Law

Legal Briefing: Mandated Reporters and Compulsory Reporting Duties

Thaddeus Mason Pope

ABSTRACT

This issue's "Legal Briefing" column, one product of a Greenwall Foundation grant, reviews recent developments concerning compulsory reporting duties.[1] Most licensed clinicians in the United States are "mandated reporters." When these clinicians discover certain threats to the safety of patients or the public, they are legally required to report that information to specified government officials. Over the past year, several states have legislatively expanded the scope of these reporting duties. In other states, new court cases illustrate the vigorous enforcement of already existing duties. I have organized all these legal developments into the following eight categories:

1. Overview of Mandatory Reporting Duties
2. Controversy over the Benefits of Mandatory Reporting
3. New and Expanded Duties to Report
4. Criminal Penalties for Failing to Report
5. Civil Liability for Failing to Report
6. Disciplinary Penalties for Failing to Report
7. Legal Immunity for Good-Faith Reporting
8. Protection against Employers' Retaliation

1. OVERVIEW OF MANDATORY REPORTING DUTIES

Clinicians are in a special position to detect and discover significant threats to the safety of patients or the public. Consequently, all U.S. jurisdictions impose legal duties on most licensed clinicians to report such threats, so that protective measures can be taken.[2] Reportable information falls into four rough categories.

First, clinicians must report harms and risks to individuals who may not be able to protect themselves. This includes abuse or neglect of a child[3] and abuse or neglect of a dependent, vulnerable adult.[4] It also includes substance abuse by pregnant women.[5] Second, clinicians must report threats to the public health. These threats might come from communicable infectious diseases,[6] from conditions that can impair driving ability,[7] or from a patient's threat to harm another.[8] Third, clinicians must report indicia of criminal activity. This includes injuries from deadly weapons such as knives and guns as well as injuries suspected to be the result of assaultive or abusive conduct.[9] It also includes domestic violence.[10] It does not matter that the clinician judges there is little prospect for future harm. Fourth, clinicians must report their own colleagues in four situations: (1) when they are impaired by drugs or alcohol, (2) when they engage in sexual misconduct with a patient, (3) when their health condition puts patients at serious risk, and (4) when they deviate substantially from professional standards.[11]

In any of these four situations, the amount of evidence normally sufficient to trigger the clinician's reporting duty is quite low. Clinicians must make a report so long as they have just a "reasonable suspicion" or "reasonable cause to believe" that the in-

Thaddeus Mason Pope, JD, PhD, is Director of the Health Law Institute and Professor of Law at Mitchell Hamline School of Law, *thaddeus.pope@mitchellhamline.edu.*

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formation is reportable. Depending on the state and on the type of information, the report is typically made either to law enforcement or to a state agency. Failure to report can result in three types of sanctions: (1) criminal penalties, (2) civil penalties, and (3) discipline from the clinician's health licensing board. I offer examples of each in the following sections.

While under reporting often leads to sanctions, over reporting rarely does. Clinicians have legal immunity for making a good-faith report. Even if they are mistaken, clinicians cannot be sanctioned for breaching confidentiality or for prompting an ultimately unnecessary investigation. Consequently, existing legal incentives lean heavily in one direction. They encourage clinicians to err on the side of caution and report.[12] In short, if you are in doubt, if you are unsure whether an incident is reportable, then it probably is.

Finally, while mandatory reporting duties are imposed by state law, federal privacy law defers to these mandates. The Health Insurance Portability and Accountability Act (HIPAA) allows mandated reporters to disclose protected health information without the individual's written authorization. "A covered entity may use or disclose protected health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law."[13] "Required by law" is, in turn, defined as "a mandate contained in law that compels . . . disclosure of protected health information and that is enforceable in a court of law."[14]

The ethics guidelines of the leading professional societies are in accord. The American Medical Association (AMA) *Code of Medical Ethics* advises: "When a jurisdiction mandates reporting suspicion of violence and abuse, physicians should comply. However, physicians should only disclose minimal information in order to safeguard patients' privacy."[15]

The American College of Physicians *Ethics Manual* similarly provides:

> Physicians should protect public health by reporting disease, injury, domestic violence, abuse, or neglect to the responsible authority as required by law. Confidentiality . . . is not absolute. It may have to be overridden to protect individuals or the public or to disclose or report information when the law requires it. . . . If breaching confidentiality is necessary, it should be done in a way that minimizes harm to the patient and heeds applicable federal and state law.[16]

2. CONTROVERSY OVER THE BENEFITS OF MANDATORY REPORTING

The purpose of mandatory reporting laws is to mitigate and prevent harm. But it is unclear whether some reporting duties prevent more harm than they create. On the one hand, broadening mandatory reporting duties lowers the risk of false negatives. Fewer risks will go undetected, uninvestigated, and unmitigated. On the other hand, broadening reporting duties increases the risk of false positives. A low threshold for reporting means that many reports go unsubstantiated.[17] Many individuals will be investigated and many family relationships disrupted for no reason.

Moreover, even if reporting led only to true positives (substantiated cases of harm), it sometimes creates risks that arguably outweigh benefits. For example, it is highly intrusive and disruptive to a family when a child protection agency, an adult protection agency, or law enforcement investigates a report of abuse or neglect. Sometimes the harm is even more concrete and direct. For example, reporting a case of suspected domestic violence often leads to a victim being "punished" by her batterer.[18] Similarly, if mental health patients feel that they have no safe outlet, then they will not share violent thoughts. The risk of savagery will go undetected and unaddressed. Indeed, mandatory reporting is correlated to increased rates of homicides and teen suicides.[19]

Furthermore, breaching patients' confidentiality to make a report can destroy the integrity of the treatment relationship. If patients know that information will be shared, they may be less open and honest.[20] And breaching confidentiality may decrease patients' trust not only in the current care-provider, but also in the entire system. So, the patient may avoid healthcare altogether. Weinberger and colleagues note, "Blanket reporting laws that compel physicians and other health professionals to report patients . . . may have unintended consequences. They can . . . create a disincentive for them to seek treatment, and undermine the patient-physician relationship."[21] This increases risks not only to the patient but also to the public. For example, legislation requiring physicians to report illegal immigrants could cause patients with tuberculosis to delay seeking care, thus causing the disease to spread.[22]

With respect to reporting child abuse, the U.S. is an outlier. Many countries give clinicians a "right" to report, but the U.S. is one of the few that imposes a "duty" to report.[23] Moreover, U.S. law is still evolving. Several states continue to adopt, implement, and

strengthen various kinds of mandatory reporting laws. The scope of clinicians' reporting duties is expanding.[24]

Yet, as one prolific commentator, Ben Mathews, observes, "the field lacks a detailed evidence base about their consequences." Accordingly, he recommends that "jurisdictions which introduce the laws should carefully monitor their implementation."[25] The AMA *Code of Medical Ethics* similarly advises that "if available evidence suggests that mandatory reporting requirements are not in the best interests of patients, physicians should advocate for changes in such laws."[26] Accordingly, it may be time to pause and reassess the benefit and risks of all the compulsory reporting duties imposed on clinicians.

3. NEW AND EXPANDED DUTIES TO REPORT

Over the past year, a number of jurisdictions have expanded clinicians' duties to report. They have done this in two ways. First, the countries of England, Wales, and Ireland, and the U.S. states of Pennsylvania and Michigan identified new types of information that are reportable. Second, the U.S. states of Connecticut and Missouri did not change the types of information that are reportable, but expanded which clinicians have a duty to report.

England and Wales

Female genital mutilation (FGM) comprises all procedures involving partial or total removal of the external female genitalia for nonmedical reasons. FGM has been illegal in England and Wales since 2003. Effective 31 October 2015, the 2003 law introduced a mandatory duty to report. It requires healthcare and social care professionals to report "known" cases of FGM in minors to the police. "Known" cases are those in which either a girl informs a person that an act of FGM has been carried out on her, or when a person observes physical signs on a girl that appear to show that an act of FGM has been carried out.[27]

Ireland

Ireland is considering an even broader new reporting duty for healthcare professionals. Irish Health Minister Leo Varadkar announced plans to legislate mandatory open disclosure of any mistakes involving patients.[28] The minister described incidents in which medical professionals fail to adhere to a duty of candor and disclose the relevant information as being "the equivalent of a hit-and-run." In early 2016, Minister Varadkar aligned his proposal with that in a major report of patients' safety.[29] The Health Information and Patient Safety Bill now limits its mandatory reporting to only adverse events that result in death or serious harm.[30]

Pennsylvania

In 2015, a major package of child abuse laws took effect in Pennsylvania. The laws are the result of recommendations by the Pennsylvania Task Force on Child Protection that convened in the wake of the high-profile Jerry Sandusky scandal at Pennsylvania State University. One law expands the definition of child abuse. For example, it lowers the threshold for physical injuries that can indicate child abuse, by replacing "serious physical injury" with "bodily injury."[31]

Michigan

Current Michigan law requires clinicians to report a person suffering a wound or other injury inflicted by means of a knife, gun, pistol, or other deadly weapon. A 2016 bill would additionally require clinicians to report a person suffering from a burn injury when there is suspicion of arson.[32] Unlike most mandatory reporting, focused on health and safety, this new law is directed at solving crime.[33]

Connecticut

While some expansion of mandatory reporting duties pertains to types of reportable information, other expansion pertains to who is a mandated reporter. For example, before October 2015, Connecticut imposed a duty to report impaired healthcare practitioners on only physicians and physicians' assistants. But new legislation now extends that duty to all licensed healthcare professionals. "Any health care professional . . . shall . . . file a petition when such health care professional . . . has any information that appears to show that a health care professional is, or may be, unable to practice his or her profession with reasonable skill or safety."[34]

Missouri

Like Connecticut, Missouri has sought to expand the number of mandated reporters. Existing law requires certain healthcare providers to submit a report when they have "reasonable cause to suspect that [an elder] has been subjected to abuse or neglect."[35] The law applies to a wide range of clinicians, from optometrists, to dentists, to pharmacists. But the list is not comprehensive. In 2016, legislators introduced a bill to add emergency medical technicians, fire fighters, and first responders to the list of mandated reporters.[36]

4. CRIMINAL PENALTIES FOR FAILING TO REPORT

The failure of a mandated reporter to make a timely report is a criminal offense. A quick perusal of the daily headlines shows that the targets of many recent criminal prosecutions are school officials and daycare providers.[37] For example, Susan Clark was recently convicted of failing to report sexual abuse at Miracle Meadow, a school for children with at-risk behaviors. But school officials are hardly the only defendants. Prosecutors have also been targeting healthcare providers.

California

In January 2016, a jury convicted Theresa Hamilton-Casalegno of failing to report the abuse of a dependent adult.[38] Hamilton-Casalegno was the chief executive officer of Rideout Health, a healthcare system north of Sacramento. In 2013, a nurse had used soft restraints, without a physician's order, to tie down and wash a patient suffering from acute psychosis. This was abuse. If the patient became agitated during the bath, the nurse should have sought an order for restraints. Hamilton-Casalegno knew about the abuse and decided not to report it. Rideout Health's senior vice president for quality was found guilty of the same offense.

5. CIVIL LIABILITY FOR FAILING TO REPORT

In addition to criminal penalties, a mandated reporter's failure to report can result in civil liability. Particularly if the individual intended to be protected by the report is later injured, then that individual or the individual's family may sue for money damages. The claim is that had the clinician made a timely report, the victim's injuries probably could have been prevented.

Pennsylvania

In late 2015, the Superior Court of Pennsylvania determined that patients may pursue medical malpractice actions against healthcare providers who fail to report suspicions of child abuse.[39] K.H. was born prematurely in 2002. Over the next several months, K.H. was hospitalized repeatedly for problems including rib fractures. A number of specialists discussed their suspicions of possible child abuse. But no one reported the potential abuse. Later, when K.H. was almost six months old, his father shook him so violently that he experienced an intracranial hemorrhage resulting in permanent brain damage. The trial court ruled that the case could not go forward because the child abuse statute included no civil liability provisions. But the Superior Court disagreed. It found that while the statute does not specifically allow for civil remedies against healthcare providers, it does not give them immunity or otherwise preclude finding them negligent in an "ordinary" medical malpractice action.

Montana

Across the United States, there is significant variability in so-called *Tarasoff* duties, the duty of psychotherapists and psychiatrists to warn potential victims.[40] In 2015, Montana clarified the duty in that state. Justin Schiller was involuntarily committed to the Montana State Hospital in June 2008. Several months later, he saw his former girlfriend, Catherine Woods, at a bar with a male friend. When Woods left the bar, Schiller killed her.

Woods's parents sued the hospital for breaching its duty to warn Woods of Schiller's potentially violent behavior. But the trial court granted summary judgment to the hospital. The Montana Supreme Court affirmed.[41] The relevant statute imposes a duty to report "only if the patient has communicated . . . an actual threat of physical violence by specific means against a clearly identified or reasonably identifiable victim." It was not sufficient that the Montana State Hospital knew of Schiller's tendency to be aggressive toward Woods. The hospital would have been obligated to report only if Schiller had communicated a specific threat of violence against Woods.

California

In late February 2016, the California Court of Appeals affirmed a trial court ruling that a physician did not breach his duty to report domestic violence.[42] In 2009, Jesse Crow murdered his wife of six months, Ryann Bunnell, and dumped her body into San Francisco Bay. Bunnell's mother sued Crow's father, a physician who had treated Bunnell several months before her death. Bunnell's mother claimed that the physician violated the law by failing to report suspected abuse.

In the prior incident, Crow had run over Bunnell's foot with his truck. He called his physician father to treat the injury. Both he and Bunnell were intoxicated and both explained that it was an accident. They told the physician that she fell as she climbed into the truck when Crow was backing it up. The court held that this was insufficient evidence to establish that the physician knew or reasonably suspected that Ryann's injury was the result of assault or abuse. Furthermore, the court held that even

if the physician had a duty to report, Bunnell's mother could not establish causation. She herself had reported abuse to the police. Their investigation did not lead to the prevention of Bunnell's murder. A report by a physician probably would not have led to a different or better outcome than the police investigation that actually took place.

In a second California case, in 2011, Renee Joy was involuntarily admitted to Aurora Vista Del Mar Hospital facility for a psychiatric hold. Another patient entered her room and attacked her. Joy was reportedly choked, raped, and sodomized. She sued the hospital for failing to keep the other patient in his room, failing to hire properly qualified personnel, and other negligence. She also sued the hospital for failing to report the rape of a dependent adult. But at the end of 2015, a jury returned a verdict in favor of the hospital.[43] The jury apparently believed the hospital witnesses and concluded that either the abuse did not happen or that it was reported.

Washington

Ho Im Bae was one of four residents at Lakeside Adult Family Home. Less than three months after being admitted, she died from acute morphine intoxication. Morphine was not one of Bae's prescribed drugs, and her death was ruled a homicide. The personal representative of Bae's estate brought a civil action for damages against two nurses for failure to report Bae's abuse under the Washington vulnerable adult protection act. The trial court granted summary judgment to the nurses. In February 2015, the court of appeals affirmed.[44] The first nurse was not required to make an immediate report because she did not observe any abuse. The second nurse did report suspected abuse almost immediately after learning about it. Thus, neither breached their duty.

6. DISCIPLINARY PENALTIES FOR FAILING TO REPORT

In addition to criminal sanctions and civil liability, mandated reporters' failure to report can result in discipline from their health licensing board.

Australia

Nathem Al-Naser owned and managed Belconnen Medical Center where he employed Maged Khalil. In 2012, Khalil engaged in sexual relations with a patient. That patient later told Al-Naser, who then treated the patient for the effects that relationship had on her health. But Al-Naser did not report Khalil and allowed him to continue working. In 2015, the Medical Board of Australia took Al-Naser to the Australian Capital Territory Civil and Administrative Tribunal (ACAT). In a February 2015 judgment, the ACAT reprimanded Al-Naser, barred him from supervising other physicians for two years, and imposed other limitations.[45]

7. LEGAL IMMUNITY FOR GOOD-FAITH REPORTING

Making a compulsory report may require clinicians to breach their duty of confidentiality. It can also be intrusive and disruptive to the person who is investigated. For example, a child abuse report may lead to parents losing physical custody of their children. The individuals who are adversely affected by a clinician's report may want to retaliate with a lawsuit. But so long as the report was made in good faith, the clinician has legal immunity.

Iowa

Clinicians are afforded immunity not only for reporting, but also for aiding and assisting in the assessment of a report. In June 2009, three-week-old Ethan Neiderbach presented to an emergency room with a broken arm. His injuries suggested child abuse. But one physician thought the father's explanation was plausible, and the investigation was stopped. The following month, young Neiderbach was hospitalized with a bleeding brain and at least 15 rib fractures. His parents were convicted and jailed for more than 20 years. Neiderbach's adoptive parents sued the physician for failing to report the initial injury. But the Iowa Supreme Court construed the statutory immunity provision broadly. It decided that a claim for failing to report may proceed to trial only when the plaintiff shows the doctor acted dishonestly.[46]

Ohio

In January 2016, Molly Blythe filed a lawsuit against physicians at Promedica Toledo Hospital.[47] Those physicians diagnosed Blythe's daughter, KB, with shaken baby syndrome. They reported Blythe to an Ohio children's services agency. The state removed both KB and her twin sister from Blythe's care. But the state later dismissed its abuse complaint. In her lawsuit, Blythe claims that the shaken-baby diagnosis was groundless. She seeks unspecified punitive and compensatory damages. But the case is unlikely to succeed, because physicians have immunity, so long as they acted in good faith. Blythe must establish not only that the physicians were mistaken, but also that there was no plausible basis for the finding of child abuse.

California

In 2010, Jill Jones told the Santa Monica UCLA (University of California Los Angeles) Medical Center that she had been holding her sleeping infant, G.J., in her arms when she tripped, and G.J. fell out of her arms, tumbled down several stairs, and landed on his head on the hardwood floor. Physicians determined that G.J.'s injuries, including a fracture on the back of his skull, were consistent with that explanation of the accident.

But Claudia Wang, the medical director of UCLA's Suspected Child Abuse and Negligence team, thought that the baby's injuries were unusual and potentially inconsistent with the parents' explanation. So, Wang had Jones bring baby G.J. back to the hospital. Wang made a report to the Department of Children and Family Services and to the UCLA police department.

Notably, Wang also recommended admitting G.J. into the hospital to determine whether the baby had a metabolic bone disorder that was causing the fractures. Wang later admitted that her primary purpose in making this recommendation was to prevent Jones from taking G.J. home. Wang's plan worked. G.J.'s parents believed that they were not allowed to take him home. Wang effectively seized the baby and took him into custody, even though there were no exigent circumstances indicating he was in imminent danger.

A social worker later issued a hold on G.J. based on Wang's suspicions. G.J.'s parents lost physical custody for months. But this was all unnecessary. Eventually, a juvenile court found that G.J. had not been abused and would not be at risk of abuse in the future.

G.J.'s parents sued for violations of their federal and state constitutional rights. The trial court denied Wang summary judgment on the basis of qualified immunity. In September 2015, the U.S. Court of Appeals for the Ninth Circuit affirmed.[48] The parents' claims concern Wang's efforts to keep G.J. hospitalized so that the parents couldn't take him home. Since Wang had already made the report before physically seizing G.J., reporting immunity did not apply.

In December 2015, the American Academy of Pediatrics, the California Medical Association, and other societies urged the Ninth Circuit to reconsider. They argue that the ruling will have a chilling effect on physicians and will impede their ability to treat, evaluate, and protect child abuse victims. Briefing on the motion for a rehearing will continue through March 2016.

8. PROTECTION AGAINST EMPLOYERS' RETALIATION

When a healthcare employee reports patient safety or patient rights violations by their employer, the employer may retaliate by terminating the employee. But most mandatory reporting laws protect whistleblowers.

Maine

Torrey Harrison was a licensed clinical social worker for Granite Bay, in Portland, Maine. Granite Bay provides services to adult clients with cognitive and physical disabilities. In 2010, she noticed that dependent adults doing maintenance work were not getting paid. In addition to this exploitation, Harrison noticed several other problems indicating neglect and abuse: (1) the electricity had been shut off at a group home, (2) alarmed windows (to prevent residents' wandering) were broken, and (3) another office was understaffed. She filed complaints with the Maine Department of Health and Human Services. Granite Bay subsequently fired Harrison.

Harrison sued Granite Bay for wrongful termination. The trial court ruled in favor of Granite Bay, because of an exception to whistleblower protection. It held that since reporting was part of her job duties, Harrison was not protected from retaliation. In January 2016, the U.S. Court of Appeals for the First Circuit reversed. It held that there is no "job duties exception" to whistleblower protection. The court of appeals remanded the case to the district court where it may now proceed.[49]

Texas

Tammy Jennings was employed by Loyds of Dallas as a caregiver. In 2014, she reported resident neglect issues involving inadequate medications and food. A few days after Jennings made these complaints, she was terminated. Jennings sued for wrongful termination. The trial court denied Loyd's motion to dismiss. In late February 2016, the Texas Court of Appeals affirmed, allowing the lawsuit to proceed.[50]

CONCLUSION

Compulsory reporting remains an important tool for identifying, mitigating, and preventing threats to the health of patients and the public. Over the past year, many states have expanded the reporting duties of medical mandated reporters. And many states have enforced compliance with these duties

through criminal, civil, and disciplinary sanctions. But we must assess whether these mandatory reporting requirements are in the best interests of patients and the public. As many of the above examples indicate, holdings remain inconsistent, and some are open to debate. Thus, there is much still to be done.

NOTES

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