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California Healthcare Workers and Mandatory Reporting of Intimate Violence

*Donna R. Mooney and Michael Rodriguez, M.D.**

Introduction

The plan seemed to spring from the best of intentions: prenatal nurses whose patients were most obviously victims of intimate violence¹ wanted a law that in no uncertain terms would be on their side so they could stop waiting and start acting. Their wish was answered by two bills that were intended to expand and clarify a dusty California law requiring medical workers to call the police. In law, we often talk about the exclusion of groups of people from the political process,² and battered patients represent an important area of dialogue that seems strangely hard to hear. This article is meant to add to the analysis of mandatory reporting laws by examining words directly from women who have had the experience of intimate violence. Modern efforts toward social change surrounding violence against women have included the use of the narrative to bring

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1. Intimate violence will be used throughout the research article to encompass adult women who are physically (including sexually) abused by their spouse or male intimate partner. The California Penal Code uses the term "domestic violence," which is defined in § 13700(b) as "abuse committed against an adult or a fully emancipated minor who is a spouse, former spouse, cohabitant, former cohabitant or person with whom the suspect has had a child or is having or has had a dating or engagement relationship." Penal Code § 13700(a) defines "abuse" as "intentionally or recklessly causing or attempting to cause bodily injury, or placing another person in reasonable apprehension of imminent serious bodily injury to himself or herself, or another." Cal. Penal Code § 13700(a) & (b) (West 1992 & Supp. 1995).

2. For example, Justice Stone in *United States v. Carolene Products Co.*, 304 U.S. 144 (1938), in the often-cited footnote four, discussed "prejudice against discrete and insular minorities . . . which tends seriously to curtail the operation of those political processes ordinarily to be relied upon to protect minorities . . ." *Id.* at 144 n.4.

understanding about the experiences of battered women.³ "Because it has historically been linked to silence and inaction from the legal system, domestic violence is another area in which the narrative can play a powerful role in destroying stereotypes and prompting legal change," wrote academician Jane C. Murphy.⁴

Politics is about the art of listening as much as it is about the ability to count and measure. What follows is an examination of the California law along with excerpts from transcripts of women who talked about their experiences in the healthcare system and what they want, expect or need from their healthcare providers. A rational inference from their words is that they want to be central within the community's response, to make choices for themselves. Indeed, a major flaw in the law is its imposition on the patient of a course of action that assumes the woman's incapacity to take that path by herself, while leaving no room for the real possibility that the potential advantage of the action is outweighed by other concerns. In sum, the law exists as a response to one aspect of the medical experience: healthcare workers who very much want to help and who had an idea about how to do so. What may be instructive is to amplify another aspect of the medical experience—the women who seek treatment—to better understand the implications of the mandatory reporting law.

A. The Problem of Intimate Violence

Nationwide, more than five of every one thousand women each year are victims of violence by an intimate offender, according to the National Crime Victimization Survey.⁵ Victims are twice as likely to be injured during a crime if the offender is related to her and not a stranger.⁶ Further, injuries from an intimate partner are more likely to require medical treatment than those from a stranger.⁷ More than forty percent of violent

3. See generally Jane C. Murphy, *Lawyering for Social Change: The Power of the Narrative in Domestic Violence Law Reform*, 21 HOFSTRA L. REV. 1243 (1993) (arguing that, similar to the works of Richard Delgado and Derrick Bell, efforts emphasizing narration have strength where statistics or analysis may not, exemplified by a campaign to reform domestic violence laws in Maryland through the use of victims' stories).

4. *Id.* at 1259.

5. RONE T. BACHMAN, BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, VIOLENCE AGAINST WOMEN: NATIONAL CRIME VICTIMIZATION SURVEY, REPORT No. 94-0092-P, Table 11 (1994) (reporting that 5.4 per 1,000 females is the average annual rate of single-offender violent victimizations from 1987-91).

6. *Id.* at 1, 8 (defining violent victimization in the report as robbery, rape and assault).

7. *Id.* at 8 (indicating in Table 14 that approximately 59% of intimate violence victimizations of women resulted in injury and, of that amount, 3% were categorized as serious injuries defined to include: gunshot or knife wounds, broken bones, loss of teeth, internal injuries, loss of consciousness, and undetermined injuries requiring two or more days of hospitalization and, of these, 27% received medical care from a medical provider, a non-medical person or through self-treatment while 15% received hospital care).

incidents by intimate partners are not reported to the police.⁸ The most often cited reasons that women victims of intimate violence gave for not reporting the crimes were: they felt the incident was a private or personal matter, they feared reprisal from the offender and they believed that police would not do anything.⁹ A study conducted in Houston and Baltimore found that seventeen percent of women assessed at prenatal clinics suffered physical or sexual abuse during pregnancy.¹⁰ Research suggests that abuse during pregnancy poses an additional threat to the health of the fetus.¹¹

Studies indicate that, overall, intimate violence as the cause of patient injuries is identified by healthcare providers only a fraction of the time it is encountered.¹² According to one study, doctors do not verbally raise the possibility of intimate violence with the patient because of their discomfort, fear of offending, feelings of powerlessness, loss of control over the situation and time restrictions.¹³

Healthcare providers in recent years have vocally addressed the problem of partner abuse. In 1992, the American Medical Association (AMA) Council on Scientific Affairs published a policy statement

8. *Id.* at 9 (indicating that 56% of women victims of violence by an intimate offender reported to the police).

9. *Id.* at 9 (reporting in Table 12 that 33% did not report because it was a personal or private matter; 18% cited fear of reprisal from the offender; 13% said the police would not do anything; 9% said they didn't want to get the offender in trouble; 6% said it was a minor accident; 1% said the police couldn't do anything; and 20% cited other reasons).

10. Judith McFarlane et al., *Assessing for Abuse During Pregnancy: Severity and Frequency of Injuries and Associated Entry into Prenatal Care*, 267 JAMA 3176, 3176 (1992) (stating that 60% of abused women reported two or more incidents of assault).

11. See Barbara Parker et al., *Abuse During Pregnancy: Effects on Maternal Complications and Birth Weight in Adult and Teenage Women*, 84 OBSTETRICS & GYNECOLOGY 323 (1994).

12. See Susan V. McLeer & Rebecca Anwar, *A Study of Battered Women Presenting in an Emergency Department*, 79 AM. J. PUBLIC HEALTH, 65 (1989) (reporting that 5.6% of female emergency patients were identified as injured by intimate violence, increasing to 30% when the protocol was changed); Wendy G. Goldberg & Michael C. Tomlanovich, *Domestic Violence Victims in the Emergency Department*, 251 JAMA 3259, 3263 (1984) (citing a random survey of 492 male and female patients in which 22% identified themselves as domestic violence victims and 5% were identified on the physician record as being so); Evan Stark & Anne H. Flitcraft, *Wife Abuse in the Medical Setting*, NAT'L CLEARINGHOUSE ON DOMESTIC VIOLENCE, Apr. 1991, 10 (stating that medical personnel linked female patient injuries to battering in 15% of 435 abusive incidents); Kevin Hamberger et al., *Prevalence of Domestic Violence in Community Practice and Rate of Physician Inquiry*, 24 FAM. MEDICINE 283 (1992) (reporting that of 394 women participating in an anonymous questionnaire, 22.7% had been physically assaulted by their partners in the past year, 38.8% was the lifetime prevalence rate and 6% had been asked about abuse by their physicians).

13. N.K. Sugg & T. Inui, *Primary Care Physicians Response to Domestic Violence: Opening Pandora's Box*, 267 JAMA 3157, 3158 (1992) (reporting that 18% of 41 respondents interviewed used the phrase "Pandora's box" to describe their feelings about whether to bring up domestic violence with the patient).

describing "physical and sexual abuse" of women as "an enormous problem."¹⁴ The announcement included a short list of recommendations urging medical facilities to offer training to increase staff awareness, implement medical protocols to identify victims, establish response staff, and provide referral sources.¹⁵ A handbook published by the AMA states, "[p]hysical and sexual violence against women is a public health problem that has reached epidemic proportions."¹⁶ In California, a survey of emergency departments in late 1992 found that just over half of those responding had written policies for suspected adult victims of domestic violence and slightly over half of those policies specifically addressed abuse by a partner or spouse.¹⁷

B. Legislative History

One news reporter noted that the 1993 session of the California state legislature was marked by an unusual array of bills aimed to curb violence affecting women.¹⁸ The laws adopted that year included AB 1652, introduced by Assemblywoman Jacqueline Speier, a Democrat from the 19th district representing San Mateo county. AB 1652 aimed to revise an existing law¹⁹ dating from the early part of the century that imposed reporting requirements on certain medical workers. It is not readily apparent whether anyone was ever prosecuted for failure to report under the law during its 60-plus years in effect.

In 1929, the California legislature created a duty for healthcare providers to report to law enforcement officials any case of a person suffering specified types of wounds.²⁰ The legislation attaches the duty

14. American Medical Ass'n Council on Scientific Affairs, *Violence Against Women: Relevance for Medical Practitioners*, 267 JAMA, 3184, 3184 (1992).

15. *Id.* at 3188.

16. ANNE H. FLITCRAFT ET AL., DIAGNOSTIC AND TREATMENT GUIDELINES ON DOMESTIC VIOLENCE 4 (American Medical Ass'n 1992). The handbook urges that physicians "must be willing to ask all women patients about abuse, and should know how to diagnose it. Failure to conduct the interview and examination apart from the suspected victim's spouse or partner may interfere with an accurate diagnosis." *Id.* at 18.

17. *Emergency Department Response to Domestic Violence*, 42 CENTERS FOR DISEASE CONTROL: MORBIDITY AND MORTALITY WEEKLY REPORT 617, 617-18 (1993). The survey was done by the Family Violence Prevention Fund with the San Francisco Injury Center for Research and Prevention. Questionnaires were sent to nurse managers and physician directors at 397 emergency departments deemed active in the state. Nurse managers from 80 percent and physician directors from 54 percent of the emergency departments responded. *Id.*

18. Dana Wilkie, *Taking Measure of Violence: There's a Bill Ready to Fight It, From Spousal Rape to Stalking*, SAN DIEGO UNION-TRIB., May 29, 1993, at A1.

19. CALIFORNIA SENATE JOURNAL, Senate Bill 132, at 99 (1929) (introduced by state Sen. C.C. Baker representing Monterey, San Luis Obispo in January 1929).

20. 1929 Cal. Stat. 417. This chapter, in its entirety, reads as follows:

to "every person, firm or corporation conducting any hospital or pharmacy."²¹ The law further specified that "the managing agent" or one "managing or in charge" of the facility or "in charge of any ward or part" is subject to this duty.²² These individuals were to report injuries from a "knife, gun, pistol or other deadly weapon" or an injury resulting from the "violation of any penal law" of California.²³ The bill mandated that the report was to list the patient's name, whereabouts and a description of the injuries.²⁴ The bill also placed a duty on the "physician or surgeon" treating the individual to make a report to law enforcement officials.²⁵ Failure to report was a misdemeanor punishable by a jail term of up to six months and/or a fine of \$500.²⁶ Among the changes from the version first submitted was an amendment deleting the words "nurse, midwife or other person," apparently exempting those individuals from the duty under the provision.²⁷ The law as adopted in 1929 was re-codified by legislation in 1953.²⁸

Section 1. It shall be the duty of every person, firm or corporation conducting any hospital or pharmacy in the state of California, or the managing agent thereof, or the person managing or in charge of such hospital or pharmacy, or in charge of any ward or part of such hospital to which any person or persons suffering from any wound or other injury inflicted by his own act or by the act of another by means of a knife, gun, pistol or other deadly weapon, or in cases where injuries have been inflicted upon any person in violation of any penal law of this state shall come or be brought, to report the same immediately, both by telephone and in writing, to the chief of police, city marshal, town marshal or other head of the police department of any city, city and county, town or municipal corporation of this state, or to the sheriff of the county, if such hospital or pharmacy is located outside the incorporated limits of a city, town or other municipal corporation. Such report shall state the name of such person, if known, his whereabouts and the character and extent of such injuries. It shall also be the duty of every physician, or surgeon, who has under his charge or care any person suffering from any wound or injury inflicted in the manner above mentioned, to make a like report to the appropriate officers hereinabove named.

Section 2. Any person, firm or corporation violating any provision of this act shall be guilty of a misdemeanor and upon conviction thereof shall be punished by imprisonment in the county jail not exceeding six months or by a fine not exceeding five hundred dollars, or by both.

Id.

21. *Id.*

22. *Id.*

23. *Id.*

24. *Id.*

25. *Id.*

26. *Id.*

27. CALIFORNIA SENATE JOURNAL, Senate Bill 132, at 612 (1929) (listing the changes for amendment 2 as "[i]n line 17 of the printed bill, strike out the words 'nurse, mid-wife or other person'").

28. The act codified chapter 417 of the statutes of 1929 by adding Article 2 to Chapter 2 of Title 1 of Part 4 of the California Penal Code, becoming §§ 11160, 11161, 11162. 1929

According to Assemblywoman Speier's office, the recent revision of the law was prompted by a two-page letter from members of the Northeastern California Perinatal Outreach Program. This letter asked her to rectify "serious flaws" in the law, specifically its lack of an immunity clause for healthcare workers who report, the exclusion of nurses from the enumerated positions given the duty to report, and unclear language.²⁹ The letter pledged, "[w]e all are interested in preventing domestic violence and intervening in the cycle of abuse to protect the woman and the unborn fetus."³⁰ Nine months later,³¹ the state governor approved a bill authored by Speier, AB 1652, which made several substantive changes to the existing law.³² The law uses the term "health practitioner,"³³ defined to include more than a dozen types of healthcare workers including nurses.³⁴ The law triggers the requirement to report when the individual "knows or reasonably suspects"³⁵ the patient is suffering from an injury inflicted by "knife, firearm, or other deadly weapon,"³⁶ or "suffering from any wound or other physical injury inflicted upon the person where the injury is the result of assaultive or abusive conduct."³⁷ The legislation goes further to

Cal. Stat. 645.

29. Letter from the Northeastern California Perinatal Outreach Program to Assemblywoman Speier (Jan. 11, 1993) [hereinafter Northeastern California Perinatal Outreach Program Letter] (copy of the letter on file with the author). Also, a prepared speech for Assemblywoman Speier for a November 1994 conference states:

In part, legislation came out of concern expressed by OB/Nursery managers of the Northeastern California Perinatal Outreach Program and others who, concerned about preventing domestic violence and intervening in the cycle of abuse to protect the woman and the unborn child of those 25-45% of battered women who are battered during pregnancy, wanted to expand our mandatory reporting laws past the obligation for physicians, surgeons, hospitals and pharmacies while at the same time providing immunity from prosecution.

Assemblywoman Jacqueline Speier, Address at the Reducing the Incidence Conference in Millbrae, California (Nov. 10, 1994) [hereinafter Speier Speech].

30. Northeastern California Perinatal Outreach Program Letter, *supra* note 29.

31. The bill was amended several times before final approval. The first version, introduced in early March, offered one substantive change from existing law, the insertion of "domestic violence as defined in Section 13700" into the list of injury types that must be reported. 1993-1994 Cal. Legis. Serv. 992 (West).

32. See generally Ann P. Wathen, *Reporting Obligations of Health Practitioners, Physicians, and Surgeons*, 25 PAC. L.J. 571 (1994).

33. CAL. PENAL CODE § 11160(a) (West 1992 & Supp. 1995).

34. CAL. PENAL CODE § 1162.5(a) (West 1992 & Supp. 1995). Health practitioner as defined in California Penal Code § 11165.8, part of the Child Abuse and Neglect Reporting Act, includes physician, surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, optometrist, marriage/family counselor or trainee or unlicensed counselor intern, emergency medical technician, paramedic, coroner, and medical examiner. CAL. PENAL CODE § 11165.8 (West 1992 & Supp. 1995).

35. CAL. PENAL CODE § 11160(a) (West 1992 & Supp. 1995).

36. CAL. PENAL CODE § 11160(a)(1) (West 1992 & Supp. 1995).

37. CAL. PENAL CODE § 11160(a)(2) (West 1992 & Supp. 1995).

define such conduct as any of twenty-four enumerated acts³⁸ including battery,³⁹ sexual battery,⁴⁰ spousal rape,⁴¹ abuse of spouse or cohabitant⁴² and attempt to commit any of the crimes listed.⁴³

The law recommends but does not require physicians and surgeons to include in the medical record comments by the injured patient regarding domestic violence and comments indicating the name of a suspect who inflicted the injury or perpetrated the abusive conduct.⁴⁴ Second, it is recommended that a map showing the injuries on the patient's body be included in the record.⁴⁵ Third, it is recommended that the medical record include a copy of the law enforcement reporting form.⁴⁶ Fourth, the law recommends that the physician or surgeon refer the patient to local domestic violence services.⁴⁷

A separate provision establishes immunity from liability for health practitioners who report as authorized.⁴⁸ Another provision provides payment of attorney fees for actions brought against health practitioners who report.⁴⁹ In addition, the law prohibits any supervisor or administrator from impeding the reporting duties.⁵⁰ The fine for failing to follow the law was increased to \$1,000.⁵¹ The law also removes privilege

38. CAL. PENAL CODE § 11160(d) (West 1992 & Supp. 1995).

39. CAL. PENAL CODE § 11160(d)(8) (West 1992 & Supp. 1995) (defining battery through § 242 of the California Penal Code).

40. CAL. PENAL CODE § 11160(d)(9) (West 1992 & Supp. 1995) (defining sexual battery through § 243.4 of the California Penal Code).

41. CAL. PENAL CODE § 11160(d)(15) (West 1992 & Supp. 1995) (defining spousal rape through § 262 of the California Penal Code).

42. CAL. PENAL CODE § 11160(d)(18) (West 1992 & Supp. 1995) (defining abuse of spouse or cohabitant through § 273.5 of the California Penal Code).

43. The other crimes listed are: murder; manslaughter; mayhem; aggravated mayhem; torture; assault with intent to commit mayhem, rape, sodomy, or oral copulation; administering controlled substances or anesthetic to aid in commission of a felony; incest; throwing any vitriol, corrosive acid, or caustic chemical with intent to injure or disfigure; assault with a stun gun or taser; assault with a deadly weapon, firearm, assault weapon, or machine gun, or by means likely to produce great bodily injury; rape; procuring any female to have sex with another man; child abuse or endangerment; sodomy; lewd and lascivious acts with a child; oral copulation; genital or anal penetration by a foreign object; and elder abuse. CAL. PENAL CODE § 11160(d) (West 1992 & Supp. 1995).

44. CAL. PENAL CODE § 11161(b)(1) (West 1992 & Supp. 1995).

45. CAL. PENAL CODE § 11161(b)(2) (West 1992 & Supp. 1995).

46. CAL. PENAL CODE § 11161(b)(3) (West 1992 & Supp. 1995). One report form (there is no uniform statewide form) consists of one page with seven questions about the patient, plus spaces for information about the health practitioner's name, medical facility, the law enforcement agency contacted, the name and serial number of the officer, and the date and time of the telephone report (copy on file with the author).

47. CAL. PENAL CODE § 11161(c) (West 1992 & Supp. 1995).

48. CAL. PENAL CODE § 11161.9 (West 1992 & Supp. 1995).

49. CAL. PENAL CODE § 11163(b)(1) (West 1992 & Supp. 1995).

50. CAL. PENAL CODE § 11160(g) (West 1992 & Supp. 1995).

51. CAL. PENAL CODE § 11162 (West 1992 & Supp. 1995).

pertaining to injury records when the information is to be used in a court proceeding or administrative hearing.⁵²

The California Medical Association⁵³ (CMA) formally opposed⁵⁴ the legislation prior to the amendments, and is the only opponent listed in legislative documents.⁵⁵ The reasons cited for opposition included criticism that the immunity provision for reporters was not as protective as that found in the child abuse reporting law and might therefore spawn lawsuits and that the proposed law would require an "unprecedented" amount of information for a physician to include in the medical record.⁵⁶ The child abuse reporting provisions had been tested in a 1986 case, where three doctors and a hospital were granted absolute immunity for reporting a suspected case of child abuse.⁵⁷ Failure to detect child abuse has been shown to raise liability for doctors. In a 1976 child abuse case, the California Supreme Court allowed a claim that a doctor's failure to identify child abuse caused the child to be returned to the abusive environment where subsequent injury occurred.⁵⁸

The bill's list of supporters named Santa Cruz County, San Mateo County, American College of Obstetricians and Gynecologists,⁵⁹ Perinatal Advisory Council of Los Angeles, Sacramento District Attorney and the OB/Nursery Managers⁶⁰ group.⁶¹ The arguments cited in support of the legislation included the ongoing lack of identification of victims of domestic violence by medical professionals and the ambiguity or limits of existing law.⁶² Included in the arguments was the statement:

52. CAL. PENAL CODE § 11163.2 (West 1992 & Supp. 1995).

53. The organization has 28,868 members statewide, according to the San Francisco office. It conducts formal lobbying in Sacramento.

54. A committee of 40 members decides whether to oppose selected legislation, according to CMA lobbyist Joan Hall.

55. SENATE COMMITTEE ON THE JUDICIARY LEGISLATIVE ANALYST DOCUMENT, July 6, 1993, at 1 (copy of this document given to author by Assemblywoman Speier's office, on file with the author).

56. *Id.* at 7. Also, a letter from the CMA to Assemblywoman Speier dated July 1, 1993, states a position of "oppose unless amended" and details these requested changes to the law. Letter from the California Medical Ass'n to Assemblywoman Jacqueline Speier (July 1, 1993) (a copy of the letter is on file with the author).

57. *Storch v. Silverman*, 186 Cal. App. 3d 671 (1986).

58. *Landeros v. Flood*, 17 Cal. 3d 399 (1976).

59. Statewide membership of the American College of Obstetricians and Gynecologists is 3,800, according to its San Francisco office.

60. The OB/Nursery Managers group is comprised of 135 individuals, according to its administrative umbrella organization, the Northeastern California Perinatal Outreach Program.

61. These organizations were named in legislative documents. SENATE FLOOR ANALYSIS, Aug. 24, 1993, at 3 (copy of this document given to author by Assemblywoman Speier's office, on file with the author).

62. *Id.*

When victims of abuse seek help from healthcare providers and are met with denial of the abuse or the seriousness of the abuse, the victims feel there is no escape from the violence. This compounds the feelings of helplessness and entrapment associated with the psychosocial problems caused by abuse.⁶³

In 1994, Assemblywoman Speier proposed a collection of amendments, AB 74, during a special session of the state legislature to clarify some of the provisions of the earlier legislation. The new language specifies that the reporting requirement is triggered when the practitioner "provides medical services for a physical condition"⁶⁴—thus, mental healthcare providers are excluded from having to report a patient's comments about past abuse. The law was also amended to include health practitioners employed at public health facilities.⁶⁵

C. The Battered Women Focus Group Study

The Battered Women Focus Group Study came about when the Robert Wood Johnson Foundation awarded a grant for a qualitative study to determine barriers to healthcare for battered women and what could be done to improve access to and the quality of healthcare.⁶⁶ According to the study principal, the focus group method was selected because of the dearth of studies from the patient's perspective on intimate violence and healthcare provision.⁶⁷

The study constituted eight focus groups separated into four ethnic⁶⁸ groups comprising a total of fifty-one women.⁶⁹ The focus groups were facilitated by two moderators, with at least one matching the ethnicity of the participants.⁷⁰ The focus groups were each ninety minutes long and were held over the course of a year, from February 1993 to March 1994.⁷¹ The number of participants ranged from five to nine women per focus

63. *Id.*

64. CAL. PENAL CODE § 11160(a) (West 1992 & Supp. 1995).

65. CAL. PENAL CODE § 11160(a) & (b) (West 1992 & Supp. 1995) (defining public health facilities as a "local or state public health department, or a clinic or other type of facility operated by a local or state public health department").

66. Michael Rodriguez et al., *Breaking the Silence: Battered Women's Perspectives on Medical Care*, ARCHIVES OF FAMILY MEDICINE (forthcoming 1996).

67. *Id.*

68. *Id.*

69. *Id.*

70. *Id.* (noting that two Latina focus groups were conducted in Spanish, one Asian focus group was conducted in Cantonese and one in Mandarin; transcripts were translated into English).

71. Complete transcripts are on file with the author. Transcriptions from audiotapes were generated upon completion of the focus group study.

group.⁷² The women were asked to talk about their feelings and attitudes relating to getting help or avoiding healthcare providers, plus personal experiences with the healthcare system.⁷³

The participants were women from the greater San Francisco region contacted through community organizations involved in serving battered women.⁷⁴ The women ranged in age from twenty-two to sixty, they had varying levels of education and most of them had children.⁷⁵ The participants represented a variety of ethnic and racial backgrounds, with forty-three percent born in the United States and the remaining being immigrants who had lived in the country from one to twenty-two years.⁷⁶

D. In Plain Words—Battered Women on Healthcare

The following are verbatim quotes from the women who participated in the Battered Women Focus Group Study. The excerpts selected for print here address what women want from their healthcare providers, experiences they have had in the past, and when possible,⁷⁷ how the women feel about healthcare workers contacting law enforcement as a result of seeking treatment for injuries from intimate violence. Quotes were selected for their relevance to the issues of healthcare workers contacting the police, confidentiality and resources women want from medical providers.⁷⁸

1. WHETHER HEALTHCARE PROVIDERS SHOULD CALL LAW ENFORCEMENT

Moderator: What would you feel, though, if you went to the doctor and the doctor is going to call the police. What do you feel about that. What do you think about that?

Participant: I think that it might help, but yet, they don't seem to really care enough, or the police don't care.

72. Rodriguez et al., *supra* note 66, at 5.

73. *Id.* at 7.

74. *Id.* at 5-6 (including organizations that advocate for family issues, shelters for battered women and drug treatment programs).

75. *Id.* at 6 (reporting that 47 participants gave demographic details: median age was 25, formal education ranged from none to university level; 29% of 45 participants who answered a question on marital status were married or living with a partner, while 68% were divorced, single or separated; 86% had children).

76. *Id.* at 6. All of the African-American and white women were born in the U.S. The Latina groups represented women from Mexico, El Salvador, Guatemala and Columbia. The Asian groups included women from China, Vietnam, Korea, the Philippines and Taiwan. *Id.*

77. A question specifically addressing mandatory reporting was added to the final two focus groups, which were comprised of white women and held in early 1994.

78. Quotes that were repetitious, ambiguous or compromised by technological problems were omitted. The author's methodology was reviewed by Heidi M. Bauer, M.P.H., M.D. candidate, to resolve the concern of misrepresentation.

Participant: I say no way. I'm sorry, but if my doctor were to call the police and they went to my husband, my husband would have beat the shit out of me. I'm sorry, but there has got to be, maybe reported to Battered Women. I don't know, but I don't think a doctor should go over your head, go to the police, it's dangerous

Participant: . . . I think there should be a middle place. For example, a social worker should be alerted. There should maybe be, you know, they're always talking about funding and all this. I agree that we put ourselves at jeopardy It would be great if the healthcare personnel would say, 'This looks a little fishy to me' and have a social worker assigned to the hospital or available or anywhere or somewhere in the hospital system where one could be referred to. And that would be the middle ground and even if it takes confrontational style. You know, 'How did you get that bruise?' you know, 'It looks suspiciously like a fist mark to me.' But this coming from the social worker, a healthcare professional recognizing some of the signs and being a little more sensitive to that. So this middle person would go rather than jumping right to the police.

Participant: As with anything, you get individuals who jump on the band wagon and they're gung ho that they're going to eradicate a certain issue or problem. And you get social workers who [pause] you're going to lose all your rights 'cause social services think they're God's gift to the world. Like a doctor feels that he's God. So you really have to be careful when you give your rights over to a person, no matter who it is, and, medically speaking, there are many issues where people don't even realize that your rights are being violated. And so in this care [sic] I think it's a very scary thought

Participant: I was just going to say I don't think it would be a good idea to ask the police and doctors [to] cooperate. It's hard enough to get the doctor to understand and if you think it's going to go further, you're going to be even more reluctant to say anything. I think it would make people less apt to tell the doctor what they need to tell him for the[ir] own health. They're thinking of all the repercussions.⁷⁹

Moderator: How would you feel about doctors reporting to the police the battered women they see? Would you feel safe?

79. Michael Rodriguez et al., Battered Women Focus Group Study, CAU222394, 17-20 (1993-1994) [hereinafter Battered Women Focus Group Study] (unpublished transcript, on file with author).

Participant: Well, as long as it's on record. The police would first have to give the person who's being battered the choice whether to have them locked up or whatever. Because otherwise it could be worse once they get released. They only hold, in certain counties, 24 hours. When they're out, then you know you're dead. You might as well dig your own grave because that's where you're going. But if it's at least on record [pause], so many of it on record, on file [pause] when the person who's being battered is finally ready, they've got all this. The D.A. can bring it up and get at least six months

Participant: When I went to the hospital, they pretty much took it out of my hands and then put it back in by saying that because it was an abuse that they were going to report it to Social Services. Which surprised me, I didn't anticipate that. And then I thought, 'Good, that's good. I'm glad that somebody's taking it and doing something about it.' But they then told me that it would be up to me to make a full report. That they would just notify the police that it had happened, but the police would not come out or do anything 'til I had made the report. So the control was still in my hands even though it was good that they did what they did. I felt that was appropriate.

Participant: I think that reporting it [pause] that the police documenting it is really important and legitimizes that this shouldn't be happening and that it did. And that this is a crime. It's a crime to be abused. Who's ever being abused, it's not okay. Then the other part that's really important is that you can't act on [pause] the police can't go out [pause] the woman has to be ready to take the steps that are necessary for her to be safe. And if it's not at that point, it's going to put her into a lot more jeopardy Police show up at your door and you're not ready [pause] you don't have your little suitcase and you're gone. You gotta be gone before that happens. And you got to be, up here, ready to stay away.⁸⁰

Moderator: Do you think if you knew that the doctor wasn't going to tell the police that [it] would have made it easier for you to tell the doctor?

Participant: Yeah, but how could you know that? Unless you confide in 'em. That's what I'm saying. So it's confusing.⁸¹

80. Battered Women Focus Group Study, *supra* note 79, CAU222894 at 22-24.

81. Battered Women Focus Group Study, *supra* note 79, AF10693 at 21.

2. WHAT MAKES IT DIFFICULT TO SEEK MEDICAL CARE: PERSONAL EXPERIENCES WHEN VISITING A HEALTHCARE PROVIDER

Moderator: Do you think that the doctor is going to tell the husband?

Participant: You don't know. You don't tell the doctor. You're scared of the husband.

Participant: Especially the Asians. Because they have a fear that the INS [immigration department] may check on you.⁸²

Moderator: What makes it difficult to go to a doctor for problems related to domestic violence?

Participant: Oh, okay, but what made it difficult for me to confide was the fact that I feared for my life, you know. And I knew that if I was to tell them what actually happened that they would call the police and I would have to file a report and they couldn't guarantee me that they would be there 24 hours to protect me from this maniac. So, therefore, I wasn't taking a chance on my life What would make it easier for me would be to, um, preferred to be my choice. Well, I need help, can you call the police? Or if, um, this happened to me but I don't want the police involved, can you please treat me and keep my confidentiality[?] There's supposed to be law that they keep confidentiality between the patient and the physician⁸³

Moderator: . . . I want you to tell me what is difficult about going to see a doctor with a domestic violence related problem.

Participant: I do not trust M.D.s.⁸⁴

Moderator: Many women go to hospitals or clinics or health care providers for a reason related to violence they've experienced in their relationship. Have you ever gone to a doctor for a problem related to abuse in the family and what was your experience?

Participant: . . . She [the physician] wanted to call the police and I said 'No, no, he is the police.' . . . She sat and argued with me and said, 'You know, this may happen again.' And I said, 'No, I'm going to have you xerox this. I'm taking a copy over to my lawyer and sending one to his lawyer. This is not going to happen again.' So she was very [pause] she went along with what I asked

82. Battered Women Focus Group Study, *supra* note 79, AS83193 at 15.

83. Battered Women Focus Group Study, *supra* note 79, AF10693 at 22.

84. Battered Women Focus Group Study, *supra* note 79, L893 at 19 (translated from Spanish).

for, made the copies and fortunately she was right, there was no battery after that.⁸⁵

Moderator: One question related with this, has there been any time in which a doctor, a nurse, has told you: 'How are you at home? Do you have problems? How is your husband?' and you say everything is all right. And why does this happen?

Participant: That is what happens that you do not trust the doctors to tell this a woman, latino women, the majority of us are distrustful, we arrive at the doctor and we are not going to tell about our problems, we have one as [another participant] said, to defend the husband so that they will not put him in jail or if they do that they do not blame you because if he comes out one is scared that will get hit or something, then what is happening here is that we do not trust the doctor⁸⁶

Moderator: . . . Do people have the experience of going to a doctor or a health professional and withholding information as to what really happened?

Participant: In the beginning I feel we put trust into these men, these abusive people, and then things started happening and we lost trust in them and, basically, trust in other people, including physicians. And it's very hard to regain that trust in other people. And that's why we don't.⁸⁷

Moderator: Now let's talk about your experience at the doctor's

Participant: . . . When he first beat me I didn't dare go to the doctor so I just took medicine at home. Later on when I went to the doctor, the doctor told me [pause] that time the doctor was a westerner and there was a Vietnamese interpreter. I told them what happened and they told me that if I reported him this time, then they would have a record on him if it happened again and he would not be able to get away. At the time I did not want to. It would be okay for me but I didn't want to be separated from my children.⁸⁸

Participant: I thought he was in love with me, but he wasn't. He wanted me to support his habit, you know, and, um, everywhere I would go he would stalk me. You know, I could be in someone's house and he would kick the whole door in. I would call the police, but I would never press any charges 'cause I was

85. Battered Women Focus Group Study, *supra* note 79, CAU22394 at 5.

86. Battered Women Focus Group Study, *supra* note 79, L893 at 29 (translated from Spanish).

87. Battered Women Focus Group Study, *supra* note 79, CAU22394 at 12-13.

88. Battered Women Focus Group Study, *supra* note 79, AS11494 at 15.

scared for my life and he would stand outside the house and wait for me to come out and just jump on me and beat the hell out of me and, you know. I would be at my family's house and he would con them into letting him just talk to me for a few minutes so he could beat me up. And I was scared for my life. I never went to the police and I never went to the hospital 'cause I knew that if I go to the hospital I would have to file a report with the police and I was scared⁸⁹

Moderator: What makes it difficult to go to a doctor for problems related to domestic violence?

Participant: What makes it difficult is because, like, after you've been, like, abused, you kinda scared to tell the doctor 'cause you, you in love with that person and it ain't like, you really don't want to see that person, you know, see that person get in trouble, but you also have to look out for yourself.⁹⁰

Moderator: What makes it difficult to tell doctors about problems related to domestic violence?

Participant: What makes it difficult is that the fact that you don't want to turn, I mean, when you tell the doctor, the doctor going to call the police and when the police get here, you already been through so much trauma and stuff that you, I mean, it's like you just going through it all over again. Um, you don't want to turn that person in It's just hard to even tell anybody because you know, you don't know what kind of response you're going to get from the individuals You don't know who you can trust⁹¹

3. SUGGESTIONS TO IMPROVE THE CARE GIVEN TO PATIENTS

Moderator: How could the physicians do a better job at helping women who are experiencing domestic violence?

Participant: Doctor could do a good job of helping women by letting women know different resources or programs or places they can go that are available⁹²

Moderator: How could physicians do a better job of helping women who are experiencing domestic violence?

Participant: I think the doctor can ask you whether or not have you been involved in domestic violence and ask you do you want to go through the procedures pressing charges or whatever. And

89. Battered Women Focus Group Study, *supra* note 79, AF10693 at 5.

90. *Id.* at 18.

91. *Id.* at 19-20.

92. *Id.* at 27.

if you say yes they help you out and if you say no they just put it in on your chart and leave it alone⁹³

Moderator: Improving services, how can physicians, nurses etcetera improve services for battered women? What should be the most helpful?

Participant: I'm thinking if we had a network of a similar abuse type system, someone could come in. It doesn't have to be a social worker, but it does have to be someone who's intimately familiar with this battered syndrome

Participant: Well, if they were educated on where the women could go. They should have a list of phone numbers that they can get a hold of—Battered Women house, emergency shelter, and stuff like that. To help the woman get in an emergency shelter where nobody will know where she's at. I think if the education is there, then he should go subtly, really approaching more subtly and lovingly and knowing what channels to go through to get this woman to a safe place 'cause many times people don't know where⁹⁴

Moderator: I think that all of you agree that the doctor should ask questions and in which way [inaudible] it is appropriate for a doctor to ask the most direct questions and which is the most preferred way?

Participant: I also think that the doctor can tell the patient, 'Look, do not have fear of saying what's wrong with you because your husband will not know or the person who is assailing you'

Participant: This is why it is so important if you have a doctor, many times this doctor with direct questions, they have information⁹⁵

Moderator: Any other thoughts regarding the subject that doctors should ask if the woman has suffered any type of violence by the husband or partner during the regular visits?

Participant: I think that if one arrives emotionally sick, like in my case that I have headaches, my face gets twisted, I have stomach pain, I have diarrhea, they are not going to cure me with one thing, with one medicine, I think that the doctors may be able

93. Battered Women Focus Group Study, *supra* note 79, AF1193 at 28.

94. Battered Women Focus Group Study, *supra* note 79, CAU22394 at 24-26.

95. Battered Women Focus Group Study, *supra* note 79, L21993 at 37, 42 (translated from Spanish).

to ask this question and may listen also, moreover they can help by giving advice⁹⁶

Moderator: . . . What can a doctor do [to make it easier] to help women who have suffered domestic violence . . . ?

Participant: One of the obstacles I believe is the language. Many times there is no volunteer that can help us and we do not have the trust because we cannot say to him what we feel is going on.⁹⁷

Moderator: Okay, what services would you like to see or receive from a physician? . . .

Participant: . . . So you need to like don't be afraid, just say, 'I'm concerned that you're being abused.' And let the person freak out and run away. Give them a little brochure as they're running out the door. And the important thing is women tend to get help when they're ready. 'Cause you can't force someone to get help. You can't drag them out of there when they're an adult, but you can say, okay, this is what it is. Keep this in a locker. Don't bring it home. 'Cause if people know you're going 'cause somebody's abused you, then they freak out even more. And show them where they can go for help. A support group I think is crucial. Because if you don't realize that you're [not] the only one who's been there then [pause] I mean, every time I go to the support group I think, 'Wow, they're really neat people.' It gives you that much more sense that, okay, maybe I'm okay, too. You know, I didn't do this to myself.⁹⁸

Participant: . . . It is possible, I think, if the doctor can [a] take picture of the injury so that they can show the right court for the criminal case I'd ask if I'm a victim of domestic violence and whatever you say to me I'm going to keep this confidential I can make . . . [a] record for you and for later on.⁹⁹

E. Analysis

The recent revisions to the mandatory reporting law sacrifice a woman's autonomy in favor of increases in activity by individuals near to the alleged victim, namely the healthcare practitioner in concert with the local law enforcement agency. The changes to the law resulted from

96. Battered Women Focus Group Study, *supra* note 79, L893 at 25 (translated from Spanish).

97. Battered Women Focus Group Study, *supra* note 79, L21993 at 23 (translated from Spanish).

98. Battered Women Focus Group Study, *supra* note 79, CAU22894 at 18, 20-21.

99. Battered Women Focus Group Study, *supra* note 79, AS83193 at 17, 19.

concerns of individuals other than those who are suffering or presumed to be suffering from intimate violence. Suspicion regarding how the law affects those women is warranted. A law responding to the articulated desires of some healthcare practitioners does not necessarily respond adequately or innocuously to others who feel the law's impact.

The legislative record provides little or no indication that mandatory reporting is desired by the majority of battered women who seek medical care either for the injuries they suffer from their intimate partners or as part of routine healthcare visits. The record indicates only that prenatal nurses sought to be included among those practitioners who have a duty to report and to be protected from potential liability for doing so.¹⁰⁰ If the recent revisions to the law were premised on those goals alone, the result could be called a success. However, the record indicates that larger goals behind these measures are to "prevent" domestic violence and "protect" the woman (and her unborn fetus),¹⁰¹ not just to ensure that healthcare workers and law enforcement officials become involved in the aftermath of the abusive incidents.¹⁰² For reasons discussed below, the law would better be described as one that clarifies the role of nurses and healthcare practitioners and modifies reporting requirements for doctors and surgeons, rather than a law to help victims and curb domestic violence.

It may not be reasonable to expect victims of ongoing domestic violence to form traditional lobbying organizations that can articulate the needs of women and influence politicians to develop laws accordingly. A key component in the problem of domestic violence is the shroud of secrecy¹⁰³ often accompanying the experiences of women. However, it is reasonable to expect, and is perhaps a political imperative, that lawmakers seek to strike a balance in the community as a whole and account for all groups of individuals who are touched by the law. While many women who are being battered may not be readily visible or organized for easy access by lawmakers, the thousands of workers at social services agencies for battered women comprise one avenue toward reaching those women, or toward a knowledgeable analysis of a proposed law. Legal historian Lawrence Friedman wrote, "the criminal code reflects, though perhaps at times as crudely as a fun house mirror, some notion of the moral sense of the community—or, to be more accurate, the moral sense

100. Northeastern California Perinatal Outreach Program Letter, *supra* note 29.

101. The U.S. Supreme Court discussed the state interest in protecting the unborn fetus in *Roe v. Wade*, 410 U.S. 113 (1973) and *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 112 S.Ct. 2791 (1992).

102. Speier Speech, *supra* note 29.

103. *DEL MARTIN, BATTERED WIVES* (1976). Martin wrote, "[w]hen the victim is a woman, she is invariably held responsible and stigmatized for what she has suffered, hence, the silence . . ." *Id.* at 24.

of the people who count, and who speak out, in the community."¹⁰⁴ To summarize thus far, the law on mandatory reporting of domestic violence by healthcare workers has developed without an ear to the needs of women who live with intimate violence, who cannot be expected to speak out.

The revisions voted into the Penal Code establish a mechanism that further infringes on the woman's perspective and autonomy by imposing a meaningful decision within her own course of action. It is central to the discussion of the reporting law that among those who could contact the law enforcement agency is the woman herself. By requiring the healthcare practitioner to report abuse to law enforcement, the law assumes that in every incident when a woman fails to make a report herself there is something wrong, representing a missed opportunity to protect the woman (and her unborn child) and prevent domestic violence. By regarding the lack of contact with law enforcement as a failing in the community's relationship with the woman, the law oversimplifies a complex problem by requiring that a healthcare practitioner report to law enforcement.

The history behind the legislation suggests that a woman who is abused is in a state of incapacitation or helplessness.¹⁰⁵ Such a suggestion finds some support in the growing literature about battered women.¹⁰⁶ In her 1979 book *The Battered Woman*, Lenore Walker asserted that:

Cultural conditions, marriage laws, economic realities, physical inferiority—all these teach women that they have no direct control over the circumstances of their lives. Although they are not subjected to electrical shocks as the dogs in the experiments were, they are subjected to both parental and institutional conditioning that restricts their alternatives and shelters them from consequences of any disapproved alternatives. Perhaps battered women, like the dogs who learn that their behavior is unrelated to their subsequent welfare, have lost their ability to respond effectively.¹⁰⁷

However, there has been no conclusive research to support a notion that the complex psychological effects of battery are uniform among women, or that women lack the capacity to contact law enforcement officials themselves, or that women are irrational if they decide not to contact the police because of numerous possible countervailing concerns.¹⁰⁸ A great

104. LAWRENCE M. FRIEDMAN, *CRIME AND PUNISHMENT IN AMERICAN HISTORY* 125 (1993).

105. SENATE FLOOR ANALYSIS, *supra* note 61.

106. "Fear immobilizes them, ruling their actions, their decisions, their very lives." MARTIN *supra* note 103, at 77. See also LENORE WALKER, *THE BATTERED WOMAN* (1979); LENORE WALKER, *THE BATTERED WOMAN SYNDROME* (1984).

107. LENORE WALKER, *THE BATTERED WOMAN* 52 (1979).

108. See, e.g., Mary Ann Dutton, *Understanding Women's Responses to Domestic Violence: A Redefinition of Battered Woman Syndrome*, 21 HOFSTRA L. REV. 1191, 1195

deal of the popular notions around the effects of battery on women have been driven by criminal self-defense efforts.¹⁰⁹ One result of the admissibility of expert testimony on the effects of domestic violence has been to emphasize "the passive, victimized aspects of battered women's experience, their 'learned helplessness,' rather than circumstances which might explain the homicide as a woman's necessary choice to save her own life."¹¹⁰ Further, "the term 'battered woman syndrome' has been heard to communicate an implicit but powerful view that battered women are all the same, that they are suffering from a psychological disability and that this disability prevents them from acting 'normally.'"¹¹¹ More accurately, however, battered woman syndrome allows a woman to take action, her "perception of the danger, and the imminence of that danger"¹¹² being reasonable. In fact, it is the woman's action, in homicide cases, that poses a problem for battered woman syndrome as a self-defense theory.¹¹³

In addition to the unsettled question of whether the effects of domestic violence would incapacitate a woman from contacting the police herself, there are numerous problems with the uniform treatment of women by the mandatory reporting law. Women who seek medical care for domestic violence should not be assumed to display the same mental state as a result of the violence. Logically, the patients represent an entire spectrum, beginning with those who may have suffered the first incident of violence and cannot be said to have reached the "syndrome" stage. At the other end of the spectrum, there may be women who, after repeated abuse, may have reached a belief that they are trapped in a situation with little or no hope for escape. The assumption of a woman's helplessness as a justification for mandatory intervention by healthcare workers and law enforcement is faulty based on the lack of definitive research and the diversity of situations healthcare workers would encounter. Thus, the law intrudes on her power

(asserting that battered women's experiences cannot accurately be encompassed by only one description); David L. Faigman, *The Battered Woman Syndrome and Self-Defense: A Legal and Empirical Dissent*, 72 VA. L. REV. 619 (1986) (challenging Lenore Walker's methodology and interpretation, while further arguing that her research points to no distinct behavior pattern in domestic violence relationships and misapplies the concept of learned helplessness).

109. Elizabeth M. Schneider, *Describing and Changing: Women's Self-Defense Work and the Problem of Expert Testimony on Battering*, 9 WOMEN'S RTS. L. REP. 195 (1986); Lenore Walker, *A Response to Elizabeth M. Schneider's Describing and Changing: Women's Self-Defense Work and the Problem of Expert Testimony on Battering*, 9 WOMEN'S RTS. L. REP. 223 (1986).

110. Schneider, *supra* note 109, at 198.

111. *Id.* at 207.

112. *Id.* at 211.

113. *E.g.*, David L. Faigman, *Review Essay: Discerning Justice When Battered Women Kill*, 39 Hastings L.J. 207 (1987). "[T]he theory's characterization of battered women as passive and 'learned helpless' further obfuscates why some battered women kill." *Id.* at 215.

to make decisions for herself as an adult citizen. Statistics indicate that in thousands of cases, women victims of domestic violence could and did call the police.¹¹⁴

With the understanding that women are not automatically rendered helpless as a result of intimate violence but can rationally decide the steps they do or do not want to take, their judgments flowing from the intricacies of domestic violence warrant attention. Women in the Battered Women Focus Group Study commented on the desirability of control over the course of action. One participant emphasized that the healthcare practitioner should "ask" the woman what procedures she wants to take.¹¹⁵ One woman who recalled a prior experience when a hospital contacted law enforcement said it was "appropriate" that the "control" was left with her.¹¹⁶ Similarly, another woman said the patient should be given the "choice" to decide how law enforcement proceeds if the healthcare practitioner reports. It was a "very scary thought" to one woman that her rights might be given over to another under the reporting scheme.¹¹⁷ A participant offered that "women tend to get help when they're ready."¹¹⁸ Another added that a "woman has to be ready to take the steps that are necessary for her to be safe."¹¹⁹

Numerous well-publicized reasons exist to rationally explain why a victim may not want to contact the police. Requiring healthcare workers to reach beyond their sphere may be like knocking down the first in a row of dominoes. Going beyond the healthcare institution could mean tapping an interconnected system that includes police, temporary restraining orders, court appearances, prosecutors, lawyers, and judges. At every step, there are potential weaknesses in the system that could likely result in no help at all for the woman.

Among the reasons why women may not want to contact the police is the fear of further attacks by the perpetrator in the absence of adequate protection. In a more perfect world, the threat of violence to a woman would end when the police reach the perpetrator. However, the systems established by communities in California and elsewhere cannot ensure that a woman will not be exposed to subsequent abuse or battery. Law enforcement agencies do not provide round-the-clock physical protection and temporary restraining orders are only as powerful as the abusers'

114. The number of police calls in California related to domestic violence was 195,019 in 1990, 240,826 in 1992 and 238,895 in 1993. CAL. DEP'T. OF JUSTICE, CRIME AND DELINQUENCY IN CALIFORNIA 1992 (1992); CALIFORNIA CRIMINAL JUSTICE PROFILE 1993 (1994). See also BACHMAN, *supra* note 5, at 9.

115. Battered Women Focus Group Study, *supra* note 79, AF1193 at 28.

116. Battered Women Focus Group Study, *supra* note 79, CAU22894 at 24.

117. Battered Women Focus Group Study, *supra* note 79, CAU22394 at 20.

118. Battered Women Focus Group Study, *supra* note 79, CAU22894 at 20.

119. Battered Women Focus Group Study, *supra* note 79, CAU22894 at 24.

willingness to abide by them. Unlike protective services for abused children that may remove the child from the violent environment,¹²⁰ the law enforcement system does not mandate the removal of the woman from her potentially dangerous home subsequent to a report of suspected or actual abuse. Further, attitudes and practices by police have been considered an obstacle in the effort to deter perpetrators.¹²¹ Clearly, police officers who downplay the seriousness of the violence or who are reluctant to make efforts based on a belief that the woman will simply rejoin the partner later will weaken the potential that is available under the law.

The concern about future abuse was voiced repeatedly in the Battered Women Focus Group Study. As one participant stated, "they couldn't guarantee me that they would be there 24 hours to protect me from this maniac. So, therefore, I wasn't taking a chance on my life."¹²² Others described contact with the police as "dangerous,"¹²³ and as putting the woman in "a lot more jeopardy."¹²⁴ Another said it could make the situation "worse."¹²⁵ A participant described a fear that the abuser would "blame" her for the police intervention and harm her.¹²⁶ When the batterer was also a police officer, the victim persuaded her doctor not to call the police and resolved her situation by taking the doctor's report to a lawyer instead.¹²⁷ One participant remarked that merely dealing with police can be a problem in itself: "when the police get here, you already been through so much trauma and stuff that you, I mean, it's like you just going through it all over again."¹²⁸

The fears expressed by the participants cannot be eased by the law's view of police protection and intervention. The United States Supreme Court has held that there is no constitutional guarantee of protection to individuals.¹²⁹ Writing for the majority in *DeShaney*, Justice Rehnquist

120. The authors are not defending this practice as a guarantee against further harm to the child.

121. MARTIN, *supra* note 103, at 93 (citing some of the problems as: low priority for domestic violence calls, late or no arrival, policies that discourage officers from taking any action after arrival and beliefs about intimate violence); LAWRENCE SHERMAN, POLICING DOMESTIC VIOLENCE 3 (1992) (concluding from a controlled study in Minneapolis and repeated in six cities that arrest decreases domestic violence in some cities while increasing it in others).

122. Battered Women Focus Group Study, *supra* note 79, AF10693 at 22.

123. Battered Women Focus Group Study, *supra* note 79, CAU22394 at 17.

124. Battered Women Focus Group Study, *supra* note 79, CAU22894 at 24.

125. Battered Women Focus Group Study, *supra* note 79, CAU22894 at 24.

126. Battered Women Focus Group Study, *supra* note 79, L893 at 29 (translated from Spanish).

127. Battered Women Focus Group Study, *supra* note 79, CAU22394 at 5.

128. Battered Women Focus Group Study, *supra* note 79, AF10693 at 20.

129. *DeShaney v. Winnebago*, 489 U.S. 189 (1989).

stated the purpose of the Due Process Clause of the Fourteenth Amendment "was to protect the people from the state, not to ensure that the state protected them from each other."¹³⁰ While other theories may be available to make the woman "whole" if injury occurs when the protection that should have been there was not, it does not allay the concern that an attack may occur. In addition to women's own experiences, the news media continually contribute to the perception that police can provide only limited, sporadic protection.¹³¹ As an alternative to calling the police as a way to help women, participants suggested patients be put into contact with "someone who's intimately familiar with this battered syndrome,"¹³² or a "middle place" such as a "social worker."¹³³

The fear of inadequate protection voiced by the women flows from the judicial system as well as the police structure. Research by Lisa Lerman fifteen years ago regarding the courts and domestic violence led her to conclude that, "[a]t present most battered women do not, in fact, have the option to file charges, because the obstacles posed by the system are so great."¹³⁴ Among the problems are lack of information about the court system, the inconvenience of going through the judicial process and fear of the abuser or emotional attachment to the abuser.¹³⁵ One study found that the stated reason for dismissal in ninety-two percent of the dismissed cases was the lack of cooperation by the victim.¹³⁶ Lerman advocated a "no-drop" policy¹³⁷ for domestic violence cases, even though such a policy threatens the woman's freedom to choose what action should be taken.¹³⁸ In addition to the potential restriction of the woman's right to

130. *Id.* at 196.

131. *E.g.*, Carla Marinucci & Erin McCormick, *Terrified Wife Seeks Investigation of Cops; Granddaughter of S.F. Supervisor Says she was Beaten, Pursued by Husband, but Police didn't have Time to Help*, S.F. EXAMINER, Mar. 21, 1995 at A1, A14. The lead story on the front page reports that the husband allegedly set fire to the house after the wife asked for help from police but was told they had to respond to another call instead. *Id.* at A1.

132. Battered Women Focus Group Study, *supra* note 79, CAU22394 at 24.

133. Battered Women Focus Group Study, *supra* note 79, CAU22394 at 18.

134. LISA LERMAN, PROSECUTION OF SPOUSE ABUSE: INNOVATIONS IN CRIMINAL JUSTICE RESPONSE 8 (1981).

135. *Id.* at 18.

136. *Id.* (citing VERA INSTITUTE OF JUSTICE, FELONY ARRESTS: THEIR PROSECUTION AND DISPOSITION IN NEW YORK CITY'S COURTS 31 (1977)).

137. *Id.* at 148. (stating "[t]o reduce case attrition, prosecutors should adopt a policy that once charges have been filed in spouse abuse cases, victims' requests for dismissal will be denied.").

138. Angela Corsilles, *No-Drop Policies in the Prosecution of Domestic Violence Cases: Guarantee to Action or Dangerous Solution?* 63 FORDHAM L. REV. 853, 864 (1994). The author states:

Although California lawmakers have not passed legislation specifically advocating no-drop policies, California law implicitly recognizes local use of such policies by according special treatment to victims who refuse to testify. Under section 1219 of California's Civil Procedure Code, judges are

decide, the action diminishes the woman's right to assess the danger to herself. One study participant remarked, "I would never press any charges 'cause I was scared for my life."¹³⁹ Further, varying policies among jurisdictions statewide could also vary the autonomy a woman may have while possibly making it more difficult for a woman to know with certainty what would follow if she initially chose to file charges.

Lack of cooperation because of the intimate relationship of the woman with the abuser represents a weak point for the law enforcement system. The emotional bond that a woman may have with her partner was mentioned by a study participant, who stated, "you in love with that person and it ain't like, you really don't want to see that person, you know, see that person get in trouble"¹⁴⁰ These feelings can contribute to pessimism or reluctance by prosecutors in their efforts to deter the perpetrator and help the victim which comes full circle to the belief that the justice system is too weak to protect women who are abused.¹⁴¹

The victim's fear of reprisal may be accompanied by a distrust of healthcare workers according to the women in the study. One participant said she simply did not "trust" doctors,¹⁴² while another said the language barrier created a trust problem.¹⁴³ A woman explained that her loss of trust in her abuser led her to lose "trust in other people, including physicians."¹⁴⁴ It could be argued that distrust in healthcare workers is symptomatic of the feelings of isolation that may accompany intimate violence, but that is only one of a myriad of possible explanations. Distrust of doctors and nurses is not only present in women who have suffered from intimate violence, but also can be the result of past negative experiences with healthcare workers, including abuse, racism, or inattention.¹⁴⁵ For undocumented immigrants, as one participant noted, there is the added concern of whether the immigration authorities will also be contacted to "check on" the woman.¹⁴⁶ Two participants articulated a need for

prohibited from jailing a domestic violence victim on the first contempt finding for refusal to testify. Instead of jail, the judge may order the victim to attend a domestic violence program for victims, or to perform up to 72 hours of community service. The judge may sentence a victim to jail only after a second finding of contempt.

Id.

139. Battered Women Focus Group Study, *supra* note 79, AF10693 at 5.

140. Battered Women Focus Group Study, *supra* note 79, AF10693 at 18.

141. Corsilles, *supra* note 138, at 868-870.

142. Battered Women Focus Group Study, *supra* note 79, AF10693 at 22.

143. Battered Women Focus Group Study, *supra* note 79, L893 at 25 (translated from Spanish).

144. Battered Women Focus Group Study, *supra* note 79, CAU22394 at 13.

145. Participants in the Battered Women Focus Group Study described these types of negative experiences with healthcare workers in excerpts not included in this work.

146. Battered Women Focus Group Study, *supra* note 79, AS83193 at 15.

assurance from the healthcare practitioner that information would be kept "confidential," or the batterer "will not know."¹⁴⁷

Economic reasons may discourage or delay a woman from contacting the police when she might otherwise do so. Recent studies give support to the concerns about financial welfare following separation and show that a woman during her first year of divorce typically suffers a thirty percent decrease in income, although her income may rise in subsequent years and will often become higher than it was prior to the divorce.¹⁴⁸ Fear of financial loss was also mentioned by some participants, although it was not a significant theme in every focus group. To the contrary, a participant described that her partner "wanted me to support his habit," suggesting that the relationship was a financial drain and not a gain for her.¹⁴⁹ One participant who said she "didn't want to be separated from" her children¹⁵⁰ may have believed that she was not financially able to take the children with her, among other possible reasons. Research has shown that child support obligations are not met by thousands of fathers, representing vast amounts of unpaid awards nationwide.¹⁵¹

The issues addressed above represent some of the major reasons why women do not want to contact the police, and why they similarly do not want healthcare workers to call the police when intimate violence occurs. The presumption that women who are battered are in a state of helplessness is not justified in light of the concerns about how the community response operates in its entirety. Nor is it appropriate to speak of battered women in the same context as abused children or elders. The law generally assumes children to be immature, and the problem of elder abuse often takes a different form¹⁵² than intimate violence and remains the subject of debate.¹⁵³

147. Battered Women Focus Group Study, *supra* note 79, AS83193 at 19, L21993 at 25 (translated from Spanish).

148. SUSAN FALUDI, *BACKLASH: THE UNDECLARED WAR AGAINST AMERICAN WOMEN* 21-22 (1991).

149. Battered Women Focus Group Study, *supra* note 79, AF10693 at 5.

150. Battered Women Focus Group Study, *supra* note 79, AS11494 at 15.

151. FALUDI, *supra* note 148, at 24. In the mid-'80s, only half of the 8.8 million mothers who should have received payments actually did so. In 1988, the federal government collected \$5 billion of the \$25 billion owed in back child support, while at the same time, more than half the states were not complying with the federal child support law. *Id.*

152. *See, e.g.,* Joyce Riffer, *Elder Abuse Victims Estimated at 1 Million*, 59 J. AM. HOSP. ASS'N 60 (1985).

153. In the case of mandatory reporting of elder abuse, one author argued in part: For the older person, the involuntary intrusion of mandatory reporting on their ability to control their own lives will all too often be negatively compounded by a further deprivation of liberty through institutionalization Mandatory reporting for cases of suspected elder abuse, while reinforcing the view that older persons, as a group, need protection, will also act to discourage many from seeking help, thus, making the stereotype of

A theme that is found in the comments of the Battered Women Focus Group Study is the desire for adequate information that can be used to make decisions. "Give them a brochure," one participant suggested.¹⁵⁴ Another offered that "the doctor could do a good job of helping women by letting women know different resources or programs or places they can go"¹⁵⁵ One woman said healthcare workers could remedy the typical patient's lack of information and "should have a list of phone numbers," including shelters "where nobody will know where she's at."¹⁵⁶ These suggestions shift the focus from a course of action that de-emphasizes the woman's decision making to an avenue facilitating informed choice. The provision of the Speier law recommending that physicians give referrals to local services is a move in the direction of meeting the articulated needs of battered women.

Participants also made some statements about the potential benefit of documentation. A police report "legitimizes" the abuse as a crime, and proves that it "did" happen, a participant suggested.¹⁵⁷ The participant who took the doctor's report to her lawyer also appears to have benefitted from documentation, considering "there was no battery after that."¹⁵⁸ One woman remarked that the physician could "put it on your chart" even if the woman at that moment did not want to have the police contacted.¹⁵⁹ Another suggested that the physician photograph the injuries and make a record for later use.¹⁶⁰ The law recommends but does not require a physician to document the injury. When a physician fails to detect intimate violence as the cause of the injury and the woman does not offer the truth out of a reasoned choice against police involvement, the potential benefits are diminished. Significantly, any doctor who documents an injury from intimate violence is required by the law to contact law enforcement. A physician who neither calls the police nor documents the injury, aside from facing liability under the law, could introduce a problem of proof for the woman who later chooses to proceed with a case against the abuser.¹⁶¹

helplessness a self-fulfilling prophecy.

Lawrence Faulkner, *Mandating the Reporting of Suspected Cases of Elder Abuse: An Inappropriate, Ineffective and Ageist Response to the Abuse of Older Adults*, 16 FAM. L. Q. 69, 89-90 (1982).

154. Battered Women Focus Group Study, *supra* note 79, CAU22894 at 20.

155. Battered Women Focus Group Study, *supra* note 79, AF10693 at 27.

156. Battered Women Focus Group Study, *supra* note 79, CAU22394 at 24.

157. Battered Women Focus Group Study, *supra* note 79, CAU22894 at 24.

158. Battered Women Focus Group Study, *supra* note 79, CAU22394 at 5.

159. Battered Women Focus Group Study, *supra* note 79, AF1193 at 28.

160. Battered Women Focus Group Study, *supra* note 79, AS83193 at 17, 19.

161. The evidentiary problem exists because of the assumption that if intimate violence had occurred, the doctor would have reported as much to the police:

In an unpublished ruling this court recently held admissible as non-hearsay the fact that a U.S. mining inspector ate his lunch in an area in a coal mine

Conclusion

The comments above suggest that the Speier law is a collection of ideas that is mismatched against the battered woman's autonomy and against the problem of domestic violence generally. While the law seems to have been created with the best of intentions, its failings and potential to endanger women deserves a reexamination by lawmakers. Reexamination must begin with the willingness to listen to the women themselves—women who are reasonable, capable, available, and who have articulated the complexities of the problem of intimate violence in the community. The use of law for social change “is only justified if it is a process of self and social empowerment that moves women not only to activate the rights they do have, but to redefine and reshape the inadequate ones as expressed in law and in practice.”¹⁶²

now alleged to have been unsafe, and that other inspectors who observed operations prior to a disastrous explosion issued no citations, when it would have been their duty to do so, if there had been safety violations.

U.S. v. Zenni 492 F. Supp. 464, 468 n.18 (E.D. Ky. 1980).

162. Heidi A. Chesley, *Book Review*, 16 HARV. WOMEN'S L. J. 303, 308 (1993) (quoting LEGAL LITERACY: A TOOL FOR WOMEN'S EMPOWERMENT 36 (Margaret Schuler & Sakuntala Kadirgarmar-Rajasingham eds., (1992))).