan et al., *infra* note 200, at 14.

c. Patient Care

Finally, opponents claim that a decrease in patient care results from any mandatory IPV reporting model because such models violate the doctrine of nonmaleficence and physician-patient trust and ultimately drive IPV victims out of the health care system.¹⁷⁹ While recognizing that further research should be conducted to profile IPV victim feedback regarding the model for mandatory reporting to social services, current research indicates that in fact victims are not driven or kept away from the system en masse despite substantial concerns and fears of reporting.¹⁸⁰ In line with the conclusion reached at a panel discussion in Kentucky regarding health care provider and patient feedback on the reporting statute, current information “suggest[s] that dangers to patients from mandatory reporting may be less than feared and that reporting suspected abuse to local social service agencies may benefit patients.”¹⁸¹

2. *Patient Response to the Mandatory Reporting to Social Services with Notification to Law Enforcement Victim Veto for Services Offered Model*

Unlike the mixed response to the mandatory reporting to law enforcement model, at least one study in Kentucky has produced overwhelming approval of the mandatory reporting to social services model. In the foremost study of Kentucky IPV victim feedback, a randomly selected sample of eight counties produced twenty-four telephone interviews with victims of IPV who had complete case files pursuant to reports filed under the statute.¹⁸² Of the twenty-four interviewed, twenty-two agreed that physicians should be required to report incidents of IPV.¹⁸³ Additionally, when asked to produce a reason why the mandatory reporting to social services law might not

¹⁷⁹ Iavicoli, *supra* note 101, at 230.

¹⁸⁰ *Id.* at 230-31.

¹⁸¹ West et al., *supra* note 159, at 1082.

¹⁸² *Id.* at 1078-79.

¹⁸³ *Id.* at 1079.

be helpful to IPV victims, fourteen out of twenty-four victims could not give a single reason, with the remainder voicing only their concerns of retaliation and their "own feelings of shame."¹⁸⁴ Seventeen of the twenty-four women also agreed that they "would *not* have prevented a report if they could have stopped it."¹⁸⁵ When asked specifically about the social workers with whom they had contact as a result of the reporting, a majority of victims indicated positive responses of feeling safer, supported, and well-informed about their options by the worker.¹⁸⁶ Although physicians still express concerns about the mandatory reporting to social services model, patients under this model appear to have a much more positive view of mandatory reporting than their counterparts under the mandatory reporting to law enforcement model.

3. *Conclusions about the Mandatory Reporting to Social Services with Notification to Law Enforcement & Victim Veto for Services Offered Model*

Of the three models explored in this Comment, the mandatory reporting to social services model seems to offer the maximum benefit of aid to the victim with the minimum cost to the victim's safety and personal autonomy. Researchers and some domestic violence organizations have attributed the positive patient feedback in Kentucky to the fact that the reporting statute: (1) does not mandate that reports go directly to law enforcement and (2) allows for reported victims to refuse services offered by the social worker.¹⁸⁷ These two passive intervention elements of the model make it the most viable option to aid pregnant IPV victims without treading too heavily upon the autonomy the woman must regain to overcome the victimization that results from abuse. However, there is still room for study and improvement before this model can be adapted for the purposes of re-

¹⁸⁴ *Id.* at 1080.

¹⁸⁵ *Id.* at 1080.

¹⁸⁶ West et al., *supra* note 148, at 1080. However, some remained apprehensive regarding their interaction with their social worker. *Id.*

¹⁸⁷ COLORADO COALITION, *supra* note 122, at 2.

porting suspected incidents of IPV against pregnant women and their unborn children, as this Comment will now explore.

V. A POSSIBLE SOLUTION TO THE PROBLEM OF IPV AGAINST PREGNANT WOMEN AND THEIR UNBORN CHILDREN

Rather than forcing a division between protection of the pregnant woman's autonomous decision-making and health interests and her unborn child's interests in survival and development through reporting statutes that target the pregnant woman as the abuser, states should recognize the real threat of harm posed by third-party IPV against the pregnant victim and her unborn child. First, states should consider the possibility of adopting a modified version of the mandatory reporting to social services model implemented in Kentucky. While the Kentucky statute mandates the reporting of all spousal abuse victims to social services, which then renders protective services to those reported upon victim consent, the same model should be modified to require reporting of IPV against pregnant women, regardless of marital status.¹⁸⁸ Second, states should consider the adoption of a supplementary or alternative protective measure system that mandates: (1) the screening of all pregnant patients for IPV by health care providers, (2) the documentation of IPV injuries in victims' medical records, and (3) the dispersal of a victim's rights notice to all IPV victims that provides information about the effects of IPV and contact information for local community resources such as shelters and domestic advocacy programs.¹⁸⁹

In contemplating adoption of the model for mandatory reporting to social services for the protection of pregnant IPV victims, states should consider the following modifications to minimize the number

¹⁸⁸ KY. REV. STAT. ANN. § 209A.010-.080 (West 2008).

¹⁸⁹ See NY. PUB. HEALTH L. § 2803-p (1)-(3) (West 2009)(describing New York law requiring all health care providers to give suspected IPV victims a notice stating the effects of family violence and services available for women and children who are experiencing such violence); see also NEW YORK STATE DEPARTMENT OF HEALTH, YOUR RIGHTS AS A HOSPITAL PATIENT IN NEW YORK STATE 35-38, www.health.state.ny.us/publications/1449.pdf (last visited Nov. 19, 2009).

of unfounded reports, avoid overwhelming the system, and maximize the protection of IPV victim autonomy. First, unlike the model for mandatory reporting to social services, which requires any individual to report abuse, a reporting statute for pregnant IPV victims should limit the group of individuals or entities required to report, at least initially, to health care providers alone.¹⁹⁰ Logically with a smaller group of individuals obligated to report who are already licensed to practice by the state, compliance with the mandatory reporting statute can be more effectively surveyed, managed, and enforced. Furthermore, health care providers in general, and physicians specifically, are in a unique position to effectively and accurately screen and identify pregnant IPV victims during prenatal care visits—appointments which are often delayed until later in the woman's term when she is being abused, making intervention to aid the pregnant victim immediately even more critical than for non-pregnant victims.¹⁹¹ Unlike attorneys or other non-health care providers obligated to report under some of the current reporting statutes, health care providers can more conclusively discern and obtain confirmation of IPV against pregnant women through careful screening methods.¹⁹² By limiting those obligated to report to health care providers alone, states can assess whether a mandatory reporting obligation on medical professionals is sufficiently effective or if the duty to report should be expanded to include other individuals, such as attorneys.

Second, states should consider a more specific and clear definition of the suspicion or belief necessary to trigger the duty to report. Under the mandatory to law enforcement and mandatory to social

¹⁹⁰ Unlike the Colorado and California statutes, Kentucky authorizes reports by "any person, including but not limited to" health care providers, law enforcement, social workers, medical examiners, mental health professionals, alternative care facility employees, and caretakers. KY. REV. STAT. ANN. § 209A.030(2).

¹⁹¹ Bellig, *supra* note 21, at 2 (describing the delay of prenatal care in cases of IPV against pregnant women).

¹⁹² See DOMESTIC VIOLENCE FACT SHEET, *supra* note 4, at 3 (internal citations omitted) ("Recent clinical studies have proven the effectiveness of a two[-]minute screening for early detection of abuse of pregnant women. Additional longitudinal studies have tested a ten[-]minute intervention that was proven highly effective in increasing the safety of pregnant abused women.").

services reporting models discussed in this Comment, the duty to report is triggered by the reporter having “reasonable cause to suspect” abuse or “know[ing] or reasonably suspect[ing]” abuse “in his or her professional capacity or within the scope of his or her employment.”¹⁹³ While both of these standards do provide for an objective evaluation of the suspicion of abuse, a more specific definition would grant health care providers less discretionary room for abuse of the duty to report, whether intentional or unintentional.

Instead, the reporting statute should provide for “clear circumstances and conditions” that trigger the duty to report and specifically narrow the objective standard for reasonable belief to that of a professional specially trained in identifying abuse.¹⁹⁴ Such a definition would require the collaboration of health care professionals and state legislatures in drafting the reporting law.¹⁹⁵ For example, the reporting duty could be triggered by (1) the victim presenting with at least one or more of a list of symptoms that the medical profession agrees are prevalent in victims of abuse in addition to and upon which (2) the health care provider believes, as a reasonable professional trained in the identification and treatment of IPV injuries would, that the victim has suffered from IPV.¹⁹⁶ Additionally, perhaps as critics of current mandatory child reporting statutes have suggested, there should be an exemption that allows for discretionary voluntary reporting in situations by health care providers who complete additional extensive training in screening for, identifying, and

¹⁹³ KY. REV. STAT. ANN. § 209A.030(2) (West 2008); CAL. PENAL CODE § 11160(a) (West 2008).

¹⁹⁴ SETH KALICHMAN, MANDATED REPORTING OF SUSPECTED CHILD ABUSE: ETHICS LAW, AND POLICY 185 (2d ed. 1999) (attributing the effectiveness of sexual abuse reporting statutes to the definition of “clear circumstances and conditions” instead of just “signs and symptoms” of abuse alone).

¹⁹⁵ See Gael Strack & Eugene Hyman, *Your Patient. My Client. Her Safety: A Physician's Guide to Avoiding the Courtroom While Helping Victims of Domestic Violence*, 11 DEPAUL J. HEALTH CARE L., Fall 2007, at 33-34 (“Victims need support and referrals from their physicians. They need advocacy from shelter providers and community based organizations to help them stay safe. They need access to legal assistance from attorneys to protect their rights. They also need abusers to be held accountable by the judicial system. Domestic violence is everyone’s responsibility. One system cannot do it alone.”).

¹⁹⁶ Clearly, the specifics of such a reporting obligation is another avenue, which legal research and discussion should proceed; however, it is a meritorious topic for another time.

assessing the threat level of abuse situations.¹⁹⁷

Finally, states that contemplate adopting a mandatory reporting statute for IPV victims should consider requiring such reports be directed only to social services. Unlike the model for reporting to social services, which requires notification to law enforcement of all reports made after they are directed to social services, states should provide for reporting directly to social services alone for investigation, corroboration, and the rendering of services, all of which may be declined by the suspected victim.¹⁹⁸ States should also restrict access to any private premises where the alleged victim can be found to only with the consent of the victim at any time during the report's investigation or the rendering of services thereafter, just as the model for mandatory reporting to social services does in states like Kentucky.¹⁹⁹ Due to differences in perception of IPV, education, and experience that encourage sensitivity to domestic violence situations, social workers alone should be the messengers of beneficent, voluntary intervention for competent adult pregnant victims of IPV.²⁰⁰ Only in instances where the health care provider, the social worker, or both believe that there is an immediate or imminent threat of grievous bodily injury or death of the pregnant victim should the report be forwarded to law enforcement. Even then, states should consider requiring victim consent to authorize such law enforcement intervention in order to avert improperly timed intervention while securing the maximum degree of autonomy for and avoiding the re-victimization of pregnant victims of IPV.

¹⁹⁷ See KALICHMAN, *supra* note 194, at 192 (internal citations omitted).

¹⁹⁸ This is, of course, exempting circumstances in which during initial contact with the victim social services discovers evidence of child abuse, which triggers a variety of other state legal duties. While this Comment does not address such situations, research should be conducted to discover the full implications of reporting statutes on IPV victims in that situation.

¹⁹⁹ KY. REV. STAT. ANN. § 209A.010-.080 (West 2008).

²⁰⁰ See McMullan et al., *Future Law Enforcement Officers and Social Workers: Perceptions of Domestic Violence*, J. of Interpersonal Violence, Oct. 2009, at 14 ("Specifically, the data supported Hypothesis 4 that social work students would be more sensitive to domestic violence identification and reporting than law enforcement and other criminal justice students.") (suggesting that social work programs offer a good source to bolster educational programs for criminal justice programs to increase sensitivity to domestic violence).

Regardless of the precise scheme of the statute enacted by each state, several additional considerations should be made in the adoption of any reporting statute to protect pregnant victims of IPV. First, states should include a sunset provision setting a future date for assessment of the reporting statute's efficacy, as advocated by the American Medical Association.²⁰¹ Second, this sunset provision should be coupled with terms that mandate government assessment or encourage private studies utilizing victim feedback to gauge the effectiveness of the practical operation of the statute during its tenure. Third, provisions should also be included for anonymous data collection of the confirmed incidents of IPV against pregnant women as a result of the reports made to social services pursuant to the statute.

Whether to substitute for or supplement a model mandatory reporting statute like the one contemplated by this Comment, states should pass a law stipulating that the continued accreditation of health care organizations be contingent upon hospitals and other health care providers establishing official written policies and procedures for the treatment of IPV, similar to the statute that accompanied California's adoption of the mandatory reporting to law enforcement model.²⁰² Such policies or protocols should require at a minimum: (1) mandatory screening of patients for IPV, (2) further training and education of all providers for effective identification of IPV, and (3) mandatory documentation of reasonably suspected and/or confirmed instances of IPV in the victims' medical files.²⁰³ Both mandatory screening and documentation of IPV are highly praised by medical professionals as attractive alternatives to any

²⁰¹ Bauer et al., *supra* note 6, at 124 (describing the American Medical Association's position regarding mandatory reporting policies for competent adult IPV victims which encourages the incorporation of a "sunset mechanism in which the legislation would be in effect only for a limited number of years").

²⁰² See discussion *supra* pp. 50-51.

²⁰³ Although this Comment does not explore the specific manner in which such policies should be enacted to maximize cost efficiency and effectiveness in enforcement, such an exploration into the practical implementation of these suggestions would be an interesting topic for further research.

formulation of mandatory reporting statute.²⁰⁴ Thus, legal scholars and state legislatures should explore methods for implementing policies that require (1) mandatory screening of patients for IPV through a short series of questions designed to accurately identify victims as well as (2) mandatory documentation of injuries incurred by IPV victims in their medical files to later aid in securing restraining orders for victims and, ultimately, in successfully prosecuting the abuser.

Similar to mandatory screening and documentation, states should also consider implementing another passive intervention tool—an information distribution similar to the victim's rights notice currently in place in New York.²⁰⁵ The IPV victim's rights notice is a small but important passive means to convey information about legal avenues a victim has through local domestic violence advocacy organizations and referral information for shelter and assistance options available to the victim in the community.²⁰⁶ Given the praise that such an option has received in hypothetical proposals during battered victim studies and focus groups, the victim's rights notice may, in fact, be the best manner in which to help pregnant victims of IPV until the effectiveness of a new reporting model to social services can be fully assessed.²⁰⁷

²⁰⁴ See Strack & Hyman, *supra* note 195, at 42-52 (describing victim and physician approval of screening and documentation as well as practical guidelines for screening for IPV and documentation of IPV in patients' medical records); Wolfson, *supra* note 6, at 6-16 (describing the importance of screening as well as documentation while recognizing that many barriers exist to screening including mandatory reporting statutes, as some argue).

²⁰⁵ New York currently has a law that requires all health care providers to give suspected IPV victims a notice containing referral information for community resources such as shelters and domestic violence advocacy centers. See NY. PUB. HEALTH L. § 2803-p (1)-(3) (West 2009)(describing New York law requiring all health care providers to give suspected IPV victims a notice stating the effects of family violence and services available for women and children who are experiencing such violence)(Westlaw 2009); see NEW YORK STATE DEPARTMENT OF HEALTH, YOUR RIGHTS AS A HOSPITAL PATIENT IN NEW YORK STATE 35-38, www.health.state.ny.us/publications/1449.pdf (last visited Nov. 19, 2009) (including a sample victim's rights notice for pregnant IPV victims as well as non-pregnant IPV victims).

²⁰⁶ *Id.*

²⁰⁷ Mooney & Rodriguez, *supra* note 7, at 110 (describing positive victim responses to the possibility of receiving a brochure of information telling victims about different resources, programs, and phone numbers of shelters by health care providers). This comment merely suggests the possibility of adopting a policy mandating the distribution of a victim's rights

VI. CONCLUSION

Ultimately, the police power to enact mandatory reporting statutes and related supplemental statutes that require the screening of pregnant women for IPV, documentation of IPV injuries, and disbursement of information to suspected pregnant IPV victims lies in the hands of the states. As such, each state will have to determine the lengths to which it will go and the manner of approach it will take to protect the interests of the pregnant victim of IPV in reproductive freedom from third-party violence and the interests of both the pregnant victim and her unborn child in survival and freedom from abuse. All that this Comment can hope to provide to state legislatures is a helping hand in evaluating the current legal protections afforded to pregnant victims of IPV and a gentle reminder that the construction of any reporting statute adopted to protect pregnant victims should be a reflection of the unified interests of both the pregnant mother and her unborn child together in being free from the harmful effects of IPV.

notice but does not fully explore the scope, effectiveness, and ramifications of such a policy. Though less intrusive upon individual autonomy, the efficacy of such a notice in comparison to the recommended reporting model might not measure up; and as such, would be an interesting avenue for further research.