Domestic Violence: Legal Issues for Health Care Practitioners and Institutions

ARIELLA HYMAN, JD

If health care practitioners and institutions became familiar with legal options available to survivors of domestic violence, they could better facilitate their patients' access to potentially life-saving recourses. Such options include calling the police and obtaining civil protection orders and bringing custody, divorce, and support actions. Provider awareness of legal obligations and other legal considerations that arise when handling domestic violence cases is important for patient care and the practice of good risk management. Examples of such issues include domestic violence protocol requirements, documentation of abuse, and repercussions of mandatory reporting laws. Health care providers should work in collaboration with community domestic violence programs in educating staff on issues pertaining to domestic violence and in crafting policies that promote patient safety and autonomy.

Physicians and other health care providers are often the first or only outside contact for many survivors of domestic violence. They are therefore in a unique position to offer crucial support and information to these patients. The clinician's role in caring for battered women includes screening for abuse, providing supportive care, addressing patient safety, and discussing with the patient her available options. (This paper often refers to "battered women," since nearly 95% of domestic violence victims are women. Domestic violence can also occur against men and in homosexual as well as heterosexual relationships.) Ideally, the provider can become a patient advocate, facilitating the patient's access to information and resources and empowering her to take steps that may enhance her safety. Important to providers' abilities to perform these roles is familiarity with legal measures available to survivors and legal considerations that arise when handling domestic violence cases. This article provides an overview of legal issues in the hope of enabling providers to direct their battered patients to legal recourses, better coordinate with community domestic violence programs, and be more active in their patients' ongoing care. Awareness of legal considerations can also facilitate the participation of providers in the creation of public policy that is more responsive to the needs of battered patients.

This article first addresses some of the legal remedies and protections available to survivors of domestic violence that health care providers might discuss with their battered patients. These include criminal justice intervention, civil protection orders, child custody and visitation orders, divorce and support actions, immigration remedies, and other legal options, such as domestic tort and civil rights actions. Health care institutions should have information regarding such recourses and updated legal referrals readily available to the provider and patient.

Second, it highlights some legal considerations for health practitioners and institutions. These include compliance with domestic violence protocol and education requirements, thorough medical record documentation, awareness of the ramifications of mandatory reporting laws for patient care, the problem of insurance discrimination against battered women, and the duty to warn a third party about a perpetrator-patient's threats against her.

Ms. Hyman is a staff attorney with San Francisco Neighborhood Legal Assistance Foundation.

Legal Remedies For Battered Women

A number of legal remedies are available to survivors of domestic violence. As laws vary significantly from state to state, the information provided below should be used as a general guide. Providers may obtain more detailed information on laws and policies in their jurisdictions from community domestic violence programs.

Criminal Justice Intervention. Most battered patients are victims of crimes. Such crimes may include assault, battery, stalking, sexual assault, rape, marital rape, threats, harassment, kidnapping, destruction of property, forcible entry of a residence, assault with a weapon, and specific "domestic violence" or "spouse abuse" crimes. Providers should explain to their patients that what happened to them may be against state laws and may carry criminal penalties. The patient could seek redress through the criminal justice system.

The nature and extent of follow-up that occurs when a victim calls the police depends on local and state laws, policies, and practices. For instance, some states mandate, while others only authorize, police to arrest perpetrators when they believe that a crime involving domestic violence has occurred.[1] Prosecution policies differ in the extent to which they take into account survivors' wishes regarding whether or not to prosecute. Attitudes of individual police officers, prosecutors, and judges significantly affect how seriously a case is treated.

The more the survivor understands her rights and role in the criminal justice process and is informed about how to navigate the system, the better off she will be. For instance, when calling the police for a domestic violence incident, a battered woman may be able to demand that the police write a report or make a private person's arrest. She may have the right to receive information regarding protection orders, shelter, transportation, and the criminal process, or assistance in acquiring medical aid. Police may be required to remain at a domestic violence scene until the survivor's safety is secured.[1] Similarly, the survivor has rights at other stages of the process: she may be able to request that the criminal court order the batterer to stay away from her, that she receive victim restitution, or that she be notified upon a batterer's release from jail.

The consequences of being unin-

formed about the criminal justice process may be substantial. For instance, it may be that if, after calling the police, the survivor does not follow up by going to the police station or contacting the prosecutor's office, nothing will become of the case. Additionally, if the perpetrator is arrested, he may simply be given a citation and released, or may be taken into custody briefly and released, only to seek retaliation against the victim.

As the health care setting may be the survivor's first outside source of help, the availability of basic information on her rights when navigating the criminal justice system can significantly enhance her well-being. Health facilities may be able to obtain information sheets on calling the police from local domestic violence programs and make them available to providers and patients. Providers might advise the battered patient to use the time the perpetrator is in custody to quickly gather her children and important belongings, find a safe place to stay, and take other safety precautions. Providers should also encourage the patient who wants criminal justice intervention to contact a domestic violence or victim witness assistance program. Advocates can furnish the survivor with important information regarding her rights and role in the criminal justice process and support her throughout that process.

Civil Protection Orders. Civil protection orders are available to battered women in every state and the District of Columbia. The types of orders vary and may include: restraining the defendant from further violence; evicting the perpetrator from the household; ordering the perpetrator to stay away from or not to contact the victim; awarding child custody, visitation, or support; ordering the defendant to attend batterer's counseling; and prohibiting the perpetrator from possessing weapons. Statutes may permit monetary compensation to the survivor for such things as replacement of destroyed property, relocation expenses, lost wages, and medical bills or other expenses incurred as a result of domestic violence injuries.[1]

States codes vary as to who is eligible to obtain a protection order and the process for applying. States may allow only current or former spouses to petition for such orders, or may enable same and opposite sex intimate partners or cohabitants, relatives, and others to apply. To obtain a protection order, one usually files a petition with the court requesting a temporary protection order without notice to the other party. The petitioner usually must prove that there is reasonable cause to believe that she is in danger of being abused or threatened with abuse by the respondent. Subsequently, a full hearing after notice to the respondent is set, at which time a more permanent order is requested. The duration of this order varies, but in the majority of states lasts for six months to one year. Many states offer a means to petition for temporary or emergency protection orders in the evenings or on weekends.[1]

In most states, violation of a protection order is a misdemeanor crime. A violation may also subject the perpetrator to contempt of court. Police are mandated in some states and authorized in others to make an arrest without a warrant if they have probable cause to believe a violation has occurred.[1] The protected person should keep a copy of the restraining order with her at all times and other copies at her residence, work, or other locations she frequents. It is also important that she send a copy to the local police department so they will have it in their registry for verification purposes.

Do protection orders help? A national survey of domestic violence organizations suggests that police and prosecutors respond ineffectively to protection order, violations and that violators are infrequently sent to jail by judges.[2] Yet other studies show that the existence of protection orders increases police responsiveness to the requests of battered women for assistance, and that most perpetrators restrained by protection orders do not recidivate while the order is in effect.[1,3] The provider may best serve the battered patient by informing her of the option of and process for obtaining a protection order while trusting her judgment about whether an order will be a help or a hindrance. Survivors usually know best whether the batterer will respect a court order, ignore it, or even retaliate. Those who do obtain protection orders should be advised to take precautions to enhance their safety rather than to rely solely on the order for protection.

Child Custody and Visitation Orders. Court orders clearly delineating custody and visitation arrangements can be critical to the safety of the survivor and her children. Abusers often use the children as a means of gaining access to or controlling their former partners, and orders may limit their ability to do so. If an abusive father takes a child from the mother, the police will likely tell the mother that they cannot bring her child back until they see a court order declaring that she has custody. Visitation orders may be crafted to allow for no contact between the parents; transfer of a child may be arranged through a third party or visitation supervised through a court-ordered program. Visitation may also be denied to the perpetrator or conditioned on his attendance at a batterer's treatment program. If a patient has an order that calls for continuing contact between the parents or one that is lacking in specificity and clarity, it may put her and the children at increased risk of violence.[4] Providers should advise survivors who have children to seek legal consultation regarding custody and visitation orders. Most state laws recognize the detrimental effects of domestic violence on children and require courts to consider domestic violence when making custody and visitation determinations. Some state laws create a presumption that it is not in the best interests of the child to award custody to the batterer or to allow joint custody in domestic violence cases.[4] Pediatricians and family practitioners, in particular, might be prepared to write letters for their patients' use in custody cases, noting such things as the extent of the violence and its impact on the child's health.

Divorce and Support Actions. Health facility referral lists should include organizations that offer assistance in obtaining child and spousal support and divorces. Awards of child and spousal support and orders that distribute the marital property may be very useful for battered women who are struggling to provide for themselves and their children apart from the batterer. Legal separation and annulment are options that may be of particular interest to battered women who are married and do not favor divorce for religious or other reasons.

Immigration Remedies. Immigrant battered women often face severe obstacles in attempting to leave their abusive partners or pursue legal remedies. It is not uncommon for a batterer to use his

wife's immigration status as a means of exerting power over her.[5] For instance, a batterer who is a US citizen or permanent resident may threaten his undocumented partner that he will report her to the immigration authorities or will not petition for her legal status if she leaves him or seeks legal redress. Due to her status and possible language barriers, the immigrant woman may encounter significant obstacles to access to benefits programs; social, legal, and health services; and other recourses that may help her live independently of the batterer.[5,6]

Fortunately, there are now specific legal recourses available that enable immigrant battered women to apply for their permanent legal status without having to rely on a coercive partner. A battered woman who has conditional status may be able to obtain a waiver of the requirement that the spouses file a joint petition for her permanent residency. Under the federal Violence Against Women Act, an undocumented battered woman may be able to apply for a suspension of deportation or self-petition for permanent residency rather than depend on the batterer to petition for her.[7] Health care providers who encounter battered patients who are confronting immigration difficulties should refer them to domestic violence and immigration assistance organizations for information about potential recourses.

Other Legal Options. There are a few less commonly used options that may prove beneficial in particular situations. Survivors may be able to sue perpetrators under civil law tort actions such as intentional or negligent infliction of emotional distress, false imprisonment, trespass to land or personal property, and invasion of privacy.[8,9] In certain instances battered women may seek redress under state antibias violence statutes[9] or bring federal civil rights actions under the Violence Against Women Act,[10] on the theory that they are victims of gender-based crimes.

Know Your Community

Providers who are knowledgeable about domestic violence resources in their communities can best guide the battered patient through her options. Examples of legal assistance that might be available include: legal aid programs providing free legal services to low-income people, legal adjuncts of shelters or other domestic violence agencies, legal clinics providing guidance to battered women representing themselves in protection order or divorce actions, bar association referral services, criminal justice advocacy units, and immigration assistance organizations.

Health care facilities should have updated referral lists, brochures, and information on legal resources readily available. Such information might include whether programs provide multilingual and multicultural services and whether they address the needs of gay and lesbian survivors of domestic violence. Good sources for information are local domestic violence programs and state domestic violence coalitions.

The goal of delivering effective care to battered patients will be furthered with the development of partnerships between health institutions and domestic violence programs. Domestic violence experts in the community can educate staff on legal recourses and assist in developing outreach and referral materials. There exist excellent models of collaboration between health facilities and domestic violence programs to provide advocacy and intervention within the health care setting. (Information on model programs is available through Family Violence Prevention Fund's Health Resource Center on Domestic Violence, 1-800-313-1310.) Given the limitations of legal remedies and the comprehensive support systems that battered women may require, such advocacy and intervention becomes all the more critical.

Other Legal Issues in Caring for the Abused Patient

Health care providers and institutions should be aware of their legal obligations with respect to domestic violence, as well as other legal issues that may arise in the context of the provider-patient relationship.

Protocol and Education Requirements. Health practitioners and institutions may be subject to requirements regarding domestic violence education and protocol development. The standards of the Joint Commission on Accreditation of Healthcare Organizations require policies and practices for identification and assessment of abuse victims, documentation and handling of evidentiary material, patient consent, and education for providers.[11,12] Some states mandate domestic violence protocol development for health care institutions or have laws regarding domestic violence training for health practitioners or in professional schools.[13] Laws concerning rape and sexual assault protocols and education[14] may also apply in cases of partner abuse. Federal legislation that would give federal funding preference to medical, nursing, and other professional schools that require training in domestic violence is pending.[15]

As a general rule, it is wise for institutions to have in place domestic violence practices and policies for identification, assessment, documentation, referral, and staff education. Providers who routinely inquire about domestic violence, help battered patients assess their safety, counsel patients on available options, document the abuse, and provide appropriate referrals are not only delivering critical care to patients, but are practicing good risk management.[16,17]

Documentation of Abuse. Thorough documentation of abuse in the medical record is not only important for the patient's ongoing care but also may considerably affect the outcome of a legal case. Battered women are at times unsuccessful in their legal efforts due to their inability to prove that the violence took place. Often there are no witnesses, and there may be no police reports, as survivors may be too frightened to call the police or the police may have failed to write a report. Medical record documentation may therefore be the only evidence of abuse aside from the survivor's personal testimony. Documentation may assist in the criminal prosecution of perpetrators and may help a battered woman in her petition for a protection order. It may be used in custody cases to show that it is not in the child's best interest to live with a violent parent. Medical records may provide the requisite proof an immigrant battered woman needs to obtain relief from the requirement that she rely on the batterer to petition for her legal status.

Helpful tips for documentation include: documenting descriptions of the injuries and the violence, including, if possible, the date and location of the incidents; noting the name and relationship of the alleged perpetrator; using the patient's own words, where appropriate, rather than provider interpretations of the incidents (ie, "'my boyfriend punched me in

the eye'" rather than "patient sustained blow to right orbit"); maintaining two body maps, one for new and one for old wounds; noting any history and pattern of physical, sexual, and/or psychological abuse; describing inconsistencies between possible causes and explanations of injuries if abuse is suspected but the patient has not confirmed it; and recording opinions corroborating abuse, such as "trauma consistent with being struck from behind with a baseball bat."

Photographs can be extremely valuable as evidence. All battered patients with visible injuries should be offered the option of being photographed; their written consent should be obtained first. Color film should be used, and Polaroid cameras are preferable since photographs can be attached to the record immediately. Photographs should be clearly marked with the patient's name, identifying data, name of photographer and others present, and the date and time. Evidence such as torn or bloody clothing or weapons should also be recorded, carefully preserved and clearly identified.[18]

Many battered women are also survivors of sexual assault or rape. In fact, spousal rape is often more violent and repetitive than other types of rape and less commonly reported.[19] Proper collection of physical evidence, thorough documentation, and compliance with forensic protocols are essential to ensure that evidence is available for criminal proceedings. Guidelines regarding how to conduct physical and forensic examinations and collect forensic specimens are reviewed elsewhere.[19] Consent must be obtained before conducting such examinations.

If not recorded with care, documentation may be misinterpreted or improperly used against a patient in a legal case. For instance, a mental health diagnosis without an indication of the impact of abuse on the patient's condition can result in harmful consequences. Battered women have lost custody to violent fathers in part because the fathers used such information to assert that the mothers were too unstable to be given custody.[20] Rather than simply note "psychiatric referral," it may be preferable to add "to deal with trauma from being abused for ten years." Documentation should be precise and not contain extraneous information; including such statements as "It was my fault he hit me because ..." is unnecessary and potentially detrimental. Excessively detailed histories may result in discrepancies with police reports and thus adversely affect legal proceedings.[19]

Practitioners may, on rare occasions, be called to testify about the contents of records or statements made. They may be requested to give expert testimony or an opinion on the cause of the patient's injuries. It is in the patient's best interests for practitioners to thoroughly prepare for such testimony with the patient's attorney.[16] Provider-patient testimonial privileges may prevent practitioners from divulging confidential information or opinions acquired in their interaction with the patient without that patient's permission. The scope of laws regarding confidentiality and testimonial privileges vary from state to state and exceptions may apply.[21,22]

Mandatory Reporting. Forty-five states and the District of Columbia have laws that, to varying extents, may require health practitioners to report cases of domestic violence to a governmental agency. Most states require reporting when a patient has an injury that appears to have been caused by a weapon. States may also mandate reporting of injuries due to crimes, or violent or nonaccidental acts. A few states have mandatory reporting laws that specifically address reporting where domestic violence is suspected. State laws vary as to which practitioners are mandated reporters and as to the degree of knowledge or suspicion that triggers the obligation to report. With few exceptions, reports are made to a criminal justice agency. Most states impose penalties for failure to report and provide practitioners with immunity from liability when making reports in good faith. A more thorough review of these statutes and a listing of their citations is published elsewhere.[23] In addition, providers may have obligations under child, elder, and vulnerable adult abuse reporting laws.

Providers may also have duties under common law. Though there appear to be no state appellate court cases in which a provider was prosecuted or sued for failure to report domestic violence, providers have been held liable for failure to diagnose and report child abuse, both under the state's reporting law and under theories of negligence. Providers may also be held liable for breaching confidentiality or privacy by reporting where not required by law.[23]

Mandatory reporting of domestic violence may fail to protect survivors, and it creates ethical dilemmas for providers when patients do not want their cases reported. Reporting may put abused patients at risk of retaliation by perpetrators; it may deter them from telling providers about the abuse or from seeking care at all. Providers who rationalize that if they report the problem it will be taken care of, may abdicate responsibility for ongoing care. Additionally, if there is no effective response to reports of abuse, mandatory reporting may create false expectations, decrease patient trust in the provider, and diminish patient safety.[23]

Although in some cases reporting may[23] lead to increased protection for the patient, in others it may jeopardize her health and safety. If the patient does not want state involvement, it is ethically questionable to override her objections on the grounds that it is in her best interests. According to the ethical guideline of respecting patient autonomy, competent, informed adults should retain the power to act in accordance with their values, goals, and life plans. Practitioners should respect a survivor's assessment of what steps may or may not enhance her safety. Mandatory reporting may in fact revictimize battered women, and may also interfere with provider-patient confidentiality, undermining patient trust and limiting her candor with the provider.[23]

If patient needs are to be met, the experiences and perspectives of battered patients and their providers must inform public policy debates regarding mandatory reporting laws. In the meantime, health practitioners and institutions should strive to minimize harm to the abused patient under current laws. Most importantly, clinicians and institutions need to provide ongoing, supportive care and help battered patients assess their safety and available options. Practitioners should learn how local authorities respond to reports of abuse. They should discuss with the patient their legal obligations to report, explain follow-up procedures that may ensue, and address the risk of retaliation and possible need for shelter or protection orders. The provider should advocate on behalf of the patient with the authorities about the preferable

way to respond and strive to maximize the patient's input regarding future action.[23]

The connection between partner abuse and the well-being of children often presents difficult questions for the provider. Should a practitioner who suspects that a patient's child is also being abused by the perpetrator report to a child protection agency? If a provider whose patient is a child sees that the child's mother has a black eye, what should the provider do? Whether one is mandated to report in such instances depends on the parameters of state law. However, it is important to be aware of potential consequences of reporting. Child protective service workers may not be educated about adult domestic violence. Punitive state measures such as taking the child from the mother's care for her failure to protect her child may abound. Such measures do not always address the source of the problem—the perpetrator of the violence—and may be harmful to the mother and child.[24,25] Clinicians in such cases might go beyond simply filing reports. They might consider consulting with their ethics committee, risk management and battered women's advocates on how to enhance the child's safety, facilitate the mother's safety and empowerment, and mitigate the potentiality of inappropriate state interventions.

Insurance Discrimination. Some insurance companies are denying health, life, disability, and other types of coverage to patients who are or have been victims of abuse (*New York Times*. May 12, 1994:A9). Such policies are discriminatory in treating battered women differently from other crime victims and perpetuate the myth that the victim chooses to be abused. They also may result in deterring survivors from seeking health care. Challenges to such insurance discrimination are underway, and state and federal legislation to prohibit these practices has been enacted or is pending.[26,27] Health providers would benefit their patients by joining with policy makers, survivors and their advocates in combating insurance policies that undermine the effectiveness of treatment.

Duty to Warn. Health care practitioners should be aware of duty to warn requirements that may apply when they have a patient who may be a perpetrator of domestic violence. Many states recognize a legal duty that practitioners have toward third parties whom they suspect may be harmed by their patients. When a patient indicates an attempt to harm his partner, the provider may be required to breach confidentiality and warn the partner or police of the potential danger.[16] As state statutes and case law in this area vary, providers might inquire about the relevant laws in their jurisdictions.

Conclusion

In gaining familiarity with options for survivors and developing institutional procedures and practices relating to domestic violence, practitioners and institutions should turn to the expertise of domestic violence programs in their communities. They should also work in collaboration with survivors and their advocates to craft public policies that promote the safety and autonomy of survivors of domestic violence. In this way, providers will go a long way toward becoming essential partners and advocates in the care of their battered patients.

Supported in part by San Francisco Neighborhood Legal Assistance Foundation through grants from the San Francisco Commission on the Status of Women and the GAP Foundation. I am most appreciative of Juhu Thukral for her legal research and assistance. I would also like to thank Dean Schillinger, MD; Susan Breall, JD; Jennifer Prado; and Kenneth Theisen for their helpful comments in the preparation of this article.

References

1. Hart BJ. *State Codes on Domestic Violence: Analysis, Commentary, and Recommendations.* National Council of Juvenile and Family Cour Judges; 1992.
2. Kinports K, Fischer K. Orders of protection in domestic violence cases: An empirical assessment of the impact of the reform statutes. *Texas Journal Women Law*. 1993;2:163-276.
3. Cooperative Restraining Order Clinic. *Cooperative TRO Clinic Effectiveness Follow-up Study*. San Francisco, Calif: Cooperative Restraining Order Clinic; 1989.
4. Hofford M, Bailey C, Davis J, Hart B. Family violence in child custody statutes: An analysis of state codes and legal practice. *Family Law Quarterly*. 1995;29:197-227.
5. Jang DL. Caught in a web: Immigrant women and domestic violence. *Clearinghouse Review*. 1994; 28:397-405.
6. Woloshin S, Bickell NA, Schwartz LM, Gany F, Welch HG. Language barriers in medicine in the United States. *JAMA*. 1995;273:724-728.
7. Violence Against Women Act of 1994, §40701, 108 stat 1953 (1994) (Codified at 8 USCA §§1154(a)(1), 1154(a)(2), 1254(a), and 1254(g) (West Supp 1995).
8. Karp L, Karp CL. *Domestic Torts: Family Violence, Conflict and Sexual Abuse*. Colorado Springs, Colo: Shepard's/McGraw-Hill;1989.
9. Shuman-Moore E, Watts DB, Giffels MM. Bias violence: Advocating for victims (part II). *Clearinghouse Review*. 1995;28:1228-1247.
10. Violence Against Women Act of 1994; Civil Rights Remedies of Gender Motivated Violence Act, §40301, 108 stat 1941 (1994) (Codified at 42 USCA §13981 (1995).
11. *Accreditation Manual for Hospitals*. Oakbrook Terrace, Ill: Joint Commission on Accreditation of Healthcare Organizations; 1995.
12. Scott CJ. Joint Commission on Accreditation of Healthcare Organizations standards to improve care for victims of abuse. *Md Med J*. 1994;43:891-898.
13. Eg, Calif Bus & Prof Code §§2089, 2091.2, 2191, 2196.5, 2736.1, 2811.5, 2914, 2915, 4980.41, 4996.2, and Calif Health & Safety Code §§1233.5, 1259.5 (West 1995).; Iowa Code Ann §135.B.7 (West Supp 1995); Md Code Ann, Health-Gen §19-1701-1705 (Supp 1994); NH Rev Stat Ann §21-m:8-d (Supp 1994); NY Exec Law §575 (McKinney Supp 1995).
14. Eg, Calif Penal Code §§13823.5-.13 (West 1992 & Supp 1995); 35 Pa Cons Stat Ann §10171 (1995); NH Rev Stat Ann §21-m:8-d (Supp 1994).
15. S. 697, 104th Cong., 1st Sess. (1995); H.R. 1521, 104th Cong., 1st Sess. (1995).
16. Flitcraft AH, Hadley SM, Hendricks-Matthews MK, McLeer SV, Warshaw C. *Diagnostic and Treatment Guidelines on Domestic Violence*. Chicago, Ill: American Medical Association; 1992.
17. Freeman J. Domestic violence: The law and physician liabilities. *Iowa Med*. 1995;85:70-75.
18. Warshaw C. Identification, assessment and intervention with victims of domestic vioence. In: Lee D, Durborow N, Salber P, eds. *Improving Health Care Response to Domestic Violence*. San Francisco, Calif: Family Violence Prevention Fund; 1995:49-86.
19. Hampton HL. Current concepts: Care of the woman who has been raped. *N Engl J Med*. 1995;332:234-237.
20. Frederick LM. The physician's response to domestic violence: Legal issues. *Minn Med*. 1992;75:35-37.
21. Smith SR. Medical and psychotherapy privileges and confidentiality: On giving with one hand and removing with the other. *Kentucky Law Journal*. 1986-1987;75:473-557.
22. Newman S. Privacy in personal medical information: A diagnosis. *University of Florida Law Review*. 1981;33:394-424.
23. Hyman A, Schillinger D, Lo B. Laws mandating reporting of domestic violence: Do they promote patient well-being? *JAMA*. 1995; 273:1781-1787.
24. Sassetti MR. Domestic violence. *Prim Care*. 1993;20:289-305.
25. Schechter S, Mihaly LK. *Ending Violence Against Women and Children in Massachusetts Families: Critical Steps for the Next Five Years*. Boston, Mass: Massachusetts Coalition of Battered Women Service Groups; November 1992.
26. Eg, **Passed into law**: Calif Health & Safety Code §1374.75 and Calif Ins Code §10144.2 (West 1996); Conn Gen Stat §38a - 816(18) (1995); Del Code Ann tit 18, §2304(24) (1995); Fla Stat Ann §626.9541(1)(g) (West 1995); Iowa Code §507B.4(7)(c) (1995); Mass Gen L ch 175, §§95B, 108G, 120D, ch 176A, §3A, ch 176B, §5A, ch 176G, §19 (1995).
27. Eg, **Pending**: S. 524, H.R. 1201 & 1920, 104th Cong, 1st Sess (1995); Calif A.B. 115, 1995-96 Reg Sess (1995); La S.B. 1369, Reg Sess (1995); Mich H.B. 4634, 88th Leg, Reg Sess (1995); NJ S.B. 1358 & A.B. 1969, 206th Leg, 1st Reg Sess (1994); NY A.B. 2769, 1995-96 Reg Sess (1995); ND H.B. 1446, 54th Leg (1995); Pa H.B. 1100, 1995 Sess (1995); Wis A.B. 292, 1995-96 Leg (1995); Wash S.B. 5436, 1995 Reg Sess (1995).