Health #3

Potential Legal Liability for Health Professionals for Actions for Inactions in Domestic Violence Cases
By Leslye E. Orloff and Minty Siu Chung[1]

If an injured victim of domestic violence is treated by a physician or nurse who does not inquire about abuse or who accepts an unlikely explanation of the injuries, and the patient then returns to the abusive situation and sustains further injuries, the physician or nurse could conceivably be held liable for those subsequent injuries.[2]

Introduction

Studies estimate that four to six million women are battered by their intimate partners each year in the United States. Of those, each year more than one million women seek medical treatment for injuries deliberately inflicted upon them by their husbands or boyfriends.[3] Battering accounts for 22-35% of cases in which women seek care in emergency departments.[4] Violence is the second leading cause of injuries to women generally, and the leading cause of injuries to women 15 through 44 years.[5]

Oftentimes health care providers are the only professionals in a position to see and help battered women. In 43% of spousal abuse cases, the victim turns to no one to discuss the problem.[6] Many battered women do not know that shelters exist or will not use them[7]. Only 10% of abuse victims report any prior

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[1]This paper has been prepared by Leslye Orloff and Minty Siu Chung of Ayuda, Inc. as a legal memorandum for the State of Alaska, Department of Health and Social Services, Division of Public Health, Section of Maternal and Child Health for its Train the Trainers Workshop 1996. Its purpose is to provide an overview of evolving issues in tort liability law that could form a basis for finding liability against health care professionals who see victims and perpetrators of domestic violence. The legal advice in this memo should not be used in any specific case without consulting an attorney who can evaluate how the law would apply to the facts of any specific case. This memo was prepared with the assistance of Rachel Arnold of George Washington University Law School and Dafna Hacker of American University Law School.

[2]Carol Warshaw and Anne Ganley, IMPROVING THE HEALTH CARE RESPONSE IN DOMESTIC VIOLENCE: A RESOURCE MANUAL FOR HEALTH CARE PROVIDERS 78 (Family Violence Prevention Fund 1995).

[3]Evan Stark and Anne Flitcraft, "Medical Therapy as Repression: The Case of the Battered Women," Health and Medicine, Summer/Fall 1982

[4]Caroline Knapp, "A Plague of Murders: Open Season on Women" The Boston Phoenix, August 1992; also "Physicians and Domestic Violence: Ethical Considerations," Trends in Health Care, Law and Ethics Vol. 8, No. 2, Spring 1993, p.13.

[5]American Journal of Epidemiology, 1991, Vol. 134 pp. 59-68.

[6]Mark A. Schulman, A Survey of Spousal Violence Against Women in Kentucky 4, U.S. Department of Justice, Washington, D.C. 1979

[7]Women of color, in particular, use battered women's shelters at a lower rate than women from the majority culture. Angela Browne, Violence Against Women By Male Partners: Prevalence, Outcomes, and Policy Implications, 48 AM. PSYCHOL. 1077 (1993). Instead, when they flee an abuser they seek refuge with friends and family members who offer

effort to seek assistance from a domestic violence program.[8] Only seven percent of assaults between spouses are reported to the police.[9]

In many cases, health care workers are the first people to encounter battered women.[10] One third of battered women see health professionals, often repetitively. Thus, health providers have enormous potential to identify and assist battered women.[11] Yet, health care providers have not been effective in meeting this potential. While one out of five women treated for serious injuries in hospitals are battered, only one out of twenty-five is detected by emergency department staff.[12]

In light of these statistics, all health care providers need to be trained in identification, treatment and referral of domestic violence victims. Training should include informing health care providers that they are open to legal liability if they fail to diagnose domestic violence or if they act inappropriately once domestic violence has been identified. Evolving trends in American tort law may lead to health professional liability if health care providers fail to act or fail to act in an appropriate manner when offering medical care to victims and perpetrators of domestic violence. There are three common circumstances in which health care providers may be open to liability if they act or fail to act in domestic violence cases.

1- Reporting abuse to the police without permission of an adult victim of abuse;

2- Negligence in identifying victims of domestic violence (diagnoses), documenting their injuries, properly treating victims, providing them with information about their options to

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support in a more culturally comfortable setting.

[8]Susan Schechter, Women and Male Violence, Boston, South End Press, 1982, p. 308

[9]Muarry Straus and Christine Smith, "Family Patterns and Primary Prevention of Family Violence," Trends in Health Care, Law and Ethics Vol. 8 No. 2 Spr. 1993, p.19.

[10]Cynthia Lynne Pike, Note: The Use of Medical Protocols in Identifying Battered Women, 38 Wayne L. Rev. 1941, 1943 (1992).

[11]Howard Holtz and Kathleen Furniss, "The Health Care Providers Role in Domestic Violence," Trends in Health Care, Law & Ethics, Vol. 8, No. 2, Spr. 1993, p.47

[12]Anwar & McLeer, *reprinted by* National Woman Abuse Prevention Project, "Some Commonly Asked Questions about Domestic Violence," Domestic Violence Fact Sheet.

counter domestic violence (including safety planning), and making referrals to specialists (domestic violence experts).

3- Failure to warn potential victims about the threat of assault from an abuser when the health professional learns that there is a danger of harm to an identifiable victim or victims by a patient who is a perpetrator of domestic abuse.

Potential Liability for Unauthorized Disclosure

Long experience with child abuse cases may inappropriately color how health care professionals act in cases of adult partner abuse. Too often health care professionals who have not received adequate training in the dynamics of adult partner abuse will report to law enforcement officials incidents of domestic violence that their patients have suffered without obtaining permission from the adult abuse victim. Absent a statute that requires reporting of adult partner abuse (domestic violence), reporting of incidents of abuse without the permission of the patient is a breach of patient confidentiality. Reporting of abuse without permission also sends a message to abuse victims that the health care setting is not a safe place for them and discourages victims from seeking medical treatment in the future.

When it comes to reporting of assaults that occur within the family, child abuse differs significantly from adult partner abuse. Crime statistics and research on battered women show that the lethality of the perpetrator's violence often increases when he suspects that the victim has left or is about to leave the relationship. [13] Women who leave their abusers assume a seventy-five percent greater risk of being killed by their abusers.[14] Many battered women have finely honed survival skills that have allowed them to survive in the relationship.[15] Adult victims of abuse need to be able to choose when and if it is safest to leave the

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[13]M. Wilson and M. Daly, "Spousal Homicide Risk and Estrangement," VIOLENCE AND VICTIMS 8(1), 3-16 (1993).

[14]Catherine F. Klein and Leslye E. Orloff, "Providing Legal Protection for Battered Women: An Analysis of State Statutes and Case Law," 21 HOFSTRA L. REV. 801, 1112 (Sum. 1993) (*citing* "National Estimates and Facts About Domestic Violence," NCADV VOICE, Special Edition: Battered Women in Prison 12 (Win. 1989)).

[15]Id.

abuser. Victims who fear retribution from their abusers will be discouraged from seeking needed medical assistance and will not disclose abuse to health care professionals if they cannot be assured that their disclosures will be kept confidential and will not be reported to the police without their permission.

An abuser strictly controls his victim's life and undermines her self-esteem to hold her hostage in the abusive relationship. For many women who are isolated by their abuser from all friends, family and social services, the health care provider may the only professional to whom she has access, and the only person who can in a safe setting communicate with her that she need not continue to suffer abuse. A breach of health professional-patient confidentiality reinforces the victim's low self-esteem, her sense of helplessness and powerlessness and cuts off an important avenue of support and potential escape.

Over exuberant reporting can lead to liability for unauthorized disclosure of patient information. Because reporting of child abuse is legally mandated in all fifty states and the District of Columbia, health care providers will generally be immune from liability for good faith disclosure of child abuse to the appropriate authorities. Child abuse reporting is required because children are presumed to be unable to protect themselves.[16] Because the reporting of non-dependent adult abuse is not mandatory in Alaska no immunity from liability exists for those who report adult abuse. Alaska has no mandatory reporting statute for adult partner abuse and does not require that health care professionals report abuse of a non-dependent adult.

Alaska Business and Professions Code Sec. 08.64.368 requires only that the following injuries be reported to the Department of Public Safety, a local law enforcement agency or a village public safety officer:

-- Second or third degree burns to 5% or more of the patient's body;

-- Burns to the patient's upper respiratory tract or laryngeal edema due to inhalation of superheated air;

-- Wounds from the discharge of a firearm;

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[16]See generally, Ariella Hyman and Ronald Chez, "Mandatory Reporting of Domestic Violence By Heath Care Providers: A Misguided Approach" published in Carole Warshaw and Anne L. Ganley, Improving the Health Care Response to Domestic Violence (Family Violence Prevention Fund, 1995).

-- Injuries caused by a knife or other sharp or pointed instrument, unless clearly accidental; and

-- Life-threatening injuries, unless clearly accidental.

Reporting of injuries other than those required by law may result in financial liability for the health care provider. Furthermore, when there is a statue requiring reporting of specific crimes the health care provider may not selectively comply with the statute by reporting only those injuries related to domestic violence. Selective reporting of domestic violence related injuries and not those injuries resulting from other forms of violence may result in successful suits by domestic violence victims against the health care provider.[17]

Common injuries suffered by battered women include: contusions, abrasions, minor lacerations, fractures, sprains, as well as injuries to the head, neck, chest, breasts and abdomen.[18] Pain, with or without a readily apparent physical source, is a common presenting symptom of abuse. Battered women often suffer from headaches, chest pain, back pain and pelvic or abdominal pain. Stress, anxiety and depression may also be signs of domestic abuse.[19] The vast majority of medical visits that are made by battered women are for routine medical care and health care for somatic symptoms or non-life threatening injuries rather than for overt trauma or the type of injuries listed above.

Courts have generally recognized and upheld the right of the patient to recover damages from a health care provider for unauthorized disclosure concerning the patient on the grounds of invasion of privacy

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[17]Courts across the country have ruled that police departments violate the Equal Protection Clause of the Fourteenth Amendment when they discriminate against domestic violence victims in they manner that they respond to calls for assistance. See Catherine F. Klein & Leslye E. Orloff, Providing Legal Protection for Battered Women: An Analysis of State Statutes and Case Law, 21 Hofstra L. Rev. 801 (1993), at 1015n1350. Hospitals who selectively report cases of domestic violence assault while failing to report other forms of assault to authorities also be open to liability.

[18] American Medical Association, Diagnostic and Treatment Guidelines on Domestic Violence, (1992), at 9.

[19] Warshaw, supra note 2, at 54.

or breach of confidence.[20] Unauthorized disclosure is often a ground for a malpractice action. In Alaska, breach of confidence may also give rise to a claim for emotional distress.[21]

Domestic violence victims are competent adults who have the right to choose when and whether to report abuse to the police and to assess the dangerousness to themselves and their children of such a report. Health care professionals who breach patient confidence and report injuries, absent a statutory mandate, not only further endanger the lives of their patients, but also risk liability for the unauthorized disclosure.

The only circumstance under which a health care provider has been found not liable for making an unauthorized release of patient medical information or medical records to a third party is when the information was released to the Anchorage District Attorney under a valid court order.[22]

It is important for health care professionals to know that a subpoena requesting medical records of a particular patient is not a court order which protects the health professional from liability. Any person involved in litigation can obtain a blank subpoena from the court, fill it in with a request that the information they are seeking be produced at a specific time and place and serve the subpoena on a person who is not a party to the litigation. Release of medical records subpoenaed by a party in a court action without obtaining prior consent from the patient may give rise to a successful law suit against the health care professional for breach of confidence or invasion of privacy. It is therefore important that health care centers develop protocol about how they will respond to subpoenas.

Protocols should include instructions to contact the client routinely upon receipt of a subpoena and seek permission to release the information. Calls to victims who are still residing with their abusers could potentially place the victim in danger. To reduce this risk of danger, it is advisable that health care professionals routinely include in the record of patients who are domestic violence victims information about how, when, where and, if necessary, through whom domestic violence victims may be safely contacted by

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[20]Judy E. Zelin, Annotation: Physician Liability for Unauthorized Disclosure of Confidential Information about Patient, 48 ALR 4th 668

[21]Chizmar v. Mackie, 896 P.2d 196 (Alas. 1995).

[22]Arnett v. Baskous, 856 P.2d 790 (Alas. 1993)

the health care provider. Once the patient has provided permission, the records may be released in response to the subpoena. If the patient does not grant permission, the health care professional must contact the person who issued the subpoena and inform them that the records cannot be released.

To obtain the records without the permission of the patient, the person seeking the records must ask the court for an order that the records be released. Before granting such an order the court will hear arguments from the parties in the case and will determine whether the records are relevant and necessary to the court proceeding and will either deny the request or issue the court order. Once the health care provider receives an order from a judge ordering release of the patients records the provider must comply with the order and will be protected from liability for breach of patient confidentiality.

Physician Liability for Negligence

When working with victims of domestic violence, health care professionals must be aware of the potential for negligence liability if they fail to identify domestic violence, and thereafter if they fail to inform the patient of risks and options and if they fail to make appropriate referrals to domestic violence experts in the community. Historically, patients who brought negligence claims against their health care provider had to prove that the provider failed to exercise the degree of care ordinarily exercised by a health care professional in a similar community. In Alaska, a health care provider must have the degree of knowledge or skill, and must exercise the degree of care, ordinarily exercised by providers practicing the same specialty in similar communities.[23] A health care professional whose failure in this charge causes a patient to suffer injuries that would otherwise not have occurred will be liable for malpractice.[24]

An increasing number of courts, however, are adopting the reasonable care or reasonably prudent health care provider standard in negligence cases. Proof of medical custom then becomes relevant to, but

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[23] Poulin v. Zartman, 542 P.2d. 251 (Alas. 1975).

[24] Alaska Stat. § 09.55.540.

not conclusive on, the issue of due care, consistent with the general tort law .[25] As growing numbers of communities are establishing protocols for the identification, treatment and referral of domestic violence victims the likelihood is rapidly increasing that health care providers who do not follow recommendations of major health care associations and institutions on domestic violence will be found liable either for not having the knowledge or exercising the customary degree of care in a community in which more and more health care professionals are adopting domestic violence procedures, or for failing to provide the care that would be provided by a reasonably prudent health care professional under similar circumstances.

Health care professionals in Alaska must be informed about and trained on the domestic violence protocols that are being implemented in growing numbers of communities for the identification, referral and treatment of domestic violence victims. A reasonably careful health care provider, at minimum, would be expected to comply with increasingly common trends in the medical profession. Organizations such as the American Medical Association, the American College of Obstetricians and Gynecologists, the American College of Nurse Midwifery and the Joint Commission on the Accreditation of Health Care Organizations as well as hospitals and clinics, throughout the nation have adopted procedures for diagnosing patients as victims of domestic violence, documenting injuries, informing victims of their options and referring identified patients to domestic violence specialists (i.e. domestic violence service providers and special hospital based social workers who have been explicitly trained on the dynamics of domestic violence.0[26] These trends signal that a health care provider of ordinary skill in any community should be able to recognize

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[25] Kalsbeck v. Westview Clinic, P.A., 375 N.W.2d 861 (Minn. App. Ct. 1985); Brown v. Dahl, 705 P.2d 781 (Wash. App. Ct. 1985) ("reasonably prudent practitioner"; references in charge to jury to "average" and "ordinary" care improper). Culbertson v. Mernity 602 N.E. 2d 98 (Supreme Court of Indiana 1992) (requiring evidence of what a "reasonable" physician would have done under the case's circumstances); Catron v. Bohn 580 So. 2d 814 (Flo. App. Ct. 1991) (the plaintiff must prove a breach of standard of reasonably prudent similar health care provider); Madlin v. Crosby 583 So. 2d 1290 (Supreme Court of Ala. 1991); Hutchinson v. Paterl 637 So. 2d 415 (Supreme Court of Louisiana 1994); Caughell v. Group Health Coop. Of Pugent Soud 124 Wash. 2d 217 (Supreme Court of Wash. 1994); St. Joluis Regional Health Ctr. Inc. v. Windler 847 S.W. 2d 168 (Missouri App. Ct. 1993); Jones v. Malloy 226 Neb. 559 (Supreme Court of Nebraska 1987); Shaw v. Caldor Inc. 1995 Super. Lexis 567 (Supreme Court Conn.) (The prevailing professional standard of care for a given health care provider shall be that level of care, skill and treatment which, in light of all relevant surrounding circumstances is recognized as acceptable and appropriate be reasonable prudent similar health care provider).

[26] Cynthia Lynne Pike, Note: The Use of Medical Protocols in Identifying Battered Women, 38 Wayne L. Rev. 1941 (1992).

signs of domestic violence in his or her patients, inform the patient about the options available to help stop the violence, recommend treatment[27] and provide appropriate referrals. Under this approach, if a jury found that compliance with the AMA Guidelines was reasonable under the circumstances, a health care professional could be held liable for failure to do follow those guidelines , even if the practice is not yet customary. A health care providers wishing to avoid malpractice litigation may not succeed in convincing a court to dismiss a malpractice claim when their practice was inconsistent with that set forth in the American Medical Association Guidelines.

[27] Treatment might include discussing steps that the victim might take to improve her safety. Safety planning is needed for battered women who plan to stay with their abusers as much as it is needed for those who are planning to leave. The health care professional should train their staff in basic safety planning and should identify domestic violence victim advocates in the community to whom patients suffering abuse in the home can be referred for more complete safety planning.

DUTY/BREACH

Guidelines promulgated by the American Medical Association recognize a duty by physicians to diagnose and address domestic violence. They recommend that medical organizations need to implement policies and procedures which include:

-- Identification -- identifying the patient as a victim of domestic violence;

-- Documentation-- documenting her injuries and the cause(s) thereof;

-- Treatment-- providing validation and appropriate treatment for physical, mental and emotional injuries;

-- Information-- providing information on the domestic violence, risk assessment, legal options, domestic violence services available and safety planning.

-- Referral-- The information should providing the patient with appropriate referrals to a specialist in domestic violence.[28]

According to the American Medical Association risk management in domestic violence cases requires that health care professionals treating repeated or chronic injuries recognize signs of domestic violence and treat not only the symptoms but address the underlying causes of the abuse by offering the patient information and referrals.[29]

Identification

Failure to recognize signs of domestic violence can result in negligence liability in the same manner as failure to diagnose other health conditions. Across the country courts have found physicians liable for failure to diagnose various conditions, such as failure to diagnose pregnancy,[30] cancer,[31] cerebral aneurysm,[32]

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[28] AMA, supra note 18.

[29] AMA supra note 18, at 9, 11.

[30] Rinard v. Biczak, 441 N.W. 441 (1989), Clapham v. Yanga, 300 N.W. 2d 727 (Mich. App. 1980), Debora S. v. Sapega, 392 NYS 2d. 79 (1977), Chapman v. Schultz, 367 NYS 2d 1018 (1975) Ziemba v. Sternberg, 357 NYS 2d 265 (1974).

[31] Williams v. Bay Hospital, 471 So. 2d, 626 (1985); DeBurlate v. Louvar 393 N.W. 2d 131(Supreme Court of Iowa 1986); Turner v. Massiah 656 So. 2d 636 (Supreme Court of Louisiana 1995); Savelle v. Heilbrunn 552 So. 2d 52 (Louis. App. Ct. 1989); Evers v. Dollinger 95 N.J. 399 (Supreme Court of N.J. 1983); Marciniak v. O'Connor, 430 N.E. 2d 536 (Ill. App. 1981); O'Brien v. Stover, 443 F.2d 1013 (8th Cir. 1971); Herskovits v. Group of Pugent Soud 99 Wash. 2d 609 (Supreme Court of Wash. 1983); Scafidi v. Seiler 119 N.J. 93 (Supreme Court of N.J. 1990).

[32] Brillant v. Royal, 582 So. 2d 512 (Ala. 1991); Larkin v. State 84 A.D. 2d 438 (Supreme Court of N.Y. 1982).

infections,[33] and glaucoma[34]. Similarly, state laws also recognize a failure to diagnose conditions as a ground for liability[35].

Since battering often increases in frequency and severity over time, early identification is crucial for the health and safety of the woman patient. In fact, when the abuse is not identified, treating only the symptoms may increase the patient's sense of entrapment and her feeling that there is no way she can escape from the violence. Still, the diagnosis of abuse is often missed. Indeed, research shows that as few as 5% of domestic violence victims are identified as such in emergency departments.[36] Due to the prevalence of the phenomena and the fact that some women may not initially recognize themselves as "battered", the AMA guidelines require that a physician will routinely ask all women direct, specific questions about abuse.[37]

Courts have already recognized that health care providers may be held liable for failure to diagnose and treat child abuse. In Landeros v. Flood,[38] a child plaintiff successfully sued his doctor for common law malpractice after the doctor failed to diagnose and report child abuse. The California Supreme Court held that the existence of a duty to diagnose and address child abuse was a question of fact for the jury to decide after it hears expert testimony.[39] The Landeros court pointed to the medical profession's own recognition of the battered child syndrome as a factor in allowing a jury to impose liability.

No reported appellate court decision to date has imposed liability for failure to diagnose and treat domestic violence when the victim is an adult. Courts may be reluctant to impose liability before the AMA

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[33]Schuler v. Berger, 275 F. Supp. 120 (Pa. 1967); Allen v. State 520 So. 2d 761 (Louis. App. Ct. 1988); Kashner v. Geisinger Clinic 638 A. 2d 980 (1994).

[34]Romero v. Riggs, 29 Cal. Rptr. 2d 219 (1994); Morrison v. Homas 519 P. 2d 981(Supreme Court of Wash. 1974); Broussard v. Sears 568 So. 2d 225 (Louis. App. Ct. 1990).

[35]Ark. Stat. Ann. § 16-114-201 (1995); Cal. Civ. Code §1714.8 (1995); RSA 507-C:1 (N.H. 1994).

[36] California Hospital Emergency Departments Response to Domestic Violence - Survey Report - August 1993.

[37] The AMA guidelines recommend that the physician should make an opening supportive statement, such as: "Because abuse and violence are so common in women's lives, I've begun to ask about it routinely". The guidelines provide a series of questions to help a physician identify an abusive situation. See AMA, supra note 18, at 8-9.

[38]551 P.2d 389, 393, 131 Cal. Rptr. 69, 73 (1976)

[39]Id.

has fully implemented the AMA Guidelines, but the chances that liability will be imposed will continue to increase dramatically as the AMA Guidelines are adopted in greater numbers of hospitals and health care facilities. Even before the AMA Guidelines become common practice, a plaintiff may succeed in basing a negligence claim on a health care provider's failure to conform to the reasonable provider standard arguing by analogy to the child abuse cases. The burden on and ability of a health care professional to diagnose child abuse would not differ substantially from diagnosing domestic violence.

The policy reasons for imposing a duty to diagnose domestic violence on health professionals are clear. Domestic violence is a significant health problem for women in the United States. Health care providers are for many abuse victims the only professional they see who can offer them a safe confidential place in which they can disclose the violence and learn about what options they may have to reduce domestic violence in their lives. Health care professionals see battered women before they disclose abuse, when they decide to stay with their abusers, when they try to leave their abusers and when they return to their abusers. Justice system professionals only have contact with abuse victims when they are trying to use the legal system to end the abuse. If they fail or get frustrated and decide that it is safer to return to their abusers contact with justice system professionals ceases and only health care professionals may have continued access to these abuse victims.

Documentation

Documenting the violence is critical to a battered woman's ability to successfully obtain legal help, either now, or in the future. The better the documentation the victim has of abuse the more likely a judge will be to award her the house, custody and reasonable child support. In addition good documentation in medical records provides supporting documentation for a future civil protection order action, for an action to enforce an existing civil protection order and can play a crucial role in criminal prosecution of abusers. Enforcement of civil protection orders and criminal domestic violence prosecutions require that the abuse victim prove that the abuse occurred beyond a reasonable doubt. Since too often abuse occurs within the home, behind closed doors, the only evidence that may be available to corroborate the victim's testimony

about the abuse are medical records which carefully document the injuries that resulted from the abuse. Documentation chronicles the violence is particularly important when there have been multiple attempts to leave by the victim. With well-documented evidence of abuse, the patient will have significantly greater success in undertaking legal proceedings to halt the violence.

The AMA requires that records will be kept in a precise, professional manner and include: chief complaints using the complaint's words, description of the abusive event, medical history, relevant social history, detailed description of the injuries, an opinion on whether the injuries were adequately explained, results of laboratory and other diagnostic procedures, color photographs and imaging studies and the names of police persons involved.[40] It is important that objective facts documented as opposed to subjective comments. Recording the complainant's words and eliminating subjective speculative observations or opinions from the medical record will improve the victim's ability to used these records to help her prove the domestic violence she has experienced in court proceedings. When the patients descriptions of the events that have led to her injuries are inconsistent with the injuries, it is best to quote what she reported, state in detail the extent and location of her injuries and make a note in the medical record -- "suspected abuse: screen for domestic violence at next checkup."

Treatment

The AMA guidelines recognize the importance of physician's validation as part of the needed intervention. For many battered women the health professional will be the first person who has an opportunity to tell the her that they believe that she has been abused, that abuse is not normal, that she need not live with abuse, and that the health care professional and others are willing to help her stop the violence. Recognition, acknowledgment, and concern confirm the seriousness of the problem and the need to solve it.[41]

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[40] AMA, supra note 18, at 15.

[41] AMA, supra note 18, at 11.

The injury or complaint of the patient requires appropriate treatment. The health care provider should conduct a thorough physical exam to reveal hidden and not yet visible injuries.[42] In addition to treating the patient's injuries, the health care professional should assess her emotional status for suicidal tendencies, depression, anxiety reaction, or abuse of drugs, alcohol, or other medications.[43]

An integral part of the treatment is an evaluation of the patient's safety. The physician should assess the situation and discuss with the patient various options to minimize future injuries and damages.[44]

Duty to Inform The Patient About Options

A patient who is a victim of abuse cannot made an informed decision not to seek assistance from experts about domestic violence unless she is provided with information about the existence of legal and social services available to help victims of domestic violence. Without information here, as with any medical condition there can be no informed choice. Generally, health care providers are in a position to advise appropriate courses of treatment to a patient. Treatment of a recurring physical victimization by domestic violence should be addressed in the same manner as all other patient maladies. Patients should be educated about the hazards of her condition and circumstances. She should be fully informed about appropriate treatment or appropriate actions she can take to secure her physical, mental and emotional well-being.

Any treatment plan for injuries or other health complaints recommended by a health care provider should take the domestic violence into account. A health care professionals who does not recommend appropriate referrals, counseling, and follow-up action must inform the patient that he or she has other treatment options. In fact, a health care professional has a duty to disclose to the patient any feasible alternative method of treatment.[45] A health care provider's failure to disclose feasible alternatives has

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[42] Warshaw, supra note 2, at 69.

[43] ACOG Technical Bulletin, August 1995, at 4.

[44] AMA, supra note 18, at 12.

[45] John H. Derrick, ANNOTATION: MEDICAL MALPRACTICE: LIABILITY FOR FAILURE OF PHYSICIAN TO INFORM PATIENT OF ALTERNATIVE MODES OF DIAGNOSIS OR TREATMENT, 38 A.L.R. 4th 900.

resulted in a finding that the provider thereby failed to obtain the patient's informed consent to the treatment method employed by the physician, and the physician was thereby liable for malpractice.[46] When health care professionals fail to ask about abuse or discuss options with victims whom they know have been abused either because the victim discloses abuse or because the victim's injuries appear to be the result of abuse, such inaction is tantamount to denying an abuse victim information critical to her health and safety. Inaction by health care professionals under these circumstances may be actionable and result in liability. A patient who is not referred to appropriate domestic violence services is not making an informed choice to not seek services.

The California Supreme Court first articulated in Cobbs v. Grant,[47] and later confirmed in Moore v. Regents of the University of California [48] what would become three well-established principles of physician disclosure.

> First, a person of adult years and in sound mind has the right, in the exercise of control over his own body, to determine whether or not to submit to lawful medical treatment. Second, the patient's consent to treatment, to be effective, must be informed consent. Third, in soliciting the patient's consent, a physician has a fiduciary duty to disclose all information material to the patient's decision.

A health care provider has a duty to disclose all information necessary to help a patient make an informed choice.[49] If a patient is not fully informed that she can get help escaping from the violence, she is not giving informed consent to a treatment plan that deals only with the immediate physical trauma.

Failure to obtain informed consent by a patient may also form the basis of a negligence claim. Alaska law recognizes the liability of a health care who fails to obtain informed consent:

> A health care provider is liable for failure to obtain the informed consent of a patient if the claimant established by a preponderance of the evidence that the provider has failed to inform the patient of

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[46]Id.

[47] 502 P. 2d 1 (Cal. 1972).

[48]Moore v. Regents of University of California, 51 Cal. 3d 120 (1990), *cert. denied,* 111 S. Ct. 1385 (1991).

[49]Mathis v. Morrissey, 11 Cal. App. 4th, 332 (1992).

the common risks and reasonable alternatives to the proposed treatment or procedure, and that but for that failure the claimant would not have consented to the proposed treatment or procedure.[50]

The Supreme Court of Alaska held that the way to measure the a physician's duty to inform is according to the modern trend test of the "reasonable patient" and not the traditional test of the "reasonable physician".[51] This approach requires that a health care provider disclose all information a reasonable woman would need to know in order to make an informed and intelligent decision about the proper treatment she needs.[52]

Upon a diagnosis of domestic violence a health care professional has a duty to advise the patient to consult a specialist. The specialist to be consulted would be a domestic violence shelter, domestic violence advocacy program or a counseling service with domestic violence experts that are recommended by the local domestic violence shelter or state domestic violence coalition.[53] The health care provider's duty to refer the patient arises when the provider knows, or should have known, that he or she does not possess the requisite skill to provide relief for the patient's condition. In those cases, where the patient might also need psychiatric treatment, the health care provider must in addition to referring the patient to domestic violence experts refer her to mental health professionals who can work with her to develop a treatment plan that includes psychiatric evaluation and treatment.[54]

CAUSATION

A health care provider shall be found negligent if he or she fails to provide competent care and that failure causes injury to the patient. Health care professionals may consider the professional negligence a two part inquiry: first, whether the provider acted with reasonable care, and secondly whether the action or inaction led to injury of the patient. In domestic violence cases, health care providers have the most control

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[50] Alaska Stat. Code of Civil Procedure 09.55.556 (1995).

[51] Korman v. Mallin 858 P. 2d 1445 (Alaska 1993), at 1148-49.

[52] Id. at 1149.

[53] Jerald J. Director, Annotation: Malpractice: Physician's Failure to Advise Patient to Consult Specialist or One Qualified in a Method of Treatment Which Physician is Not Qualified to Give, 35 A.L.R. 3d 349 (1995).

[54] AMA, supra note 18, at 11.

over the first aspect, and must act to exercise due care. A health care professional must act with reasonable diligence in identifying domestic violence, providing the patient with appropriate information and making the appropriate referrals. A health care provider that acts with reasonable diligence identifying, treating, informing and referring domestic violence victims will not be insulated from liability based on what might be the predictable actions of the victim's abuser. On the other hand, when a health care provider does not identify abuse, inform the patient about options and make appropriate referrals, the health care provider is gambling that the behavior of the abuser will change in the future. If the abuser causes subsequent harm to the victim, the health care provider may be held liable for that additional harm.

An essential element of any negligence claim is that there be some reasonable connection between the act or omission of the health care provider defendant and the damage which the plaintiff has suffered. Although when a domestic violence patient suffers further injury, it is most likely directly caused by the abuser, the health care professional who failed to diagnose and refer the patient is not free from liability. A patient can demonstrate that a reasonable health care provider would have suspected abuse and made appropriate inquires and referral, but the provider in her case failed to do so, and that the health care professional's failure to act was a substantial factor in her ultimately suffering subsequent harms. If the health care provider's failure to appropriately diagnose and treat the patient is a substantial factor in the woman's injury or death, the provider becomes liable for negligence.

The *Landeros* court formulated the causation test as one of whether the defendant could reasonably foresee the likelihood of further serious injury to plaintiff.[55] The independent acts of a third party, such as an abuser, do not relieve a health care professional of liability when the risk of harm is foreseeable under the circumstances. Once a health care provider has or should have identified a battered child (as in *Landeros*), or an adult domestic violence victim, it is then a question of fact whether the provider's failure to diagnose and address the abuse would be a causal factor in the resumption of the abuse.

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[55] Landeros, 551 P.2d at 395.

Often defendants in malpractice suits have relied on the assertion that the patient would more likely than not have succumbed to illness, and that even appropriate medical intervention would not have raised the likelihood of survival to a probability. However, a growing number of courts are rejecting this theory and find liability under two theories. First, the malpractice itself causes the patient emotional distress for which she will be able to recover.[56]

In the case of a domestic violence victim, a patient who comes to a health care professional for care and does not receive appropriate intervention may subsequently be able to recover for the emotional distress of discovering that her risk and danger was increased by the physician's failure to act appropriately, and for the emotional distress of not receiving help despite her urgent needs. Secondly, under the "lost chance" doctrine, some states apply a mathematical formula for recovery for patients whose suffer increased risk through a health care provider's malpractice.[57] For instance, if a patient's chance of survival would have been 40% absent the malpractice, but was decreased to 13% due to the health care professional's inaction, traditionally patients would not have recovered against the negligent provider because death was more likely to occur than not. However, the "lost chance" doctrine allows the patient's estate to recover 27% of what would have been awarded in a successful wrongful death action.

Although no case has found a health care provider directly liable for failure to diagnose, inform and refer a patient to appropriate domestic violence services, trends in the law predict that health care professionals will soon be found liable for failure to provide appropriate domestic violence treatment. At this time, malpractice issues along these lines will be questions of fact for a jury, requiring extensive litigation to resolve. Wise health care professionals will protect themselves from liability and potential litigation by making appropriate inquiries and providing information and referrals to domestic violence victims.

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[56] Werner v. Blankfort, 42 Cal. Rptr. 2d. 229 (1995); Duarte v. Zachariah 22 Cal. App. 4th 1664 (1994); Smith v. State 677 So. 2d 653 (App. Of Louisiana 1994).

[57] Scafidi v. Seiler 119 N.J. 93 (Supreme Court of N.J. 1990); Thomson v. Sun City Community Hospital 688 P. 2d 605 (Supreme Court of Arizona); DeBurkarte v. Louvar 393 N.W. 2d 131 (Supreme Court of Iowa 1986); McBride v. U.S. 462 F. 2d 72 (9th Cir 1972).

Duty to Warn Victims of the Potential for Abuse

Health care providers treating abusers may also be held liable for failure to warn foreseeable victims of the potential for abuse. Under Alaska law, the general rule of negligence law is that a defendant owes a duty of care "to all persons who are foreseeably endangered by his conduct, with respect to all risks which make the conduct unreasonably dangerous".[58] This doctrine can be applied to physician-patient relations, as has been done in cases across the country. In Tarasoff v. Regent of the University of California,[59] a case that became one of the most celebrated cases in tort law in all the U.S.,[60] the court found hospital therapist liable for not warning a minor child and those responsible for her that a patient is planning to kill her. The Tarasoff court held that:

> Once a therapist[61] does in fact determine, or under applicable professional standards reasonably should have determined, that a patient poses a serious danger of violence to others, [the therapist] bears a duty to exercise reasonable care to protect the foreseeable victim of that danger.[62]

Many jurisdictions either have followed or have indicated they would follow the lead of Tarasoff and impose a duty to warn.[63]

The Supreme Court of Alaska in Division of Corrections v. Neakok [64] adopted Tarasoff as Alaska law in a case in which they held the State of Alaska liable for three murders a parolee committed after he was released from prison, among other reasons, because the State failed to warn the small community the victims belonged to about the danger the parolee posed to them. The Neakok court decided that the prison's

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[58] Division of Corrections v. Neakok, 721 P.2d 1121, 1125-26 (Alas. 1986).

[59] 551 P. 2d 334 (Cal. 1976).

[60] Peter F. Lake, Revisiting Tarasoff, 58 Albany L. Rev. 97 (1994).

[61] The term "therapist" is a broad category. Court have relied on Tarasoff doctrine in different kind of trust relations, such as doctor-patient, state-parolee, university-professor etc. See Id, at 98-90.

[62] Tarasoff, supra note 59, at 345.

[63] Timothy E. Gammon & John Hulston, The Duty of Mental health care Providers to Restrain Their Patients or Warn Third parties, 60 Miss. L. Rev. 749 (1995), at 749-50.

[64] Division of Corrections v. Neakok, 721 P. 2d 1121 (Alas. 1986), at 1126.

professional personal who observed the one who committed the crimes acts have a duty to warn when the acts were foreseeable.[65]

The Alaska court's holding that "consideration of the foreseeability of injury is central to a determination of whether a duty to care exist"[66] can be satisfied in cases where a health care provider cares for an abuser who discloses to the health care provider the abuser's intent to hurt his wife in a way that exposes her to a serious danger of violence.

Even the most narrow interpretation of the foreseeability demand, that there will be "a specifically identifiable, potential victim"[67] can be satisfied in domestic abuse cases since the specifically identifiable victims in almost always apparent. Unlike a mental patient that might threaten to harm people in general, without specific targets, when a health care provider identifies the patient as a perpetrator of domestic violence the potential victim is specific and known -- usually the wife or the abuser's intimate partner, her friends or extended family members. It is clear from the Neakok court's adoption and expansion of Tarasoff to require warning not only to individuals, but in that case to the victim's community, that Alaska law will continue to evolve to hold health care professionals liable for failing to warn an abuse victim that her husband or intimate partner intends to severely harm her. The health professional is authorized to breach client confidentiality with the abuser and required to warn the potential abuse victim. Failure to warn is likely to result in liability for injuries that could be foreseeable caused by the actions of the patient who is the perpetrator of the abuse.

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[65]Many cases regarding therapist liability towards third parties required specific threats to a readily identifiable victim. See Eckhardt v. Harold, 534 N.E. 2d 1339 (Ill. App. Ct. 1989); Evans v. Morehead Clinic 749 S.W. 2d 696 (Cent. App. 1988); Sherrill v. Wilson 653 S.W. 2d 661 (Mo. 1983); Bradley v. Hopper 570 F. Supp. 1333 (D. Colo. 1983); Thompson v. County of Alamed 27 Cal. 3d 741 (1980).

[66] Neakok, supra note 59, at 1127.

[67]Kirk v. Michael Reese Hospital, 117 Ill. 2d 507 (1987).