

## COMMENTS

# Ethical concerns related to mandatory reporting of sexual violence

**JAGADEESH N, PADMA BHATE-DEOSTHALI, SANGEETA REGE**

### **Abstract**

*The provision of care for survivors of sexual violence is a medico-legal emergency. However, due to social issues, healthcare providers face several ethical and legal dilemmas when administering care to such survivors at hospitals. Added to these are the compulsions under mandatory reporting laws, which oblige healthcare providers to abide by the ethical commitments of care and treatment, and make it mandatory for them to report cases of sexual violence to the police, failing which they face legal sanctions. This article draws on global evidence related to mandatory reporting of violence against women and children and the lessons learnt from it. While doing so, it presents the current status of mandatory reporting by healthcare providers in India and the challenges faced by them in operationalising the survivors' autonomy, ensuring confidentiality and overcoming obstacles that may impede treatment and care.*

A 17-year-old girl was brought to a public hospital by her parents for an abortion. She was 18 weeks pregnant. She and her parents disclosed that she had been sexually abused by her uncle, who had subsequently been thrown out of the house. They did not want to report the matter to the police. The doctor explained to the parents that according to the law, he had to inform the police, but also assured them that the police would not force them into anything and that the doctors were with them. However, the girl absconded.

A man brought his nine-year-old son to a public hospital as he complained of pain in the anal region. The father told the doctor that his own brother had sexually assaulted his son. He had confronted his brother, informed his elder brother and sent the former back to his village. The doctor informed him that treatment would start immediately, but the police would have to be informed. The father explained that they did not

want to file a case against his brother as the burden of the brother's family would fall on him. He said they would leave the hospital if the police was contacted.

Both situations pose several challenges to a health professional. Should it be mandatory for a health professional to report rape/sexual assault even if it is without the consent of the survivor and his/her family? Does this not violate the confidentiality of the doctor-patient relationship?

Does abiding by the provision of mandatory reporting amount to denial of treatment, as illustrated above? Will it prevent patients from disclosing the cause of injuries and/or ill health? Will it deter survivors from seeking healthcare, thus putting them at further risk?

Does mandatory reporting take into account the dynamics and circumstances surrounding rape/sexual assault? How does the law on mandatory reporting harmonise with other existing laws, especially those on seeking informed consent (Section 164A, Code of Criminal Procedure [CrPC]) (1) and on ensuring the confidentiality of the survivor, particularly in the case of medical termination of pregnancy (as per the Medical Termination of Pregnancy (MTP) Act, 1971 and MTP Regulations, 2003)(2).

These are some of the vexing questions posed by the new laws against sexual violence, ie the Protection of Children from Sexual Offences Act, 2012 (POCSO) (3) and the Criminal Law Amendment Act, 2013, (CLA) (4). Both laws make it mandatory for all health professionals to report every case of sexual violence. This paper discusses the concerns arising from the "mandatory reporting of rape/sexual assault survivors to police" by health professionals and its effect on the survivors. It also raises questions pertaining to the very concept of mandatory reporting in the absence of good-quality services for protection or additional options for survivors to heal from abuse. The paper suggests that such forced reporting may, in fact, amount to a disservice to the survivors, especially those who go to a health facility in search of treatment and care.

### **The legal provisions**

It is important to note that both these laws aim to punish the perpetrator. The consequences of the assault on the victim's health are well documented and health professionals play a critical role in mitigating them. However, the new role that they are required to play (mandatory reporting) is most likely to jeopardise their therapeutic role.

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Section 357C, CrPC after the CLA, 2013(4) states that all hospitals, private or public, run by the central or state governments must provide first aid or medical treatment, free of cost, to the victims of any offence covered under sections 326A, 376, 376A, 376B, 376C, 376D or 376E of the Indian Penal Code (IPC), and shall immediately inform the police of the incident.

Section 166B, IPC (4), states that any person in charge of a hospital, whether public or private and whether run by the central government, state government, local bodies or any other person, who contravenes the provisions of section 357C of the CrPC, 1973 shall be punished with imprisonment for a term which may extend to one year, or with a fine or with both.

Section 19 of the POCSO (3) states that any person (including a child) who fears that an offence under this Act is likely to be committed, or has knowledge that such an offence has been committed, shall inform the special juvenile police unit or the local police. Section 21 of the POCSO states that a person who fails to report the commission of an offence under subsection (1) of section 19 shall be punished with imprisonment of either description that may extend to six months, or with a fine or with both.

### Global evidence on mandatory reporting

There has been considerable debate on the issue of "mandatory reporting" to law enforcement agencies in instances of rape/sexual assault and of non-reporting of domestic violence (including sexual violence by intimate partners). Several concerns have been raised by studies conducted in different parts of the world. There is research evidence that women are likely to not access healthcare if the requirement for mandatory reporting is enforced. Studies from the United States have shown that non-white women are less likely than others to support mandatory reporting. This could have to do with their experience of coming up against an unresponsive system and also, negative experiences of formal systems, such as the criminal justice system, which are racially biased against non-white people. Similar biases can be observed in the context of women belonging to the minority communities in India, with those subjected to violence being afraid of mandatory reporting. In India, there is a dearth of services for the survivors of violence and in the absence of these the application of mandatory reporting should not violate the victims' right to autonomy and agency.

In 1994, the USA passed the Violence against Women Act (VAWA), which encouraged several states to adopt the policy of mandatory reporting to law enforcement, with the hope that this would help to curb violence against women. However, as the literature shows, strong criticism has been levelled against such reporting. A report published by a centre providing services to survivors of date rape states that teenagers are reluctant to report date rapes because of fears related to "mandatory reporting" laws. They fear unwanted disclosure of their personal information, and this has discouraged young women from seeking prenatal, reproductive and sexual

healthcare. The report also warns that health professionals themselves are becoming increasingly reluctant to provide services to such teenagers as they are constantly in a conflict about reporting cases, on the one hand, and fulfilling their role as carers, on the other (5). In a survey in California, which has provisions for mandatory reporting, at least one in two physicians reported that they did not comply with mandatory reporting if the patient objected (6).

Following a review of the VAWA, several changes were introduced. Amendments in different states pushed for an expansion of mandatory reporting and suggested that it go beyond merely intimating the law enforcement agencies. An example is that of the state of Kentucky, which expanded the requirement of mandatory reporting to Adult Protective Services (besides the law enforcement department). This enabled survivors to access services required for dealing with the aftermath of violence. Protective services help women and children to deal with the effects of any form of violence and recover from its effects by working out safety plans, which include emergency and long-term shelter services, housing, nutrition and healthcare services, counselling and therapy. In fact, in Kentucky, it is a social worker who contacts the survivor and not the police, enabling the survivor to receive support and care and make an informed decision. The survivor is offered social or/and legal services, as determined by her/him, and the course of action is determined on the basis of a dialogue with her/him. The Kansas state domestic violence and sexual assault support programme has laid down a model policy regarding mandatory reporting. The policy states that the decision to report to law enforcement agencies or to social and rehabilitation services lies with the survivor. It also states that specific personnel directed by the VAWA to mandatorily report cannot dismiss their responsibility by merely intimating the police machinery, and that their responsibility is also to provide psychosocial interventions and put survivors in touch with appropriate support agencies (7).

A review carried out by the National Coalition for Child Protection Reforms in the USA clearly states that mandatory reporting has, in fact, increased the burden on protective agencies. According to the review, undertaken in 2012, fear of penalties may lead stakeholders responsible for reporting to start reporting people without adequate scrutiny, creating an unnecessary burden on services. Another study conducted to understand health professionals' perceptions of mandatory reporting demonstrates how they are compelled to act in consonance with the law even if it violates medical ethics. Health professionals acknowledge the difficulty of striking the inevitably difficult balance between patients' safety, patients' autonomy, legal requirements and potential police protection. A recently published article in *Time* magazine (February 2013) has raised questions related to the operational aspects of the VAWA with respect to mandatory reporting. The article states that the rate of prosecution has increased as a result of the VAWA, but there is no evidence to suggest that the Act has been able to reduce the incidence of violence against women. Given the evidence on problems

related to the “mandatory reporting laws,” especially VAWA, lawyers, feminists and human rights experts suggest that the funding for law enforcement agencies be redirected to prevention, job training and additional services to heal those who have already faced violence.

As a response to the growing concern about the lack of therapeutic care for survivors of sexual violence, several countries, such as Denmark, Norway and Sweden, have developed healthcare-based models to maximise the medical response to the victims. These models provide comprehensive care, including forensic medical examination, psychological counselling and follow-up, as well as complete medical care. The healthcare services recognise the fact that survivors may visit the facility to avail themselves of care and may not have decided to file a police complaint. At the Copenhagen Centre for Victims of Sexual Assault at Rigshospitalet in Denmark, the situation is explained to the survivor, who is offered the option of getting evidence collected and given three months to decide whether or not to file a police complaint. According to the centre, those reporting to the police after sexual assault are more likely to report non-genital assault, ie physical assault, and sexual assault by a stranger/non-family person. Victims identifying a friend as the perpetrator of the sexual assault are more likely to report to the hospital-based centre. This may indicate that before the availability of dedicated sexual assault centres, this “silent” group of adult victims of sexual assault (by friend/family member) may not have received services, even if they had the same needs of medical treatment. It does make a case for reporting of sexual assault at the level of health settings because these settings allow for voluntarily reporting and the provision of healthcare (8).

In South Africa, there is a contradiction between the laws on mandatory reporting of sexual assault and the Children Act, 2005 (Act no. 38 of 2005), which allows sexually active children access to condoms, contraceptives, abortion and medical care. McQuoid-Mason argues that the provision on mandatory reporting violates the constitutional principle of ensuring the “best interests of the child”, and unreasonably and unjustifiably limits the constitutional rights of children to bodily and psychological integrity and privacy (9). The Teddy Bear case, as it is now referred to, is significant as the court recognised that adolescents of 12–15 years of age have a right to engage in “healthy sexual behaviour” (paragraph 107). Thus, for the first time in South Africa, a court recognised that the disparate approaches to adolescent sexuality in the Sexual Offences Act, 1957 and Children’s Act, 2005 were not in the best interests of children. Strode et al argue that this is the first step towards developing a more coherent approach to adolescent sexuality, which has both public health and human rights benefits. However, doctors and researchers remain in a dilemma about whether or not to report in certain circumstances (such as when the child is under the age of 12; when a 12–15-year-old is having consensual sex with a much older partner; when a 16–17-year-old is having consensual sex with a partner more than 2 years younger; or when the child is having sex with a person over 18). They argue for further debate on reforms that

would give service providers some discretion in determining when reporting a consensual sexual offence would be in the best interests of the child (10).

### **Mandatory reporting contradicts the existing laws in India**

Making it mandatory for hospitals to report all cases of rape and sexual assault to the police under section 357C, CrPC(4) and section 21, POCSO (3), respectively, is in contradiction of various existing legal provisions. These are as follows.

#### *Informed consent*

Section 164A of the CrPC, amended in 2005(1) made it binding for medical professionals to carry out the medico-legal examination only after seeking informed consent. This meant that no part of the medico-legal examination could be conducted without the survivor’s consent. The underlying principle was a recognition of the fact that survivors are autonomous individuals and can make informed decisions. The process of informed consent allows the survivor to understand the rationale and scope of the medical examination, areas of the body that would be examined, relevance of the evidence collected from the body and nature of the treatment. Such a dialogue with survivors puts them at ease about the procedural aspect of medico-legal examination. It recognises their right to undergo a partial examination. The doctor has to mention in the medico-legal case report that informed consent was obtained for all parts of the examination and treatment. Therefore, it becomes mandatory for doctors to document informed refusal for any part of the procedure. Section 357C, CrPC contradicts this, as it makes “providing treatment and informing police” compulsory in every case. So when survivors tell the doctor that they do not want the hospital to inform the police but only want treatment and/or evidence collection, the doctor will be in a dilemma regarding what to do, or may end up having to deny treatment.

#### *Voluntary reporting*

Both the POCSO (3) and CLA, 2013(4) recognise the right to treatment and voluntary reporting to hospital (this means that survivors can directly approach a hospital without a police requisition for treatment and evidence collection). This has come about after a long period of struggle. A landmark Supreme Court judgment in the case of State of Karnataka vs. Manjanna as far back as the year 2000 called rape a medico-legal emergency and made it obligatory for health facilities to provide survivors with immediate healthcare. The judgment also highlighted pathways by which survivors could go to a health facility – either voluntarily, by police requisition or through a court directive. It recognised that survivors may visit a health facility to receive treatment and, therefore, they ought to be provided services immediately, without any police requisition. When we speak of voluntary reporting, we recognise the fact that survivors may go to hospitals for treatment before they report to the police, since they may need time to decide whether they would like

to take legal action. The judgment was intended to make access to healthcare enabling for survivors of sexual violence. Mandatory reporting contradicts the concept of voluntary reporting, as the former deters survivors from seeking treatment. This is a setback.

#### *Abortion law*

The MTP Act (2) makes it mandatory for doctors to keep all information on those seeking abortions confidential. It lays down that the facility must keep all records in sealed envelopes. On the other hand, the POCSO Act, 2012, makes it mandatory to report all sexual activity (whether consensual or not) in the case of those under 18 years of age to the police. Thus, all sexual activity under the age of 18 years is regarded as statutory rape and must be reported to the police. According to this law, if a girl wants to undergo MTP on humanitarian grounds but does not want to file a police complaint (when pregnancy is an outcome of sexual assault/rape), the doctor must inform the police that the cause for pregnancy was rape. This is in contravention of the MTP law, as it violates the principle of confidentiality.

#### *Right to privacy*

Article 21 of the Constitution (11) recognises the right to privacy and, therefore, nothing can be done against the will of a person. However, while Rule 5.2 of the POCSO Act states that "emergency medical care shall be rendered in such a manner as to protect the privacy of the child", Section 21 of the Act contradicts this by making reporting mandatory.

### **Mandatory reporting – conflict with medical ethics**

#### *Violation of informed consent*

The law requiring mandatory reporting by health facilities severely compromises the principle of informed consent. Survivors who go to a health facility confide in the health professional on the basis of an implicit contract of "confidentiality of information". However, when a health professional tells the survivor that s/he has to reveal the information to the police, irrespective of the survivor's consent, the survivor feels cheated. Informed consent then becomes irrelevant since the survivor's autonomy to make a decision on whether or not the matter should be reported to the police becomes a mere formality. Mandatory reporting, therefore, raises concerns about the health professional's primary responsibility as a carer and stereotypes survivors as helpless people incapable of making decisions for themselves. Complying with the requirement of mandatory reporting may lead health professionals to feel that their job is done by simply reporting to the police, and they might make no effort to either develop support strategies to heal the survivors or refer them to psychosocial services.

#### *Threat to confidentiality*

The health provider–patient relationship is based on an assurance of confidentiality. A contract of confidentiality helps patients to have honest and open discussions with

their providers. At the same time, health professionals are able to provide comprehensive and complete treatment if the patient gives them all the information. However, mandatory reporting poses a challenge to the assurance of confidentiality. Survivors who do not wish to involve the police may not reveal that they were abused and may also not mention all the injuries/health consequences suffered by them, thus compromising on their health. In a primary research study undertaken in the state of Michigan to understand survivors' opinions on mandatory reporting by medical professionals, it was found that most participants did not support such reporting. They stressed that they should be allowed to consider all the potential consequences of reporting before their experience of violence is reported to the police. Some of the reasons cited by the participants for opposing mandatory reporting were the fear that the child would be separated from the non-abusive parent, the apprehension that their history would become public and fear of being deported (12). Victims may not report abuse due to financial and emotional dependence on the perpetrator; not wanting to go through the court system; not wanting the perpetrator to be arrested if he is a family member; and wanting time to think or make a decision on the matter.

#### *Clashing obligations*

Health professionals have a duty to provide first-line psychological support, besides medical treatment. Some of the basics of first-line psychological support are to probe and ascertain how safe the survivor is; assess whether there is any suicidal ideation; work out a safety plan, reassure the survivor; and discuss sexual violence as an abuse of power (13). However, the recent laws do not allow health professionals to engage in a constructive dialogue with survivors. Mandatory reporting will deprive survivors not wishing to take the route of the criminal justice system of the chance to communicate honestly with the health professional. Health professionals can get caught in an ethical dilemma between the provision of care versus mandatory reporting as it would be difficult to decide whether to fulfil their obligation to the survivor or be accountable to the state.

### **Positive step in setting standards for healthcare – establishing right to health**

There has been much discussion on the need for healthcare providers to adopt an ethical, legal and gender-sensitive approach (14), along with the dissemination of standard protocols and guidelines. The Union Ministry of Health and Family Welfare (15) realised that the contact between survivors seeking care and the healthcare system is critical, and provided clear directions to health systems on dealing with the aspect of "mandatory reporting". According to the ministry's guidelines, in instances in which survivors may not want to report to the police and have gone to a health facility only for treatment, health professionals have the responsibility of informing them of the benefits of reporting to the police; if they decide against reporting the matter,

“informed refusal” should be documented and treatment should not be compromised upon. In cases in which doctors feel that informing the police would result in the denial of treatment to the patient, documenting “informed refusal” is a way forward. However, the ministry’s guidelines must be supported by corresponding legal amendments. Simultaneously, efforts must be made to refer cases to services that are designed to provide protection to survivors and heal and reintegrate them into their daily routine of life. In the process, the violence would get reported to the protection services and not mandatorily to the police. In order for such a change to occur, there is a need to address the absence of comprehensive and quality services for the protection of victims.

To conclude, we must ask the basic question as to who benefits from laws for mandatory reporting. Mandatory reporting clearly aims to punish offenders and reduce crime, and does not directly focus on the best interest of survivors or what they desire. Against this background, when we analyse the reasons why survivors do not report crimes, they include the fear of losing shelter; apprehensions about retaliation by the perpetrator; anxiety that others will come to know about the assault; and fear of losing community support. Those working with survivors of sexual violence need to collate data related to “mandatory reporting” and the challenges it poses. This would provide much-needed evidence for the formulation of policy decisions/directions. The need of the hour is to set up more services that provide comprehensive healthcare, including crisis intervention, so that more survivors are able to seek care and support.

### Conflict of interest

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