

## **Course Description for Strangulation: All Things Medical & All Things Legal for Judges and Court Staff**

**Strangulation: All Things Medical.** In this one-hour webinar designed specifically for Judges and Court Staff, Gael Strack, JD, and Casey Gwinn, JD, will cover key medical terms; the medical signs and symptoms of strangulation; the seriousness and lethality of strangulation and suffocation assaults and the short and long term consequences of asphyxia for victims. Gael and Casey will also share promising practices, national resources available at the Training Institute on Strangulation Prevention and leave plenty of time for questions and answers.

**Strangulation: All Things Legal.** In this one-hour webinar designed specifically for Judges and Court Staff, Gael Strack and Casey Gwinn will discuss strangulation laws, typical legal defenses, the identification of the dominant aggressor, recent case law and the use of experts in the courtroom. Gael and Casey will also share promising practices, national resources available at the Training Institute on Strangulation Prevention and also leave plenty of time for questions and answers.

Gael Strack and Casey Gwinn are attorneys and recognized as national experts in strangulation and founders of the Training Institute on Strangulation Prevention, a project of the National Family Justice Center Alliance. They have authored numerous articles and manuals in strangulation, including the [\*Domestic Violence Report in August/September 2014\*](#) which dedicated an entire issue to this subject. To learn more about their work go to [www.strangulationtraininginstitute.com](http://www.strangulationtraininginstitute.com).

[Casey Gwinn](#) is the President of the National Family Justice Center Alliance. Casey served as the elected San Diego City Attorney for eight years. Prior to being the elected City Attorney, Casey founded the San Diego City Attorney's Child Abuse and Domestic Violence Unit recognized by the National Council of Juvenile and Family Court Judges as a national model. Casey is the visionary behind the Family Justice Center model and has served on the U.S. Attorney General's National Advisory Committee on Violence Against Women, the ABA's Commission on Domestic Violence and chaired the California Attorney General's Task Force on Domestic Violence. Casey is also the recipient of numerous awards and has authored many articles and books on the subject Family Justice Centers, Intimate Partner Violence and Children Exposed to Violence.

[Gael Strack](#) is the Chief Executive Officer and Co-Founder of the National Family Justice Center Alliance and former Director of the San Diego Family Justice Center the inspiration for the President's Family Justice Center Initiative. Gael is a former public defender, county council handling juvenile dependency matters and prosecutor. She is the former President of the San Diego Domestic Violence Council and former commissioner of the ABA's commission on domestic violence. She has received numerous awards, including San Diego Attorney of the year and was recognized by US Attorney General Eric Holder with the National Crime Victim Service Award for Professional Innovation in Victim Services. In her "spare time" she teaches law school at Cal Western School of Law on the subject of Domestic Violence and the Law.



# Training Institute on Strangulation Prevention

A Program of the National Family Justice Center Alliance

## Welcome to the Webinar!

*While waiting for the presentation to begin, please read the following reminders:*

- The presentation will begin promptly at 9:00 a.m. Pacific Time
- If you are experiencing technical difficulties, email [mehry@nfjca.org](mailto:mehry@nfjca.org)
- To LISTEN to the presentation on your phone, dial (415) 655-0059  
Access Code: 978-459-993 or listen on your computer speakers
- Attendees will be muted throughout the presentation
- To send questions to the presenter during presentation:
  - Click on "Questions" in the toolbar (top right corner)
  - Type your comments & send to presenter
- There will be a Q & A session at the end of the presentation.
- The presentation will be recorded & posted on <http://strangulationtraininginstitute.com/>
- Please complete the evaluation at the end of the presentation. We value your input.



# Strangulation: All Things Legal – What Judges and Court Staff Need to Know

Casey Gwinn, Esq., President  
Gael Strack, Esq., Chief Executive Officer

# Your Presenters for Today

- [casey@nfjca.org](mailto:casey@nfjca.org)



- [gael@nfjca.org](mailto:gael@nfjca.org)



# Thank you to the Office of State Courts Administrator

## **Susan Proctor**

Office of Court Improvement,  
Office of State Courts Administrator

[proctors@flcourts.org](mailto:proctors@flcourts.org)

- Reminder CLE's are available for attendees: CLE#15011705N
- CJE's have been requested.



# Training Institute on Strangulation Prevention



- Project of the Family Justice Center Alliance
- Launched October 2011
- Sponsored by the Office on the Violence Against Women
- To provide Training and Technical Assistance
- Fee-based and federally supported program

# National Advisory Team



# Family Justice Center Alliance



Casey Gwinn, JD



Gael Strack, JD



Natalia Aguirre



Chris Burlaka, CPA



Jennifer Anderson



Ruth Samson



Michael Burke

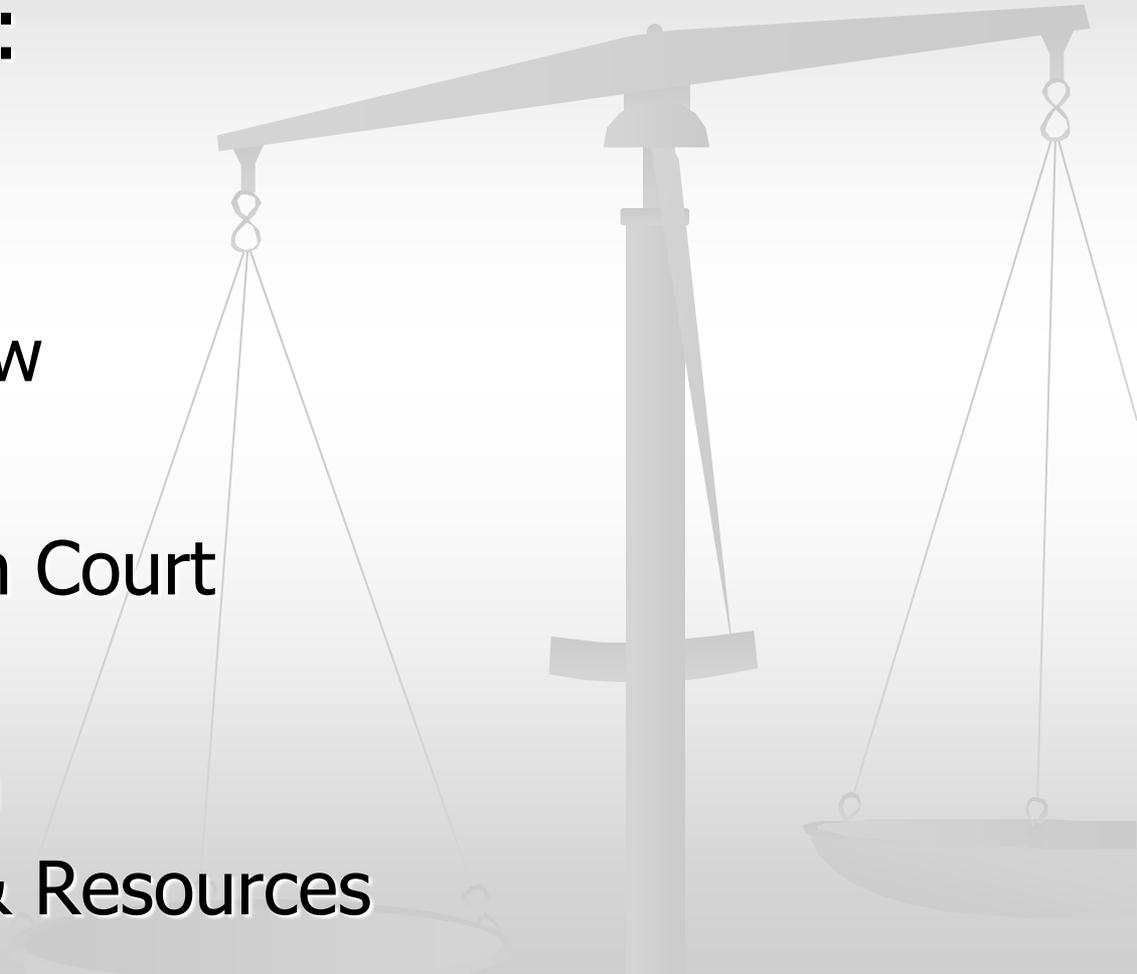


# Overview

- Last Webinar (All Things Medical) we covered:
  - Findings from 300 Strangulation Cases
  - Lethality and Use of Risk Assessment Tools
  - Medical Perspective - When They Survive
  - What we can learn from Fatal Strangulation
  - Understanding Traumatized Victims

# Today's Webinar

- All Things Legal:
  - Documentation
  - The Law
  - Recent Case Law
  - The Defenses
  - Legal Aspects in Court
  - Use of Experts
  - Implementation
  - Best Practices & Resources



# Florida Strangulation Law

## F.S.A. Section 784.041 (2007):

- (2)(a) A person commits domestic battery by strangulation if:
  - Knowingly and intentionally,
  - Against the will of another,
  - **Impedes the normal breathing or circulation of the blood**
  - Of a family or household member, or
  - Of a person with whom he or she is in a dating relationship
  - So as to **create a risk of or cause great bodily harm** by
  - Applying pressure on the throat or neck of the other person or
  - By blocking the nose or mouth of the other person
  - This paragraph does not apply to any act of medical diagnosis, treatment or prescription which is authorized under the laws of this state.

# The Challenge:

- How do you know the victim was strangled or suffocated – if most victims have no visible injury?
- How do you know if blood flow or air flow was impeded – if no one asks the right questions?
- How do you know if you have a serious strangulation case in your courtroom – if no one has documented the evidence?

# Near-Fatal Strangulation Cases

- Petechiae
- Loss of Consciousness
- Urination
- Defecation



# Documentation Tools



# Use of Forms is a Best Practice

- The San Diego Police Department's Domestic Violence reporting form is a "revolutionary sheet of paper." 13 BYU Journal of Public Law 427 (1999).

# Specialized Documentation Form

## Documentation Chart for Strangulation Cases

### Symptoms and/or Internal Injury:

Breathing Changes	Voice Changes	Swallowing Changes	Behavioral Changes	OTHER
<input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Hyperventilation <input type="checkbox"/> Unable to breathe Other:	<input type="checkbox"/> Raspy voice <input type="checkbox"/> Hoarse voice <input type="checkbox"/> Coughing <input type="checkbox"/> Unable to speak	<input type="checkbox"/> Trouble swallowing <input type="checkbox"/> Painful to swallow <input type="checkbox"/> Neck Pain <input type="checkbox"/> Nausea /vomiting <input type="checkbox"/> Drooling	<input type="checkbox"/> Agitation <input type="checkbox"/> Amnesia <input type="checkbox"/> PTSD <input type="checkbox"/> Hallucinations <input type="checkbox"/> Combativeness	<input type="checkbox"/> Dizzy <input type="checkbox"/> Headaches <input type="checkbox"/> Fainted <input type="checkbox"/> Urination <input type="checkbox"/> Defecation

### Use face & neck diagrams to mark visible injuries:



Face	Eyes & Eyelids	Nose	Ear	Mouth
<input type="checkbox"/> Red or flushed <input type="checkbox"/> Pinpoint red spots (petechiae) <input type="checkbox"/> Scratch marks	<input type="checkbox"/> Petechiae to R and/or L eyeball (circle one) <input type="checkbox"/> Petechiae to R and/or L eyelid (circle one) <input type="checkbox"/> Bloody red eyeball(s)	<input type="checkbox"/> Bloody nose <input type="checkbox"/> Broken nose (ancillary finding) <input type="checkbox"/> Petechiae	<input type="checkbox"/> Petechiae (external and/or ear canal) <input type="checkbox"/> Bleeding from ear canal	<input type="checkbox"/> Bruising <input type="checkbox"/> Swollen tongue <input type="checkbox"/> Swollen lips <input type="checkbox"/> Cuts/abrasions (ancillary finding)
Under Chin	Chest	Shoulders	Neck	Head
<input type="checkbox"/> Redness <input type="checkbox"/> Scratch marks <input type="checkbox"/> Bruise(s) <input type="checkbox"/> Abrasions	<input type="checkbox"/> Redness <input type="checkbox"/> Scratch marks <input type="checkbox"/> Bruise(s) <input type="checkbox"/> Abrasions	<input type="checkbox"/> Redness <input type="checkbox"/> Scratch marks <input type="checkbox"/> Bruise(s) <input type="checkbox"/> Abrasions	<input type="checkbox"/> Redness <input type="checkbox"/> Scratch marks <input type="checkbox"/> Finger nail impressions <input type="checkbox"/> Bruise(s) <input type="checkbox"/> Swelling <input type="checkbox"/> Ligature mark	<input type="checkbox"/> Petechiae (on scalp) Ancillary findings: <input type="checkbox"/> Hair pulled <input type="checkbox"/> Bump <input type="checkbox"/> Skull fracture <input type="checkbox"/> Concussion

© Training Institute on Strangulation Prevention: [www.strangulationtraininginstitute.com](http://www.strangulationtraininginstitute.com)

### Questions to ASK: Method and/or Manner:

How and where was the victim strangled?

One Hand (R or L)     Two hands     Forearm (R or L)     Knee/Foot

Ligature (Describe): \_\_\_\_\_

How long? \_\_\_\_\_ seconds \_\_\_\_\_ minutes     Also smothered?

From 1 to 10, how hard was the suspect's grip? (Low): 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 (high)

From 1 to 10, how painful was it? (Low): 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 (high)

Multiple attempts: \_\_\_\_\_     Multiple methods: \_\_\_\_\_

Is the suspect **RIGHT** or **LEFT** handed? (Circle one)

What did the suspect say while he was strangling the victim, before and/or after?

Was she shaken simultaneously while being strangled? Straddled? Held against wall?

Was her head being pounded against wall, floor or ground?

What did the victim think was going to happen?

How or why did the suspect stop strangling her?

What was the suspect's demeanor?

Describe what suspect's face looked like during strangulation?

Describe Prior incidents of strangulation? Prior domestic violence? Prior threats?

### MEDICAL RELEASE

To All Health Care Providers: Having been advised of my right to refuse, I hereby consent to the release of my medical/dental records related to this incident to law enforcement, the District Attorney's Office and/or the City Attorney's Office.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

© Training Institute on Strangulation Prevention: [www.strangulationtraininginstitute.com](http://www.strangulationtraininginstitute.com)

# Minnesota Study re Felonies

- More cases were prosecuted as felonies when:
  - Good description of the assault
  - Use of the word “strangulation”
  - Documentation of pain and/or injuries
  - Photos
- Bottom line: Using the checklist of questions or documentation form resulted in identification of serious cases



# Language is Important

Writing is Important  
Questions are Important

# “Choking” vs. “Strangulation”



# What was the Method of Strangulation?

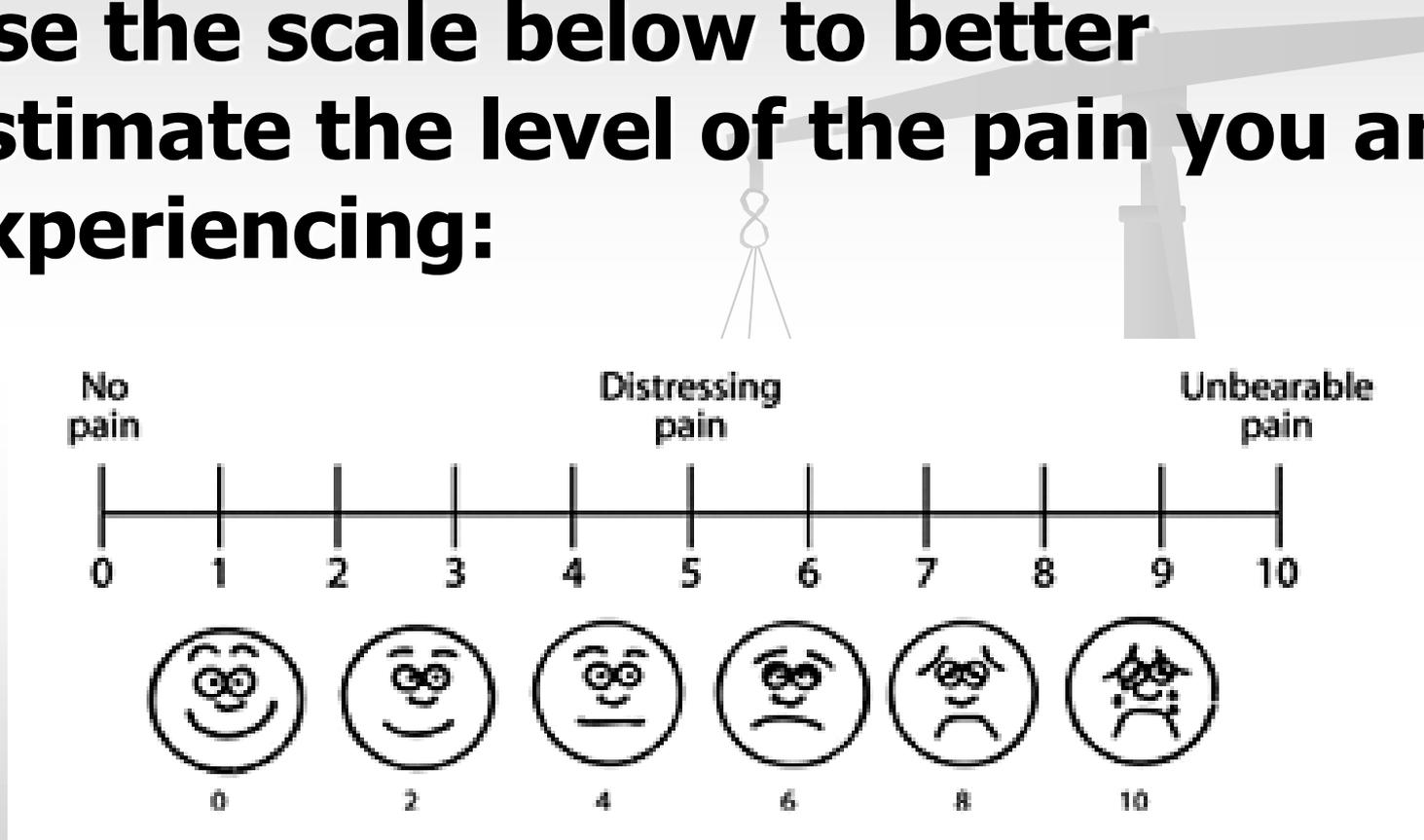


# How much pressure was applied?

- How long?
  - Did he grab the victim briefly?
  - Prolonged?
  - Repeated?
  - Continuous?
  - Increasing pressure?
- How hard?
  - On a scale from 1 to 10 with 10 being the hardest, how much pressure do you think was applied?

# How Painful?

- Use the scale below to better estimate the level of the pain you are experiencing:

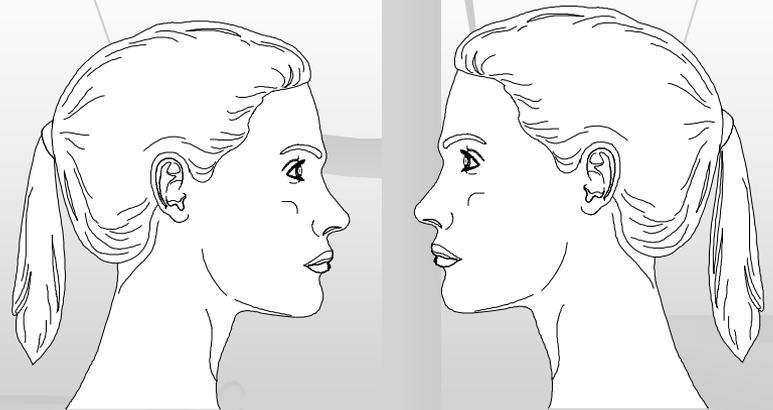




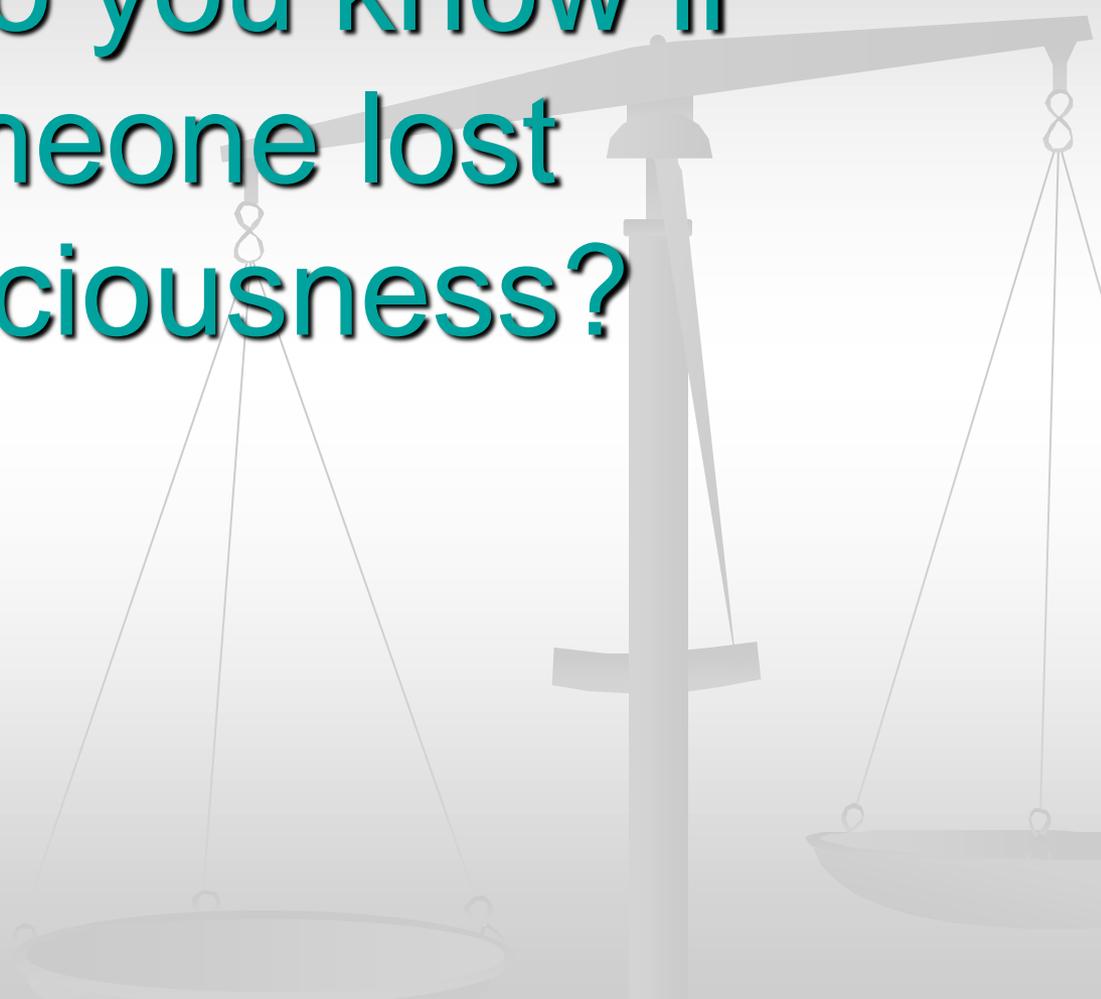
13 2:40 PM

# Once you know the method, look for injuries consistent with the method of strangulation

- Carotid restraint: shoulders
- One hand, C-clamp: neck
- Two hands: neck, chest, behind the ear, jaw
- Ligature



**How do you know if  
someone lost  
consciousness?**



# What did you see?



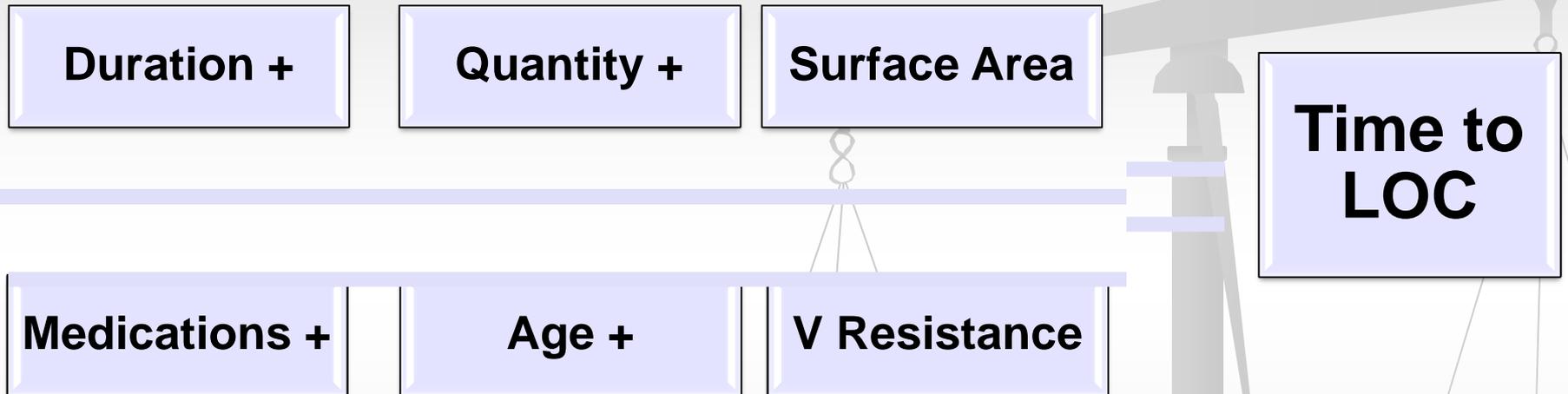
**Rossen Study 1942**  
**Red Wing, MN**  
*Acute Arrest of Cerebral  
Circulation in Man*



***Visual Changes***

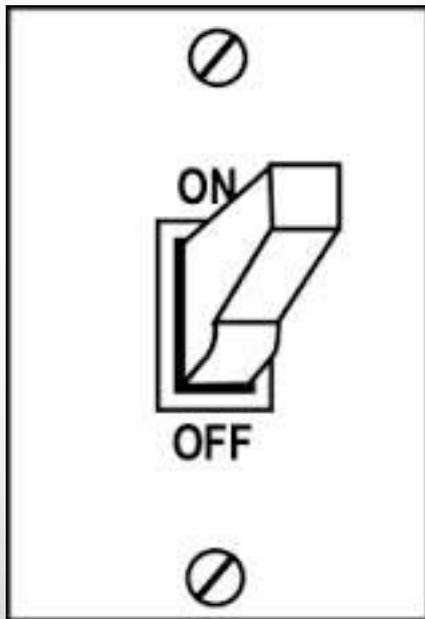
Thank you Mike Agnew

# Factors



# Unconsciousness

- It's not an on or off switch



- It's more of a dimmer switch



# Where did it happen?





# Legal Aspects of Near-Fatal Strangulation Cases



# Strangulation Laws

- Alabama (2011)
- **Alaska (2005)**
- Arizona (2012)
- Arkansas (2009)
- **California (2011)**
- Connecticut (2007)
- Delaware (2010)
- Florida (2007)
- **Georgia (2014)**
- Hawaii (2006)
- Idaho (2005)
- Illinois (2009)
- Indiana (2006)
- Iowa (2012)
- Louisiana (2007)
- Maine (2012)
- Maryland (Sexual Assault Only)
- **Massachusetts (2014)**
- Michigan (2013)
- **Minnesota (2005)**
- Mississippi (2010)
- Missouri (2000)

# Strangulation Laws Continued

- **Nebraska (2004)**
- Nevada (2009)
- New Hampshire (2010)
- New York (2010)
- North Carolina (2004)
- Oklahoma (2004)
- **Oregon (2003)**
- Rhode Island (2012)
- South Dakota (2012)
- Tennessee (2011)
- Texas (2009)
- Vermont (2006)
- Virginia (2011)
- Washington (2007)
- **Wisconsin (2008)**
- Wyoming (2011)
- Federal Assault Statute (2013)
- Pending/Proposed:
  - New Mexico
  - Ohio
  - Kansas
  - Kentucky
  - Maryland (proposed leg. to fall under assault statute, in addition to current SA statutes).

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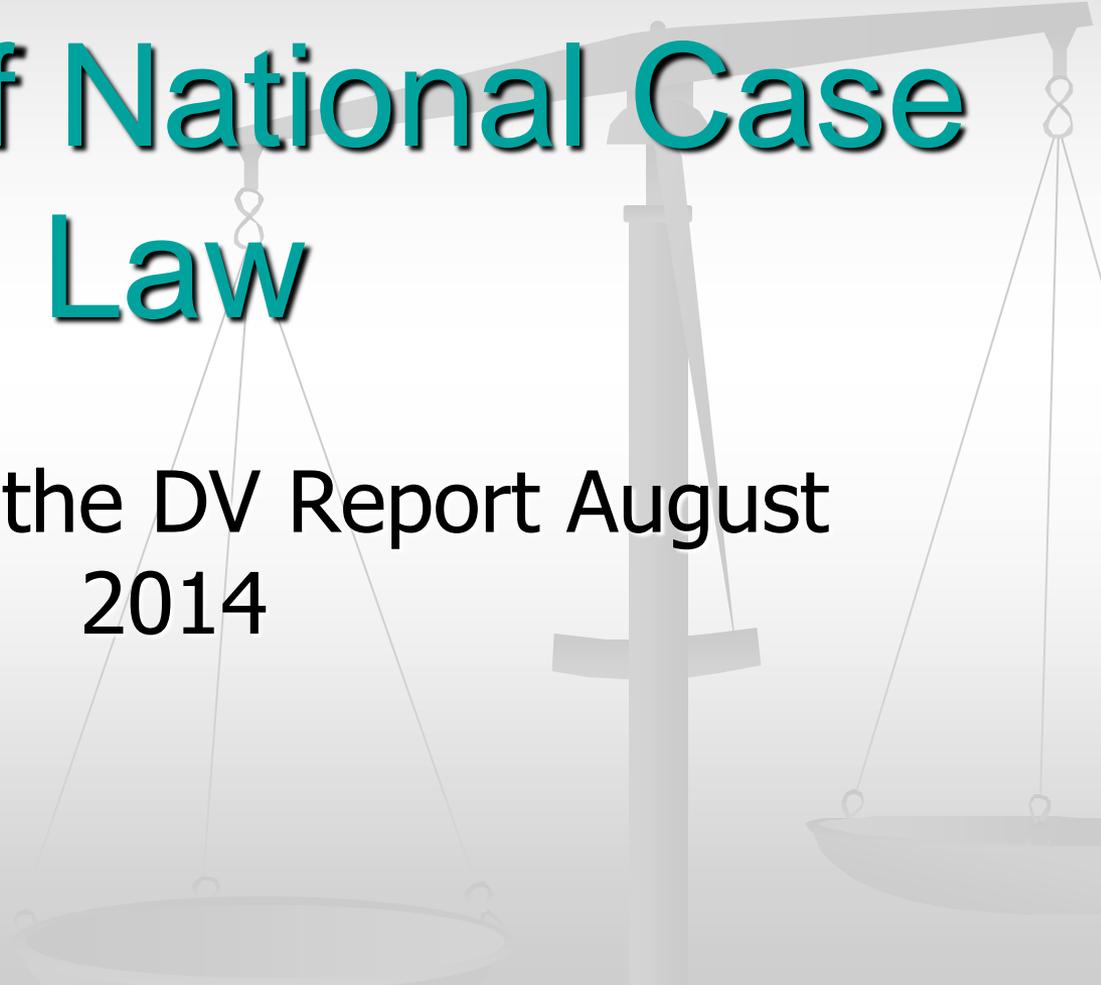
# Florida Supreme Court

- The Florida Supreme Court has ruled that strangulation of a conscious victim transforms a murder into a death penalty offense because it is *per se* “heinous, atrocious and cruel.” Johnson v. State, 969 So.2d 938, 956-957 (Fla. 2007).
- Strangulation is cruel act, with far-reaching consequences. “The particular cruelty of the offense and its potential effects upon a victim both physically and psychologically, merit its categorization and a ranked felony offense...”

# VAWA 2013

- Gave tribal governments jurisdiction to prosecute non-natives for DV.
- Made strangulation/suffocation a felony.
- Strangulation is defined as “intentionally knowing, or recklessly impeding the normal breathing or circulation of the blood of a person by applying pressure to the throat or neck, regardless of whether that conduct results in any visible injury or whether there is any intent to kill or protractedly injure the victim”

# Review of National Case Law



Published in the DV Report August  
2014

# Experts: Law Enforcement

- Detective's Testimony that Strangulation Does not Necessarily Result in External, Physical Injury Relevant (State v. Supino, No. A08-64, 2009 WL 1515255, \*1 (Minn. Ct. App. 2009)).
- Officer's Testimony Admissible Regarding Strangulation Signs and Symptoms (Carter v. State, 235 P.3d 221 (Alaska Ct. App. 2010)).
- Detective Qualified to Testify about Bruising in the Context of Strangulation Even if Not Medical Expert (State v. Battle, 415 S.W.3d 783 (Mo. Ct. App. 2013)).

# Experts: Medical

- Nurse's Non-Percipient Expert Testimony on Domestic Violence and Strangulation Properly Admitted (State v. Cox, 842 N.W.2d 822 (Neb. Ct. App. 2014)).
- Doctor Without Formal Strangulation Training Qualified to Opine about Strangulation Injuries (State v. Delgado 303 P.3d 76 (Ariz. Ct. App. 2013)).

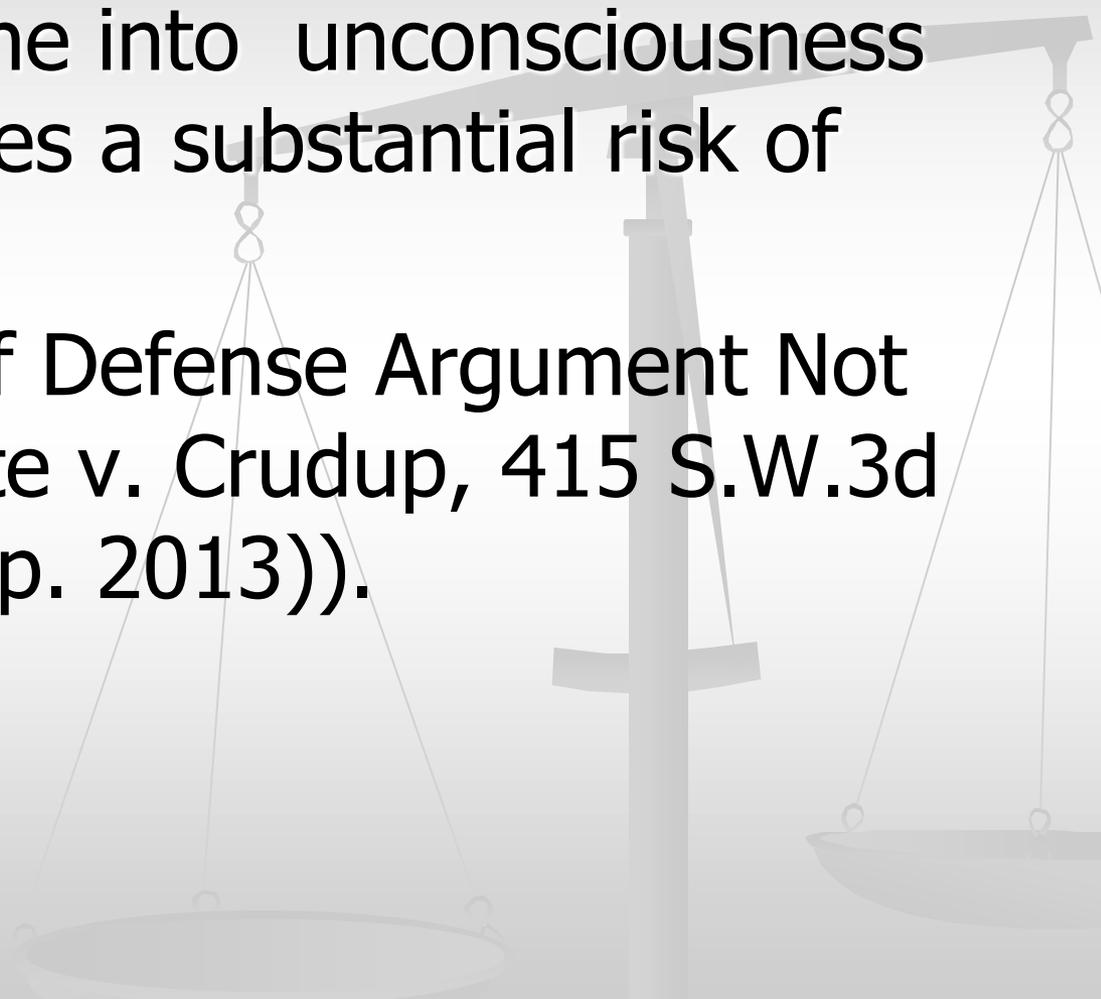
# Defendant Denied Self Defense Instruction

- Defendant claims he choked Victim in self-defense and burned her by accident. Crudup was not entitled to self-defense instructions on either claim.
- Crudup used deadly force in choking Victim unconscious.
- “Deadly force ... cannot be used to repel simple assault or battery.”
- (State v. Crudup, 415 S.W.3d 170 (Mo. Ct. App. 2013)).

# Evidence to Support Strangulation

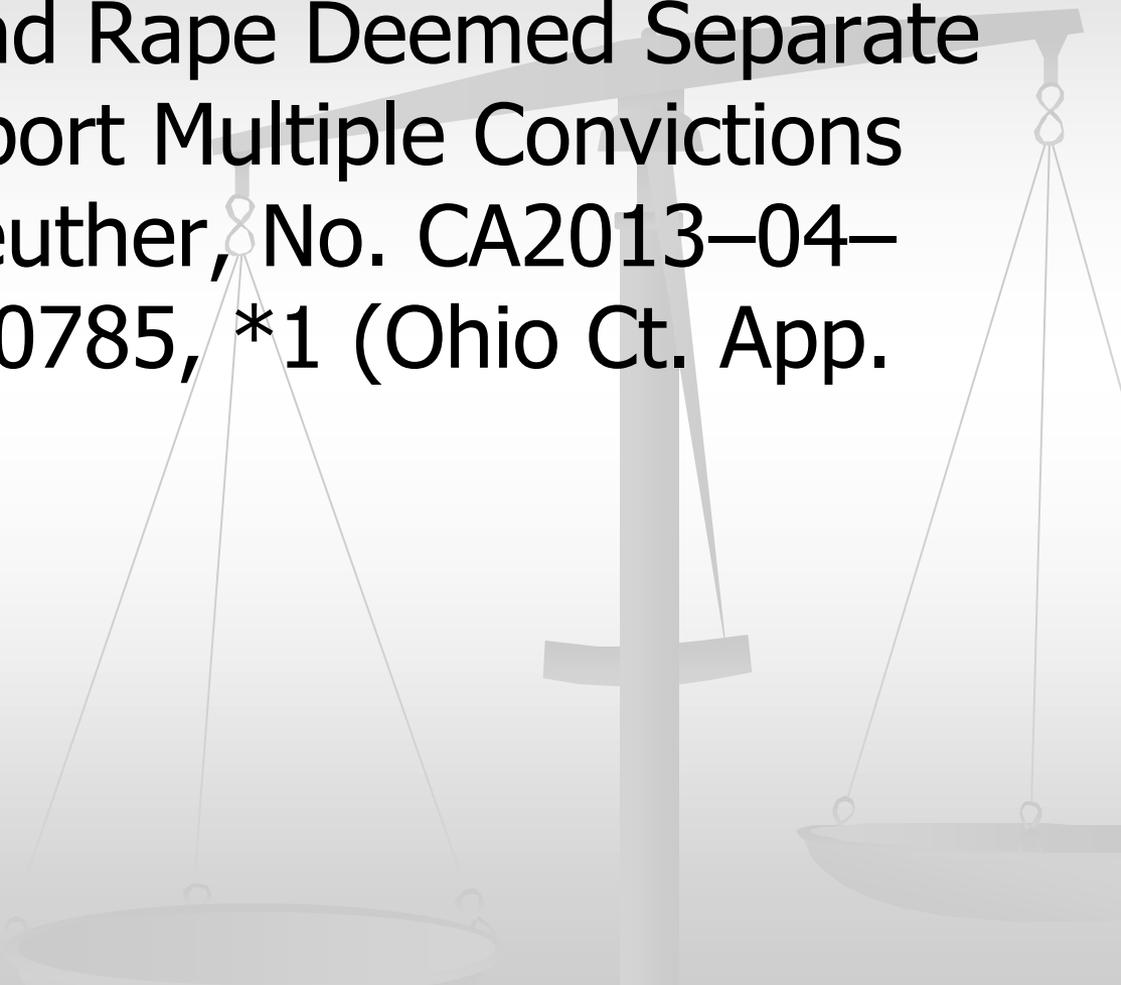
- Evidence of a “sore throat” due to strangulation assault is circumstantial evidence that supports a finding of “traumatic condition” (People v. Romero, No. B217891, 2011 WL 322393, \*1 (Cal. Ct. App. 2011)).

# Serious Physical Injury



- Choking someone into unconsciousness inherently creates a substantial risk of death.
- Defendant's Self Defense Argument Not Warranted (State v. Crudup, 415 S.W.3d 170 (Mo. Ct. App. 2013)).

# Sentencing



- Strangulation and Rape Deemed Separate Conduct to Support Multiple Convictions (State v. Tannreuther, No. CA2013–04–062, 2014 WL 10785, \*1 (Ohio Ct. App. 2014)).

# Strangulation Defined

- Detailed Case Law Example Noting Strangulation Lethality and Injuries and Legislative Intent (People v. Figueroa 968 N.Y.S.2d 866 (N.Y. City Ct. 2013)).

# Typical Defenses



# Self-Defense



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## Prosecutors: Woman bites finger off of man in attack

[Email](#) [Facebook](#) 346 [Twitter](#) 31 [+1](#) 1

By Erin Meyer, Tribune reporter

4:33 pm, October 28, 2012

A woman bit a man's finger off Friday in self-defense, prosecutors said Sunday in Cook County Bond Court.

With a shotgun and shells in reach, Jerry Stevenson allegedly threatened to kill the 45-year-old woman and her twin children in their home in the 1600 block of South Hamlin Avenue during an argument in the early morning Friday, according to court records.

Fearing for her life, the woman ran from the house, according to court records.



CHICAGO POLICE DEPT.

Jerry Stevenson



**SEASON'S BEST EVENT**



# Self-Inflicted Injuries

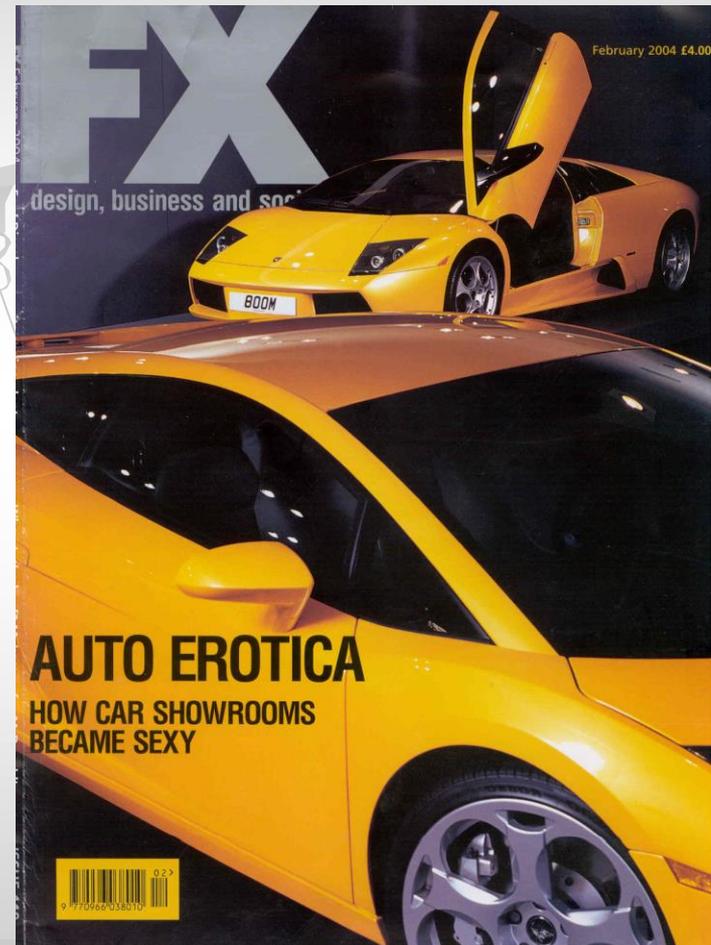
- She lied.
- Injuries are self-inflicted.
- It's a set up.
- Jealous of the new girlfriend.



# Autoerotic Asphyxia

## ■ Autoerotica

- Sexual asphyxia during solo masturbation
- Evidence of a ligature mark
- Look for evidence at the scene
- Ligature set ups: ropes, chains, blindfolds, and gags



# Consent

- Asphyxiation applied or monitored by sexual partner
  - She likes sex that way
  - Bondage
  - “Choke holding” during intercourse

## Strangulation Death Was Consensual Sex, Suspect Says

The victim's boyfriend says she willingly took part in sexual asphyxia. So why did he wait eight hours to summon help?

By [Linda Hersey](#) | August 29, 2012



THE HUFFINGTON POST

DOWNLOAD THE APP

Update: A charge of manslaughter in the death of Jennifer Zale was upgraded to second degree murder Wednesday. St. Petersburg homicide detectives said they changed the manslaughter charge, after an autopsy revealed additional injuries to the victim's body "consistent with intentional homicidal violence."

# New York Case – Sex strangulation

Photo Books, Holiday Car... (348 unread) – gaelstrac... Law grad accused of stra... Reservations – Review R... AmazonSmile : Color Wo... Print Boarding Pass(es)

## Law grad accused of strangling woman in 'BDSM' pad

By [Rebecca Rosenberg](#) and [Jamie Schram](#) March 13, 2015 | 10:56pm



**Ryan Hemphill**  
Photo: Steven Hirsch



### COLUMNISTS

**Michael Goodwin**   
**De Blasio allowing city to trickle back to bad old 'Taxi Driver' days**

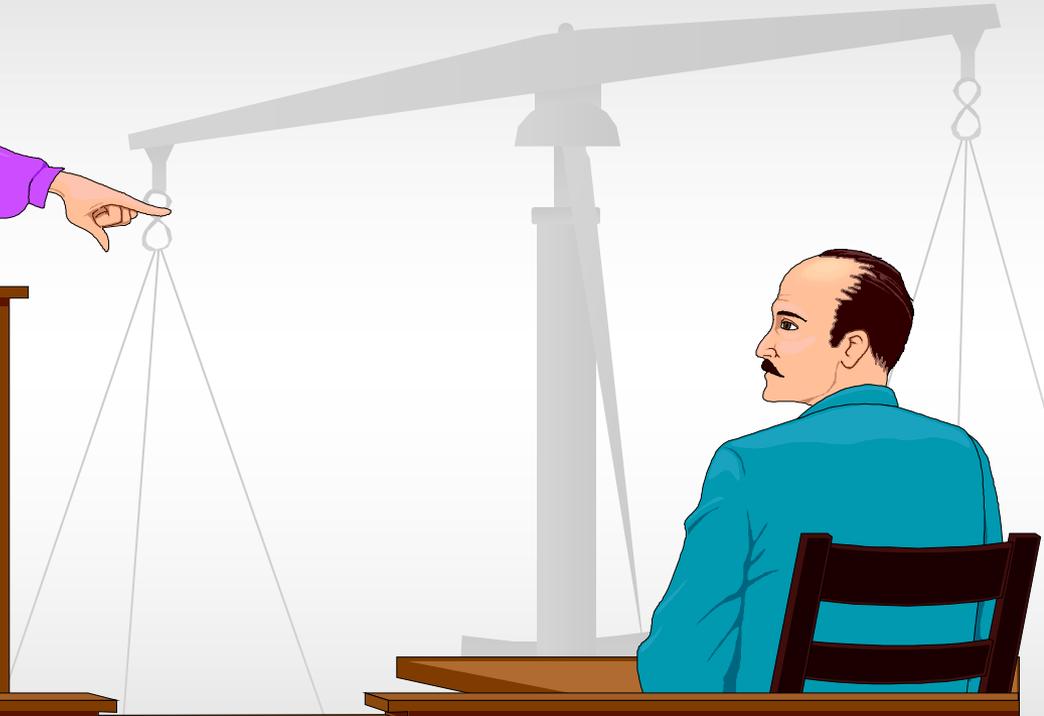
**Fredric U. Dicker**   
**Catsimatidis trying to slip pricey biofuels mandate into budget**

**Andrea Peyser**   
**I don't regret my office romance –**

# How do you know if a case raises issues of consensual sexual behavior?

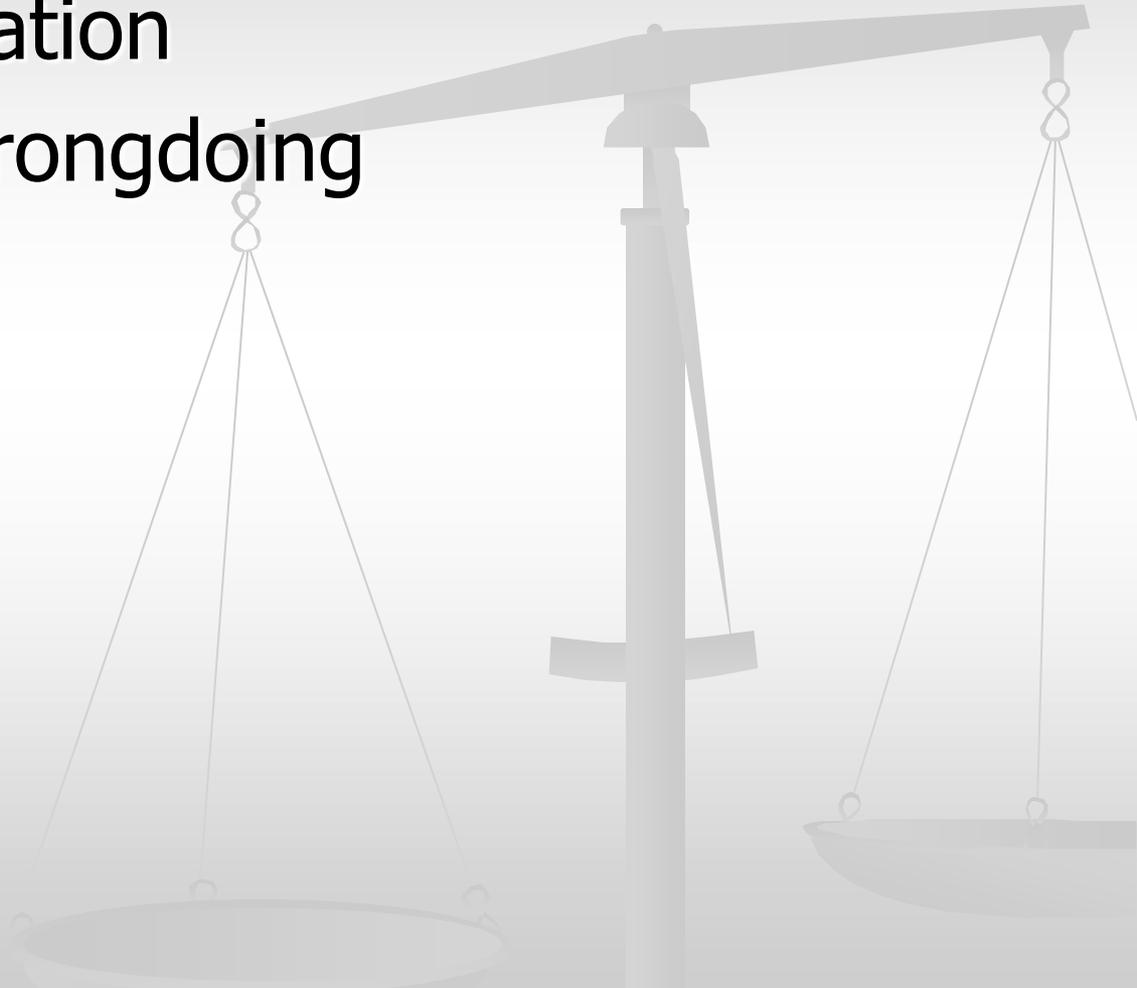
- The presence of sexually stimulating paraphernalia: vibrators, dildos, and pornographic magazines
- Books on subject
- The presence of bondage or complex ligature arrangements: ropes, chains, blindfolds, and gags
- History. Repeated use of special fantasy items and objects
- The use of feminine attire or cross-dressing

# The Trial



# What are the Legal Issues at Trial?

- Witness Intimidation
- Forfeiture by Wrongdoing
- Use of Experts



# Crawford v. Washington

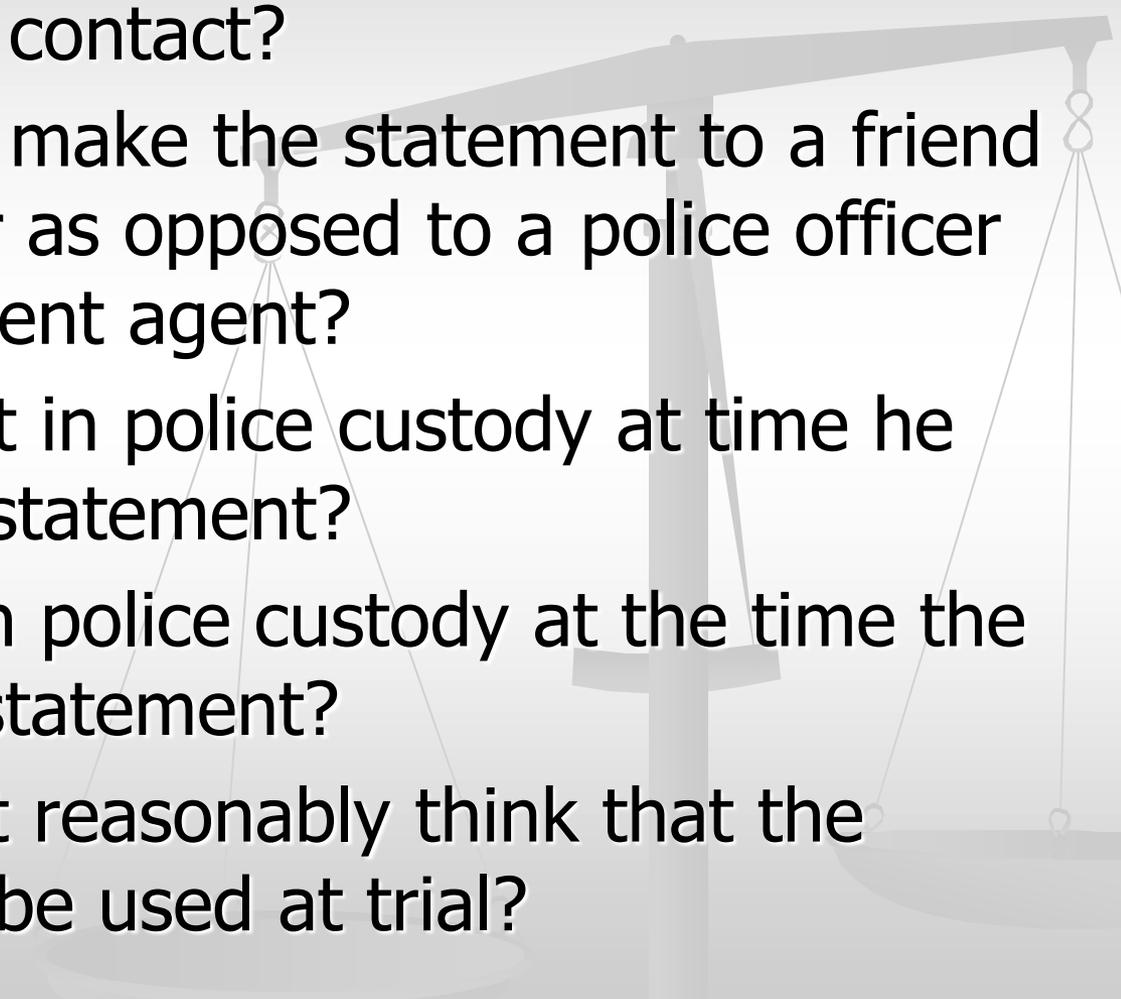
## 124 S. Ct. 1354 (March 8, 2004)



# Forfeiture by wrongdoing

- Defendant forfeits the right to object if victim is unavailable because of his actions, threats, intimidation, harassment.
- Intimidation happens in every case but how to prove it?

# 10 Years Later: Totality of the Circumstances



- Who initiated the contact?
- Did the declarant make the statement to a friend or family member as opposed to a police officer or other government agent?
- Was the declarant in police custody at time he or she made the statement?
- Was the abuser in police custody at the time the victim made the statement?
- Did the declarant reasonably think that the statement would be used at trial?

# 10 Year Later: Totality of the Circumstances

- Were the statements made in response to structured questioning or simply trying to determine if there was still an emergency or need for medical attention?
- What was the demeanor of the declarant?
- What was the goal of the statement – protection or prosecution?
- How much time has elapsed from the assault to the time of the statement?

# Witness Intimidation Book

**Witness Intimidation:  
Meeting the Challenge**

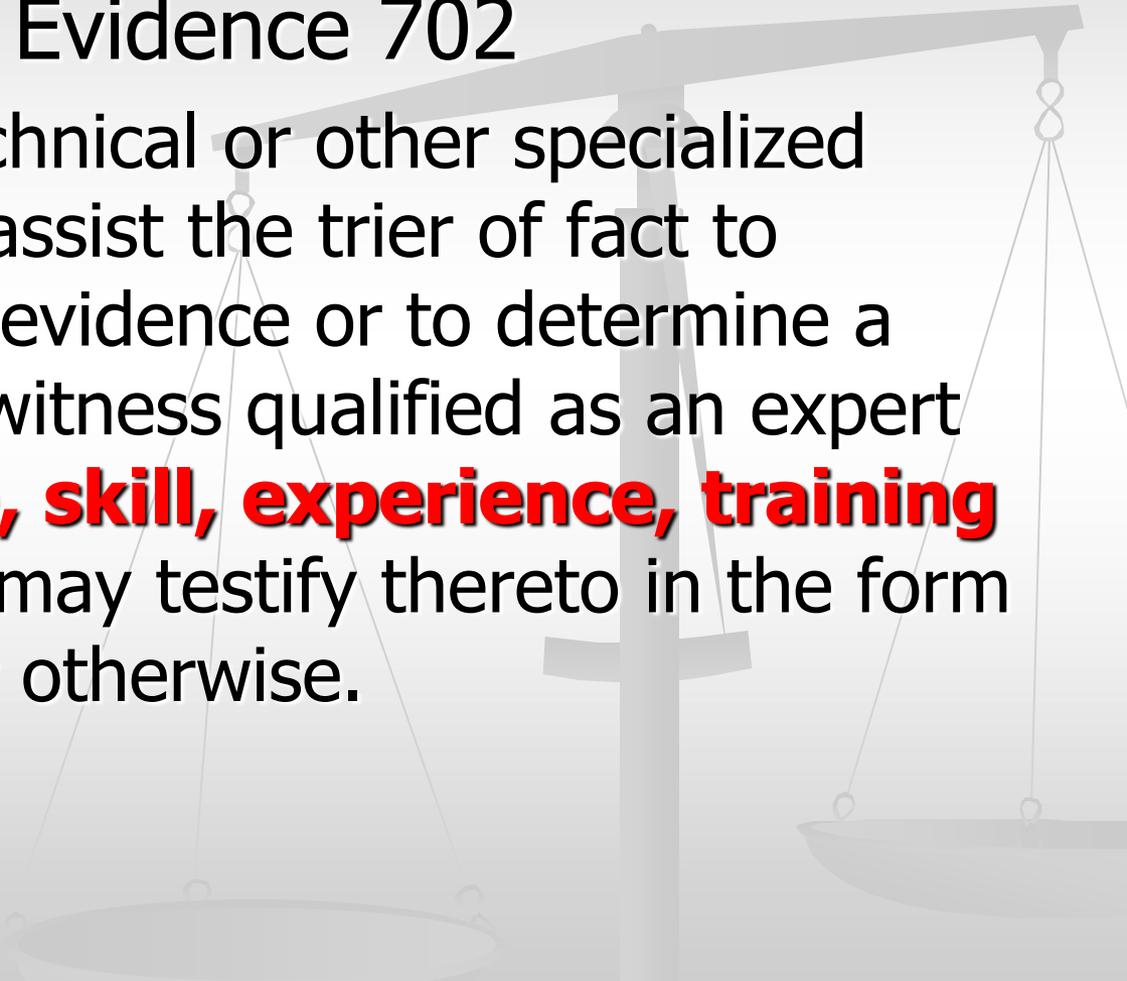


- Lessons learned from San Diego, CA; Knoxville, TN; and Duluth, MN
- Excellent Chapter on Trial Strategies
- Go to [www.aequitasresource.org](http://www.aequitasresource.org)

# The Use of Experts



# Expert Testimony

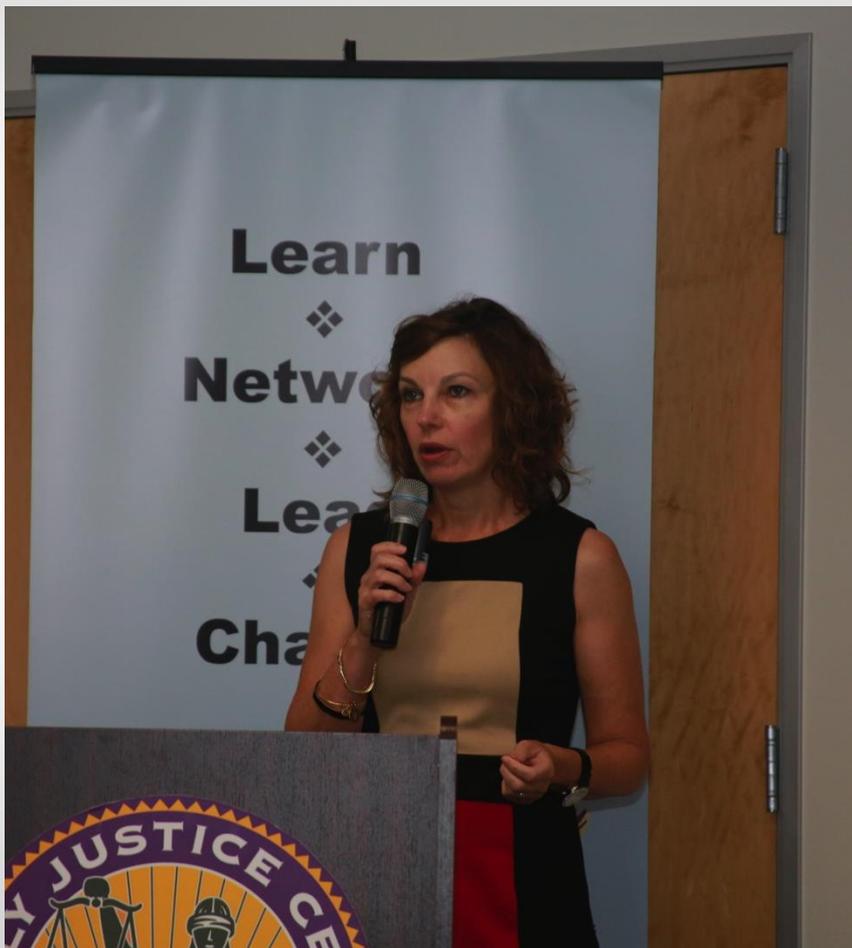


- Federal Rule of Evidence 702
  - “If scientific, technical or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert **by knowledge, skill, experience, training or education**, may testify thereto in the form of an opinion or otherwise.

# Developing your Local Expert

- Emergency room physician - Specialist
- Medical Examiner
- Certified Forensic Pathologist
- Forensic/SANE nurse
- Paramedic
- DV Detectives/Law enforcement officers
- YOU CAN BE AN EXPERT
- Adding Strangulation to DV Experts

# Jean Jordan's Transcript



1           IN THE SUPERIOR COURT OF THE STATE OF CALIFORNIA  
2                           IN AND FOR THE COUNTY OF YOLO  
3                           HON. TIMOTHY L. FALL, DEPARTMENT TWO  
4   --oOo--  
5  
6           PEOPLE OF THE STATE OF                            )  
          CALIFORNIA,    )  
7    Plaintiff.                            )  
8           vs.    )  
9           JESUS CISNEROS,                                    )  
10    Defendant.                            )  
11           \_\_\_\_\_

Case No 12-2423  
**COPY**

12    REPORTER'S TRANSCRIPT  
13    EXCERPT OF PROCEEDINGS

14    --oOo--  
15

# Investigator Mike Wallace Shasta District Attorney's Office

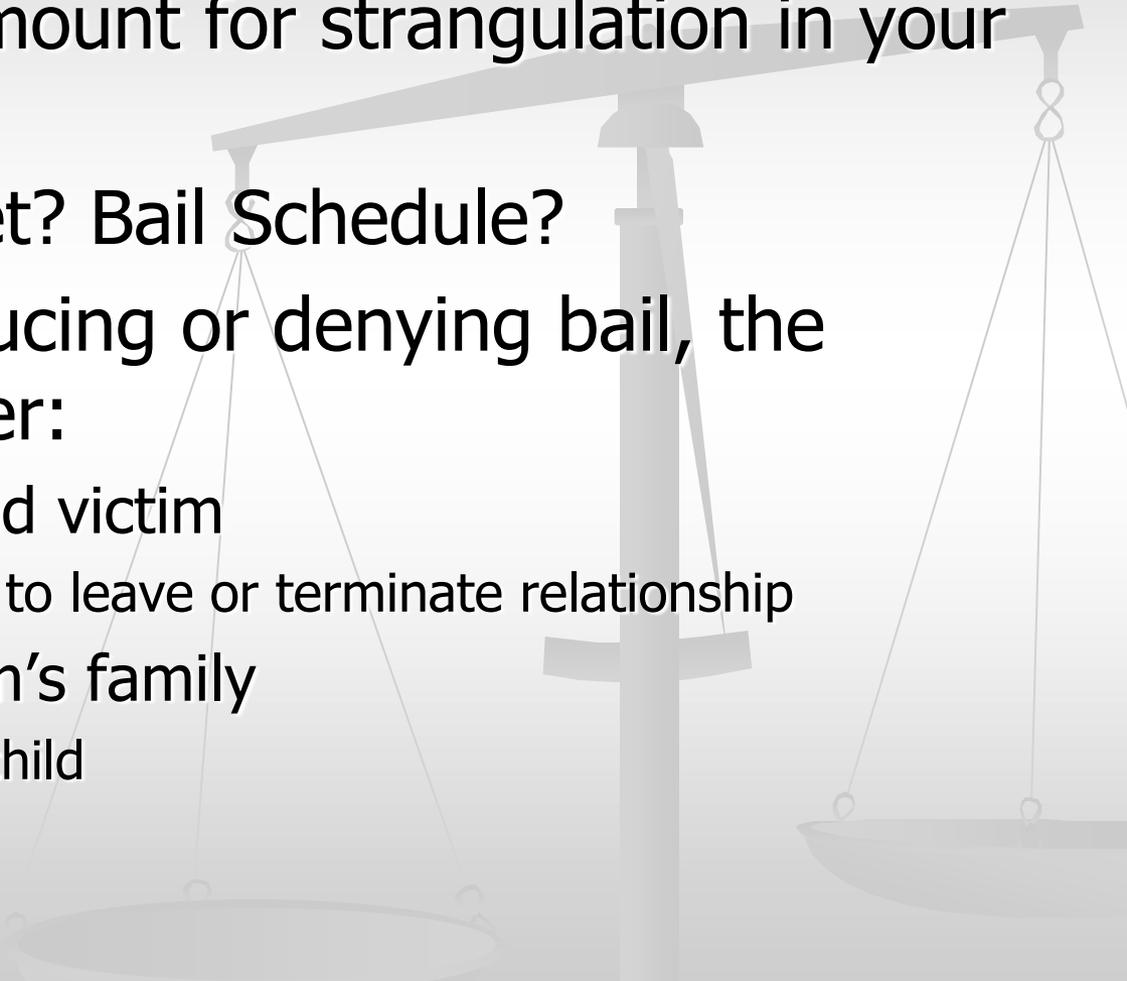


- Provided trainings to local professionals
- All DA Investigators and FJC Staff have watched on-line course
- Created a great sample CV
- Testified 4 times, subp'd 12; most plead guilty

# Other Legal Considerations



# Bail Considerations (California)



- What is the bail amount for strangulation in your state?
- How does it get set? Bail Schedule?
- When setting, reducing or denying bail, the court must consider:
  - Safety of public and victim
    - Attempts of victim to leave or terminate relationship
  - Safety of the victim's family
    - Including unborn child

# What Not to Do:



# Plea Bargains – The Courtroom is where Justice Keeps its Promise – Lt. Mark Wynn (ret.)

## Judge Refuses Plea Deal in Strangulation, Child Abuse Case

March 15, 2015 By Marie Albiges

WYDaily.com is your source for free news and information in Williamsburg, James City & York Counties.

A judge rejected a plea deal Friday for a 40-year-old man accused of **choking and assaulting teenager**.

The prosecutor and the defense attorney came to an agreement in which two felony charges against Henry Matthew Holland Jr. would be dropped in exchange for a guilty plea on one misdemeanor count of assault and battery.

The agreement would also allow the misdemeanor charge to be dropped without any sentence imposed as long as Holland followed the law for two years.



The Williamsburg-James City County Courthouse (staff photo)

# Sentencing – California Rules of Court 4.410

- Objectives:
  - Stop the violence
  - Protect the victim, children and family
  - Protect the general public
  - Hold the batterer accountable for the conduct
  - Provide restitution to the victim
  - Rehabilitate the batterer
  - Uphold legislative intent to treat domestic violence as a serious crime

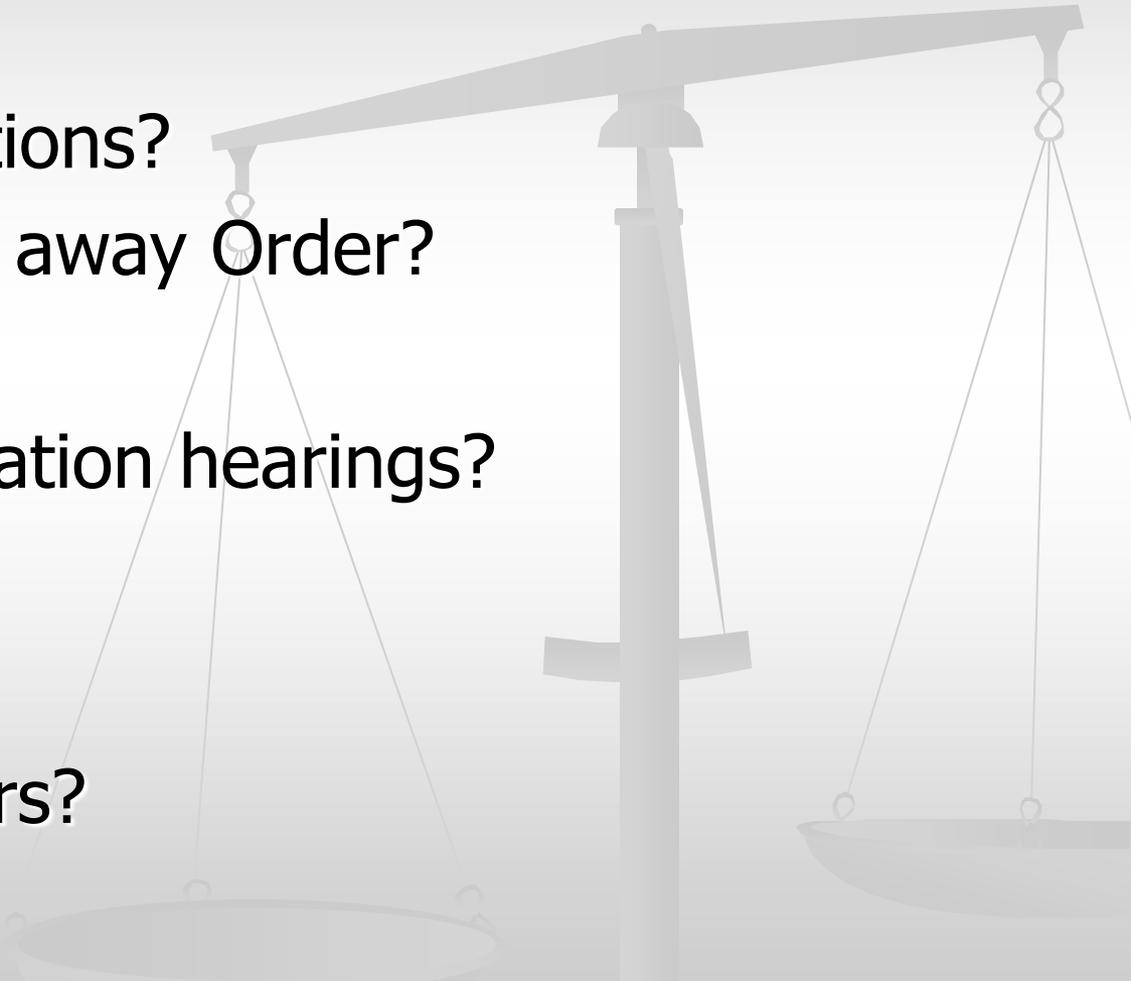
# Sentencing – California Rules of Court 4.410

- Considerations of the crime:
  - Viciousness and callousness
  - Use of weapon
  - Victim particularly vulnerable
  - Planning, sophistication or premeditation
  - Took advantage of position of trust or confidence to commit the offense

# New Federal Sentencing Guidelines

- Testimony and data also indicated that cases of strangulation and suffocation often involve other bodily injury to a victim separate from the strangulation and suffocation. Congress specifically addressed strangulation and suffocation in the domestic violence context, and testimony and data indicated that almost all cases involving this conduct occur in that context and that strangulation and suffocation is most harmful in such cases”
- 79FR25996, doc No. 2014-10264

# Key is Implementation



## ■ Criminal Cases

- Bail? Bail Conditions?
- Ordering a Stay away Order?
- Plea bargains?
- Probation revocation hearings?
- Sentencing?

## ■ Civil Cases

- Protection Orders?
- Child Custody?

# How to Find our Materials



# Handouts: How to Find Them

www.strangulationtraininginstitute.com

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## Training Institute on Strangulation Prevention

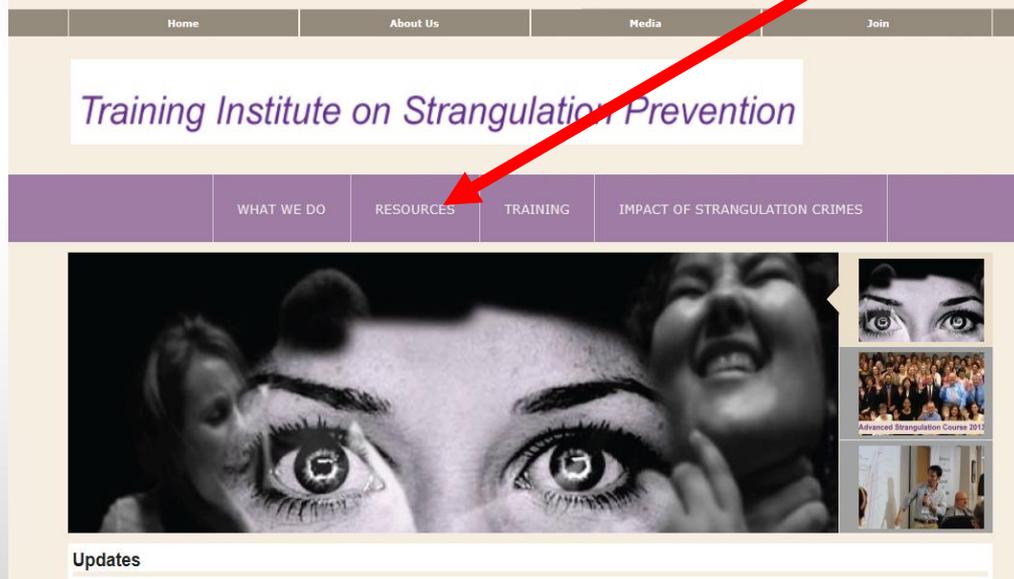
WHAT WE DO RESOURCES TRAINING IMPACT OF STRANGULATION CRIMES

Indian Country Strangulation & Suffocation Seminar - National Advocacy Center 2013

Advanced Strangulation Course 2013

# Download Course Materials

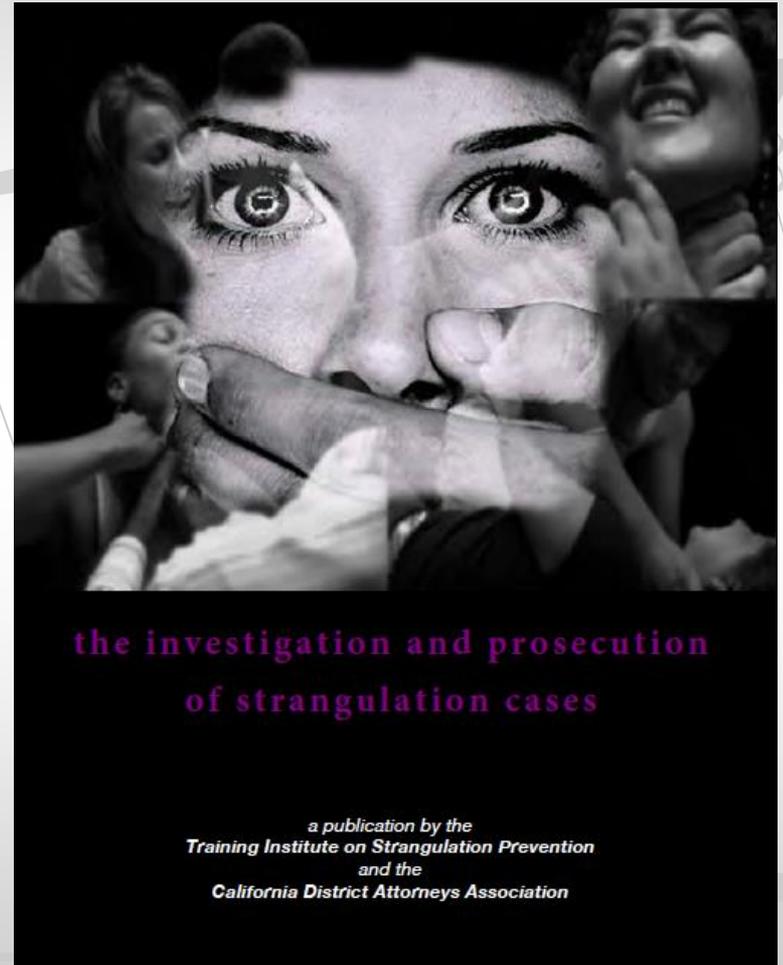
- From homepage, go to “Resources”
- Select “Library”
- Select “Basic Course Materials”
- Part II - All Things Legal - Florida Judicial Training – April 2015”



# Alliance Publishes New Manual in 2013!

## IPV Strangulation Crimes

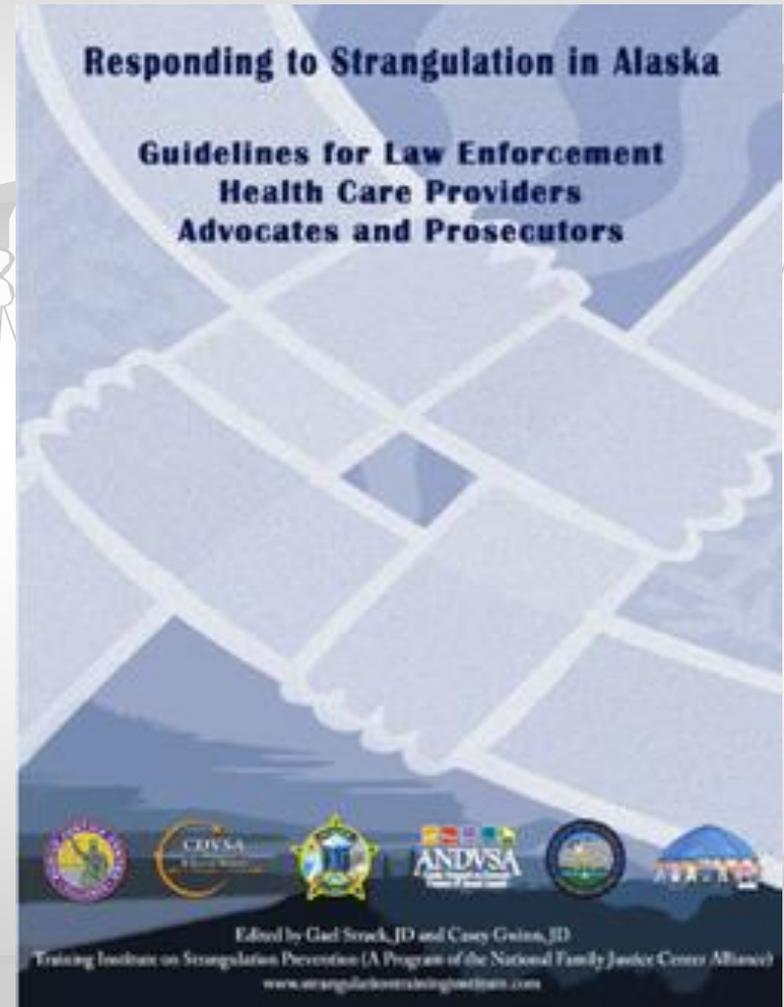
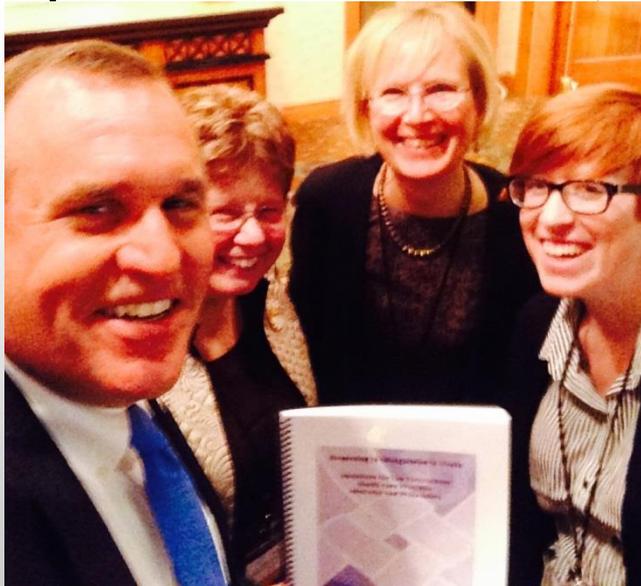
- IPV Strangulation Crimes Manual – Developed by the National Family Justice Center Alliance/Training Institute on Strangulation Prevention
- In Partnership with the California District Attorneys Association
- Manual includes chapters on advocacy, investigations, prosecution, and legislation, among other topics



# Alaska Strangulation Manual

## New Chapters

- Children
- Elders
- Community Based Advocacy



# Thank you Kelly Weisberg

## DOMESTIC VIOLENCE REPORT™

LAW • PREVENTION • PROTECTION • ENFORCEMENT • TREATMENT • HEALTH

Vol. 19, No. 6

ISSN 1086-1270

Pages 81 – 100

August/September 2014

### Strangulation and Domestic Violence: The Edge of Homicide

by Gael Strack, J.D. and Casey Gwinn, J.D.

In March 1995, as San Diego's coordinated community response to domestic violence was getting national attention with a 50% drop in domestic violence homicides since 1985, Sgt. Anne O'Dell, the founder of the Police Department's specialized Domestic Violence Unit, called us as the founders of the City Attorney's specialized Child Abuse/Domestic Violence Unit to question whether any of us were treating so called "choking" cases seriously. Her soul searching, and soon ours, came from the first two domestic violence homicides of 1995: two teenagers with small children who lost their lives after a history of domestic violence and reports of being "choked" by their boyfriends. The City Attorney or the District Attorney prosecuted none of the reported cases. And then both Casandra Stewart and Tamara Smith were murdered.

The deaths of Casandra Stewart and Tamara Smith triggered profound changes in San Diego and ultimately around the world, but such profound change started with Gael Strack going into the file room of the San Diego City Attorney's Child Abuse/Domestic Violence Unit and reviewing every case where

See *EDGE OF HOMICIDE*, page 90

### Law Reform Targets the Crime of Strangulation

by Casey Gwinn, J.D., Gael Strack, J.D., and Melissa Mack

*"Actually, when I came out of that [strangulation incident], I was more submissive—more terrified that the next time I might not come out—I might not make it. So I think I gave him all my power from there because I could see how easy it was for him to just take my life like he had given it to me."*

—Former San Diego Family Justice Center Client (2010)

Survivors of non-fatal strangulation have known for years what prosecutors and civil attorneys are only recently learning: Many domestic violence offenders and rapists do not strangle their partners to kill them; they strangle them to let them know they can kill them—any time they wish. Once victims know this truth, they live under the power and control of their abusers day in and day out. This complex reality creates challenges for prosecutors who have to decide whether to prosecute non-fatal strangulation cases

as attempted murders, serious felony assaults, or misdemeanors.

For many years in California and across the country, prosecutors have failed to treat non-fatal strangulation assaults as serious crimes, due to lack of physical evidence. Today, because of (1) involvement of the medical profession, (2) specialized training for police and prosecutors, and (3) ongoing research, strangulation has become a focus area for policymakers and professionals working to reduce intimate partner violence and sexual assault.

As of May 2014, 37 states and one territory (U.S. Virgin Islands) have passed strangulation laws that provide clear legislative definitions of the violent, life-threatening assault now properly referred to as "strangulation." One state, Utah, passed an "Intent of the Legislature" resolution, which made legislative findings to help

See *LAW REFORM*, next page

#### About This Issue . . .

We are delighted to present this special issue on Strangulation, a topic of great interest because of the importance of the issue today, particularly in light of the high lethality of these cases, the profound consequences for survivors, and the challenges for law enforcement. We are especially pleased that Gael Strack and Casey Gwinn are Guest Editors. These two former prosecutors are leading national experts on strangulation as well as founders of the Family Justice Center movement.

D. Kelly Weisberg, Editor, *Domestic Violence Report*

#### ALSO IN THIS ISSUE

Investigation and Prosecution of Strangulation Cases . . . . .	83
Men Who Strangle Women Also Kill Cops . . . . .	85
Summary of Recent Strangulation Case Law . . . . .	86
Why Didn't Someone Tell Me? The Consequences of Strangulation Assaults . . . . .	87

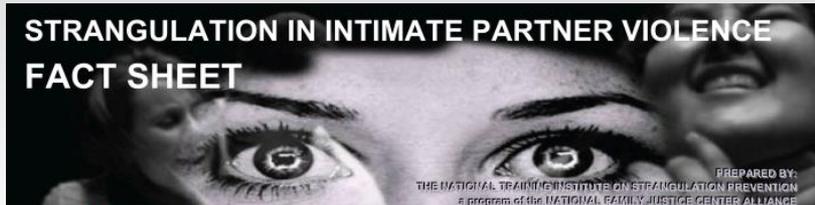


# Electronic Link to the Domestic Violence Report



<http://www.civicresearchinstitute.com/nfjca.html>

# New Alliance Fact Sheet



**1 in 4** women will experience intimate partner violence (IPV) in their lifetime.  
 Of women who experience IPV...  
**10% experience attempted strangulation by their partner.**



**Strangulation: the obstruction of blood vessels and/or airflow in the neck resulting in asphyxia.**



**Loss of consciousness can occur within 5-10 seconds.**

**Death within 4-5 minutes.**



**83%** Are strangled manually (with hands).



**12%** are strangled along with sexual assault/abuse. 9% are also pregnant.



**38%** report losing consciousness.



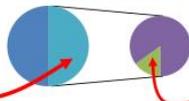
**97%** of strangulation attempts also involve blunt force trauma.

**And odds for homicide increase 6x**  
 for victims who have been previously strangled, compared to victims who have never been strangled.

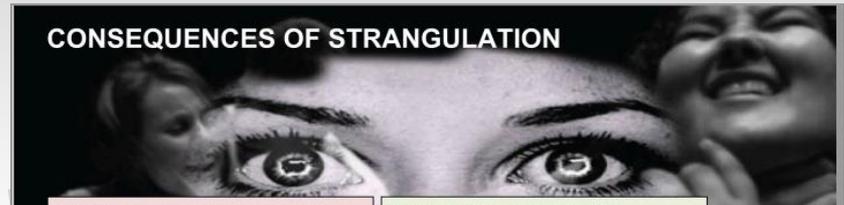
**HOWEVER...**

**Oftentimes, even in fatal cases, there is **no external evidence** of injury.**

Only half of victims have visible injuries



Of these, only 15% could be photographed



## PHYSICAL INJURY

death, unconsciousness, fractured trachea/larynx, internal bleeding (*hemorrhage*) and artery damage (*intimal tears*), dizziness, nausea, sore throat, voice changes, throat and lung injuries, swelling of the neck (*edema*),

## PSYCHOLOGICAL INJURY

PTSD, depression, suicidal ideation, memory problems, nightmares, anxiety, severe stress reaction, amnesia and psychosis

## NEUROLOGICAL INJURY

facial or eyelid droop (*palsies*), left or right side weakness (*hemiplegia*), loss of sensation, loss of memory, paralysis

## DELAYED FATALITY

death can occur days or weeks after the attack due to carotid artery dissection and respiratory complications such as pneumonia, ARDS and the risk of blood clots traveling to the brain (*embolization*).

**Today 38 states have legislation against strangulation.**



**WHERE DO YOU STAND ON STRANGULATION?**



707 Broadway, Suite 700  
 San Diego, CA 92101  
 1-888-511-3522  
[strangulationtraininginstitute.com](http://strangulationtraininginstitute.com)

# Training Bulletin for Judges – Judge Pendleton, Minnesota

MAY 5, 2014 TRAINING UPDATE 14-7

**MINNESOTA JUDICIAL TRAINING UPDATE**

**BAIL HEARINGS IN FELONY STRANGULATION CASES  
SEVEN (7) MEDICAL-LEGAL FACTS EVERY JUDGE SHOULD KNOW**

**QUESTION:** When making bail decisions in Felony Strangulation cases, what seven (7) well-established medical-legal facts should every judge (and attorney) be aware of?

**1. DEFINITION OF STRANGULATION:** Strangulation is a form of asphyxia (lack of oxygen) characterized by closure of the blood vessels and/or air passages of the neck as a result of external pressure on the neck.

**2. WIDESPREAD LACK OF UNDERSTANDING:**

- Many judicial officers and attorneys do not understand the medical and psychological severity of the act of strangulation.
- In many cases, the lack of observable physical injuries to the victim cause judges to minimize the seriousness of strangulation.
- In order to make sure judges understand the seriousness of strangulation, some prosecutors have asked courts for permission to have an expert in the field of strangulation testify at bail hearings as to the following: see 3-7 below.

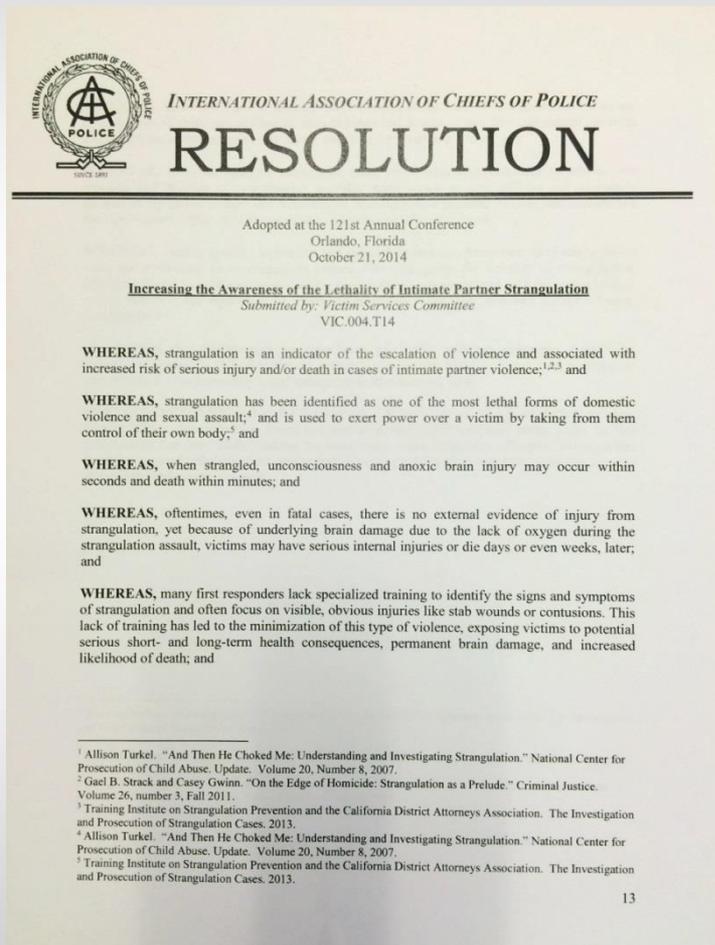
**3. STRANGULATION IS ONE OF THE MOST LETHAL FORMS OF VIOLENCE USED BY MEN AGAINST THEIR FEMALE INTIMATE PARTNERS:**

- The act of strangulation symbolizes an abuser's power and control over the victim. The sensation of suffocating can be terrifying.
- Most victims of strangulation are female.
- The victim is completely overwhelmed by the abuser; she vigorously struggles for air, and is at the mercy of the abuser for her life.
- The victim will likely go through four stages: denial, realization, primal and resignation.
- A single traumatic experience of strangulation or the threat of it may instill such intense fear that the victim can get trapped in a pattern of control by the abuser and made vulnerable to further abuse.

Hon. Alan F. Pendleton, Anoka County District Court, Anoka, MN 55303; 763-422-7309



# IACP Resolution 2014



- Increasing Awareness of the Lethality of Intimate Partner Violence
- Strangulation is a felony or attempted homicide
- Support training, documentation forms, legislation and MDT

# Free On Line Training for the First Responder – or ANYONE!

Home About Us Media Join

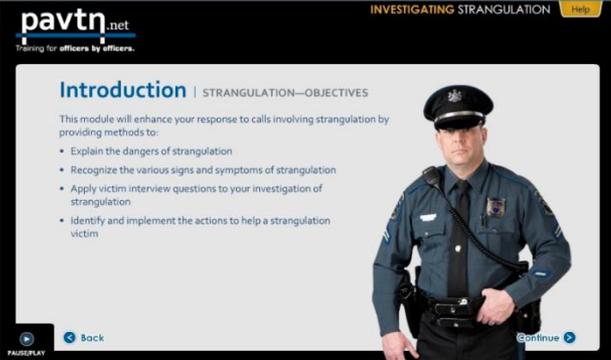
## Training Institute on Strangulation Prevention

WHAT WE DO RESOURCES TRAINING IMPACT OF STRANGULATION CRIMES

### Training

- Upcoming and Recent Trainings
- Online Strangulation Training**
- Training Tracker

### INVESTIGATING STRANGULATION TRAINING



**To view the Investigating Strangulation Course, click [here](#).**

**To take the Investigating Strangulation test, click [here](#).**

*Thanks to pavtn.net for providing this training.*

# DVD on Strangulation

[www.familyjusticecenter.org](http://www.familyjusticecenter.org)

SPECIAL DVD-ROM SET

**Visit Our STORE!**

**Dream Big**  
Hope for Hearting Families

*a simple, complicated idea to stop family violence*

**Casey Gwinn**  
with **Gael Strack**

How to Start a Family Justice Center in Your Community

**Featured Product**

**Strangulation:**  
WHAT WE HAVE LEARNED

# Upcoming August Institute

**Save the Date!**

**For the next Advanced Strangulation Course  
August 4-7, 2015  
San Diego, CA  
More details to follow soon.**



**The Advanced Strangulation Course - San Diego, August 2014**



# The Challenge for the Nation

# Thank You

In memory of Casondra Stewart & Tamara Smith





Casey Gwinn, JD  
President  
Family Justice Center Alliance  
Phone: (888) 511-3522  
[Casey@nfjca.org](mailto:Casey@nfjca.org)

---

Casey Gwinn, J.D. serves as the President of the National Family Justice Center Alliance. Casey has been recognized by *The American Lawyer* magazine as one of the top 45 public lawyers in America.

Casey served for eight years as the elected City Attorney of San Diego from 1996 to 2004. Prior to entering elected office, Casey founded City Attorney's Child Abuse and Domestic Violence Unit, leading the Unit from 1986 to 1996 – prosecuting both misdemeanor and felony cases. In 1993, the National Council of Juvenile and Family Court Judges recognized his Child Abuse/Domestic Violence Unit as the model domestic violence prosecution unit in the nation. During Casey's tenure, the Unit's work was honored for playing a major role in the 90 percent drop in domestic violence homicides in the City of San Diego over the last twenty years. San Diego now has the lowest domestic violence homicide rate of any major city in the nation. In 1986, Casey co-founded the San Diego Task Force on Domestic Violence. In 1991, he founded the San Diego Domestic Violence Council.

In 2002, Casey saw his vision of a comprehensive, "one stop shop" for services to victims of family violence become a reality in San Diego. In partnership with former San Diego Police Chief David Bejarano and current Chief Bill Lansdowne, he led the effort to open the nationally acclaimed San Diego Family Justice Center. The Family Justice Center opened its doors in downtown San Diego on October 10, 2002.

In January, 2003, Casey and the San Diego Family Justice Center were profiled on the Oprah Winfrey Show as leading the way for other communities in its coordinated approach to co-locating services for victims of domestic violence, child abuse, elder abuse, and sexual assault. In October, 2003, President George W. Bush announced a national initiative to begin creating Family Justice Centers across the country and asked Casey to provide leadership to the effort. Casey currently oversees a national technical assistance team that supports all existing and developing Family Justice Centers in the United States and around the world, speaks in communities across America, and provides leadership to the YWCA of San Diego County.

Casey also serves on the Board of the YWCA of San Diego County which manages the Becky's House shelter, transitional, and affordable housing programs for victims of

domestic violence and their children and programs for homeless women and families, legal services for domestic violence victims, after school programs, a city school for children housed in shelter, and other social service and support programs for women and children. He is currently focused on assisting in redeveloping the YWCA's historic downtown building at 10th and C to create a unique 55,000 square foot building full of services for women, children, and families.

Casey has served on the U.S. Attorney General's National Advisory Committee on Violence Against Women and the American Bar Association Commission on Domestic Violence. He chaired the California Attorney General's Task Force on Domestic Violence (See the report at [www.safestart.org](http://www.safestart.org)). He also served on the congressionally created Department of Defense task force, studying the handling of family violence throughout the Department of Defense. He has authored a host of articles on domestic violence and has authored two books on the Family Justice Center movement and co-authored two more. The first book entitled "Hope for Hurting Families" calls for the creation of Family Justice Centers across America to help hurting and violent families. His second book, co-authored with Gael Strack, was released in April 2007, "Hope for Hurting Families II: How to Start a Family Justice Center in Your Community." The first two books are available at [www.familyjusticecenter.org](http://www.familyjusticecenter.org). Gael and Casey authored a third on-line book, published in Arabic, focused on developing co-located service centers in the Middle East ([www.familyjusticecenter.org/ebook](http://www.familyjusticecenter.org/ebook)). Casey's newest book, "Dream Big: A Simple, Complicated Idea to Stop Family Violence" was published in 2010 by Wheatmark and is available at [www.amazon.com](http://www.amazon.com) and many other retail outlets.

Casey has received many local and national awards, including the L. Anthony Sutin Civic Imagination Finalist Award, Stephen L. Lewis Lecturer of Merit Award from the National College of District Attorneys, the San Diego Domestic Violence Council's Lifetime Achievement Award, the Women's International Living Legacy Award, the Men's Leadership Forum Hometown Hero Award, Sharp Healthcare's Excellence in Education Award, the San Diego Press Club's Diogenes Award, the San Diego Mediation Center's Peacemaker Award, the San Diego Ecumenical Council's Christian Unity Award, Lifetime Television's Times Square Salute Award, Advocate of the Year Award presented on Disability Independence Day from the disabled community in San Diego, the California Peace Prize from the California Wellness Foundation, New York's Abely Award for Leading Women and Children to Safety, and the Avon Foundation's Community Advocate of the Year Award.

One of Casey's great personal passions is Camp HOPE, the unique camping initiative he founded at the San Diego Family Justice Center. Camp HOPE is the first specialized camp in America focused exclusively on children exposed to domestic violence.

Casey and his wife, Beth, have three grown children: Kelly; Karianne; and Chris.

Casey is an honors graduate of Stanford University and UCLA School of Law.



**U.S. Department of Justice**

Criminal Division

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*Office of Policy and Legislation*

*Washington, D.C. 20530*

March 6, 2014

The Honorable Patti B. Saris, Chair  
United States Sentencing Commission  
One Columbus Circle, NE  
Suite 2-500, South Lobby  
Washington, DC 20002-8002

Dear Chief Judge Saris:

On behalf of the U.S. Department of Justice, we submit the following comments regarding the proposed amendments to the federal sentencing guidelines and issues for comment published in the Federal Register on January 17, 2014. We thank the members and staff of the Commission for being responsive to many of the Department's sentencing policy priorities this amendment year and for working hard to address all of the guideline issues under consideration. We look forward to continuing our work with the Commission during the remainder of the amendment year on all of the published amendment proposals.

\* \* \*

**TABLE OF CONTENTS**

<b><u>Proposed Amendment</u></b>	<b><u>Page No.</u></b>
1. Circuit Conflict Involving the Interpretation of §1B1.10.....	- 3 -
2. Implementation of the Violence Against Women Reauthorization Act.....	- 5 -
3. Sentencing Policy for Drug Trafficking Offenses .....	- 16 -
4. Circuit Conflict Involving Felon in Possession Offenses.....	- 21 -
5. Alien Smuggling in Dangerous Locations.....	- 23 -
6. Circuit Conflict Involving Supervised Release Terms .....	- 25 -
7. Cases Involving An Undischarged Term of Imprisonment.....	- 27 -

**U.S. DEPARTMENT OF JUSTICE VIEWS ON THE PROPOSED AMENDMENTS TO  
THE FEDERAL SENTENCING GUIDELINES AND ISSUES FOR COMMENT  
PUBLISHED BY THE U.S. SENTENCING COMMISSION IN THE FEDERAL  
REGISTER ON JANUARY 17, 2014.**

**1. Circuit Conflict Involving the Interpretation of §1B1.10**

The Sentencing Commission proposes two options for resolving two separate circuit conflicts relating to proceedings under 18 U.S.C. § 3582(c) when the defendant was convicted of an offense carrying a mandatory minimum sentence but nonetheless received a sentence below the mandatory minimum at the original sentencing after providing substantial assistance to the government in the investigation or prosecution of another person.<sup>1</sup> As the Commission is well aware, there have been many such § 3582(c) proceedings following the retroactive application of the guideline amendments implementing the Fair Sentencing Act.<sup>2</sup>

Section 1B1.10(b)(2)(B) provides that in applying a retroactive guideline amendment reducing an applicable guideline range, a defendant who originally received a reduced sentence by virtue of substantial assistance may be given a further reduced sentence comparably lower than the *amended guideline range*.<sup>3</sup> This makes good sense as a policy because it allows for proportionate decreases reflecting an important mitigating factor, namely providing substantial assistance. Two circuit splits, though, have emerged over what is the *amended guideline range* in different circumstances. The differing interpretations stem from differing views over the operation of §5G1.1(b), which specifies that a mandatory minimum sentence trumps an otherwise applicable guideline range if the top of the range falls below the mandatory minimum.<sup>4</sup>

We appreciate the Commission's willingness to resolve these circuit conflicts. In our view, either solution, Option 1 or Option 2, will improve the current situation by resolving the conflict. We believe Option 1, though, which permits a defendant whose amended §2D1.1 range

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<sup>1</sup> Proposed Amendments to the Sentencing Guidelines, Amendment 1B1.10, January 17, 2014, available at [http://www.ussc.gov/Legal/Amendments/Reader-Friendly/20140114\\_RFP\\_Amendments.pdf](http://www.ussc.gov/Legal/Amendments/Reader-Friendly/20140114_RFP_Amendments.pdf).

<sup>2</sup> Amendment 759 applied Amendment 750, which reduced sentences for certain crack cocaine offenses pursuant to the Fair Sentencing Act of 2010, retroactively. USSG Appendix C, Vol III, 416, available at [http://www.ussc.gov/Guidelines/2013\\_Guidelines/Manual\\_PDF/Appendix\\_C\\_Vol\\_III.pdf](http://www.ussc.gov/Guidelines/2013_Guidelines/Manual_PDF/Appendix_C_Vol_III.pdf).

<sup>3</sup> USSG §1B1.10(b)(2)(B): "If the term of imprisonment imposed was less than the term of imprisonment provided by the guideline range applicable to the defendant at the time of sentencing pursuant to a government motion to reflect the defendant's substantial assistance to authorities, a reduction comparably less than the amended guideline range determined under subdivision (1) of this subsection may be appropriate."

<sup>4</sup> "Where a statutorily required minimum sentence is greater than the maximum of the applicable guideline range, the statutorily required minimum sentence shall be the guideline sentence." USSG §5G1.1(b).

falls below a mandatory minimum sentence to receive a proportionate sentence reduction notwithstanding the “trumping” mechanisms of Chapter 5, Part G, is the better choice.

In our view, the guidelines as amended in 2011 clearly foreclosed this better result, and cases such as the Third Circuit’s decision in *Savani* strained to find ambiguity in the guideline application rules.<sup>5</sup> Nonetheless, the sentiment and policy underlying those decisions has persuasive weight: that a defendant who provided substantial assistance is entitled to consideration for a reduced sentence from the applicable guideline range without respect to any mandatory minimum.

The correct application of sentencing law requires a district court that has granted a § 3553(e) motion for a reduced sentence to consider the properly calculated §2D1.1 range when determining the appropriate sentence. We think the court should do the same when the range is reduced pursuant to a retroactively applied guideline. Allowing relief with reference to the applicable guideline range in substantial assistance cases is consistent with the general policy embodied in §1B1.10, as adopted in 2011, that prohibits a reduction below the amended guideline range – even if the original sentence was lower due to a departure or variance – but provides an exception allowing a reduction below the amended guideline range proportionate to a substantial assistance departure previously granted to the defendant. That exception recognizes the propriety of assuring a benefit for substantial assistance to achieve appropriate proportionality.

While the courts have struggled with interpreting the *amended guideline range* as defined under provisions of the current guidelines, we believe the correct policy is fairly clear and the guidelines should be amended to reflect that policy. All of the applicable cases involve defendants who have provided substantial assistance in the investigation of another. As such, under § 3553(e), those defendants are not subject to any mandatory minimum, regardless of the instructions for, and order of, application of the Guidelines Manual. Putting aside those existing instructions, the correct policy – for proportionality reasons and to properly account for substantial assistance – is to permit a reduction from the applicable guideline range without regard to any mandatory minimum (*since the defendant is not subject to any mandatory minimum*) to reflect the assistance provided in relation to the defendant’s individual culpability. To do otherwise will leave some substantial assistance unaccounted for and create unwarranted disparities in sentencing. **We think Option 1 reflects that better policy and should be adopted.**

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<sup>5</sup> *United States v. Savani*, 733 F.3d 56, 66–7 (3<sup>rd</sup> Cir. 2011).

## **2. Implementation of the Violence Against Women Reauthorization Act**

President Obama signed the Violence Against Women Reauthorization Act of 2013 (“VAWA 2013”) into law on March 7<sup>th</sup>, 2013, marking a historic day in our nation’s effort to reduce domestic and sexual violence. The Act reauthorizes and expands successful programs that address violence against women across the country, includes important new law enforcement authorities, and through various provisions, defends the rights of all victims and survivors of domestic and sexual violence.

Because of the nature of federal jurisdiction, the federal criminal justice system’s role in fighting violence against women is focused significantly in Indian Country.<sup>6</sup> Both Congress and the Justice Department recognize that violence against Native women has reached epidemic rates. Recently, a Centers for Disease Control and Prevention survey found that 46 percent of Native American women have experienced rape, physical violence, and/or stalking by an intimate partner in their lifetime. VAWA 2013 closes jurisdictional gaps that had long compromised American Indian women’s safety and access to justice.

To give the Commission some context related to its work on the guidelines for domestic and sexual violence, we first lay out some of the Department’s ongoing efforts to ensure public safety in Indian Country and specifically to address domestic and sexual violence. We then address the guideline issues facing the Commission in implementing the new law nationwide.

### **I. Making Native America Safer**

The Justice Department has long been concerned about the high rate of crime occurring in Indian Country – in particular the high rate of violence against women – and this Administration has launched focused initiatives alongside our tribal law enforcement partners to stem this tide. Since 2009, the Department has pursued an aggressive strategy consisting of law enforcement action, prosecution, grant funding, training, technical support, and collaboration with tribal partners that is showing some genuine success. For example, the Department’s renewed commitment to the vigorous prosecution of federal crimes in Indian Country has resulted in a more than 50 percent increase in the number of Indian Country prosecutions by United States Attorney’s Offices nationwide over the past four years. We recognize, though, that an increase in federal arrests and convictions alone cannot solve the public safety challenges on the reservations. That is why we have augmented our enhanced law enforcement focus with critical support for tribal criminal justice institutions.

#### **A. Establishing Unprecedented Levels of Cooperation**

Improving public safety in Indian Country poses unique challenges because of geography, varying tribal cultures, and many other factors. These challenges demand the use of

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<sup>6</sup> “Indian Country” is the legal term used to describe reservations and other lands set aside for Indian use, such as Indian allotments and lands held in trust for Indians or Indian tribes. 18 U.S.C. § 1151.

all existing authorities to strengthen capacity at every level of the criminal justice system through close cooperative ties between federal, state, local, and tribal governments and between governments and the community.

Since taking office, Attorney General Holder has consistently emphasized that combating violent crime in Indian Country and fostering safe communities is a top priority of the Department of Justice. In early 2010, each United States Attorney's Office with responsibilities in Indian Country was required to draft and implement a district-specific operational plan to formalize its strategy for consulting and working with tribal, state, and local law enforcement, prosecutors, and other leaders, to improve public safety in Indian Country. For example, beginning in 2010, United States Attorney for the District of Montana Mike Cotter began convening bi-monthly meetings with the federal prosecutors assigned to each reservation, the tribal prosecutors for the reservation, and tribal and federal law enforcement officers. During these meetings, cases arising on a particular reservation during the preceding two-week period are discussed, and a joint decision is made concerning which jurisdiction – federal or tribal or both – will prosecute a particular case. This close communication ensures that serious Indian Country crimes are appropriately investigated and that the decision as to whether a matter will be charged in federal court or tribal court is fully informed.

Nationwide, federal Indian Country caseloads have increased from 1,091 criminal cases filed in fiscal year (FY) 2009, to 1,138 in FY 2010, to 1,547 in FY 2011, and to 1,677 in FY 2012.<sup>7</sup> These results are the product of the Department's renewed focus on leveraging partnerships with tribal, local, state, and federal partners to address violent crime. In North Dakota, the operational plan and anti-violence strategy developed by United States Attorney Tim Purdon combine enhanced enforcement of federal criminal laws and greater collaboration with support for viable crime prevention programs and efforts to build a sustainable offender reentry program. The plan has been in place for almost three years and has resulted in unprecedented levels of communication and collaboration between the U.S. Attorney's Office and the tribes in North Dakota as well as a large increase in the number of Indian Country prosecutions by the U.S. Attorney's Office.

Also contributing to the increase in prosecutions is the Department's enhanced Tribal Special Assistant U.S. Attorney (SAUSA) program. Tribal SAUSAs are tribal prosecutors who are "cross-deputized" and able to prosecute crimes in both tribal court and federal court as appropriate. These Tribal SAUSAs are able to strengthen tribal governments' role in fighting Indian Country crime and improve U.S. Attorney coordination with tribal law enforcement personnel.

In 2012, the Office on Violence Against Women augmented the existing Tribal SAUSA program through awards to four tribes in Nebraska, New Mexico, Montana, North Dakota, and South Dakota. The goal of the Tribal SAUSA program is for every prosecutable crime of

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<sup>7</sup>See *Indian Country Investigation and Prosecution Report (ICIP) for Calendar Years (CYs) 2011 and 2012* at [www.justice.gov/tribal/tloa-report-cy-2011-2012.pdf](http://www.justice.gov/tribal/tloa-report-cy-2011-2012.pdf).

intimate partner violence to be pursued in federal court, tribal court, or both. This program has shown promising and tangible results.<sup>8</sup>

The work of Tribal SAUSAs can also help to accelerate implementation of the Tribal Law and Order Act of 2010 by addressing the broader need for skilled, committed prosecutors, be they AUSAs or Tribal SAUSAs, working on the ground in Indian Country. Recognizing the potential and importance of ensuring adequate staffing, Attorney General Holder announced in November the creation of a new fellowship within the Attorney General's Honors Program – the Attorney General's Indian Country Fellowship – to inspire and train the next generation of prosecutors to serve in Indian Country. This fellowship will create opportunities for highly qualified law school graduates to spend three years working on Indian Country cases, primarily in U.S. Attorneys' Offices, developing a pool of attorneys with deep experience in Federal Indian law, tribal law, and Indian Country issues.

Our efforts to increase collaboration and communication between U.S. Attorney's Offices and our tribal partners have also strengthened the bond of trust between federal and tribal investigators, prosecutors, other criminal justice personnel, and localities and have made Indian Country communities safer as a result. In an effort to move forward the government-to-government relationships between the Department and sovereign tribes even more, the Department is in the process of adopting a new Statement of Principles to guide all of the actions we take in working with federally-recognized Indian tribes. This proposed Statement will codify our determination to serve as a partner in fighting crime and enforcing the law in Indian Country. It will also memorialize our commitment to Indian tribes, serving as a blueprint for reinforcing relationships, reforming the criminal justice system and aggressively enforcing federal criminal laws and civil rights protections.

The Statement of Principles will be meaningful only to the extent that it is crafted in consultation with tribal leaders. In order to gain the benefit of their insights, expertise, goals, and aspirations, we have posted the document on our website<sup>9</sup> and have shared it directly with the leaders of all 566 federally-recognized tribes. We plan to hold consultations with tribal leaders over the next several months so that we are in a position to finalize and publish the Statement this year and in doing so, establish a set of core principles by which we can chart our future course.

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<sup>8</sup> This past November in the District of North Dakota, non-Indian Tracy Peters was convicted of assaulting a Native woman with whom he had a relationship on the Standing Rock Sioux reservation. In *U.S. v. Marcus Flying Horse*, an enrolled member of the Standing Rock Sioux reservation and a repeat domestic-abuse offender was sentenced to two years and three months in federal prison, followed by three years of supervised release, for assault by a habitual offender. Both of these cases were prosecuted by a Tribal SAUSA working in partnership with the United States Attorney's Office.

<sup>9</sup> <http://www.justice.gov/tribal/>

## B. Combating Domestic Violence

The fight against domestic violence in Indian Country has been an especially important priority for the Department of Justice. VAWA 2013 strengthens federal domestic violence offenses and the federal assault statute – a statute frequently used in Indian Country intimate-partner violence crimes. It also contributes to tribal self-determination by recognizing that tribes have full civil jurisdiction to issue and enforce protection orders involving any person – Indian or non-Indian – in matters arising anywhere in Indian Country or otherwise within the tribe’s authority. These provisions were first proposed and have long been championed by the Department.

VAWA 2013 represents a historic step forward for tribal sovereignty and jurisdiction. It recognizes the tribes’ inherent power to exercise “special domestic violence criminal jurisdiction” over those who commit acts of domestic violence or dating violence or violate certain protection orders in Indian Country, regardless of their Indian or non-Indian status. While this jurisdictional provision of the new law takes effect on March 7, 2015, VAWA 2013 also authorizes a voluntary “Pilot Project” to allow tribes to begin exercising this jurisdiction sooner. Just last month, the Associate Attorney General granted three tribes’ Pilot Project requests, and they will soon begin exercising this criminal jurisdiction. We look forward to continuing to assist these and other tribes with the implementation of this important law.

### II. Implementing VAWA 2013 in the Sentencing Guidelines

The two primary statutes governing federal criminal jurisdiction in Indian Country are 18 U.S.C. §§ 1152 and 1153. Section 1153, known as the Major Crimes Act, gives the federal government jurisdiction to prosecute certain enumerated offenses, such as murder, manslaughter, rape, aggravated assault, and child sexual abuse, when they are committed by Indians in Indian Country. Section 1152, known as the General Crimes Act, gives the federal government jurisdiction to prosecute all crimes committed by non-Indians against Indian victims in Indian Country. Section 1152 also grants the federal government jurisdiction to prosecute some crimes by Indians against non-Indians, although that jurisdiction is shared with tribes, and provides that the federal government may not prosecute an Indian who has been punished by the local tribe. To protect tribal self-government, section 1152 specifically excludes non-major crimes between Indians, which fall under exclusive tribal jurisdiction. The federal government also has jurisdiction to prosecute federal crimes of general application, such as drug and financial crimes, when they occur in Indian Country, unless a specific treaty or statutory provision provides otherwise. Certain domestic violence and stalking offenses, commonly referred to as “the Violence Against Women Act Crimes” (18 U.S.C. §§ 2261-2265A), are also crimes of general application. This means that the status of the defendant and victim as Indian or non-Indian is irrelevant. U.S. Attorney’s Offices can prosecute these felony domestic violence and stalking crimes when committed in Indian Country if the statutory elements are met. On a limited number of reservations, the federal criminal responsibilities under sections 1152 and 1153 have

been ceded to the States under “Public Law 280” or other federal laws.<sup>10</sup> The federal assault statute (18 U.S.C. § 113) is used for prosecuting cases of domestic and sexual violence where there is federal jurisdiction pursuant to either the Major Crimes Act or the General Crimes Act. Therefore, any changes made to the sentencing guidelines for either §2A2.2 (Aggravated Assault) or §2A2.3 (Minor Assault) will apply to both Indian and non-Indian defendants.

#### A. Proposed Changes to §2A2.2, Aggravated Assault

Law enforcement is only recently learning what survivors of non-fatal strangulation have known for years: “Many domestic violence offenders and rapists do not strangle their partners to kill them; they strangle them to let them know they can kill them – any time they wish.”<sup>11</sup> There are clear reasons why strangulation assaults, particularly in an intimate partner relationship, should be a separate felony offense and taken extremely seriously at sentencing:

- Strangulation is more common than was once realized. Recent studies have shown that 34 percent of abused pregnant women reported being “choked.”<sup>12</sup> In another study, 47 percent of female domestic violence victims reported being “choked.”<sup>13</sup>
- Victims of multiple non-fatal strangulations “who had experienced more than one strangulation attack, on separate occasions, by the same abuser, reported neck and throat injuries, neurologic disorders and psychological disorders with increased frequency.”<sup>14</sup>
- Almost half of all domestic violence homicide victims have experienced at least one episode of strangulation prior to a lethal or near-lethal violent incident. Victims of one episode of strangulation are over six times more likely to be a victim of attempted

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<sup>10</sup> Federal jurisdiction was ceded under Public Law 83-280, 18 U.S.C. § 1162, which required six states to assume jurisdiction over Indian Country crimes and divested the federal government of jurisdiction to prosecute under the Major and General Crimes Acts in those areas. The Act also gave other states the option to assume that jurisdiction. Congress has also passed a variety of tribe-specific statutes providing for a similar framework of state jurisdiction over crimes in those locations. The federal government retains jurisdiction to prosecute generally applicable offenses in P.L. 83-280 areas.

<sup>11</sup> Casey Gwinn, *Strangulation and the Law*, in *THE INVESTIGATION AND PROSECUTION OF STRANGULATION CASES*, 5, 5 (Training Inst. on Strangulation Prevention & Cal. Dist. Att’ys Assoc. eds. 2013).

<sup>12</sup> Linda Bullock, et al., *Abuse Disclosure in Privately and Medicaid Funded Pregnant Women*, 51 *JOURNAL OF MIDWIFERY & WOMEN’S HEALTH*, 361, 366 (2006).

<sup>13</sup> Carolyn Block, *The Chicago Women’s Health Risk Study: Risk of Serious Injury or Death in Intimate Violence, A Collaborative Research Project 236*, (Illinois Criminal Justice Information Authority ed.) (2000).

<sup>14</sup> Donald J. Smith, Jr. et al., *Frequency and Relationship of Reported Symptomology in Victims of Intimate Partner Violence: The Effect of Multiple Strangulation Attack*, 21 *J. EMERGENCY MED.* 323, 325-26 (2001).

homicide by the same partner, and are over seven times more likely of becoming a homicide victim at the hands of the same partner.<sup>15</sup>

- Even given the lethal and predictive nature of these assaults, the largest non-fatal strangulation case study ever conducted (“the San Diego Study”) found that most cases lacked physical evidence or visible injury of strangulation – only 15 percent of the victims had a photograph of sufficient quality to be used in court as physical evidence of strangulation, and no symptoms were documented or reported in 67 percent of the cases.<sup>16</sup>
- The San Diego Study found major signs and symptoms of strangulation that corroborated the assaults, but often only minor visible external injury.<sup>17</sup>
- Loss of consciousness can occur within 5-10 seconds, and death within 4-5 minutes.<sup>18</sup> The seriousness of the internal injuries, even with no external injuries, may take a few hours to be appreciated, and death can occur days later.<sup>19</sup>
- Because most strangulation victims do not have visible external injuries, strangulation cases are frequently minimized by law enforcement, medical advocacy, mental health professionals, and courts.<sup>20</sup>
- Even in fatal strangulation cases, there is often no evident external injury (confirming the findings regarding the seriousness of non-fatal, no-visible-injury strangulation assaults).<sup>21</sup>
- Non-fatal strangulation assaults may not fit the elements of other serious assaults due to the lack of visible injury. Studies are confirming that an offender can strangle someone

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<sup>15</sup> Nancy Glass et al., *Non-Fatal Strangulation Is an Important Risk Factor for Homicide of Women*, 35 J. EMERGENCY MED. 329, 333 (2008).

<sup>16</sup> Gael B. Strack, George E. McClane & Dean Hawley, *A Review of 300 Attempted Strangulation Cases Part I: Criminal Legal Issues*, 21 J. EMERGENCY MED. 303, 305-06 (2001).

<sup>17</sup> *Id.*

<sup>18</sup> GWINN, *supra* note 6, at 8 (citing Dean A. Hawley, *Forensic Medical Findings in Fatal and Non-Fatal Intimate Partner Strangulation Assaults*, 6 (2012), available at <http://www.strangulationtraininginstitute.com/index.php/library/viewcategory/843-scholarly-works-and-reports.html>2013 (last visited Jan. 27, 2014)).

<sup>19</sup> *Id.*

<sup>20</sup> *Id.*

<sup>21</sup> *Id.* (citing Dean A. Hawley, *Forensic Medical Findings in Fatal and Non-Fatal Intimate Partner Strangulation Assaults*, 6 (2012), available at <http://www.strangulationtraininginstitute.com/index.php/library/viewcategory/843-scholarly-works-and-reports.html>2013 (last visited January 27, 2014)).

nearly to death with no visible injury, resulting in professionals viewing such an offense as a minor misdemeanor or as no provable crime at all.<sup>22</sup>

- Experts across the medical profession now agree that manual or ligature strangulation is “lethal force” and is one of the best predictors of a future homicide in domestic violence cases.<sup>23</sup>

The Commission published two options for amending §2A2.2 in cases of assault by strangling, suffocating, or attempting to strangle or suffocate. **The Department urges the Commission to adopt Option 2. We urge the Commission to make the enhancement for strangulation or suffocation five offense levels, and that the cumulative adjustment for application of subdivisions (3) and (4) not exceed 10 levels.**

The amended assault statute provides for the new offense of assault of a spouse, intimate partner, or dating partner by strangling or suffocating, or attempting to strangle or suffocate (18 U.S.C. § 113(8)). During the debate on the legislation, extensive information was presented to Congress, consistent with the research cited above, that strangulation is present in a large number of assaults by men against female intimate partners; that such conduct is particularly terrifying, both to the victim and to witnesses (most often children); and that the conduct is often recurring and enhances the abuser’s control over the victim. Evidence was further presented that strangulation and suffocation often do not result in visible physical injury or leave physical evidence of abuse, making it difficult for law enforcement to detect, but may cause long-term psychological and physiological damage to the victim.

Option 1 proposes a 3 to 7 level enhancement for strangulation or suffocation only where the victim has not sustained bodily injury. The Department sees no reason to limit any strangulation/suffocation enhancement to situations in which there is no bodily injury to the victim. As discussed above, strangulation and suffocation, or an attempt of either, is specific serious conduct that warrants enhanced punishment even when some enhancement would already be applied due to the existence of an injury.

We believe the appropriate enhancement for suffocation/strangulation is five levels, which is the same as the enhancement for serious bodily injury. We recognize, however, that when injury occurs, the cumulative adjustment under the guidelines should be limited, and we recommend that the cumulative adjustment for application of subdivisions (3) and (4) not exceed 10 levels.

The Department also recommends a change to the commentary language found on page 17 of the reader-friendly compilation of the proposed amendments. The background

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<sup>22</sup> *Id.* at 9.

<sup>23</sup> *Id.* at 8 (citing Nancy Glass et al., *Non-Fatal Strangulation Is an Important Risk Factor for Homicide of Women*, 35 J. EMERGENCY MED. 329, 333 (2008)).

commentary states that “this guideline covers felonious assaults that are more serious than minor assaults because of the presence of an aggravating factor, *i.e.*, serious bodily injury; the involvement of a dangerous weapon with intent to cause bodily injury; strangling, suffocating, or attempting to strangle or suffocate; or the intent to commit another felony.” We recommended that “minor” be replaced with “other.” Use of the word “minor” in a domestic violence situation or an assault where a dangerous weapon (including a firearm) was used is inappropriate and does a disservice to victims and the community in that such language can be interpreted by officials, victims, and defendants as minimizing or trivializing potentially lethal behavior.

#### B. Proposed Changes to §2A2.3, Minor Assault

Prior to the amendments of VAWA 2013, 18 U.S.C. § 113(a)(7) provided for a maximum imprisonment term of five years for assault resulting in substantial bodily injury to an individual who has not attained the age of 16. Now, although the maximum imprisonment term remains five years, § 113(a)(7) has been expanded to apply to a spouse, an intimate partner, and a dating partner, in addition to a victim who has not attained the age of 16. The Department asked Congress for this change because assaults resulting in substantial bodily injury represent an intermediate step on the ladder of escalating domestic violence, and federal law should recognize this. Under the federal assault statute prior to the passage of VAWA 2013, the offense was inadequate. If an adult Indian victim suffered a substantial bodily injury at the hands of her spouse, intimate partner, or dating partner, the maximum possible prison sentence was typically only six months if the perpetrator was non-Indian. And if the perpetrator was Indian, the federal government lacked jurisdiction altogether.

The Commission proposes two options for broadening the scope of the four-level specific offense characteristic now in §2A2.3. **The Department urges the Commission to adopt Option 2, which would apply the enhancement to *any case in which the offense resulted in substantial bodily injury*.** Option 1 would apply the enhancement only to cases in which the offenses resulted in substantial bodily injury to an individual less than 16 years old, a spouse, an intimate partner, or a dating partner. We believe Option 2 is appropriate because it focuses on the level of injury sustained by the victim, and represents an approach for accounting for injuries that is most consistent with all the purposes of sentencing. The enhancement for substantial bodily injury should not be limited to victims under the age of 16, a spouse, an intimate partner, or a dating partner, but rather should be applicable to all assault victims.

The Department also recommends that the Commission consider a change to the title of §2A2.3 (Minor Assault) and some of the commentary language in the guideline. We believe the title for the guideline should be changed to “Assault.” Section 2A2.3 applies to felony assaults, like assault resulting in substantial bodily injury. Substantial bodily injury is defined in 18 U.S.C. § 113 as a temporary but substantial disfigurement or a temporary but substantial loss or impairment of the function of any bodily member, organ, or mental faculty. By definition, a felony-level assault is not “minor.” Furthermore, the commentary for §2A2.3 states that this guideline applies where “the offense involved physical contact, or if a dangerous weapon (including a firearm) was possessed and its use was threatened.” Given the number of serious

crimes committed with a firearm or other dangerous weapon, especially in the context of intimate partner violence, it seems prudent that the word “minor” be dropped from the guideline title and all corresponding references in the guideline. Use of the word “minor” in a domestic violence situation or an assault where a dangerous weapon, including where a firearm was possessed and its use threatened, does a disservice to victims and the community in that it can be interpreted by officials, victims, and defendants as minimizing or trivializing potentially lethal behavior.<sup>24</sup>

### C. Proposed Changes to §2A6.2, Stalking or Domestic Violence

The Commission proposes that the new offense of assault by strangling, suffocating, or attempting to strangle or suffocate a spouse, of an intimate partner, or dating partner found at 18 U.S.C. § 113(a)(8) be referenced to §2A6.2 in addition to §2A2.2. The Department supports this change. We believe the change is consistent with the structure of the current guidelines’ treatment of domestic violence. The Commission proposes that guidelines define the terms “strangling” and “suffocating” by reference to the definitions provided in 18 U.S.C. § 113. We support this as well.

The Commission proposes two options for amending §2A6.2 to account for cases involving strangulation or suffocation. Option 1 provides for a two-level enhancement for strangling or suffocating to be applied independently of bodily injury. For the reasons discussed above, **the Department supports Option 1**, which recognizes the aggravating conduct of strangling, suffocating, or attempting to strangle or suffocate as an independent aggravating factor. Option 2, on the other hand, combines bodily injury with strangling, suffocating, or attempting to strangle or suffocate into one aggravating factor. As we stated, combining injury and the act of strangulation fails to appreciate and account for the independent harms of both aggravating factors. Strangulation and suffocation, or an attempt of either, is specific serious conduct that deserves enhanced punishment regardless of injury. If the strangulation victim has suffered injury at the hand of the assailant, the injury, too, should be scored as an aggravating factor.

### D. Issues for Comment Not Addressed in Previous Comments

#### 1. Supervised Release

Supervised release is particularly important in cases of intimate-partner violence because victims are uniquely vulnerable to abusive partners and because there is a high degree of recidivism in cases of domestic violence. **The Department believes the Commission should provide additional guidance for such cases and “highly recommend” the imposition of supervised release, as it does for defendants with a history of drug abuse.** We suggest the Commission consider three provisions of federal law as it reviews this issue and as Congress considers additional legislation in this area.

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<sup>24</sup> In the “Background” commentary, we suggest that the word “minor” be replaced with “misdemeanor.”

First, 18 U.S.C. § 3583(a) provides for including a term of supervised release after imprisonment. It requires “that the defendant be placed on a term of supervised release if such a term is required by statute or if the defendant has been convicted for the *first time* (emphasis added) of a domestic violence crime as defined in section 3561(b).” Second, 18 U.S.C. § 3563(a)(4) provides that for a defendant convicted of a domestic violence offense for the first time, “that the defendant attend a public, private, or private nonprofit offender rehabilitation program that has been approved by the court, in consultation with a State Coalition Against Domestic Violence or other appropriate experts, if an approved program is readily available within a 50-mile radius of the legal residence of the defendant.”

And finally, §5D1.3(a)(3) of the guidelines, outlining the mandatory conditions of supervised release, states that “the defendant who is convicted for a domestic violence crime as defined in 18 U.S.C. § 3561(b) *for the first time* (emphasis added) shall attend a public, private, or private nonprofit offender rehabilitation program that has been approved by the court, in consultation with a State Coalition Against Domestic Violence or other appropriate experts, if an approved program is readily available within a 50-mile radius of the legal residence of the defendant.” We believe that defendants, their victims, and the community would benefit if those individuals convicted of a *second, third or subsequent* domestic violence crime also receive a term of supervised release. We also believe that in certain circumstances, defendants serving a term of supervised release following a domestic violence crime should be required, as a condition of that supervised release, to participate in a public, private, or private nonprofit offender rehabilitation program that has been approved by the court, in consultation with a State Coalition Against Domestic Violence or other appropriate experts, if an approved program is readily available within a 50-mile radius of the legal residence of the defendant. These types of programs have the potential to benefit all domestic violence offenders and not just those sentenced to a term of probation.

Additionally, §5D1.3(d)(1) addresses a “special” condition of supervised release prohibiting a defendant previously convicted of a felony or for having used a firearm or other dangerous weapon during commission of the offense from possessing a firearm or other dangerous weapon. The Department strongly recommends the addition of another “special” condition prohibiting the purchase or possession of a firearm or ammunition where the defendant has a conviction for a qualifying misdemeanor crime of domestic violence (18 U.S.C. § 922(g)(9)) or is subject to a qualifying protection order (18 U.S.C. § 922(g)(8)).

2. Assault with Intent to Commit Certain Sex Offenses Under Sections 113(a)(1) and (2)

The Commission seeks comment on whether changes are necessary to the guidelines to address the statutory changes to 18 U.S.C. §§ 113(a)(1) and (2). VAWA 2013 amended § 113(a)(1) so that it now includes the crimes of assault with intent to commit aggravated sexual abuse (18 U.S.C. § 2241) and assault with intent to commit sexual abuse (18 U.S.C. § 2242). Assault with intent to commit any felony, § 113(a)(2), has been amended to conform to changes in § 113(a)(1), so the offenses of assault with the intent to commit murder, aggravated sexual

abuse, and sexual abuse are exceptions to the charge of assault with intent to commit any felony. The crimes of assault with intent to commit sexual abuse of a minor or ward and assault with intent to commit abusive sexual contact are still included within 18 U.S.C. § 113(a)(2). We recommend that assault with intent to commit sex offenses be treated in the guidelines as an attempted sex offense. We urge the Commission, for example, to amend the guidelines' Statutory Index to reference the offenses of assault with intent to commit aggravated sexual abuse and sexual abuse to §2A3.1. Section 2A3.1 currently includes specific offense characteristics appropriate for sex offenses, and the Department sees no need to further amend §2A3.1.

3. Proposed Amendment to Appendix A for 18 U.S.C. §§ 1152 and 1153

The Commission requests comment on whether it is appropriate to add §2A6.2 (Domestic Assault and Stalking) to the Statutory Index referencing 18 U.S.C. § 1153. Although we believe it is unnecessary to list 18 U.S.C. § 1153 in the Statutory Index, if it remains, we think it appropriate to add §2A6.2 because it may be the most appropriate guideline for certain assault cases prosecuted under 18 U.S.C. § 113. Section 1153 is a jurisdictional statute that enumerates specific covered offenses. The specific offense committed, *i.e., murder, assault, sex offense*, should govern the most appropriate guideline and, consequently, we think a reference to § 1153 is unnecessary.

The Commission also requests comment on whether it is necessary to have a Statutory Index referencing 18 U.S.C. § 1152. We think the reference to 18 U.S.C. § 1152 in Appendix A should be deleted. Section 1152 is also a jurisdictional statute that provides jurisdiction for specific covered offenses. The specific offense committed, *i.e., murder, assault, sex offense*, should govern the most appropriate guideline and, consequently, a reference to § 1152 is unnecessary.

4. 18 U.S.C. §§ 2261, 2261A, 2262 (Domestic Violence and Stalking)

The Department offers no comments or suggested edits to the Commission's proposed amendment to the Application Notes for §2A6.2.

### 3. Sentencing Policy for Drug Trafficking Offenses

#### I. Amendments to the Drug Quantity Table

The Commission has proposed an amendment to revise the Drug Quantity Table ("Table") used in the sentencing guideline for those convicted of drug trafficking offenses. The Table, found in subsection (c) of §2D1.1 (Unlawful Manufacturing, Importing, Exporting, or Trafficking (Including Possession with Intent to Commit These Offenses); Attempt or Conspiracy), provides the starting point for the guideline calculation for these offenses and is based on the quantity of drug an offender is involved with.

The Commission's proposed amendment to the Table (together with conforming adjustments to the chemical quantity tables and certain clerical changes) would change the offense level associated with quantities that trigger the statutory five- and ten-year mandatory minimum penalties to base offense levels 24 and 30 respectively, from levels 26 and 32 that are in the current guideline. The amendment would have the effect of modestly reducing guideline penalties for drug trafficking offenses while keeping the guidelines consistent with the current statutory minimum penalties.

**The Department supports this amendment.** Modestly reducing the quantity-based guideline for drug offenses, while continuing to ensure higher penalties for drug offenders involved in violence, or who are career criminals, or who use weapons in their offenses, is consistent with the Attorney General's Smart on Crime initiative and will help further our current need for efficient and strategic criminal justice reforms. Over the last 20 years, combined efforts among law enforcement, prosecutors, judges, and policymakers have resulted in reduced crime rates to their current, generational lows. As a result, communities across the country are safer and more productive. Nevertheless, our crime reduction strategies have been extremely costly and have caused incarceration rates to skyrocket, so much so that our nation now has the largest rate of imprisonment in the world.

The recent budget crisis has magnified this reality and has made clear that such extensive use of imprisonment as our first line of defense against crime is unsustainable. State and federal governments spent a combined \$80 billion on incarceration in 2010 alone. The federal prison and detention budget has been increasing steadily, while other critical public safety spending has been shortchanged. This pattern of funneling more resources into prisons and away from other crucial justice investments, such as investigators and prosecutors and support for victims and reentry programming, has persistently impacted the allocation of funding among the Department's various activities. It has become clear that we must find ways to control federal prison spending in order to better focus limited resources on combating the most serious threats to public safety.

Prison overcrowding and insufficient investment in effective reentry programming must both change if we are to continue to push crime rates lower. Nearly 40 percent of federal prisoners and over 60 percent of state prisoners reoffend or violate the terms of their community

supervision within three years after their release. Unreasonably high recidivism rates have caused many Americans to lose confidence in the criminal justice system. The hundreds of official and unofficial collateral consequences of incarceration have only furthered this loss of trust as communities have struggled to receive citizens returning home from prison no longer able to secure gainful employment, housing, or educational opportunities. The socioeconomic realities of life after prison have had particularly devastating effects on disadvantaged populations and communities of color. This has only helped to perpetuate the cycle of poverty, criminality, and incarceration that has isolated such individuals from the prospects of upward mobility. Such failures of our current approach to public safety highlight a need for considerable reforms.

Relying on evidence-based approaches, several states have already successfully implemented necessary reforms and innovations. As we have noted before, Justice Reinvestment Initiative efforts have decreased corrections spending in many states by redirecting some resources away from expensive imprisonment and towards more cost-effective, community-based efforts. Importantly, instead of compromising public safety, many states have seen drops in recidivism rates and crime rates overall as their prison populations have declined. The Department has also taken steps to address inefficient criminal justice practices at the federal level. We are encouraging the use of diversion programs that can serve as effective alternatives to incarceration; ensuring U.S. Attorneys have designated Prevention and Reentry Coordinators in their respective districts; and directing Department components to take into account unnecessary collateral consequences that may attach to proposed regulations.

Despite significant progress at the state and federal levels, there is still the need for further reform. Of the more than 216,000 federal inmates currently behind bars, almost half are serving time for drug-related crimes. Thus, strategically revising the ways in which we address this particular group of offenders – maintaining strong penalties but reserving the longest ones for repeat and dangerous drug offenders – will measurably improve our overburdened system. In August 2013, the Attorney General announced his “Smart on Crime” initiative, which among other things changed the Department’s charging policies to ensure people accused of certain low-level federal drug crimes will face sentences appropriate to their individual conduct while reserving more stringent mandatory minimum sentences for the most serious offenders. The Commission’s proposed Part B amendment to §2D1.1(c), lowering the base offense levels by two levels across drug types, is consistent with the Department’s initiative and goals of controlling the prison population and ensuring just and proportional sentences for all offenders. By reserving the most severe penalties for serious, violent drug traffickers, we can better promote public safety, deterrence, and rehabilitation while saving billions of dollars and strengthening communities.

## II. Environmental Harms and Marijuana Production Operations

The Commission seeks comment on the environmental and other harms caused by offenses involving drug production operations and whether the guidelines provide adequate penalties to account for such harms. We believe the Commission should indeed amend the

guidelines to address the significant environmental harms and public safety risks associated with illegal marijuana cultivation. As set out in greater detail in written testimony by the U.S. Forest Service for the Commission's March 13<sup>th</sup> public hearing, our national forests are seriously harmed and threatened by large-scale, illegal marijuana cultivation, as are our national parks. Those involved in the production clear-cut trees, divert, pollute and poison water supplies, apply dangerous pesticides, herbicides, and rodenticides, kill wildlife and fish, and endanger the safety of human visitors. These are not minor or victimless crimes; the lands in the National Forest System are a treasured national resource, part of our history and culture that include high-quality wildlife habitats, diverse wildlife and fish populations, and abundant clean water. In fact, the National Forest System watersheds serve as the largest source of drinking water in the contiguous United States.<sup>25</sup> The harms caused by illegal marijuana cultivation are significant and should be accounted for under the current sentencing guideline structure.

#### A. Magnitude of the Problem, Public Safety and Environmental Harm

The U.S. Forest Service ("Service") estimates that illegal marijuana cultivation by drug trafficking organizations is currently ongoing in 22 states and in 72 national forests,<sup>26</sup> and the Service recorded 5,592 illegal marijuana "grow" sites containing over 19 million plants between Fiscal Year 2005 and 2013.<sup>27</sup>

Illegal marijuana grows are a safety risk to unexpected visitors and Service personnel, as perpetrators set up camp for months at a time – usually the length of the growing season – and defend the secrecy of the operation with weapons and traps. Many national forests have warnings posted regarding the dangers of coming across an illegal marijuana grow site.

The illegal growers typically cut down vast swaths of established growth and native trees, and divert and pollute water supplies with toxic chemicals and fertilizers. According to the Service, as well as the Environmental Protection Agency, growers use rodenticides, pesticides, and insecticides in these pristine areas. Rodenticides commonly used in illegal marijuana cultivation poison small animals. Predators feed on their carcasses, spreading the poisons through the food chain. According to the EPA and the Service, pesticides and herbicides are absorbed by native plants and consumed by local wildlife and may persist for years. Because of the degree of irrigation required, many of the toxic chemicals applied in a grow site end up in streams, rivers and lakes that support many aquifer systems.

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<sup>25</sup> See *The U.S. Forest Service - An Overview*, 10, available at [http://www.fs.fed.us/documents/USFS\\_An\\_Overview\\_0106MJS.pdf](http://www.fs.fed.us/documents/USFS_An_Overview_0106MJS.pdf) ("About 124 million Americans rely on national forests and grasslands as the primary source of clean drinking water.").

<sup>26</sup> Chris Boehm, Assistant Director, Law Enforcement And Investigations, U.S. Forest Service, Statement Before the United States Sentencing Commission, for the Hearing Entitled *Marijuana Cultivation And The Environmental Impacts On Public Lands 4* (Mar. 13, 2014).

<sup>27</sup> *Id.*

The Service has noted in its testimony the cost of cleanup and reclamation associated with individual grow sites.<sup>28</sup> These costs only tell part of the story, though; they represent only the costs to undo harms that can be undone. The Service cannot quantify the costs associated with polluted streams, rivers, and watersheds, nor of dead wildlife.

#### B. Sophisticated Means of Illegal Growers and Expected Profits

The growing techniques used at most of the illegal grow sites are sophisticated. For example, illegal growers typically use elaborate irrigation systems. In Fiscal Year 2013, the Service removed eighty miles of irrigation tubing from illegal grow sites in California alone.<sup>29</sup> The growers build dedicated structures for drying the final product and use extensive and dangerous pesticides, herbicides and rodenticides. Some of the products seized from grow sites are highly specialized, smuggled into the United States for the sole purpose of growing marijuana. For example, the highly toxic pesticide, Carbofuran, was completely banned by the EPA in 1994 and cannot be purchased legally anywhere in the United States. Yet it has been found at a number of illegal grow sites.

The expected annual profits for those who choose to engage in illegal marijuana cultivation are significant – a conservative estimate is between one to two million dollars per grow site. The Forest Service estimates that most illegal grow sites in national forests are between four and six acres, with about three to four thousand plants each. The estimates on the average yield per plant vary from less than one half pound to more than five pounds.<sup>30</sup> The average wholesale price per pound also varies greatly by study and by region, from about five hundred dollars per pound, to several thousand.<sup>31</sup> The Rand Corporation reports that 2,000 to 3,000 pounds of dry cannabis can be anticipated per acre, in addition to 575 pounds to “bud.”<sup>32</sup>

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<sup>28</sup> *Id.* at 8.

<sup>29</sup> *Id.* at 5.

<sup>30</sup> See Jonathan P. Caulkins, *Estimated Cost of Production for Legalized Cannabis*, Table 2, 15 (Rand Corporation Working Paper) (July, 2010). For sentencing purposes, §2D1.1 in the current Guidelines use the actual weight of each marijuana plant, but the Guidelines assume a floor of 100 grams per plant when the actual weight is not available. USSG §2D1.1(c). Notes to Drug Quantity Table (E).

<sup>31</sup> *Id.* See also Press Release, DEA Phila. Div., *Philadelphia Lawyer Convicted in Marijuana Grow House Case* (Dec. 10, 2010) (available at <http://www.justice.gov/dea/divisions/phi/2010/phila121710p.html> (15-20 pounds of high grade marijuana sold for \$5,000 to \$5,500 per pound)); Press Release, DEA Phoenix Div., *Three Convicted by Jury of Charges Related to a Large Scale Marijuana Trafficking Organization* (Apr. 24, 2009) (available at <http://www.justice.gov/dea/divisions/phx/2009/phnx042409p.html> (seized marijuana part of a planned 760 pound deal with a negotiated price of \$550 per pound)); Press Release, D. Mont. U.S. Attorney's Office, *Saul Nuno Pleads Guilty In U.S. Federal Court* (Jan. 27, 2009) (available at <http://www.justice.gov/usao/mt/pressreleases/20090127162939.html> (pound quantities of marijuana for sale in Billings at \$800 per pound)).

<sup>32</sup> Caulkins, at 14.

Even if an illegal grower uses only the bud and throws away the rest of the plant (the Service has not received reports of discarded dry cannabis at any illegal grow sites), it is a conservative estimate that a typical illegal marijuana grow site yields about 2,300 pounds of marketable marijuana, worth one to two million dollars.

### C. Recommendation

We do not believe the current guidelines sufficiently address the significant environmental harms and public safety risks associated with illegal marijuana cultivation. With the Environmental Protection Agency and the Forest Service, we think the Commission should consider amending the guidelines to better capture these harms and risks, just as the guidelines currently do for the environmental risks associated with the production of methamphetamine. The guidelines currently provide for a three-level increase when there has been a substantial risk of harm to human life or the environment as a result of the production of methamphetamine.<sup>33</sup> We believe that such an increase is also appropriate in the context of the illegal production of marijuana. We further believe guideline commentary should make clear that the presence of a significant amount of dangerous rodenticide, pesticide, or herbicide will normally trigger this enhancement.

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<sup>33</sup> USSG §2D1.1(b)(13)(C)(ii) (2013).

#### **4. Circuit Conflict Involving Felon in Possession Offenses**

The Commission presents two options for clarifying how principles of relevant conduct affect sentencing for firearms offenses. There are two fact patterns for which guideline application has been particularly inconsistent: (1) when a defendant unlawfully possessed a firearm on one occasion and a different firearm on another occasion, and (2) when a defendant unlawfully possessed a firearm and also used that firearm in connection with another offense. In such circumstances, the court must determine, under §2K2.1, whether to apply the specific offense characteristic at (b)(6)(B) (which raises the offense level “if the defendant . . . used or possessed any firearm . . . in connection with another felony offense”), the cross reference at (c)(1) (which raises the offense level “if the defendant used or possessed any firearm . . . in connection with the commission or attempted commission of another offense”), or both, and this determination must be guided by §1B1.3 (Relevant Conduct (Factors that Determine the Guideline Range)) subsections (a)(1) through (a)(4). Circuit courts have varied in their application of (b)(6)(B) and (c)(1), primarily as a result of divergent views on whether and to what extent limiting principles apply in the §1B1.3 relevant conduct analysis.

**The Department recommends the Commission adopt Option 2 to clarify the operation of the guidelines in these firearms cases.** Option 2 would amend the commentary to §2K2.1 to clarify that subsections (b)(6)(B) and (c)(1) are not limited to firearms identified in the offense of conviction, provide the manner in which the two subsections function together, and explain how the §1B1.3 factors govern the scope of these subsections in the context of the two given situations.

For the situation where a defendant unlawfully possessed a firearm on one occasion and a different firearm on another occasion, the new commentary included in Option 2 makes clear that the court may take the prior possession into consideration and that (c)(1) would apply *in addition* to (b)(6)(B) if the application of (c)(1) would result in a greater offense level. The commentary adopts the §1B1.3 limitation that the court must first find the two unlawful possession offenses to be part of the same course of conduct or common scheme or plan (§1B1.3(a)(2)). The courts are in general agreement that the prior firearm possession is probative of a defendant’s dangerousness and that both the specific offense characteristic and the cross reference can apply; this can be seen in the cases cited in the Commission’s proposal.<sup>34</sup> The divergence among the cases lies with the limiting principle – most have held that §1B1.3 requires a clear connection between the two offenses, while one has held that §1B1.3 does not apply at all (though the offenses must at least be related). The new commentary resolves this conflict by not only making it clear that a §1B1.3 analysis is required for this situation, but also by listing (a)(2) (“all acts . . . that were part of the same course of conduct or common scheme or plan as the offense of conviction”) as one of the specific subsections the sentencing court should look to. The Department considers the resolution of this conflict important as it will promote

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<sup>34</sup> See *United States v. Mann*, 315 F.3d 1054, 1055-57 (8th Cir. 2003); *United States v. Jardine*, 364 F.3d 1200, 1207 (10th Cir. 2004); *United States v. Williams*, 431 F.3d 767, 769-71 (11th Cir. 2005).

judicial consistency as well as fairness to defendants and the public, and Option 2 best accomplishes this.

Regarding the second situation, in which a defendant unlawfully possessed a firearm at one time and also used that firearm in connection with another offense, Option 2 includes commentary that will similarly clarify the application of the guidelines consistent with the purpose of sentencing policy for firearms offenses. As in the earlier situation, the new commentary clarifies that it is permissible to take the prior conduct into consideration and that (b)(6)(B) and (c)(1) can apply if the application of (c)(1) results in a greater offense level. And also like the situation above, the new commentary settles what if any threshold analysis is required by the §1B1.3 constraint. There is disagreement among circuits as to whether any relevant conduct analysis is necessary, if it is, which subsections should be used, and, even when a particular subsection is used, what is required by that subsection.<sup>35</sup> The proposal resolves this issue by guiding that “the use of the [firearm] in connection with [another offense] . . . is relevant conduct under §1B1.3(a)(4) [(“any other information specified in the applicable guideline”)]” (emphasis added). In abrogating the threshold analysis requirement and simply providing that in this situation relevant conduct is established *per se*, the application of the (b)(6)(B) and (c)(1) will be simplified and made consistent across districts, further advancing the goals of sentencing.

The Department believes that taking into account the prior conduct discussed in *both* types of cases is the best sentencing policy, for doing so will best achieve the purposes of sentencing. The very aim of the firearms guideline is to identify the more dangerous offenders, using information beyond the elements of the offense of conviction, and provide for proportionate sentences in relation to dangerousness. Option 2 does just that. Option 1 does the opposite, artificially eliminating from consideration critical and unquestionably relevant aggravating information from the sentencing calculus. We also believe there should be more consistency between circuits in the way the limiting principles govern the application of these guidelines. The additions to the commentary proposed by the Commission in Option 2 address these concerns, give appropriate guidance to the courts, and fall within the legal and equitable framework of the Guidelines.

Option 2 reflects, generally, the current thinking accepted by the circuits, and codifying these principles into the guidelines will promote stability and continuity. For the two issues where there is disagreement, namely the application of the limiting principle, Option 2 brings the circuits together in a straightforward, coherent, and reasonable fashion on *both* applications.

The Commission also requests comment on whether the scope of the provisions should be narrowed and whether the cross reference in (c)(1) should be deleted. We do not think the Commission should narrow the scope of these provisions, nor should it delete subsection (c)(1), as the current formulation of the guidelines (with additional commentary proposed by Option 2) affords and ensures courts important authority to account for unquestionably relevant aggravating factors and indicators of dangerousness.

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<sup>35</sup> See *United States v. Gonzales*, 996 F.2d 88, 92 n. 6 (5th Cir. 1993); *United States v. Horton*, 693 F.3d 463, 478-79 (4th Cir. 2003); *United States v. Kulick*, 629 F.3d 165, 170 (3rd Cir. 2010).

## 5. Alien Smuggling in Dangerous Locations

The Commission proposes amending Application Note 5 in §2L1.1 (Smuggling, Transporting, or Harboring an Unlawful Alien) to clarify application of the two-level enhancement for “intentionally or recklessly creating a substantial risk of death or serious bodily injury to another person.” As noted by the Commission, the Fifth Circuit has held that the enhancement should not apply *per se* to aliens transported through the South Texas brush country, but rather that the district court must base the enhancement on additional facts presented to the court.<sup>36</sup>

The Commission proposes amending Application Note 5 by adding the phrase “or guiding persons through, or abandoning persons in, dangerous terrain without adequate food, water, clothing or protection from the elements” as an example of intentionally or recklessly creating a substantial risk of death or serious bodily injury to another.<sup>37</sup> **We support the proposed amendment.** We suggest, though, that the term “dangerous terrain” be changed to “dangerous or remote geographic area” to ensure that it includes dangerous river and canal crossings and other appropriate locations.

When a defendant has guided persons through or abandoned persons in dangerous or remote locations without adequate food, water, clothing or protection from the elements, such conduct is a serious aggravating factor that should be recognized at sentencing. Such conduct increases the risk of serious bodily injury or death and contributes to more deaths along the border. We think – in response to issue for comment 1(A) – that transporting aliens through desert-like terrain, or through mountainous regions, is inherently dangerous.

According to the Department of Homeland Security, among the 350,000 or so alien apprehensions along the southwest border by the U.S. Border Patrol during Fiscal Year 2012, 1,312 required emergency rescues, 463 involved the death of an alien, and 549 involved the assault of an alien.<sup>38</sup> Based on data provided by the Border Patrol, the National Foundation for American Policy reports that the number of “immigrant deaths” has increased nearly 80 percent from 1998 to 2012, despite the fact that the number of apprehensions has actually declined.<sup>39</sup> The report concludes that the lethality of “immigrant deaths” at the border has increased about

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<sup>36</sup> See *United States v. Mateo Garza*, 541 F.3d 290, 294 (5th Cir. 2008).

<sup>37</sup> Proposed Amendments to the Sentencing Guidelines, 2L1.1, January 17, 2014, 81, available at [http://www.ussc.gov/Legal/Amendments/Reader-Friendly/20140114\\_RFP\\_Amendments.pdf](http://www.ussc.gov/Legal/Amendments/Reader-Friendly/20140114_RFP_Amendments.pdf).

<sup>38</sup> United States Border Patrol, Sector Profile - Fiscal Year 2012 (Oct. 1st through Sept. 30th), available at [http://www.cbp.gov/linkhandler/cgov/border\\_security/border\\_patrol/usbp\\_statistics/usbp\\_fy12\\_stats/usbp\\_sector\\_profile.ctt/usbp\\_sector\\_profile.pdf](http://www.cbp.gov/linkhandler/cgov/border_security/border_patrol/usbp_statistics/usbp_fy12_stats/usbp_sector_profile.ctt/usbp_sector_profile.pdf).

<sup>39</sup> Stuart Andersen, *How Many More Deaths? The Moral Case For A Temporary Worker Program*, National Foundation for American Policy, NFAP Policy Brief, March 2013, 2, available at <http://www.nfap.com/pdf/NFAP%20Policy%20Brief%20Moral%20Case%20For%20a%20Temporary%20Worker%20Program%20March%202013.pdf>.

six-fold, from about two per 10,000 in 1998 to more than 13 per 10,000 in 2012. We think the proposed amendment is an important step in recognizing and addressing the dangerous behavior taking place along the border.

Regarding issues for comment 1(B) and 1(C), the Commission should also consider adding language to account for other aggravating conduct such as when private land or ranch property has been damaged or destroyed in excess of a specific dollar amount (perhaps \$10,000) or where the rescue of smuggled aliens by special border patrol teams results in substantial costs to the government.

## **6. Circuit Conflict Involving Supervised Release Terms**

### **I. When a Statutory Minimum Term of Supervised Release Applies**

The Commission has proposed two options for resolving a circuit conflict involving the range of possible terms of supervised release when a statute provides a minimum term that is greater than the minimum term recommended by the guidelines. Subsection (c) of §5D1.2 is intended to resolve any inconsistency, but the courts have interpreted subsection (c) in conflicting ways.

Option 1 would create a new Application Note 6 to resolve the conflict and would spell out the guideline application in two circumstances. First, when the range of supervised release terms provided in §5D1.2(a) overlaps with the range provided by statute, but the guidelines range begins at a lower point (for example, when the statutory range is three years to life, but the guidelines range is two to five years), the bottom of the statutory range would provide only the floor (in the previous example, the guideline range would become three to five years). When the ranges provided by §5D1.2(a) and by the relevant statute overlap only at the maximum of the guideline range and the minimum of the statutory range, that one point would become the recommended guideline term. For example, if the guidelines range is two to five years, and the relevant statute provides for five years to life, the recommended guideline term, through the operation of §5D1.2 (c), would become precisely five years.

In contrast, Option 2 specifies that when the ranges of supervised release terms provided by §5D1.2(a) and the relevant statute are inconsistent, the statutory range supersedes the range provided by §5D1.2(a) and becomes the guideline recommended range. For example, when the statutory range is three years to life, but the guidelines range at §5D1.2(a) is two to five years, by operation of §5D1.2(c), the guideline range would become three years to life.

**The Department supports Option 1.** We believe Option 1 – which provides that the statutory minimum term of supervised release becomes the floor of the recommended guideline range, or, where the entire guideline range is lower than the minimum, becomes the recommended guideline term – is preferable for two reasons. First, Option 1 is consistent with the treatment in the guidelines of statutory mandatory minimum terms of imprisonment. Moreover, it is consistent with the very purpose of the guidelines: to narrow the statutory ranges of punishment provided by Congress through the evaluation of detailed information, policy analysis and public comment.

### **II. When the Defendant is Convicted of Failure to Register as a Sex Offender**

Application Note 1 to §5D1.2 currently defines “sex offense” in part as “(A) an offense, perpetrated against a minor” under a number of chapters of Title 18, United States Code, including chapter 109B. The proposed amendment would delete subsection (A)’s reference to chapter 109B, which includes two offenses: 18 U.S.C. § 2250(a) (failing to register as a sex offender) and 18 U.S.C. § 2250(c) (commission of a crime of violence while in failure to register

status). Although we agree that the definition of “sex offense” in §5D1.2 should be amended to account for the problems identified in the *Goodwin* case, we oppose the way the Commission proposes to treat chapter 109B offenses for purposes of supervised release.<sup>40</sup>

Those who violate the offenses under chapter 109B are convicted sex offenders who have further violated the law by failing to register as required by the Sex Offender Registration and Notification Act (SORNA). Section 2250(c) offenders additionally have committed a crime of violence under federal, state or tribal law. Given the repeated failures of these defendants to comply with the law and the very serious criminal histories associated with many of these defendants, the minimum five-year term of supervised release is inadequate to ensure public safety and provide sufficient reentry services and monitoring for at least some of these offenders.

Thus, while we agree with the proposed amendment’s deletion of chapter 109B offenses from subsection (A) of the “sex offense” definition, we recommend that for such offenses, sentencing courts be directed to impose supervised release terms greater than five years in relation to a defendant’s criminal history, instant offense and duration of the obligation to register as a sex offender. We think it is sensible sentencing policy, for example, to recognize that a defendant convicted under § 2250(c) should be treated differently than a defendant convicted under § 2250(a), because of the nature of the instant conviction.

Depending upon the nature of the prior sex offense or crime of violence committed, a greater term of supervised release will be appropriate, as will be additional conditions of supervised release. A shorter supervised release term may be appropriate for the least serious offenders. But certainly, such a term will be inadequate for others. We think the best course of action for the Commission is to follow the framework in §2A3.5 – the existing sentencing guideline for failure to register as a sex offender – which uses an offender’s “Tier” level (as defined by statute) to determine the applicable base offense level. Specifically, we think §5D1.2 should recommend a term of supervised release that corresponds, at least, to the original duration of the offender’s obligation to register as a sex offender. We suggest that chapter 109B offenses be added as a separate subsection (3) to §5D1.2(b) and that a policy statement be added providing that if the instant offense of conviction is an offense under chapter 109B, the recommended term of supervised release should be – (1) at least fifteen years if the offender was required to register as a Tier I offender; (2) twenty-five years if the offender was required to register as a Tier II offender; and (3) life if the offender was required to register as a Tier III offender. These terms correspond to the statutory registration periods for each tier as set out at 42 U.S.C. § 16915(a).

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<sup>40</sup> See *United States v. Goodwin*, 717 F.3d 511 (7th Cir. 2013).

## **7. Cases Involving An Undischarged Term of Imprisonment**

### **I. Revision to Subsection (b)**

The first of the three amendments proposed by the Commission to §5G1.3 relating to undischarged terms of imprisonment – Part A – revises subsection (b) by removing the requirement that the offense for the undischarged term of imprisonment be “the basis for an increase in the offense level for the instant offense under Chapter Two (Offense Conduct) or Chapter Three (Adjustments).”<sup>41</sup> If amended, this subsection would only require that the offense for the undischarged term of imprisonment be “relevant conduct” in relation to the instant offense of conviction, as defined by sections §§1B1.3(a)(1), (a)(2), or (a)(3), in order for a court to adjust the sentence and impose a concurrent term.

**The Department supports the first proposed amendment.** In an earlier version of §5G1.3, subsection (b) applied if the undischarged term of imprisonment “resulted from offense(s) that have been fully taken into account in the determination of the offense level for the instant offense.”<sup>42</sup> In 2003, this language was changed to the current version of subsection (b) (applying to “another offense that is relevant conduct . . . and that was the basis for an increase in the offense level . . .”<sup>43</sup>), in an amendment the Commission characterized as “clarifying.”<sup>44</sup> A clarifying amendment “changes nothing concerning the legal effect of the guidelines, but merely clarifies what the Commission deems the guidelines to have already meant.”<sup>45</sup> In contrast, “[s]ubstantive amendments typically reflect new policy choices by the Commission.”<sup>46</sup> Despite the Commission’s stated intent in revising the 1992 version of §5G1.3(b), the interpretation of the current language effectively alters the substance of the provision. The proposed Part A amendment would restore the prior meaning of subsection (b). Moreover, we think the policy embodied by the proposed amendment will best ensure sentencing proportionality, by providing concurrent terms where two separate sentences are based on identical conduct.

### **II. Adjustment to Certain Sentences**

The second proposal – Part B – provides for an adjustment to a federal sentence in cases in which §5G1.3(a) does not apply but there is an anticipated, but not yet imposed, term of imprisonment for another offense that is relevant conduct to the instant offense of conviction

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<sup>41</sup> USSG §5G1.3(b) (2013).

<sup>42</sup> See USSG §5G1.3(b) (1992).

<sup>43</sup> USSG § 5G1.3(b) (2013)

<sup>44</sup> See USSG App. C Amend. 660, (effective: Nov. 1, 2003).

<sup>45</sup> *United States v. Capers*, 61 F.3d 1100, 1109 (4th Cir. 1995) (internal quotation marks omitted).

<sup>46</sup> *United States v. Goines*, 357 F.3d 469, (4th Cir. 2004).

under subsections §§1B1.3(a)(1), (a)(2), or (a)(3). In addition, the Commission seeks comment on specific language regarding whether a sentencing court “shall” or “may” adjust such a sentence. The Commission also seeks comment on whether the other relevant offense must be the basis for a Chapter Two or Chapter Three increase in the offense level or whether, as in Part A, this requirement should be removed.

**The Department opposes the second proposed amendment.** There is broad variation in sentencing decisions between jurisdictions and among individual judges, and anticipated terms of imprisonment are sometimes never imposed or sometimes vacated after being imposed. The Commission should not advise federal courts to reduce a sentence on the basis of an anticipated state sentence. Instead, to address the legitimate proportionality concerns that generated this proposal, we recommend a provision directing sentencing courts to impose the federal sentence to run concurrently with any projected and related sentence. In *Setser v. United States*, the Supreme Court held that a district court has discretion to order that a federal sentence run consecutively to a state sentence to be imposed in the future for a probation violation.<sup>47</sup> The reasoning in *Setser* also supports an order that a future sentence run *concurrently* to the state sentence. This is a better alternative to the Commission’s Part B proposal, which would create distortions for cases subject to unforeseeable state court proceedings. We recognize that there may be circumstances where defendants first complete their federal sentence before returning to state jurisdiction. However, we believe the responsibility for ensuring a fair total outcome in those cases lies with the state courts and that such courts are well able to fulfill this responsibility.

With respect to the precise language of the Part B amendment, the Department suggests the new provision state: “. . . the court shall impose the sentence to run concurrently with any anticipated state term of imprisonment.” We believe “shall” – as opposed to “may” – is appropriate here as it reflects sensible policy and will eliminate defendants serving consecutive terms of imprisonment for relevant and related offenses. On the second issue for comment, the Department does not believe there should be a requirement that the other offense be the basis for a Chapter Two or Chapter Three increase in the offense level for reasons stated in our comments on Part A.

### III. Addition of New Subsection (c)

The third Commission proposal – Part C – adds a new subsection (c) to provide for an adjustment if a defendant is a deportable alien who is likely to be deported after imprisonment and the defendant is serving an undischarged term of imprisonment for an unrelated offense. The Commission also seeks comment on whether a sentencing court “shall” or “may” adjust such a defendant’s sentence. The Commission has also bracketed for comment whether this new subsection (c) should apply regardless of whether §5G1.3(a) or §5G1.3(b) would ordinarily apply to the defendant or whether subsection (c) should only apply if subsection (a) does not otherwise apply. The Commission’s Part C proposal further amends §5K2.23 to provide that if a

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<sup>47</sup> *Setser v. United States*, 132 S. Ct. 1463, 1468 (2012).

defendant who is a deportable alien likely to be deported after imprisonment has completed serving a term of imprisonment and the proposed §5G1.3(c) would have provided for an adjustment had the completed term been undischarged at the time of sentencing for the instant offense, a departure is warranted.

**The Department opposes the third proposed amendment.** Affording deportable aliens an adjustment or departure in the federal sentence because of a prior, unrelated offense would provide unwarranted sentencing reductions, effectively disregarding and leaving unaccounted for the criminal conduct of the unrelated conviction. There is no readily apparent reason why deportable aliens should serve reduced sentences relative to similarly situated defendants unlikely to be deported after incarceration. The guidelines foundational design is to ensure incremental additional punishment for additional significant aggravating conduct. We see no reason to diverge from this design in this one particular situation. The proposed amendment simply runs counter to the purposes of sentencing.<sup>48</sup>

Our same line of reasoning applies to the Commission's proposed amendment to §5K2.23. Sentencing courts already have the discretion to grant a departure in any case in which the current guideline range is excessive in light of the defendant's history or because of the likelihood of deportation. There is no discernible reason to codify the credit as suggested by this proposed amendment.

In the event the Commission does adopt Part C, we recommend the new subsection state that a sentencing court "may" adjust the applicable defendant's sentence. The use of "may" as opposed to "shall" would comport with courts' current discretion to do so based on the circumstances of a particular case.

#### IV. Issues For Comment

We support amending §5G1.3(b) to expand application of the provision to undischarged terms of imprisonment for offenses constituting relevant conduct under §1B1.3(a)(4). We believe sensible sentencing policy suggests that any offense qualifying as "relevant conduct" pursuant to any of the §1B1.3(a) subsections should be eligible for §5G1.3(b) application.

We believe our recommendation substituting the proposed Part B amendment for a provision directing the court to impose a sentence to run concurrently with the anticipated state sentence should also apply to pretrial custody in connection with the projected state sentence. As we have previously stated above, we are opposed to a guideline instructing district courts to adjust a sentence or provide for a departure provision to account for an *anticipated* state term of imprisonment. Nevertheless, if a defendant has *already* spent time in pretrial custody for a state offense that constitutes relevant conduct (under §1B1.3(a)) in relation to the instant federal

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<sup>48</sup> Furthermore, this amendment, like the proposed Part B, directs courts to adjust sentences based on a future occurrence – possible deportation. We do not think a sentence should generally be dependent upon speculation of future events.

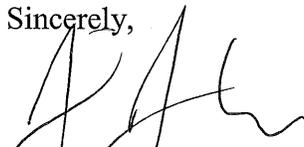
offense, then, regardless of whether a state sentence is actually imposed, the guidelines should direct sentencing courts to adjust the sentence for the instant federal offense to reflect time spent in pretrial custody. This way, any time a defendant has already spent in custody (albeit pretrial custody) for related offenses, whether state or federal, can count toward the federal term of imprisonment without the district court needing to anticipate the sentencing decision of a state court.

Finally, for the reasons we oppose the proposed Part C amendment, we believe revising §2L1.2 to provide for a downward departure along the lines suggested in the issue for comment would be imprudent. Like the Part C amendment, such a departure would appear to reward deportable aliens for having committed a state offense in addition to unlawfully entering or remaining in the United States. Moreover, the disconnect between the offense for the undischarged term of imprisonment and the cause for deportation further suggests each offense should be addressed and sentenced independently of the other.

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We appreciate the opportunity to provide the Commission with our views, comments, and suggestions. We look forward to working further with you and the other commissioners to refine the sentencing guidelines and to develop effective, efficient, and fair sentencing policy.

Sincerely,

A handwritten signature in black ink, appearing to read 'Jonathan J. Wróblewski', written over the printed name below.

Jonathan J. Wróblewski  
Director, Office of Policy and Legislation

cc: Commissioners  
Ken Cohen, Staff Director  
Kathleen Grilli, General Counsel



Gael B. Strack, JD  
Chief Executive Officer and Co-Founder  
Family Justice Center Alliance  
[gael@nfjca.org](mailto:gael@nfjca.org) or 760-445-3559  
Biographical Information

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Gael B. Strack is the Chief Executive Officer and Co-Founder of the Family Justice Center Alliance which provides technical assistance to over 100 existing and pending Family Justice Centers across the world ([www.familyjusticecenter.com](http://www.familyjusticecenter.com)). Gael also oversees the Training Institute on Strangulation Prevention, launched in 2011, which provides specialized training and consulting services to professionals on the identification, documentation and prosecution of non-fatal strangulation cases ([www.strangulationtraininginstitute.com](http://www.strangulationtraininginstitute.com)).

Prior to this position, Gael served as the Director of the San Diego Family Justice Center from October 2002 through May 2007. In that capacity, she worked closely with 25 on-site agencies (government and non-profit) who came together in 2002 to provide services to victims of domestic violence and their children from one location. The San Diego Family Justice Center was featured on Oprah in January 2003, recognized as a model program by President Bush in October 2003 and was the inspiration for the President's Family Justice Center Initiative which launched 15 Centers across the nation.

Prior to her work at the Family Justice Center, Gael was a domestic violence prosecutor for 17 years at the San Diego City Attorney's Office. She joined the office in 1987 and served in many capacities including an Assistant City Attorney for former City Attorney Casey Gwinn and Head Deputy City Attorney responsible for the Child Abuse and Domestic Violence Unit. Gael has also worked as a deputy public defender and a deputy county counsel for the San Diego County Counsel's office handling juvenile dependency matters. She graduated from Western State College of Law in December 1985.

Gael is a former board member of the California Partnership to End Domestic Violence, past President of the San Diego Domestic Violence Council and former commissioner of the ABA's Commission on Domestic Violence. In her spare time, Gael is an adjunct law professor for California Western School of Law teaching "Domestic Violence and the Law." Gael has been honored with numerous awards, including San Diego Attorney of the Year for 2006 and most recently by United States Attorney General Eric Holder as the 2010 Recipient of the National Crime Victim Service Award for Professional Innovation in Victim Services.

Gael has also co-authored a series of strangulation articles in the Journal of Emergency Medicine, the National College of District Attorney's Practical Prosecutor, and the Journal of the California Dental Association. Gael has co-authored five books with Casey Gwinn, JD, on the Family Justice Center movement including a Guide to Co-Located Services in the Middle East and in Mexico. Gael has also co-authored a book with Judi Adams, called "The Big Girls Club – Little Girl Rules for the Big Girl Workplace" which describes the ten rules of friendship that can help women thrive and succeed in the changing workplace.



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### Strangulation and Domestic Violence: The Edge of Homicide

by Gael Strack, J.D. and Casey Gwinn, J.D.

In March 1995, as San Diego's coordinated community response to domestic violence was getting national attention with a 50% drop in domestic violence homicides since 1985, Sgt. Anne O'Dell, the founder of the Police Department's specialized Domestic Violence Unit, called us as the founders of the City Attorney's specialized Child Abuse/Domestic Violence Unit to question whether any of us were treating so called "choking" cases seriously. Her soul searching, and soon ours, came from the first two domestic violence homicides of 1995: two teenagers with small children who lost their lives after a history of domestic violence and reports of being "choked" by their boyfriends. The City Attorney or the District Attorney prosecuted none of the reported cases. And then both Casandra Stewart and Tamara Smith were murdered.

The deaths of Casandra Stewart and Tamara Smith triggered profound changes in San Diego and ultimately around the world, but such profound change started with Gael Strack going into the file room of the San Diego City Attorney's Child Abuse/Domestic Violence Unit and reviewing every case where

*See EDGE OF HOMICIDE, page 90*

### Law Reform Targets the Crime of Strangulation

by Casey Gwinn, J.D., Gael Strack, J.D., and Melissa Mack

*"Actually, when I came out of that [strangulation incident], I was more submissive—more terrified that the next time I might not come out—I might not make it. So I think I gave him all my power from there because I could see how easy it was for him to just take my life like he had given it to me."*

*—Former San Diego Family Justice Center Client (2010)*

Survivors of non-fatal strangulation have known for years what prosecutors and civil attorneys are only recently learning: Many domestic violence offenders and rapists do not strangle their partners to kill them; they strangle them to let them know they can kill them—any time they wish. Once victims know this truth, they live under the power and control of their abusers day in and day out. This complex reality creates challenges for prosecutors who have to decide whether to prosecute non-fatal strangulation cases

as attempted murders, serious felony assaults, or misdemeanors.

For many years in California and across the country, prosecutors have failed to treat non-fatal strangulation assaults as serious crimes, due to lack of physical evidence. Today, because of (1) involvement of the medical profession, (2) specialized training for police and prosecutors, and (3) ongoing research, strangulation has become a focus area for policymakers and professionals working to reduce intimate partner violence and sexual assault.

As of May 2014, 37 states and one territory (U.S. Virgin Islands) have passed strangulation laws that provide clear legislative definitions of the violent life threatening assault now properly referred to as "strangulation."<sup>1</sup> One state, Utah, passed an "Intent of the Legislature" resolution, which made legislative findings to help

*See LAW REFORM, next page*

**About This Issue . . .**

We are delighted to present this special issue on Strangulation, a topic of great interest because of the importance of the issue today, particularly in light of the high lethality of these cases, the profound consequences for survivors, and the challenges for law enforcement. We are especially pleased that Gael Strack and Casey Gwinn are Guest Editors. These two former prosecutors are leading national experts on strangulation as well as founders of the Family Justice Center movement.

D. Kelly Weisberg, Editor, *Domestic Violence Report*

**ALSO IN THIS ISSUE**

Investigation and Prosecution of Strangulation Cases . . . . .	83
Men Who Strangle Women Also Kill Cops . . . . .	85
Summary of Recent Strangulation Case Law . . . . .	86
Why Didn't Someone Tell Me? The Consequences of Strangulation Assaults . . . . .	87

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# From Hippocrates to HIPAA: Privacy and Confidentiality in Emergency Medicine—Part I: Conceptual, Moral, and Legal Foundations

**John C. Moskop, PhD**  
**Catherine A. Marco, MD**  
**Gregory Luke Larkin, MD,**  
**MSPH**  
**Joel M. Geiderman, MD**  
**Arthur R. Derse, MD, JD**

From the Department of Medical Humanities, The Brody School of Medicine at East Carolina University, Bioethics Center, University Health Systems of Eastern Carolina, Greenville, NC (Moskop); the Department of Emergency Medicine, St. Vincent Mercy Medical Center, Toledo, OH (Marco); the Departments of Surgery, Emergency Medicine, and Public Health, University of Texas Southwestern, Dallas, TX (Larkin); Ruth and Harry Roman Emergency Department, the Department of Emergency Medicine, Cedars-Sinai Center for Health Care Ethics, Burns and Allen Research Institute, Cedars-Sinai Medical Center, Los Angeles, CA (Geiderman); and the Center for the Study of Bioethics and the Department of Emergency Medicine, Medical College of Wisconsin, Milwaukee, WI (Derse).

Respect for patient privacy and confidentiality is an ancient and a contemporary professional responsibility of physicians. Carrying out this responsibility may be more challenging and more important in the emergency department than in many other clinical settings. Part I of this 2-part article outlines the basic concepts of privacy and confidentiality, reviews the moral and legal foundations and limits of these concepts, and highlights the new federal privacy regulations implemented under the Health Insurance Portability and Accountability Act of 1996. Part II of the article examines specific privacy and confidentiality issues commonly encountered in the ED. [Ann Emerg Med. 2005;45:53-59.]

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## SEE RELATED ARTICLE, P. 60.

### INTRODUCTION

Respect for patient privacy and confidentiality has been affirmed as a professional responsibility of physicians since antiquity. In the famous oath attributed to Hippocrates, ancient Greek physicians pledged to respect confidentiality in these words: "What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself, holding such things shameful to be spoken about."<sup>1</sup>

Privacy and confidentiality are no less significant in Western medicine today, and contemporary medical oaths echo the Hippocratic principle of respect for confidentiality. The World Medical Association's Declaration of Geneva, for example, contains the statement "I will respect the secrets which are confided in me, even after the patient has died."<sup>2</sup> In the United States, a variety of state and federal statutes and common law rules establish legal obligations of physicians to protect patient confidentiality.<sup>3</sup> Potential threats to patient confidentiality from electronic health care transactions were the impetus for US federal regulations recently implemented under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These regulations require physicians and health care institutions

to adopt a variety of new procedures to protect patient information.<sup>4,5</sup>

Privacy and confidentiality also figure prominently in the "Principles of Ethics for Emergency Physicians," part of the Code of Ethics of the American College of Emergency Physicians. Principle 5 states: "Emergency physicians shall respect patient privacy and disclose confidential information only with consent of the patient or when required by an overriding duty such as the duty to protect others or to obey the law."<sup>6</sup> Because respect for privacy and confidentiality is a basic professional responsibility, it is essential that emergency physicians understand how to protect patient interests in the distinctively open setting of the emergency department (ED).

For a variety of reasons, protecting privacy and confidentiality may prove more difficult and more important in the ED than in most other practice settings. It is particularly difficult to ensure privacy and confidentiality in the ED because the ED is typically a public, crowded environment in which many people are present, including multiple patients, physicians (attending physicians, consultants, and residents), nurses, emergency medical technicians, students, family, friends, law enforcement officers, and others. Until recently, many EDs recorded patient information on a "status board" in plain view of passersby and other patients.<sup>7</sup> Endemic crowding in today's EDs also interferes with protection

of privacy and confidentiality.<sup>8,9</sup> Semiopen wards, congested hallways, and a fishbowl atmosphere provide little or no physical privacy and limited opportunities to communicate personal information confidentially.

These physical challenges to privacy and confidentiality are paradoxical, because ED patients frequently need treatment for conditions most people find embarrassing and strongly desire to keep confidential. Such sensitive conditions include sexual assault, family violence, sexually transmitted diseases, unwanted pregnancy, suicide attempts, acute psychoses, drug overdoses, and disfiguring trauma, to name but a few. Despite risks to their privacy and confidentiality, however, severely ill or injured patients often have little choice but to accept care in the ED, because they depend on others for transportation and only the ED offers round-the-clock care to all in need. Thus, acutely ill or injured ED patients are highly vulnerable to harmful disclosures and remain at the mercy of their caregivers to protect their confidential information.

To carry out the difficult and important responsibility of guarding patient privacy and confidentiality in the ED, emergency physicians must have a clear understanding of the nature, scope, and limits of that responsibility. This 2-part article is intended to help emergency physicians achieve such an understanding. Part I of the article will outline the concepts of privacy and confidentiality and examine moral and legal foundations and limits of respect for privacy and confidentiality, including federal privacy regulations recently implemented under HIPAA. Part II of the article will examine specific privacy and confidentiality issues frequently encountered in the ED.

## CONCEPTS OF PRIVACY AND CONFIDENTIALITY

To show appropriate respect for patient privacy and confidentiality, physicians must first understand clearly what is meant by these terms. Although they have overlapping meanings and are sometimes used synonymously, privacy and confidentiality are distinct concepts. Both terms can be used to refer to matters of fact, social values, and moral or legal rights.

### Privacy

Defined simply in an early and influential law review article by Warren and Brandeis<sup>10</sup> as “the right to be let alone,” privacy is often characterized as freedom from exposure to or intrusion by others.

Allen<sup>11</sup> distinguishes 3 major usages of the term “privacy”: physical privacy, informational privacy, and decisional privacy. Physical privacy refers to freedom from contact with others or exposure of one’s body to others. In contemporary health care, physical privacy is unavoidably limited. Patients grant their caregivers access to their bodies for medical examination and treatment, but expect caregivers to protect them from any unnecessary or embarrassing bodily contact or exposure.

Informational privacy refers to prevention of disclosure of personal information. Informational privacy is also limited in health care by the need to communicate information about

one’s condition and medical history to one’s caregivers. In disclosing this information, however, patients expect that access to it will be carefully restricted. This use of the term “privacy” is most closely related to the concept of confidentiality.

Decisional privacy refers to an ability to make and act on one’s personal choices without interference from others or the state. The US Supreme Court has relied on a constitutional right to privacy to protect freedom of choice about contraception<sup>12</sup> and abortion,<sup>13</sup> and state courts have used it as the basis for termination of life-sustaining medical treatment.<sup>14</sup> Because decisional privacy is closely linked to the principle of respect for autonomy and the doctrine of informed consent to treatment, and because these latter topics have already been widely discussed in the medical and bioethics literature,<sup>15</sup> the remainder of this article will focus on the physical and informational aspects of privacy.

### Confidentiality

As noted above, confidentiality is closely related in meaning to one of the major uses of the term “privacy,” namely, informational privacy. In health care interactions, patients communicate sensitive personal information to their caregivers so that the caregivers can understand patients’ medical problems and treat them appropriately. By calling such information confidential, we indicate that those who receive the information have a duty to protect it from disclosure to others who have no right to the information. Caregivers can breach confidentiality intentionally by directly disclosing patient information to an unauthorized person or inadvertently by discussing patient information in such a way that an unauthorized person can overhear it.

In discussions of limiting access to patient information, most authors prefer the term “confidentiality” to “privacy.” A notable exception, however, is the HIPAA privacy rule, because that document consistently refers to the privacy of health care information and only infrequently uses the term “confidentiality.” Unless otherwise noted, the rest of this article will use the term “privacy” to refer to protection from the physical presence of or exposure of one’s body to unauthorized persons and “confidentiality” to refer to protection of patient information from disclosure to unauthorized persons.

## MORAL FOUNDATIONS OF PRIVACY AND CONFIDENTIALITY

As noted above, pledges to protect patient privacy and confidentiality have been standard features of medical oaths and codes of ethics since antiquity. The centrality and persistence in medical ethics of the commitment to privacy and confidentiality is no historical accident. Rather, these values are grounded in fundamental moral principles of human dignity, autonomy, and beneficence.

Respect for privacy and confidentiality recognizes the unique moral worth, or dignity, of patients as persons. Human beings are accorded special status as persons based, in part, on their ability to make moral choices and act on them. To make

effective life plans and choices, persons require significant control over their physical environment and private information about themselves. Without such control, each of us would be powerless to avoid the physical intrusions of others or prevent the unwelcome disclosure to others of our most intimate personal information. Privacy and confidentiality are, therefore, necessary preconditions for personal autonomy.

In addition to protecting personal autonomy, respect for privacy and confidentiality is also essential for securing the benefits of a strong therapeutic alliance between physician and patient. If patients are confident that their physicians will protect their privacy and confidentiality, they are more likely to seek medical care and to communicate personal information fully and accurately, thereby enabling caregivers to diagnose and treat them more effectively.

### MORAL LIMITS OF PRIVACY AND CONFIDENTIALITY

Despite their importance in health care, privacy and confidentiality are not absolute values, that is, values that must always be maximized. Instead, privacy or confidentiality may sometimes be limited or overridden by still more important moral considerations.

Privacy and confidentiality are, therefore, best understood as *prima facie* duties, duties that must be honored unless there exists a stronger conflicting duty.<sup>16</sup> Professional duties that may conflict with respecting privacy or confidentiality include duties to protect the patient, duties to protect others, and duties to obey the law. When morally complex situations arise in medicine, physicians typically confront a variety of interests and moral or legal duties that appear to conflict. In response, physicians must engage in careful clinical and moral reasoning. Such reasoning should generally include a clear statement of the problem, collection of relevant information, identification of options for action, comparative evaluation of the options, a decision, action, and assessment of the consequences. In evaluating options for action, physicians must weigh the various reasons (rights, duties, values, interests) for and against different options and choose the option that, all things considered, has the strongest reasons in its favor. Emergency care often requires rapid decisions. Emergency physicians should, therefore, examine potential moral conflicts involving privacy and confidentiality in advance of actual emergency situations and settle on appropriate courses of action for particular circumstances. Using this critical reasoning process, emergency physicians will decide in some situations to protect confidentiality and in others to override it to secure another important value or carry out another important duty.

### LEGAL FOUNDATIONS OF PRIVACY AND CONFIDENTIALITY

Legal obligations to protect patient privacy and confidentiality are grounded in state and federal statutes and the common law. The privacy rule implemented in 2003 under HIPAA establishes significant new confidentiality protections, and that

federal rule will be described below. This section will outline common law rules and statutes designed to protect privacy and confidentiality.

#### Common Law Rules

As noted above, Warren and Brandeis<sup>10</sup> described privacy in an 1890 law review article as “the right to be let alone.” The first US legal case based on this right addressed a health care setting.<sup>11</sup> In *De May v. Roberts* (1881), a Michigan court upheld a couple’s interest in physical privacy after a physician allowed an “unprofessional young, unmarried man” to enter their home and help deliver their baby.<sup>17</sup> As the right of privacy has evolved in US common law, courts have recognized 4 distinct kinds of invasion of privacy, including “unreasonable and highly offensive intrusion upon the seclusion of another” (physical privacy) and “public disclosure of private facts” (confidentiality).<sup>18</sup> To succeed in an action for intrusion on a person’s “seclusion,” the intrusion must be into a private place or matter and must be “offensive or objectionable to a reasonable person.”<sup>18</sup>

In addition to invasion of privacy, US courts have found physicians liable for unauthorized release of medical information through the concept of a fiduciary duty of confidentiality in the physician-patient relationship.<sup>3</sup> Physicians who reveal a patient’s personal information to third parties without appropriate justification may be liable for damages if the patient experiences harm as a result of the disclosure. Breach of confidentiality has also been recognized as a malpractice offense because it violates a professional standard of care.<sup>3</sup> (Other court rulings have established physician duties to disclose medical information in specific circumstances; these exceptions to the legal duty to keep confidentiality will be addressed below.)

#### State and Federal Statutes

A variety of state statutes create general and specific obligations to protect patient confidentiality. Many medical licensing statutes include clauses that identify disclosure of medical information as a type of unprofessional conduct. Statutes in a majority of states also grant testamentary privilege to the physician-patient relationship; this privilege allows defendants to constrain physicians from disclosing patient information in a trial or other legal proceeding. In addition to these more general statutory protections, other statutes create special confidentiality protections for specific conditions. Among the conditions granted such protection are alcohol and drug abuse and HIV-AIDS.<sup>3</sup> Federal statutes also provide protection for health information, including information held by federal agencies, by health care institutions operated by the federal government, and by health care institutions participating in Medicare, Medicaid, and other federal health care programs.<sup>19</sup>

### THE HIPAA PRIVACY REGULATIONS

#### Overview of the Regulations

In addition to the longstanding legal protections for confidential medical information described above, federal

regulations that went into effect in 2003 impose new standards for health care confidentiality across the United States.<sup>4,5</sup> These new regulations, implemented under HIPAA, require providers to protect the confidentiality, integrity, and availability to patients of “individually identifiable personal health information” in any form, whether electronic, written, or oral. Personal health information includes information that relates to a person’s physical or mental health, the provision of health care, or the payment for health care. The regulations apply to all health care organizations, including hospitals, physicians’ offices, health care plans, employers, public health authorities, life insurers, clearinghouses, billing agencies, information systems, and “any ... person or organization who furnishes, bills or is paid for health care in the normal course of business.”

HIPAA regulations require provision of a written “notice of privacy practices” to patients on contact in the ED. This notice must be written in plain language; it must explain who will have access to personal health information and describe patient rights about access, inspection, retrieval, and correction of their health information. The notice must also explain provider duties, grievance procedures, and any anticipated uses or disclosures of patient information. Patients are required to acknowledge receipt of this privacy notice in writing.

Under the HIPAA regulations, emergency physicians may use and disclose personal health information without the patient’s written authorization only in the following circumstances. (1) Personal health information may be given to the patient himself or herself. (2) Caregivers may use and disclose personal health information for their own treatment, payment, and health care operations activities. (“Health care operations” includes a variety of activities, such as quality assessment, education of health care professionals, insurance underwriting, and business management.) (3) With the patient’s “informal permission,” caregivers may disclose personal health information to family members or in facility directories. (4) Caregivers may use and disclose personal health information for 12 “national priority purposes” listed in Figure 1. The original version of the HIPAA privacy rule required that patients give explicit consent for all uses or disclosures of personal health information for treatment, payment, and health care operations.<sup>20</sup> Before the compliance deadline of April 14, 2003, however, the rule was revised to omit this consent requirement on the grounds that it was unnecessary and too burdensome.<sup>21</sup> Some privacy advocates objected that this change severely compromised patients’ abilities to protect their health information.<sup>22</sup>

Under the privacy rule, EDs must implement policies and procedures for ensuring that disclosures of personal health information are limited to the “minimum necessary” to accomplish the purpose of disclosure and nothing more. “Minimum necessary” standards do not, however, apply to disclosures to a health care provider for treatment purposes, disclosures to the patient, and disclosures required by law.

For disclosures made in error, the HIPAA regulations assess civil penalties of US\$100 per violation up to a maximum of US\$25,000 per year. Although patients cannot sue privately for

1. When required by law (statute, regulation, or court order)
2. For public health activities (eg, disease, vital statistics, and adverse events reporting)
3. For reporting of abuse, neglect, or domestic violence
4. For health oversight activities (eg, audits, inspections)
5. For judicial and administrative proceedings
6. For law enforcement purposes (eg, criminal investigations)
7. For disclosures about deceased persons, to coroners, medical examiners, and funeral directors
8. For organ, eye, and tissue donation purposes
9. For some types of research (eg, when an institutional review board has waived the authorization requirement)
10. To avert a serious threat to the health or safety of a person or the public (eg, from an escaped prisoner)
11. For specialized government functions, such as military missions or correctional activities
12. For Workmen’s Compensation claims

**Figure 1.** Twelve “National Priority Purposes” for which personal health information may be used or disclosed under the HIPAA Privacy Rule without the person’s written authorization. Source: 45 CFR §164.512.<sup>4</sup>

a HIPAA privacy violation, the Office of Civil Rights of the Department of Health and Human Services is responsible for overseeing and enforcing the privacy regulations. Maximum criminal penalties for egregious violations include US\$5,000 and 1 year’s imprisonment for wrongful disclosure, US\$100,000 and 5 years’ imprisonment for disclosure under false pretenses, and US\$250,000 and 10 years’ imprisonment for disclosure for profit or malice. In the first year of implementation of the HIPAA privacy rule, the Office of Civil Rights received more than 5,000 complaints of infractions and referred several dozen cases to the Department of Justice for prosecution.<sup>23</sup>

### HIPAA and Research

Emergency medical researchers are permitted to use personal health information if they have specific patient authorization. In the absence of such authorization, researchers may use personal health information only if they have obtained a waiver of authorization from an institutional review board or privacy board and if it is clear that the research may not be conducted without access to the personal health information. The HIPAA Privacy Rule waiver requires that personal identifiers be protected from improper use. Researchers must provide written assurances that personal health information will not be reused or disclosed, and they must provide a written plan to destroy any identifiers at the conclusion of the research, absent a legal justification to retain them.

Health care institutions may also enter into agreements with researchers to disclose “limited data sets” of health care

1. Names
2. Postal address information, other than town or city, state, and ZIP code.
3. Telephone numbers
4. Fax numbers
5. E-mail addresses
6. Social security numbers
7. Medical record numbers
8. Health plan beneficiary numbers
9. Account numbers
10. Certificate/license numbers
11. Vehicle identifiers and serial numbers, including license plate numbers
12. Device identifiers and serial numbers
13. Web universal resource locators
14. Internet protocol numbers
15. Biometric identifiers (including finger and voice prints)
16. Full-face photographic images and any comparable images

**Figure 2.** Sixteen identifiers that must be removed from “limited data sets” of health care information for research purposes. Source: 45 CFR § 164.514(e).<sup>4</sup>

information for research purposes. Such limited data sets must exclude the 16 specific identifiers listed in Figure 2.<sup>24</sup> State laws relating to deidentification of health information may impose additional burdens and limit areas where HIPAA-compliant deidentified information may be used.

## LEGAL LIMITS OF PRIVACY AND CONFIDENTIALITY

In law, as in ethics, obligations to respect the privacy and confidentiality of patients are not absolute. Several exceptions to these obligations are widely recognized in the law, including duties to warn third parties of harm, duties to report various medical conditions, and duties to inform legal guardians and other surrogates about the care of minors and other incompetent patients.

### Duty to Warn

In particular circumstances, physicians have a legal obligation to breach the confidentiality of a patient to warn another individual not under the care of the physician, a so-called third party, of a risk of danger posed by the patient. Early in the past century, in cases of infectious disease, a legal duty was ascribed to physicians to warn third parties of dangers of transmission of the disease to them, despite the fact that this disclosure would breach the confidentiality of the patient.<sup>25-28</sup> A sentinel case, *Tarasoff v. the Regents of the University of California*, involved the failure of a psychologist and supervising psychiatrist to warn of the danger posed by their patient to a woman whom the patient identified and threatened, who was not the psychiatrist’s patient, and who was later murdered by the patient.<sup>29</sup> The holding of this case asserted that the physician has a duty to warn a third

party of danger posed by the patient. Other state courts have varied about whether that duty is a duty to warn or a duty to protect and whether the duty owed is to an identified victim or to any “foreseeable” victim. The level of risk of harm that engenders the duty to warn has also varied from decision to decision. Nonetheless, the duty to breach confidentiality to warn a potential victim has been established in US common law during the past 30 years.

As noted above, statutes in a number of states require special measures to protect the confidentiality of persons infected with HIV. These measures are counterbalanced by common law duties to protect third parties from harm and by reporting requirements described below. A federal law, the Ryan White Comprehensive AIDS Resources Emergency Act, also requires that, in response to requests for information by emergency response employees, medical facilities must notify emergency care providers of any HIV exposure.<sup>30</sup>

### Reportable Conditions

Statutory law requires the reporting of confidential information about a variety of health conditions. Some of these involve a duty closely related to the duty to warn, namely, the duty to protect the public health. Thus, physicians have for centuries had a legal duty to report to the authorities certain infectious diseases, such as tuberculosis and sexually transmitted diseases, despite the patient’s wish to keep the information confidential.<sup>31,32</sup> Lists of reportable diseases are established and updated by state public health authorities; current lists include bioterrorism agents (eg, anthrax, smallpox, plague, botulism, tularemia, viral hemorrhagic fevers) and new epidemic diseases such as severe acute respiratory syndrome.

In addition to infectious diseases, physicians in most states are by law permitted or required to report conditions that affect a patient’s ability to operate a motor vehicle safely. Such reporting is obviously intended to protect travelers from dangers posed by medically impaired operators of public or private modes of transportation.

Legislation in all states mandates reporting of injuries that are suspected to be caused by child abuse, and protects from liability physicians who report in good faith, but in error, a condition which later does not prove to be abuse.<sup>33</sup> Although many emergency physicians have been unaware of family violence reporting statutes involving adults,<sup>34</sup> most states also have mandated the reporting of suspected abuse of elders or dependent adults,<sup>35</sup> and several have mandated reporting of domestic violence against intimate partners.<sup>36</sup> Most states require reporting of any injury, including injuries inflicted by an intimate partner, if the injury was caused by a gun, knife, or other deadly weapon.<sup>37</sup> Requirements vary greatly from state to state about who must report (physician, any health provider, any citizen) and to whom to report (hospital administrator, police, social services agency). A current American Medical Association Code of Ethics opinion opposes mandatory reporting for intimate partner violence on the grounds that the adult victims of domestic violence should retain control over whether and when to report

these actions.<sup>38</sup> Similarly, the American College of Emergency Physicians has a policy opposing mandatory reporting of domestic violence to the criminal justice system.<sup>39</sup>

Mandatory reporting for conditions such as gunshot wounds may be defended on public health grounds (because society wishes to prevent another injury inflicted by the person who caused the original injury), but are more clearly related to law enforcement goals of capturing and punishing perpetrators of violent crimes. Generally, mandatory reporting laws do not require reporting of “victimless crimes” (eg, drug abuse or prostitution) or crimes that are less deadly (eg, battery).

### Minors and Other Incompetent Patients

Parents, as the natural guardians of their minor children, legal guardians, and other legally recognized representatives for incompetent patients are authorized to make health care decisions on behalf of those patients. To make informed health care choices, these individuals must be informed about the medical condition and care of the patients.

In the case of minors, the law recognizes several exceptions to the duty to provide medical information about minor patients to parents or guardians. Although state laws vary, most states have established a status of emancipation for certain minors; criteria for emancipation often include being married and being financially independent.<sup>40,41</sup> Emancipated minors may make health care decisions without parental involvement and are entitled to the same confidentiality protections as adult patients. Additionally, many states recognize the concept of the “mature minor” and grant some decisionmaking and confidentiality protections to minors who have reached a certain age and are intellectually and emotionally capable of making certain health care decisions. Many states also have laws permitting or requiring confidential treatment for minors for such issues as pregnancy, contraception, substance abuse, and sexually transmitted disease.<sup>42</sup>

Legal guidelines about disclosure of patient information may exist in other specific situations. Deceased patients, for example, are incapable of protecting their own interests, but federal law requires the reporting of their vital statistics. Disclosures to family and others must be made discreetly to preserve the decedent’s reputation and dignity where possible.<sup>43</sup>

### PRIVACY AND CONFIDENTIALITY STANDARDS IN HOSPITAL ACCREDITATION

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the recognized accreditation agency for US hospitals, has adopted explicit standards requiring respect for patient confidentiality and privacy. Although not legally required, JCAHO accreditation is a practical necessity for most hospitals. Failure to meet established JCAHO standards may jeopardize a hospital’s accreditation.

The 2003 JCAHO standards on Patient Rights and Organization Ethics includes this statement: “The hospital demonstrates respect for the following patient needs: confi-

deniality; privacy; ...”.<sup>44</sup> The accreditation manual goes on to describe the following as “examples of implementation” of these standards: “Policies and procedures, based on applicable law and regulations, address confidentiality of patient information. The patient is informed of the hospital’s policy on confidentiality at the time of admission”; “cubicle curtains in the emergency area give visual privacy”; and “spacing of stretchers and examination areas in the emergency area give auditory privacy.” As these examples illustrate, accreditation requirements provide additional safeguards for protection of privacy and confidentiality in hospitals and EDs.

In summary, respect for patient privacy and confidentiality is a professional responsibility with both ancient origins and contemporary significance. After a brief review of the concepts of privacy and confidentiality, this first part of the article has outlined the moral and legal foundations and limits of privacy and confidentiality. Part II of the article will examine the claims of privacy and confidentiality in specific ED contexts.

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Address for correspondence: John C. Moskop, PhD, The Brody School of Medicine at East Carolina University, 600 Moyer Boulevard, Greenville, NC 27834; 252-744-2361, fax 252-744-2319; E-mail moskopj@mail.ecu.edu.

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### REFERENCES

1. Oath of Hippocrates. In: Reich WT, ed. *Encyclopedia of Bioethics*. Vol. 5. New York, NY: Macmillan; 1995:2632.
2. World Medical Association. Declaration of Geneva. In: Reich WT, ed. *Encyclopedia of Bioethics*. Vol. 5. New York, NY: Macmillan; 1995:2646-2647.
3. Liang BA. Medical information, records, and confidentiality. In: Liang BA, ed. *Health Law and Policy*. Boston, MA: Butterworth-Heinemann; 2000:45-62.
4. US Department of Health and Human Services, Office for Civil Rights. Standards for privacy of individually identifiable health information; security standards for the protection of electronic protected health information; general administrative requirements including civil monetary penalties: procedures for investigations, imposition of penalties, and hearings. Regulation text. 45 CFR Parts 160 and 164. December 28, 2000, as amended: May 31, 2002, August 14, 2002, February 20, 2003, and April 17, 2003. Available at: <http://www.hhs.gov/ocr/combinedreg-text.pdf>. Accessed February 2, 2004.
5. US Department of Health and Human Services, Office for Civil Rights. Summary of the HIPAA privacy rule. Available at: <http://www.hhs.gov/ocr/privacysummary.pdf>. Accessed February 2, 2004.
6. American College of Emergency Physicians. *Code of Ethics for Emergency Physicians*. Dallas, TX: American College of Emergency Physicians; 2003.
7. Mines D. The ED status board as a threat to patient confidentiality. *Ann Emerg Med*. 1995;25:855-856.

8. Richardson LD, Asplin BR, Lowe RA. Emergency department crowding as a health policy issue: past development, future directions. *Ann Emerg Med.* 2002;40:388-393.
9. Derlet RW, Richards JR. Emergency department overcrowding in Florida, New York, and Texas. *Southern Med J.* 2002;95:846-849.
10. Warren S, Brandeis L. The right to privacy. *Harvard Law Rev.* 1890;4:193-220.
11. Allen AL. Privacy in health care. In: Reich WT, ed. *Encyclopedia of Bioethics.* Vol. 4. New York, NY: Macmillan; 1995:2064-2073.
12. *Griswold v. Connecticut.* 381 U.S. 479 (1965).
13. *Roe v. Wade.* 410 U.S. 113 (1973).
14. *Bouvia v. Superior Court,* 179 Cal.App3d 1127, 225 Cal. Rptr. 297 (1986).
15. Faden RR, Beauchamp TL, King NMP. *A History and Theory of Informed Consent.* New York, NY: Oxford University Press; 1986.
16. Beauchamp TL, Childress JF. Confidentiality. In: *Principles of Biomedical Ethics.* 5th ed. New York, NY: Oxford University Press; 2001, 303-312.
17. *De May v. Roberts,* 46 Mich 160, 9 NW 146 (1881).
18. Keeton WP, Dobbs DB, Keeton RE, et al, eds. *Prosser and Keeton on the Law of Torts.* 5th ed. St. Paul, MN: West Publishing; 1984: 849-869.
19. Roach WH. *Medical Records and the Law.* 3rd ed. Gaithersburg, MD: Aspen Publishers; 1998: 98-102.
20. Ascher J. HIPAA standards for privacy of individually identifiable health information: an introduction to the debate. *J Health Law.* 2002;35:387-394.
21. Rosati K. DHHS wisely proposed to remove the "consent" requirement from the HIPAA privacy standards. *J Health Law.* 2002;35:395-402.
22. Kidera GA. The proposed changes to the final privacy rule suggest a disturbing reduction in an individual's ability to exercise a right to healthcare privacy. *J Health Law.* 2002;35:403-417.
23. Finkelstein JB. One year later, mixed reviews for privacy rule [American Medical News Web site]. Available at: <http://www.ama-assn.org/amednews/2004/05/03/gvsc0503.htm>. Accessed June 28, 2004.
24. 45 CFR §164.514(e).
25. *Edwards v Lamb,* 69 NH 599, 45 A 480 (1899).
26. *Skilling v Allen,* 173 NW 663 Minn (1919).
27. *Davis v Rodman,* 147 Ark 385, 391, 227 SW 612, 614 (1921).
28. *Jones v Stanko,* 118 Ohio St 147 (1928).
29. *Tarasoff v. Regents of the Univ of Cal.,* 17 Cal.3d 425, 131 Cal. Rptr 14, 551 P.2d 334 (1976).
30. Ryan White CARE Act. Available at: <ftp://ftp.hrsa.gov/hab/compile.pdf>. Accessed February 4, 2004.
31. Talbot MD. Confidentiality, the law in England, and sexually transmitted diseases. *Genitourinary Med.* 1986;62:270-276.
32. Coker R. Tuberculosis, noncompliance and detention for the public health. *J Med Ethics.* 2000;26:157-159.
33. Berkowitz CD, Bross DC, Chadwick DL, et al. *Diagnostic and Treatment Guidelines on Child Sexual Abuse.* Chicago, IL: American Medical Association; 1992.
34. Clark-Daniels CL, Daniels RS, Baumhover LA. Abuse and neglect of the elderly: are emergency department personnel aware of mandatory reporting laws? *Ann Emerg Med.* 1990;19:970-977.
35. US Congress, House Select Committee on Aging. *Elder Abuse: What Can Be Done?* Washington, DC: Government Printing Office; 1991.
36. Houry D, Sachs CJ, Feldhaus KM, et al. Violence-inflicted injuries: reporting laws in the fifty states. *Ann Emerg Med.* 2002;39: 56-60.
37. Hyman A, Schillinger D, Lo B. Laws mandating reporting of domestic violence. *JAMA.* 1995;273:1781-1789.
38. American Medical Association. Abuse of spouses, children, elderly persons, and others at risk. CEJA opinion E-2.02. Available at: [http://www.ama-assn.org/apps/pf\\_new/pf\\_online?f\\_n=browse&doc=policyfiles/HnE/E-2.02.HTM&&s\\_t=&st\\_p=&nth=1&prev\\_pol=policyfiles/HnE/E-1.02.HTM&nxt\\_pol=policyfiles/HnE/E-2.01.HTM&](http://www.ama-assn.org/apps/pf_new/pf_online?f_n=browse&doc=policyfiles/HnE/E-2.02.HTM&&s_t=&st_p=&nth=1&prev_pol=policyfiles/HnE/E-1.02.HTM&nxt_pol=policyfiles/HnE/E-2.01.HTM&). Accessed February 4, 2004.
39. American College of Emergency Physicians. Mandatory reporting of domestic violence to law enforcement and criminal justice agencies. ACEP policy, reaffirmed 2001. Available at: <http://www.acep.org/3,615,0.html>. Accessed July 8, 2004.
40. Tsai AK, Schafermeyer RW, Kalifon D, et al. Evaluation and treatment of minors: reference on consent. *Ann Emerg Med.* 1993;22:1211-1217.
41. Jacobstein CR, Baren JM. Emergency department treatment of minors. *Emerg Med Clin North Am.* 1999;17:341-352.
42. Holder AR. *Legal Issues in Pediatrics and Adolescent Medicine.* 2nd ed. New Haven, CT: Yale University Press; 1985.
43. Callahan JC. On harming the dead. *Ethics.* 1987;97: 341-352.
44. Joint Commission on Accreditation of Healthcare Organizations. *2003 Comprehensive Accreditation Manual for Hospitals.* Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organizations; 2003. RI-15.

# From Hippocrates to HIPAA: Privacy and Confidentiality in Emergency Medicine—Part II: Challenges in the Emergency Department

**John C. Moskop, PhD**  
**Catherine A. Marco, MD**  
**Gregory Luke Larkin, MD,**  
**MSPH**  
**Joel M. Geiderman, MD**  
**Arthur R. Derse, MD, JD**

From the Department of Medical Humanities, The Brody School of Medicine at East Carolina University, Bioethics Center, University Health Systems of Eastern Carolina, Greenville, NC (Moskop); the Department of Emergency Medicine, St. Vincent Mercy Medical Center, Toledo, OH (Marco); the Departments of Surgery, Emergency Medicine, and Public Health, University of Texas Southwestern, Dallas, TX (Larkin); Ruth and Harry Roman Emergency Department, the Department of Emergency Medicine, Cedars-Sinai Center for Health Care Ethics, Burns and Allen Research Institute, Cedars-Sinai Medical Center, Los Angeles, CA (Geiderman); and the Center for the Study of Bioethics and the Department of Emergency Medicine, Medical College of Wisconsin, Milwaukee, WI (Derse).

Part I of this article reviewed the concepts of privacy and confidentiality and described the moral and legal foundations and limits of these values in health care. Part II highlights specific privacy and confidentiality issues encountered in the emergency department (ED). Discussed first are physical privacy issues in the ED, including problems of ED design and crowding, issues of patient and staff safety, the presence of visitors, law enforcement officers, students, and other observers, and filming activities. The article then examines confidentiality issues in the ED, including protecting medical records, the duty to warn, reportable conditions, telephone inquiries, media requests, communication among health care professionals, habitual patient files, the use of patient images, electronic communication, and information about minor patients. [Ann Emerg Med. 2005;45:60-67.]

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## SEE RELATED ARTICLE, P. 53.

### INTRODUCTION

Part I of this article focused on the conceptual, moral, and legal foundations and limits of privacy and confidentiality. It addressed 3 important questions: (1) How are privacy and confidentiality defined? (2) What are the major moral and legal reasons for respecting patient privacy and confidentiality? and (3) What are the major moral and legal limits on the professional duty to respect patient privacy and confidentiality? This second part of the article will use the conceptual, moral, and legal framework of Part I to address privacy and confidentiality issues commonly encountered in the emergency department (ED). Following the convention adopted in Part I of the article, this part of the article will use the term “privacy” to refer to protection from the physical presence of or exposure of one’s body to unauthorized persons and “confidentiality” to refer to protection of patient information from disclosure to unauthorized persons. The article will begin by examining privacy issues and then consider confidentiality issues in the ED.

### PRIVACY ISSUES IN THE ED

#### ED Design and Patient Volume

Unlike other hospital units, where private and semiprivate rooms assist in the protection of privacy and confidentiality, EDs often contain large treatment bays in which multiple patients may be housed for long periods, separated from one another only by curtains, if at all. In one study, investigators reported frequent breaches of privacy and confidentiality in a university hospital ED.<sup>1</sup> ED patients in another university hospital reported that they were more likely to be seen and overheard by unauthorized persons in curtained treatment areas than in rooms with solid walls.<sup>2</sup> Although 92.6% of the 104 patients in the latter study reported that their expectations for privacy in the ED were met, 4 patients (all in curtained treatment areas) reported withholding part of their medical history, refusing part of their examination, or both because of privacy concerns. These limited studies, and the authors’ personal experience, suggest that patient privacy in the ED is routinely compromised by physical ED design, crowding, or lack of caregiver vigilance.

When the ED becomes crowded, there may be no practical alternative to placing patients on gurneys in close proximity to one another in treatment areas and hallways for extended periods, greatly exacerbating endemic problems of protecting privacy. ED crowding has become such a common and widespread occurrence that one recent commentator satirically describes “the emerging subspecialty of Hallway Medicine.”<sup>3</sup> Thus, the physical limitations of the ED and the high volume of patients may make the preservation of privacy (and confidentiality) extremely difficult.

Problems of ED design and crowding are, of course, institutional and social issues largely beyond the control of individual emergency physicians. In response to these difficult conditions, however, emergency physicians can take important steps to protect their patients from unnecessary and undesired physical exposure. Emergency physicians should strive to minimize patient waiting time in ED treatment areas, thereby reducing overall patient volume. Emergency physicians should also use all available treatment areas and partitions to separate patients from one another as effectively as possible. They should insist on the use of movable privacy screens when procedures and tests (such as ECGs) must be performed on patients in open areas. When the opportunity arises, emergency physicians should advise designers of new and renovated EDs about ways to make patient privacy and confidentiality a high priority in a patient-centered ED environment.

### **Patient and Staff Safety**

In some cases, it may be appropriate to limit the physical privacy of a particular patient to protect the patient or ED staff from harm. If, for example, a patient poses a grave risk of self-destructive behavior and staffing levels do not allow near-constant observation of the patient, placing the patient in an easily observable area near the nursing station may be preferable to restraining the patient physically or chemically. Similarly, when staffing levels are limited, it may be necessary to place severely ill or injured patients in an area where a single nurse can continuously monitor several patients simultaneously. Patients who exhibit or seriously threaten violence against ED staff or others in the ED may need to be interviewed, observed, and treated in secure areas and in the presence of hospital security personnel or law enforcement officers to protect staff or others at risk.

### **Visitors**

Visitors often provide important comfort and support to the ED patient, but at times certain visitors may add stress or otherwise be unwelcome to the patient. Emergency physicians should protect patient privacy by allowing visitors into patient care areas only when approved by the patient. If the patient is unable to consent, a surrogate should give permission before allowing visitors to enter the clinical area. Visitors should be identified and registered with security before ED entry. On arrival at the bedside, visitors should be instructed to remain with the patient they are visiting and restricted from entering

unauthorized areas of the ED, where they may inappropriately observe other patients or overhear confidential information.

### **Law Enforcement Officers**

Law enforcement officers play several legitimate professional roles in the ED. They may be present in the ED at the request of caregivers to provide physical protection to ED staff, patients, and visitors from a potentially violent patient or visitor. Law enforcement officers may transport injured or ill patients to the ED from the scene of an accident or a violent crime. They may also come into the ED to collect physical evidence, interview crime victims or suspects, or otherwise pursue investigation of an actual or potential crime.

Each of these activities may justify giving law enforcement officers access to ED patients, thereby intruding on their privacy. Ordinarily, ED patients should be asked for and give their permission to be visited by law enforcement officers and to have patient information released to law enforcement officers.<sup>4</sup> Persons transported to the ED in the custody of law enforcement officers, as, for example, crime suspects or prison inmates, may have limited rights to physical privacy and confidentiality. Although *ex parte* warrants can grant police access to patient information, law enforcement activities should not otherwise interfere with patient care. Similar to other visitors, law enforcement officers should also not be allowed to wander and view patient care activities not related to their reason for being in the ED.

### **Students and Other Observers**

Observation of and participation in clinical care are essential aspects of medical education, and medical and other health professions students are frequently present in the ED. Because the presence of students in the ED serves socially valuable educational and therapeutic roles, whether patients should have control over their presence is a controversial issue. Some maintain that patients may not refuse the presence of students in a teaching institution, whereas others believe that consent to the presence of students may be presumed if the patient does not actively object, and still others maintain that explicit consent should be obtained from patients for the presence of students.<sup>5</sup> Most patients accept the participation of students in their own medical care despite its circumscription of their privacy.<sup>6-10</sup> Patients should be informed of the identity and role of all of their caregivers, including students. Careful consideration should be given to patient requests that students not participate in their care. Honoring such requests may depend on the reasons for the request. For example, if a request is based on the student's race, it should not be honored. If, in contrast, a request is made because of a personal relationship between the patient and the student, it should be honored.

Others may also request permission to observe care in the ED, as, for example, a high school student considering a health professions career. Because these observers do not play a role in caring for the patient, the patient's explicit consent should be

obtained for their presence. If patients are unable to consent or refuse, a reasonable person test may be used to determine whether it is morally permissible for an observer to be present by asking the question, "Would a (hypothetical) reasonable person object to the presence of the observer?" Observers without a legitimate clinical service or educational role should not be allowed in the clinical area.<sup>11</sup>

### Filming Activities

Recorded images of patients, including photographs, films, and videotapes, are produced in EDs, as in many other health care settings, for a variety of reasons, including documentation of the patient's condition and treatment, quality assessment and improvement, education of health care professionals, and biomedical research. Videotaping as a valuable tool in emergency medicine education, for example, was reported as early as 1969.<sup>12</sup> The use and disclosure of images made for the above purposes raise important questions of patient confidentiality that will be discussed below. Because physicians, nurses, or others already participating in the care of the patient are typically the ones who take photographs or make videotapes for the above purposes, these activities do not generally raise additional issues of invasion of the patient's physical privacy.

In the past decade, a new impetus for the filming of patients in hospitals and EDs has emerged, namely, the popularity and proliferation of reality-based television programming depicting emergency medical treatment. Emergency physicians have been active in participating in these programs and have even surveyed the attitudes of ED patients and caregivers toward filming for this purpose.<sup>13</sup> The appropriateness of filming in the ED for commercial television programming has been the subject of spirited debate in the emergency medicine literature.<sup>14-25</sup> Proponents of filming in the ED for reality TV programs argue that this practice offers a variety of potential social benefits, including more accurate public education about emergency treatment and injury prevention and increased public scrutiny of emergency practices.<sup>15,16,18</sup> Although they acknowledge that patient privacy and confidentiality are compromised by filming and that patients' abilities to consent may be limited, proponents claim that invasions of privacy are already commonplace in the ED and that most patients do not resent the loss of privacy and are in fact eager for their "15 minutes of fame" on national television.

Opponents of filming in the ED for commercial television argue that this activity unjustifiably invades patient privacy.<sup>14,17,19-25</sup> They point out that some filmmakers use the approach of filming without permission and asking for permission to air the film later. Under this approach, by the time permission to air a film is requested, the patient's physical privacy has already been violated by the very presence of a film crew within an area where the patient has a "reasonable expectation of privacy," the standard that must be satisfied both legally and ethically. If filmmakers do seek consent from patients before filming, another problem confronts them. To capture the sense of drama and life-threatening danger to which

these shows aspire, patients who are approached for consent are often vulnerable and in a state of compromised decisionmaking capacity. Included in this category are patients with acute medical conditions (eg, myocardial infarction), chronic medical conditions (eg, stroke), psychiatric disturbances, mental retardation, limited education, language barriers, or incarceration. Such patients often cannot give valid consent to be filmed. ED staff or students are also vulnerable to coercion and may feel obliged to consent to being filmed.<sup>25,26</sup> Because they are dependent on their supervisors or instructors for their continuing employment or advancement, staff and students, like many patients, may believe that they will not be treated as well if they do not accede to requests to be filmed.

In recent years, several professional organizations have formulated policies about the filming of patients. These policies emphasize the role of consent before filming. In its *2004 Comprehensive Accreditation Manual for Hospitals*, for example, the Joint Commission on Accreditation of Healthcare Organizations has added the following new standard: "Consent is obtained for recordings or filming made for purposes other than the identification, diagnosis, or treatment of the patients."<sup>27</sup> The Joint Commission on Accreditation of Healthcare Organizations recognizes a limited exception to this standard if the patient is unable to give consent before filming and consent is obtained for any subsequent use of the film. An American Medical Association Code of Ethics opinion issued in 2001 also requires previous consent of the patient for filming, except when the patient is "permanently or indefinitely incompetent."<sup>28</sup> An American College of Emergency Physicians policy adopted in 2002 "discourages the filming of television programs in emergency departments except when patients and staff members can give fully informed consent prior to their participation."<sup>29</sup> One final policy, adopted by the Society for Academic Emergency Medicine in 2001, rejects all commercial filming of patients in the following words: "Image recording by commercial entities does not provide benefit to the patient and should not occur in either the out-of-hospital or emergency department setting."<sup>30</sup> Physicians and administrators should also be aware that civil lawsuits for the tort of invasion of privacy have recently been filed against some hospitals and producers involved with these activities, and some hospitals have already entered into out-of-court settlements.

## CONFIDENTIALITY ISSUES IN THE ED

### Protecting Medical Records

Because it documents the patient's care and facilitates communication among health professionals, the medical record is an essential source of personal health information. In addition to ED records, access to medical records from previous hospitalizations informs and thereby improves treatment in the ED. Emergency physicians must, however, protect patient confidentiality by preventing unauthorized persons from viewing patient records. Standard measures for protecting medical records include establishing a secure location for records, returning records to that location after use rather than

leaving them on a counter or table, and removing or covering information on the front of the patient's chart.<sup>31,32</sup>

Many EDs are now using computer applications for patient tracking, physician order entry, prescription and aftercare instructions, and keeping the medical record. In such cases, lists of patients along with their chief complaints are typically displayed on status boards that can be accessed by various computers around the department (similar to the white grease boards that used to be a staple in many EDs). In such cases, computers must be situated so that the public cannot view them, and privacy screens may be required in certain locations. All such computers should require password access, and access should be granted only to those with a legitimate need for it. These computers must also be set to automatically "time out" (revert to the screen saver) within a short period when not in use, if they are not closed by the user. Computer systems that are used to view imaging studies should have similar safeguards.

### **Duty to Warn**

As noted in Part I, US courts have recognized a physician duty to warn third parties when a patient poses a significant danger to their health or safety. This duty will, for several reasons, usually be more difficult to identify and carry out in the ED than in other practice settings. There are, to be sure, ED patients who may endanger others through their violent or reckless actions or their infectious diseases. Because emergency physicians typically lack an ongoing or long-term relationship with their patients, they will often be unable to assess the degree or seriousness of the risk a psychiatric or substance-abusing patient may pose to third parties. Even if they do diagnose a severe and highly contagious disease, emergency physicians will usually require the cooperation of the patient to identify third parties who may be at risk. A possible alternative, if such a patient refuses to cooperate, may be to impose isolation or quarantine on the patient, in concert with public health officials.<sup>33</sup>

### **Reportable Conditions**

In response to recent national emergencies, particularly the terrorist attack of September 11, 2001, public health authorities have expanded the existing list of reportable conditions. The subsequent discovery of anthrax-infected mail has focused attention on reporting of suspected bioterrorist agents such as anthrax, tularemia, plague, botulinum, and smallpox.<sup>34</sup> In response to the worldwide spread of several new and potentially lethal infectious diseases, exacerbated by increased international airline travel, reporting has also been mandated for severe acute respiratory syndrome, West Nile virus, monkey pox, and Ebola virus. The recent emphasis on these conditions and the legal duty to report them impose clear limits on confidentiality.<sup>33</sup> Because patients with these catastrophic infectious diseases are likely to seek care at an ED, emergency physicians must be prepared to identify the conditions and to communicate with public health authorities in ways that protect the populace and guard patient confidentiality whenever possible.

As noted in Part I, state statutes establish clear legal duties to report suspected abuse or neglect of children and dependent elderly persons. The moral basis for this duty, protection of vulnerable individuals from harm, is also clear. Unlike pediatricians or family physicians who may observe and care for children over a period of years, however, emergency physicians must typically make a decision about reporting on the basis of a single patient encounter. The potential danger to children and elders of unrecognized abuse and neglect underlines the importance of careful examination and history taking in the ED to identify suspected cases of abuse or neglect.

### **Telephone Inquiries From Family and Friends**

Telephone inquiries for patient information raise several problems of confidentiality. ED professionals may have difficulty, especially if they are not already acquainted with the caller, in ascertaining his or her identity and relationship to the patient. Even if the caller's identity can be confidently established, the patient may not be able to give consent for release of information. Institutions should develop policies for responding to telephone inquiries, including mechanisms for obtaining patient consent for release of information and for ascertaining the identity of the caller (by, for example, returning a telephone call).<sup>35,36</sup> Unless the caller's identity and relationship to the patient is confidently established and the patient or a surrogate gives consent for release of information, telephone inquiries for patient information should generally not be honored. Other overriding concerns may occasionally justify the limited release of information over the telephone. For example, an emergency physician may judge that it is permissible to reassure a frantic relative that a loved one who has been involved in a major traffic accident is actually alive and well or may encourage a family member to come to the hospital, if the opposite is the case. In such situations, the family member should be expected to identify the patient by their exact full name, without prompting.

### **Media Requests for Patient Information**

In general, it is best for requests by the media for information about patients to be referred to the hospital's public relations department or to someone else administratively charged with handling such requests. Some hospitals confirm that a particular patient has been transported to the hospital and provide information about the patient's general condition (eg, fair, critical, stable, treated and released). Hospitals should obtain the patient's permission for release of this information when possible. Other hospitals use a "no comment" policy in all cases. Inquiries related to possible crimes should be referred to the police conducting the investigation. If the patient is a celebrity or public figure, emergency physicians may be inundated with media requests for information; often, such requests can be referred to a personal spokesperson or publicist.

### **Communication Among Health Care Providers**

Emergency physicians must often share protected health information with other physicians and health care professionals to provide appropriate care for the patient. Communication of

patient information to other health care professionals for this purpose does not constitute a violation of confidentiality. Such information should, however, be shared with others involved in the patient's care only as needed and in appropriate settings.<sup>37-39</sup> In the ED, for example, physicians should avoid discussing patient information or dictating patient notes in treatment bays or open workstations where they can easily be overheard by anyone nearby. Health care professionals may be tempted to divulge patient information to colleagues (or others) in situations when it is not necessary for any medical purpose.<sup>40,41</sup> This temptation may arise when the patient is a public figure, is well known in the institution, or has an unusual condition, but health care professionals must recognize that disclosing private information in such circumstances is morally and legally unjustifiable.

The above review of privacy issues examined the relationship between patient privacy and the presence in the ED of health professions students. Student access to patient information raises similar questions about confidentiality. If students are viewed as professionals-in-training who contribute to patient care and who understand and respect patient confidentiality, their access to patient information may be justified on therapeutic grounds. As noted in Part I, the Health Insurance Portability and Accountability Act (HIPAA) privacy rule places the training of health professions students under the category of "health care operations," thereby allowing the disclosure of information to students without patient authorization.<sup>42</sup>

### Habitual Patient Files

EDs commonly keep files of patients who are suspected of seeking drugs—most often opiates or benzodiazepines—for nontherapeutic purposes, including recreation, abuse, or resale. Such files have been termed "habitual patient files" and, less appropriately, "repeater files," "frequent flyer files," and "special needs files."<sup>43</sup> Although the efficacy of these files in reducing total visits to EDs or altering patient treatment plans has never been established, their common use mandates an examination of the confidentiality issues arising from their existence.

In establishing and using habitual patient files, emergency physicians should be familiar with state and federal laws that regulate these activities. Ideally, a hospital or other health care attorney with expertise in confidentiality issues should be consulted to ensure that a particular process conforms to these laws.

In general, habitual patient files are permissible if their goals include protecting patients from harm as the result of drug abuse, preventing the inappropriate use of valuable ED resources, or protecting society from harms caused by the resale of ill-gotten drugs or the actions of intoxicated persons. Habitual patient files may also contain specific treatment plans—worked out in advance with managing physicians—for patients with chronic pain conditions.

It is permissible (under HIPAA and other regulations) for physicians to share protected health information with other physicians for the purposes of treatment. Other members of the

health care team may also be permitted access to patient information on a need-to-know basis. In general, such sharing should occur within a single institution, and calls between institutions for information should not be honored. The habitual patient file should be kept in a secure location and should be viewed in private. Access should be limited to authorized personnel, and browsing of the file should not be permitted. One suggestion is to create an electronic habitual patient file with password protection and the ability to access the files from many sites within a department. Inappropriate release of information contained in habitual patient files could result in fines or other penalties.

### Use of Patient Images

This article has reviewed the potential threat to patient privacy from filmmakers recording patient images, especially for commercial purposes. Once images have been made, their possible use or dissemination also poses a threat to patient confidentiality. As noted above, images can serve a wide variety of purposes, including documentation, treatment, quality assessment, education of health professionals and the public, research, and commercial entertainment. The rationale for and scope of disclosure of patient information differs significantly among these various purposes.

Images made for documentation and treatment typically contribute directly to patient welfare and remain a part of the patient's medical record. Standard measures to protect the medical record from inappropriate access should therefore be sufficient to protect the confidentiality of these images.

Patient images are also recorded for quality assessment (eg, the practice in some EDs of videotaping some or all trauma resuscitations).<sup>44</sup> Although the potential value of this use of patient images for improving emergency treatment is significant, the patients taped do not benefit directly from their own taping and are unable to consent to the taping. Only health professionals directly involved in the practices under analysis and in the quality assessment process have access to these images, however. Although the HIPAA privacy rule does not require patient authorization for using patient information for this purpose, some notification of this practice, such as signs posted in the ED, may be advisable on moral grounds.

The use of traditional photographs for teaching purposes has been a longstanding practice in medical education, and the use of digital photography and videotaping is rapidly expanding.<sup>45,46</sup> Multimedia educational presentations also offer clear educational benefits.<sup>47-51</sup> Because this information is usually disseminated only to health professional educators and their students, its use has been largely accepted by the professional community and the general public. Nevertheless, an American Medical Association policy entitled "Filming Patients for Educational Purposes" asserts that "informed consent should be obtained before filming whenever possible. If it is not possible to obtain consent from the patient before filming, then consent must be obtained before the film is used for educational purposes."<sup>52</sup> This policy allows surrogate consent for the use of

a film only in the case of minor children or permanently incompetent adults. In a similar statement, the International Committee of Medical Journal Editors asserts that “identifying information should not be published in written descriptions, photographs, or pedigrees unless the information is essential for scientific purposes and the patient (or parent or guardian) gives written informed consent for publication.”<sup>53</sup>

If explicit informed consent is required for use of images in professional education, it should follow that it is also required for use of images in research, public education, and entertainment, where the potential scope of dissemination of the images is much greater. Informed consent should ordinarily be obtained for publication of a patient image even if the image does not identify the patient.<sup>54</sup>

### Electronic Communications

Technology has greatly facilitated the transfer of patient information, and health care providers are using electronic records with increasing frequency.<sup>55-57</sup> The benefits of electronic storage, retrieval, and transmittal are numerous; they include the timely availability of information to clinicians such as medical history, medications, and previous ECGs. These benefits may be especially important in the ED because patients often arrive without documentation of their condition or of treatment provided at other institutions. A disadvantage, however, is that widespread availability of electronic records and the use of electronic data transmission opens the door to unauthorized access, a clear violation of confidentiality. Stories abound of “hackers” who have found access to supposedly “secure” information, such as financial and even national security information. The HIPAA privacy rule requires that access to electronic records be given only to authorized individuals.<sup>42</sup> A HIPAA-authorized security rule, to take effect in April 2005, will require that electronically transmitted health information be encrypted according to strict standards.<sup>58</sup>

Medical records are also sometimes transmitted by fax. In such cases, safeguards must be in place, including ensuring that the receiving fax number is correct and that machines that receive faxes are in secure locations accessible only to authorized personnel. When ED reports are automatically transmitted to primary care providers after an ED visit, it is important that the database of fax numbers be updated periodically. (Similarly, the database of e-mail addresses must also be periodically updated if reports are automatically transmitted by e-mail.) It is also good practice for the fax cover sheet to indicate the confidential nature of the items being faxed. When documents that are received either electronically or by fax will not be made part of the permanent medical record, care must be taken to dispose of them confidentially. Shredders or dedicated locked trash bins are often used for this purpose.

### Minors and Confidentiality

Confidentiality for minor patients presents special concerns in emergency medicine. Numerous factors must be considered when a minor patient requests confidential health care,

1. Keep doors and partitions closed to prevent observation of patients by unauthorized persons.
2. Ask patients before allowing third parties (friends, law enforcement officers, ED observers) to visit them.
3. Obtain the patient’s informed consent before filming, especially for commercial purposes.
4. Keep paper and electronic medical records, including laboratory results and radiographs, out of the reach or sight of unauthorized persons.
5. Do not discuss patients or dictate patient notes within the earshot of unauthorized persons.
6. Do not disclose patient information to colleagues or others unnecessarily.
7. Do not disclose patient information by telephone without patient permission.
8. Obtain the patient’s informed consent for the dissemination, publication, or broadcast of recorded patient images.
9. When a document containing patient information is not needed, dispose of it properly by, for example, shredding or placing in a locked receptacle.
10. Guard and do not share your password to computerized patient information.
11. Educate staff about privacy and confidentiality practices in the ED.

**Figure.** Practical ways to protect privacy and confidentiality in the ED.

including the best interest of the patient, future patient attitudes toward health care, concerns of the parents, federal and state laws, and public health issues.<sup>59-61</sup> Physician attitudes about issues of adolescent confidentiality show considerable variation in different health care settings.<sup>62,63</sup>

For minors who do not meet criteria for emancipation or “mature minor” status and whose conditions do not receive statutory confidentiality protection, issues of confidentiality can be difficult. For example, parents may request health information about their child, but the minor patient may, for a variety of reasons, request that the information not be disclosed to them. Ideally, education of minor patients about the importance of parental involvement in their health care may bridge the gap between the parties. In most such cases, minor patients should be encouraged to be open about health care decisions with their parents. If consent cannot be obtained from the minor patient, the issue of disclosure to parents becomes more controversial. Some argue that parents have a right to receive health information about their dependent children. Others believe that minor patients have the same rights of privacy and confidentiality about health care as adults, particularly because adolescent minors are more likely to seek health care when confidentiality is ensured.<sup>64,65</sup> In general, decisions about disclosure without consent of a minor patient should be made in the best interests of the patient and his or her parents, with careful consideration of state and federal law.

Emergency physicians should generally respect the confidentiality of students seeking treatment for substance misuse, sexually transmitted diseases, contraception, and pregnancy, but

seriously ill teenagers and those threatening to harm themselves or others will generally require hospitalization and disclosure to their parents or guardians. In such cases, consent from the adolescent patient should be obtained whenever possible.

In conclusion, respect for privacy and confidentiality in health care is a professional responsibility with strong moral and legal foundations. Given this mandate, it is paradoxical that emergency physicians often treat patients for whom privacy and confidentiality are of vital importance in settings where privacy and confidentiality are extremely difficult to protect. This article addresses the paradox by examining the scope and limits of the emergency physician's responsibility to protect privacy and confidentiality. The Figure offers a summary listing of practical ways to protect privacy and confidentiality in the ED.

The recent HIPAA privacy rule attempts to reinforce the protection of personal health information and to make the use and disclosure of such information by providers more understandable to patients.<sup>42</sup> Whether such transparency engenders more trust or more suspicion in the minds of ED patients remains to be seen. Because legal mandates are neither necessary nor sufficient to satisfy the moral obligations of physicians, it is essential that physicians understand and accept their responsibility to protect privacy and confidentiality on moral and legal grounds.

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Address for correspondence: John C. Moskop, PhD, The Brody School of Medicine at East Carolina University, 600 Moye Boulevard, Greenville, NC 27834; 252-744-2361, fax 252-744-2319; E-mail moskopj@mail.ecu.edu.

## REFERENCES

1. Mlinek EJ, Pierce J. Confidentiality and privacy breaches in a university hospital emergency department. *Acad Emerg Med.* 1997;4:1142-1146.
2. Barlas D, Sama AE, Ward MF, et al. Comparison of the auditory and visual privacy of emergency department treatment areas with curtains versus those with solid wall. *Ann Emerg Med.* 2001;38:135-139.
3. Freeman J. The emerging subspecialty of hallway medicine. *Can J Emerg Med.* 2003;5:283-285.
4. American College of Emergency Physicians. Law enforcement information gathering in the emergency department. ACEP policy statement, approved September 2003. Available at: [http://www.acep.org/3\\_33206\\_0.html](http://www.acep.org/3_33206_0.html). Accessed February 2, 2004.
5. Sullivan F. Intruders in the consultation. *Fam Pract.* 1995;12:66-69.
6. Purdy S, Plasso A, Finkelstein JA, et al. Enrollees' perceptions of participating in the education of medical students at an academically affiliated HMO. *Acad Med.* 2000;75:1003-1009.
7. Devera-Sales A, Paden C, Vinson DC. What do family medicine patients think about medical students' participation in their health care? *Acad Med.* 1999;74:550-552.
8. Magrane D, Gannon J, Miller CT. Obstetric patients who select and those who refuse medical students' participation in their care. *Acad Med.* 1994;69:1004-1006.
9. Rizk DE, Al-Shebah A, El-Zubeir MA, et al. Women's perceptions of and experiences with medical student involvement in outpatient obstetric and gynecologic care in the United Arab Emirates. *Am J Obstet Gynecol.* 2002;187:1091-1100.
10. Ching SL, Gates EA, Robertson PA. Factors influencing obstetric and gynecologic patients' decisions toward medical student involvement in the outpatient setting. *Am J Obstet Gynecol.* 2000;182:1429-1432.
11. Ziel SE. Spectators in the OR. *AORN J.* 1997;65:429-430.
12. Peltier LF, Geertsma RH, Youmans RL. Television videotape recording: an adjunct in teaching emergency medical care. *Surgery.* 1969;66:233-236.
13. Rodriguez RM, Graham GM, Young JC. Patient and provider attitudes toward commercial television film crews in the emergency department. *Acad Emerg Med.* 2001;8:740-745.
14. Geiderman JM. Fame, rights, and videotape. *Ann Emerg Med.* 2001;37:217-219.
15. Iserson KV. Response to fame, rights and videotape. *Ann Emerg Med.* 2001;37:219.
16. Iserson KV. Film: exposing the emergency department. *Ann Emerg Med.* 2001;37:220-221.
17. Geiderman JM. Response to film: exposing the emergency department. *Ann Emerg Med.* 2001;37:222.
18. Zibulewsky J. Filming of emergency department patients [letter]. *Ann Emerg Med.* 2001;38:189.
19. Geiderman JM. In defense of patient privacy [letter]. *Ann Emerg Med.* 2002;39:99.
20. Marco CA, Larkin GL, Silbergleit R. Filming of patients in academic emergency departments. *Acad Emerg Med.* 2002;9:248-250.
21. Geiderman JM, Solomon RC. Filming patients without prior consent [letter]. *Acad Emerg Med.* 2002;9:259.
22. Larkin GL. Filming patients without prior consent [letter]. *Acad Emerg Med.* 2002;9:259-261.
23. Lerman B. Filming patients without prior consent [letter]. *Acad Emerg Med.* 2002;9:261-262.
24. Rodriguez RM. Filming patients without prior consent [reply]. *Acad Emerg Med.* 2002;9:262-263.
25. Geiderman JM, Larkin GL. Commercial filming of patient care activities in hospitals. *JAMA.* 2002;288:373-379.
26. Moreno J, Caplan AL, Wolpe PR. Updating protections for human subjects involved in research. *JAMA.* 1998;280:1951-1958.
27. Joint Commission on Accreditation of Healthcare Organizations. *2004 Comprehensive Accreditation Manual for Hospitals: The Official Handbook.* Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organizations; 2004. RI-10-RI-11.
28. American Medical Association. Filming patients in health care settings. CEJA opinion E-5.045 December 2001.
29. American College of Emergency Physicians. Filming in the emergency department. ACEP policy statement, approved February 2002. Available at: [http://www.acep.org/1\\_5065\\_0.html](http://www.acep.org/1_5065_0.html). Accessed February 2, 2004.
30. Society for Academic Emergency Medicine Board of Directors. SAEM position on filming of emergency patients. *Acad Emerg Med.* 2002;9:251.
31. Critical Path Network. Is your ED ready for HIPAA? How to protect privacy. *Hosp Case Manag.* 2002;10:135-137.
32. Bradley D. HIPAA compliance efforts. *Ped Emerg Care.* 2004;20:68-70.
33. Singer PA, Benatar SR, Bernstein M. Ethics and SARS: lessons from Toronto. *BMJ.* 2003;327:1342-1344.

34. Horton HH, Misrahi JJ, Matthews GW, et al. Critical biological agents: disease reporting as a tool for determining bioterrorism preparedness. *J Law Med Ethics*. 2002;30:262-266.
35. Tammelleo AD. Staying out of trouble on the telephone. *RN*. 1993;56:63-64.
36. Morris MR. On the legal side: patients' privacy on the line. *Am J Nurs*. 1996;96:75.
37. Ubel PA, Zell MM, Miller DJ, et al. Elevator talk: observational study of inappropriate comments in a public space. *Am J Med*. 1995;99:190-194.
38. Siegler M. Confidentiality in medicine: a decrepit concept. *N Engl J Med*. 1982;307:1518-1521.
39. Clark P. Confidentiality and the physician-patient relationship: ethical reflections from a surgical waiting room. *Med Sci Monit*. 2002;8:SR31-34.
40. Weiss BD. Confidentiality expectations of patients, physicians, and medical students. *JAMA*. 1982;247:2695-2697.
41. Lindenthal JJ, Thomas CS. Consumers, clinicians and confidentiality. *Soc Sci Med*. 1982;16:333-335.
42. US Department of Health and Human Services, Office for Civil Rights. Summary of the HIPAA privacy rule. Available at: <http://www.hhs.gov/ocr/privacysummary.pdf>. Accessed August 6, 2004.
43. Geiderman JM. Keeping lists and naming names: habitual patient files for suspected nontherapeutic drug-seeking patients. *Ann Emerg Med*. 2003;41:873-881.
44. Ellis DG, Lerner EB, Jehle DV, et al. A multi-state survey of videotaping practices for major trauma resuscitations. *J Emerg Med*. 1999;17:597-604.
45. Brooks AJ, Phipson M, Potgieter A, et al. Education of the trauma team: video evaluation of compliance with universal barrier precautions in resuscitation. *Eur J Surg*. 1999;165:1125-1128.
46. Olsen JC, Gurr DE, Hughes M. Video analysis of emergency medicine residents performing rapid-sequence intubations. *J Emerg Med*. 2000;18:469-472.
47. Herxheimer A, McPherson A, Miller R, et al. Database of patients' experiences (DIPEX): a multimedia approach to sharing experiences and information. *Lancet*. 2000;355:1540-1543.
48. Hovenga EJ. Using multimedia to enhance a flexible learning program: lessons learned. *Proc AMIA Symp* 1999:530-534.
49. Xie ZZ, Chen JJ, Scamell RW, et al. An interactive multimedia training system for advanced cardiac life support. *Comput Methods Programs Biomed*. 1999;60:117-131.
50. Clark LJ, Watson J, Cobbe SM, et al. CPR 98: a practical multimedia computer-based guide to cardiopulmonary resuscitation for medical students. *Resuscitation*. 2000;44:109-117.
51. McGee JB, Neill J, Goldman L, et al. Using multimedia virtual patients to enhance the clinical curriculum for medical students. *Medinfo*. 1998;9(Pt 2):732-735.
52. American Medical Association. AMA policy H-140.888: filming patients for educational purposes. Available at: [http://www.ama-assn.org/apps/pf\\_new/pf\\_online?f\\_n=browse&doc=policy-files/HnE/H-140.888.HTM](http://www.ama-assn.org/apps/pf_new/pf_online?f_n=browse&doc=policy-files/HnE/H-140.888.HTM). Accessed February 20, 2004.
53. International Committee of Medical Journal Editors. Style matters: protection of patients' rights to privacy. *BMJ*. 1995;311:1272.
54. Hood CA, Hope T, Dove P. Videos, photographs, and patient consent. *BMJ*. 198;316:1009-1011.
55. Neinstein L. Utilization of electronic communication (E-mail) with patients at university and college health centers. *J Adolesc Health*. 2000;27:6-11.
56. Lowrance WW. *Privacy and Health Research: A Report to the US Secretary of Health and Human Services*. Washington, DC: Department of Health and Human Services; 1997.
57. National Research Council. *For the Record: Protecting Electronic Health Information*. Washington, DC: National Academy Press; 1997.
58. US Department of Health and Human Services. Health insurance reform: security standards. Final rule. 68 Fed Reg 8334-8381 (2003).
59. English A, Simmons PS. Legal issues in reproductive health care for adolescents. *Adolesc Med*. 1999;10:181-194.
60. Silber TJ. Ethical and legal issues in adolescent pregnancy. *Clin Perinatol*. 1987;14:265-270.
61. Silber TJ. Ethical considerations concerning adolescents consulting for contraceptive services. *J Fam Pract*. 1982;15:909-911.
62. Lovett J, Wald MS. Physician attitudes toward confidential care for adolescents. *J Pediatr*. 1995;106:517-521.
63. Akinbami LJ, Gandhi H, Cheng TL. Availability of adolescent health services and confidentiality in primary care practices. *Pediatrics*. 2003;111:394-401.
64. Proimos J. Confidentiality issues in the adolescent population. *Curr Opin Pediatr*. 1993;9:325-328.
65. Reddy DM, Fleming R, Swain C. Effect of mandatory parental notification on adolescent girls' use of sexual health care services. *JAMA*. 2002;288:710-714.



## MINNESOTA JUDICIAL TRAINING UPDATE



### BAIL HEARINGS IN FELONY STRANGULATION CASES SEVEN (7) MEDICAL-LEGAL FACTS EVERY JUDGE SHOULD KNOW

**QUESTION:** When making bail decisions in Felony Strangulation cases, what seven (7) well-established medical-legal facts should every judge (and attorney) be aware of?

**1. DEFINITION OF STRANGULATION:** Strangulation is a form of asphyxia (lack of oxygen) characterized by closure of the blood vessels and/or air passages of the neck as a result of external pressure on the neck.

#### **2. WIDESPREAD LACK OF UNDERSTANDING:**

- Many judicial officers and attorneys do not understand the medical and psychological severity of the act of strangulation.
- In many cases, the lack of observable physical injuries to the victim cause judges to minimize the seriousness of strangulation.
- In order to make sure judges understand the seriousness of strangulation, some prosecutors have asked courts for permission to have an expert in the field of strangulation testify at bail hearings as to the following: see 3-7 below.

#### **3. STRANGULATION IS ONE OF THE MOST LETHAL FORMS OF VIOLENCE USED BY MEN AGAINST THEIR FEMALE INTIMATE PARTNERS:**

- The act of strangulation symbolizes an abuser's power and control over the victim. The sensation of suffocating can be terrifying.
- Most victims of strangulation are female.
- The victim is completely overwhelmed by the abuser; she vigorously struggles for air, and is at the mercy of the abuser for her life.
- The victim will likely go through four stages: denial, realization, primal and resignation.
- A single traumatic experience of strangulation or the threat of it may instill such intense fear that the victim can get trapped in a pattern of control by the abuser and made vulnerable to further abuse.

**4. THE "NECK" IS THE MOST VULNERABLE PART OF THE BODY:**

- Blood and oxygen all flow from the body to your brain through the NECK.
- The NECK is the most unprotected and vulnerable part of the body.
- More serious injuries occur from NECK trauma than any other part of the body.

**5. MEDICAL FACTS:**

- Strangulation **stops the flow of blood** to the brain (carotid artery).
- Lack of blood flow to the brain will cause **unconsciousness in 10 seconds**.
- Lack of blood flow to the brain will cause **death in 4 minutes**.
- It takes **very little pressure to stop blood flow** to the brain (4 psi):
  - a. It takes less pressure than opening a can of soda (20 psi);
  - b. It takes less pressure than an average handshake (80-100 psi);
  - c. It takes less pressure than pulling the trigger of a handgun (6 psi).
- It only takes 33 psi to **fracture a victim's larynx** (far less than a handshake).

**6. LACK OF EXTERNAL EVIDENCE ON THE SKIN:**

- CAUTION: Lack of visible findings (or minimal injuries) does not exclude a potentially life threatening condition. Strangulation often leaves no marks.
- A study by the San Diego City Attorney's Office of 300 domestic violence cases involving strangulation revealed that up to 50% of victims had no visible injuries.

**7. STRANGULATION CAN CAUSE SUBSTANTIAL INJURIES (OFTEN DELAYED) SUCH AS:**

- a. **Physical injuries** (e.g. death, unconsciousness, fractured trachea/larynx, internal bleeding (*hemorrhage*) and artery damage (*intimal tears*), dizziness, nausea, sore throat, voice changes, throat and lung injuries, swelling of the neck (*edema*), breathing and swallowing problems, ringing in the ears (*tinnitus*), vision change, miscarriage);
- b. **Neurological injuries** (e.g. facial or eyelid droop (*palsies*), left or right side weakness (*hemiplegia*), loss of sensation, loss of memory, paralysis);
- c. **Psychological injuries** (e.g. PTSD, depression, suicidal ideation, memory problems, nightmares, anxiety, severe stress reaction, amnesia and psychosis);
- d. **Delayed fatality** (e.g. death can occur days or weeks after the attack due to carotid artery dissection and respiratory complications such as pneumonia, ARDS and the risk of blood clots traveling to the brain (*embolization*)).

## MINNESOTA HISTORICAL FACTS OF INTEREST

1. It is estimated that 23% to 68% of women victims of domestic violence have experienced at least one strangulation assault during their lifetime. Victims of prior attempted strangulation are 7 times more likely of becoming a homicide victim.
2. In response, the Minnesota Coalition for Battered Women (MCBW) with the assistance of WATCH and its member programs, pushed for the creation of a felony statute for domestic strangulation during the 2005 legislative session.
3. In 2005, Minnesota became one of just six states with a specific statute making strangulation of a family or household member a felony-level crime. MS 609.2247.
4. Under Section 609.2247 strangulation means intentionally impeding normal breathing or circulation of the blood by applying pressure on the throat or neck or by blocking the nose or mouth of another person.
5. Prior to the law's passage, most domestic strangulation cases were charged as misdemeanors even though strangulation is one of the most dangerous forms of domestic violence.
6. As of 2014, thirty-eight (38) states have passed similar strangulation statutes.
7. Minnesota is the only state to have conducted an evaluation of the felony strangulation law. Three nationally distributed reports prepared by WATCH in 2007 and 2009, identified the goals, the challenges and the benefits of the law including homicide prevention; interviewed professionals from the criminal justice system, analyzed court files, and made numerous recommendations to enhance the effectiveness of the law. (Watch 2007, 2009).

**STRANGULATION IS OFTEN ONE OF THE LAST ABUSIVE ACTS COMMITTED BY A VIOLENT DOMESTIC PARTNER BEFORE MURDER.**

2004 Report, Hennepin County Domestic Fatality Review Team

NOTE: The above referenced reports can be obtained by contacting "WATCH" 608 2nd Ave. S., # 465 Minneapolis, MN 55402, 612-341-2747, [watch@watchmn.org](mailto:watch@watchmn.org), [www.watchmn.org](http://www.watchmn.org).

**REFERENCES:** Gael B. Strack, JD, CEO and Co-Founder of the Family Justice Center Alliance, San Diego, CA, [gael@nfjca.org](mailto:gael@nfjca.org), 888-511-3522; Dr. Michael Weaver, M.D., Medical Director, St. Luke's Hospital's Sexual Assault Treatment center, Kansas City, Missouri.

Hon. Alan F. Pendleton, Anoka County District Court, Anoka, Mn 55303; 763-422-7309