

American Medical Association

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Diagnostic and Treatment Guidelines

on

Domestic Violence

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These guidelines are not intended to be construed or to serve as a standard of medical care. Standards of medical care are determined on the basis of all the facts and circumstances involved in an individual case and are subject to change as scientific knowledge and technology advance and patterns of practice evolve. These guidelines reflect the views of scientific experts and reports in the scientific literature as of March 1992.

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Introduction

Physical and sexual violence against women is a public health problem that has reached epidemic proportions. An estimated 8-12 million women in the United States are at risk of being abused by their current or former intimate partners. This violence causes serious physical, psychological, and social sequelae for these women and their families.

Domestic violence, also known as partner-abuse, spouse-abuse, or battering, is one facet of the larger problem of family violence. Family violence occurs among persons within family or other intimate relationships, and includes child abuse and elder abuse as well as domestic violence. Family violence usually results from the abuse of power or the domination and victimization of a physically less powerful person by a physically more powerful person.

Until the mid-1970s, assaults against wives were considered misdemeanors in most states, even when an identical assault against a stranger would have been considered a felony. The current consensus among state and federal policy makers is:

- Domestic violence is a crime
- Safety for victims of domestic violence and their children must be a priority
- Changes in traditional services, including medical care, are needed to meet the needs of abused women

Most states have improved the legal remedies available to battered women, and a number of state health departments have developed protocols for health care providers. Since January 1992, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has required that all accredited hospitals implement policies and procedures in their emergency departments and ambulatory care facilities for identifying, treating, and referring victims of abuse. The standards require educational programs for hospital staff in domestic violence, as well as elder abuse, child abuse, and sexual assault.

Because a physician may be the first nonfamily member to whom an abused woman turns for help, he or she has a unique opportunity and responsibility to intervene. Battered women often present with repeated injuries, medical complaints, and mental health problems, all of which result from living in an abusive relationship. Physicians in all practice settings routinely see the consequences of violence and abuse, but often fail to acknowledge their violent etiologies. By recognizing and treating the effects of domestic violence, and by providing referrals for shelter, counseling and advocacy, physicians can help battered women regain control of their lives.

These guidelines are intended to:

- Familiarize you with the magnitude of the problem
- Describe how to identify abuse and violence through routine screening and recognition of clinical presentations
- Help you assess the impact of abuse and violence on your patients' health and well-being
- Provide examples of how to ask questions in ways that can elicit meaningful responses and help women to explore their options and take action
- Provide information on appropriate resources for referral and address frequently encountered obstacles
- Familiarize you with the legal aspects of medical care, including reporting requirements

Facts About Domestic Violence

Domestic violence is characterized as a pattern of coercive behaviors that may include repeated battering and injury, psychological abuse, sexual assault, progressive social isolation, deprivation, and intimidation. These behaviors are perpetrated by someone who is or was involved in an intimate relationship with the victim. Although some women are successful in escaping a violent relationship after the first assault, most abuse is recurrent and escalates in both frequency and severity. In addition, a woman's independence may be compromised by her partner's need to dominate her and control many aspects of her life: He may restrict her access to food, clothing, money, friends, transportation, health care, social services or employment.

Research has failed to demonstrate a psychological or cultural profile of battered women. However, certain groups of women appear to be at somewhat higher risk for abuse: women who are single, separated, or divorced (or are planning a separation or divorce); women between the ages of 17 and 28; women who abuse alcohol or other drugs—or whose partners do; women who are pregnant; or women whose partners are excessively jealous or possessive. Children raised in violent homes may be at increased risk for perpetrating or experiencing violence in adulthood, but not all abusive partners or abused women were exposed to family violence while growing up.

Domestic violence cuts across all racial, ethnic, religious, educational, and socioeconomic lines. However, physicians should be aware that a woman's family background, as well as her cultural and religious beliefs may influence her perceptions of abuse. In addition, her socioeconomic status influences her access to medical care. Women of higher socioeconomic status are more likely to seek care in private practice settings, while low-income women are more likely to go to clinics and emergency departments.

Conservative studies indicate that two million women per year are assaulted by their partners, but experts believe that the true incidence of partner violence is probably closer to four million cases per year.

- Nearly one quarter of women in the United States—more than 12 million—will be abused by a current or former partner some time during their lives.
- 47% of husbands who beat their wives do so three or more times a year.
- According to FBI statistics, 30% of women who were murdered in 1990 were killed by husbands or boyfriends. It is estimated that 52% of female murder victims were killed by a current or former partner.
- 14% of ever-married women report being raped by their current or former husbands, and rape is a significant or major form of abuse in 54% of violent marriages.

Clinical studies underscore the prevalence of domestic violence and its relationship to continued or repeated trauma and consequent medical and psychiatric problems. More than half of all nonfatal assaults result in injury, and 10% of the victims require hospitalization or emergency medical treatment. Seventy-five percent of battered women first identified in a medical setting will go on to suffer repeated abuse. According to various studies, battered women may account for:

- 22% to 35% of women seeking care for any reason in emergency departments, the majority of whom are seen by medical or other nontrauma services
- 19% to 30% of injured women seen in emergency departments
- 14% of women seen in ambulatory-care internal medicine clinics (28% have been battered at some time)
- 25% of women who attempt suicide
- 25% of women utilizing a psychiatric emergency service
- 23% of pregnant women seeking prenatal care
- 45% to 59% of mothers of abused children
- 58% of women over 30 years old who have been raped

Most research has focused on women who have been battered by male partners, and, in fact, women are more likely than men to be seriously injured by their partners. However, the terms spouse-abuse and partner-abuse reflect an awareness that men also can be abused in intimate relationships. The extent to which findings about battered women can be applied to men who are abused by women, or to the underrecognized problem of violence within gay and lesbian relationships, is not known. In clinical practice, these issues also must be addressed in a sensitive and nonjudgmental manner.

Forms of Abuse

Domestic violence is an ongoing, debilitating experience of physical, psychological and/or sexual abuse in the home, associated with increased isolation from the outside world and limited personal freedom and accessibility to resources. Whenever a woman is placed in physical danger or controlled by the threat or use of physical force, she has been abused. The risk for abuse is greatest when a woman is separated from supportive networks.

Physical abuse is usually recurrent and escalates in both frequency and severity. It may include the following:

- Pushing, shoving, slapping, punching, kicking, choking
- Assault with a weapon
- Holding, tying down, or restraining her
- Leaving her in a dangerous place
- Refusing to help when she is sick or injured

Emotional or psychological abuse may precede or accompany physical violence as a means of controlling through fear and degradation. It may include the following:

- Threats of harm
- Physical and social isolation
- Extreme jealousy and possessiveness
- Deprivation
- Intimidation
- Degradation and humiliation
- Calling her names and constantly criticizing, insulting and belittling her
- False accusations, blaming her for everything
- Ignoring, dismissing, or ridiculing her needs
- Lying, breaking promises, destroying trust
- Driving fast and recklessly to frighten and intimidate her

Sexual abuse in violent relationships is often the most difficult aspect of abuse for women to discuss. It may include any form of forced sex or sexual degradation, such as:

- Trying to make her perform sexual acts against her will
- Pursuing sexual activity when she is not fully conscious or is not asked or is afraid to say no
- Hurting her physically during sex or assaulting her genitals, including use of objects or weapons intravaginally, orally, or anally
- Coercing her to have sex without protection against pregnancy or sexually transmissible diseases
- Criticizing her and calling her sexually degrading names

Interviewing Process

Domestic violence and its medical and psychiatric sequelae are sufficiently prevalent to justify *routine screening* of all women patients in emergency, surgical, primary care, pediatric, prenatal, and mental health settings. Because some women may not initially recognize themselves as “battered,” the physician should routinely ask all women direct, specific questions about abuse. Such questions may be included in the social history, past medical history, review of systems, or history of present illness, as appropriate.

Although women may not bring up the subject of abuse on their own, many will discuss it when asked simple, direct questions in a nonjudgmental way and in a confidential setting. The patient should be interviewed *alone*, without her partner present. The physician should make an opening supportive statement, such as: “Because abuse and violence are so common in women’s lives, I’ve begun to ask about it routinely.” Even if the patient does not respond at the time, the fact that a provider is concerned and believes that battering is a possibility will make an impression. The physician’s concern about abuse validates her feelings and reinforces her capacity to seek help when she feels ready and able to do so.

Routine questions about violence not only identify women who are currently being abused but also serve to assess the safety of women who have been battered in the past and to heighten the awareness of those who have not been in abusive relationships. Routine assessment is particularly important for women who have left a violent relationship; leaving an abusive partner or finalizing a divorce may increase her risk for abuse. The physician should provide appropriate follow-up during legal proceedings, and assess the woman’s need for emergency shelter or other resources.

A medical encounter may provide the only opportunity to stop the cycle of violence before more serious injuries occur, and intervention begins by gathering information. Providing the woman with a different kind of experience—one in which she is respected and taken seriously; one that lets her know she doesn’t deserve to be abused; one that offers the possibility of support and safety, and one that encourages her own choices and decision-making is, in itself, therapeutic and an important step. Questions about domestic violence should be asked in the physician’s own words and in a nonjudgmental way. Here are some examples of recommended questions:

- Are you in a relationship in which you have been physically hurt or threatened by your partner? Have you ever been in such a relationship?
- Are you (have you ever been) in a relationship in which you felt you were treated badly? In what ways?
- Has your partner ever destroyed things that you cared about?
- Has your partner ever threatened or abused your children?
- Has your partner ever forced you to have sex when you didn’t want to? Does he ever force you to engage in sex that makes you feel uncomfortable?

- We all fight at home. What happens when you and your partner fight or disagree?
- Do you ever feel afraid of your partner?
- Has your partner ever prevented you from leaving the house, seeing friends, getting a job, or continuing your education?
- You mentioned that your partner uses drugs/alcohol. How does he act when he is drinking or on drugs? Is he ever verbally or physically abusive?
- Do you have guns in your home? Has your partner ever threatened to use them when he was angry?

Diagnosis and Clinical Findings

Injury: Episodes of physical assault characterize abusive relationships. Physicians should especially consider the possibility of assault when the woman's explanation of how an injury occurred does not seem plausible or when there has been a delay in seeking medical care. Common types of injury include:

- Contusions, abrasions, and minor lacerations, as well as fractures or sprains
- Injuries to the head, neck, chest, breasts, and abdomen
- Injuries during pregnancy
- Multiple sites of injury
- Repeated or chronic injuries

Medical findings: The stress of living in an ongoing abusive relationship may cause any of the following:

- Chronic pain, psychogenic pain, or pain due to diffuse trauma without visible evidence
- Physical symptoms related to stress,
- chronic post-traumatic stress
- disorder, other anxiety disorders, or
- depression. Examples are:
 - Sleep and appetite disturbances
 - Fatigue, decreased concentration, sexual dysfunction
 - Chronic headaches
 - Abdominal and gastrointestinal complaints
 - Palpitations, dizziness, paresthesias, dyspnea
 - Atypical chest pain
- Gynecologic problems, frequent vaginal and urinary tract infections, dyspareunia, pelvic pain
- Frequent use of prescribed minor tranquilizers or pain medications
- Frequent visits with vague complaints or symptoms without evidence of physiologic abnormality

Many practitioners have noted that chronic illnesses such as asthma, seizure disorders, diabetes, arthritis, hypertension, and heart disease may be exacerbated or poorly controlled in women who are being abused.

Sexual coercion and assault are common expressions of domestic violence. Assessment for sexual abuse and rape should be addressed in the sexual or social history taken during routine primary care visits, in discussions of birth control and safer sexual practices and in evaluations during gynecologic and obstetric visits.

Pregnancy: Because of the risk to the mother and fetus, assessment for abuse should be incorporated into routine prenatal and postpartum care. Presentations include:

- Injuries, particularly to the breasts, abdomen, and genital area, or unexplained pain.
- Substance abuse, poor nutrition, depression, and late or sporadic access to prenatal care
- “Spontaneous” abortions, miscarriages, and premature labor

Mental Health/Psychiatric Symptoms:

Assessment for domestic violence should be included as a routine part of psychiatric intakes and evaluations. The stress of domestic violence may aggravate comorbid psychiatric disorders. Psychiatric symptoms of abuse include the following:

- Feelings of isolation and inability to cope
- Suicide attempts or gestures
- Depression
- Panic attacks and other anxiety symptoms
- Alcohol or drug abuse
- Post-traumatic stress reactions and/or disorder

Routine assessment of domestic violence in the patient’s family is important for both men and women in alcohol and drug rehabilitation programs. Nearly 75% of all wives of alcoholics have been threatened, and 45% have been assaulted by their addicted partners.

Control in a Relationship: An abusive partner’s use of control within a violent relationship may result in:

- Limited access to routine and/or emergency medical care
- Noncompliance with treatment regimens
- Not being allowed to obtain or take medication
- Missed appointments Lack of independent transportation, access to finances, ability to communicate by phone Failure to use condoms or other contraceptive methods
- Not being told by a partner that he is infected with HIV or other sexually transmissible diseases

Behavioral Signs: Battered women exhibit a variety of responses to the stress of ongoing abuse; such patients may appear frightened, ashamed, evasive or embarrassed. A battered woman may believe she deserves the abuse because the abuser tells her so, and she may take responsibility for his violence to maintain some sense of control over her situation.

Other findings may include the following:

- Partner accompanies patient, insists on staying close, and answers all questions directed to her
- Reluctance of a patient to speak or disagree in front of her partner
- Intense irrational jealousy or possessiveness expressed by partner or reported by patient
- Denial or minimization of violence by partner or by patient
- Exaggerated sense of personal responsibility for the relationship, including self-blame for her partner's violence

Interventions

Important Considerations

Once abuse is recognized, a number of interventions are possible, but even if a woman is not ready to leave the relationship or take other action, the physician's recognition and validation of her situation is important. Silence, disregard, or disinterest convey tacit approval or acceptance of domestic violence. In contrast, recognition, acknowledgment, and concern confirm the seriousness of the problem and the need to solve it. *Optimal care for the woman in an abusive relationship also depends on the physician's working knowledge of community resources that can provide safety, advocacy, and support.*

The injury or complaint that precipitated the health care encounter requires evaluation and appropriate treatment. In addition, the physician should ask about the patient's use of pain, sleeping, or antianxiety agents. Psychiatric problems, including severe depression, panic disorder, suicidal tendencies or substance abuse, may hinder the battered woman's ability to assess her situation or take appropriate action. When serious psychiatric conditions are present, an appropriate treatment plan includes psychiatric evaluation and treatment. On the other hand, emotional, behavioral, and cognitive symptoms of abuse can be misinterpreted as psychiatric in origin. Physicians must make sure that the mental health professional to whom they refer the patient is sensitive to these issues.

Alcohol or drugs may be used to rationalize violent behavior. Perpetrators and family members may insist that substance abuse is the problem. Evidence indicates that while substance abuse and violent behavior frequently coexist, the violent behavior will not end unless interventions address the violence as well as the addiction. Similarly, mental illness is rarely the cause of domestic violence, although mental illness in a batterer can lead to loss of control and increased frequency and severity of violence. Treating the mental illness alone will not end the violence. Both issues must be addressed.

Couples' counseling or family intervention is generally contraindicated in the presence of domestic violence. Attempts to implement family therapy in the presence of ongoing violence may increase the risk of serious harm. *The first concern must be for the safety of the woman and her children.*

Often women are not the only victims at home: Child abuse has been reported to occur in 33% to 54% of families where adult domestic violence occurs. In situations when children are also being abused, coordinated liaisons between advocates for victims of domestic violence and child protective service agents should be used to ensure the safety of both the mother and her children. Otherwise, the reporting and investigation of alleged child abuse may increase the mother's risk of abuse.

Patient Safety

It is imperative that the physician inquire about a battered woman's safety *before she leaves the medical setting*. The severity of current or past injury is not an accurate predictor of future violence; and many women minimize the danger they face. After assessing the situation, plans for the woman's safety should be discussed before she leaves the physician's office. Various options should be considered:

- Does she have friends and family with whom she can stay?
- Does she want immediate access to a shelter?
- If none is available, can she be admitted to the hospital?
- If she doesn't need immediate access to a shelter, give her written information about shelters and other resources *if it is safe to do so*.
- Does she need immediate medical or psychiatric intervention?
- Does she want immediate access to counseling to help her deal with the stress caused by the abuse?
- Does she want to return to her partner, with a follow-up appointment at a later date?
- Does she need referrals to local domestic violence organizations?

Information and Resources

If the patient feels it is safe to do so, provide her with *written* information (including phone numbers) on legal options, local counseling and crisis intervention services, shelters, and community resources. In addition, educational materials on domestic violence in waiting areas and examination rooms may help patients identify violence as a personal health problem.

National organizations on domestic violence and many local and state battered women's programs have information available for use in physician offices. The National Domestic Violence hot line 800 799-SAFE (7233), 800 787-3224 (TDD) is a 24-hour resource to help women find local shelters. Counselors speak Spanish as well as English. The National Woman Abuse Prevention Center (202 857-0216) publishes fact sheets on domestic violence, a quarterly newsletter, and a series of brochures. Some of the material is translated into Spanish and Polish.

The American College of Obstetricians and Gynecologists (202 863-2518) publishes “The Abused Woman,” a publication for patients. The Family Violence Prevention Fund (415 821-4553) provides direct services to victims and develops public policy and training programs.

Local domestic violence shelters and statewide domestic violence programs are frequently listed in the phone book. They can help with housing, information about legal rights, welfare applications, and counseling (including peer groups and counseling for children). They may have brochures for distribution to women patients that address issues and list local resources. Many programs offer these services without charge.

Barriers to Identification

Patient Barriers

Many women are reluctant or unable to seek help. Some are literally held captive and not allowed out of the house. Others may not have money or means of transportation. If they do come to a physician’s office, they may have to leave before they are seen, rather than risk further abuse for “getting home late.” Childhood experiences of physical or sexual abuse, or witnessing domestic violence, may make it more difficult for a battered woman to recognize a relationship as abusive and to take steps to protect herself. Cultural, ethnic or religious background may also influence a woman’s response to abuse and her awareness of viable options. Other reasons for not mentioning abuse include:

- Fear that revelation will jeopardize her safety
- Shame and humiliation at the way she is being treated
- Thinking she deserved the abuse and is not deserving of help
- Feeling protective of her partner. He may be her sole source of love and affection when he is not abusive and may provide the financial support for her and her children.
- Lack of awareness that her physical symptoms are caused by the stress of living in an abusive relationship
- Belief that her injuries are not severe enough to mention

Because the experience of abuse is so degrading and humiliating, a woman may be reluctant to discuss it with someone who may not take her seriously, who may discount her experience, who may perceive her as deserving the abuse, or blame her for staying with her abuser. She may fear that reporting the abuse will jeopardize her safety and destroy her means of support; she may stay in the relationship hoping that the situation will improve. Her partner may not always be abusive and this gives her hope that he will change.

Physician Barriers

Until recently, physicians rarely addressed issues of abuse and violence, even when the signs or symptoms were present. There are many reasons why physicians may avoid asking about abuse and why it may seem difficult to do so initially. Among these are:

- Lack of awareness of the prevalence, means of identification, or severity of the problem and lack of recognition of the social and psychological costs of abuse
- Thinking it is not a physician's place to intervene, or that the woman must have provoked the abuse
- Believing identification of abuse and referral for services is not part of the physician's role
- Not knowing how to intervene or help even if a woman is recognized as being battered
- "Blaming the patient" and feeling frustrated or angry if the woman doesn't leave her partner (She becomes the problem for being noncompliant with the physician's timetable)
- Disbelief because the alleged assailant is present and seems very concerned and pleasant
- Concern that discussing psychosocial issues will take an overwhelming amount of time
- Difficulty dealing with the feelings evoked by listening to a woman describe what has been done to her. The physician may feel helpless or inadequate if he or she can't "do something" to "fix" the situation.

Documentation

Thorough, well-documented medical records are essential for preventing further abuse. Furthermore, they provide concrete evidence of violence and abuse and may prove to be crucial to the outcome of any legal case. If the medical record and testimony at trial are in conflict, the medical record may be considered more credible. Records should be kept in a precise, professional manner and should include the following:

- Chief complaint and description of the abusive event, using the patient's own words whenever possible rather than the physician's assessment. "My husband hit me with a bat" is preferable to "Patient has been abused."
- Complete medical history
- Relevant social history
- A detailed description of the injuries, including type, number, size, location, resolution, possible causes, and explanations given. Where applicable, the location and nature of the injuries should be recorded on a body chart or drawing.
- An opinion on whether the injuries were adequately explained
- Results of all pertinent laboratory and other diagnostic procedures
- Color photographs and imaging studies, if applicable
- If the police are called, the name of the investigating officer and any actions taken

In addition to complete written records, photographs are particularly valuable as evidence. The physician should ask the patient for permission to take photographs. Imaging studies also may be useful. State laws that apply to the taking of photographs usually apply to x-rays as well.

- When possible, take photographs before medical treatment is given
- Use color film, along with a color standard
- Photograph from different angles, full body and close-up
- Hold up a coin, ruler, or other object to illustrate the size of an injury
- Include the patient's face in at least one picture
- Take at least two pictures of every major trauma area
- Mark photographs precisely as soon as possible with the patient's name, location of injury, and names of the photographer and others present

For medical records to be admissible in court the doctor should be prepared to testify:

- That the records were made during the "regular course of business" at the time of the examination or interview
- That the records were made in accordance with routinely followed procedures
- That the records have been properly stored and their access limited to professional staff

Legal Developments

Protection of Victims

Today every state has some form of legislation designed to offer protection to victims of domestic violence. Some states have placed additional duties on police, requiring them to make arrests in certain cases, accompany women to their homes to collect children and belongings, and inform them of their legal rights. However, despite the increased interest in domestic violence and the enhanced availability of legal remedies, compliance with or enforcement of the laws on the part of some physicians, police, prosecutors, government agencies, and courts is often less than ideal. *Physicians need to be aware of state laws and of the services available in their community for abuse victims.*

The legal remedies available to battered women vary from state to state and these laws are changing rapidly. Advocacy programs often can explain to women the legal options that are available, and can help them access the legal system. The most common civil action in domestic violence cases is a protective order, injunction, or restraining order, which is a court order that directs the batterer to stop abusing the victim. In some states, the court may have the authority to order a batterer to leave a shared residence, receive counseling, make support payments, pay medical bills, or take other action. Depending on the jurisdiction, police also may be required to arrest abusers who violate protective orders. *In any event, a woman's safety must be continually reassessed since a protective order does not guarantee it.*

Criminal actions against batterers may include prosecution for assault, battery, aggravated assault or battery, harassment, intimidation, or attempted murder. Historically, abused women often have been unable to pursue such charges against their spouses, and even today they may encounter police who are reluctant to take action, prosecutors who downgrade charges, and courts that are not receptive to such claims. Some states have adopted specific provisions that criminalize domestic abuse, but the lack of explicit laws does not necessarily mean that criminal prosecution is unavailable.

State Reporting Requirements

Few states have explicit mandatory reporting laws for domestic abuse, and it is not clear that mandatory reporting would best ensure the safety of competent adult victims or connect them with needed resources. However, virtually all states have some type of statute that requires physicians to report to law enforcement officials certain injuries that appear to have resulted from a criminal act. *Disclosure of a diagnosis of abuse to partners or any third party and reporting to authorities should be done only with the abused woman's knowledge and consent.*

In addition, in most areas, there are no government agencies to coordinate case management and put victims in contact with needed services for domestic violence. Thus, physicians need to be aware of local resources to make appropriate referrals and to advocate for expanded resources. In any case, physicians should emphasize that they will remain available to help in the future and should provide the patient with a list of available resources. The physician should document the diagnosis, the information conveyed and any pamphlets or materials given to the patient, as well as the patient's decision on whether or not to allow the physician to take further action such as notifying the police.

Testimony

Medical evidence is not required in every judicial undertaking, such as divorce or custody hearings. If court evidence becomes necessary, a well-documented medical record may reduce the time a physician is required to spend in judicial proceedings. It may be possible to place the physician "on call" for court, so that he or she need appear only when it is time to testify.

The physician may be called to testify about the contents of the record or statements made. This function is distinct from the use of the physician as an expert. The physician may be requested to give expert medical testimony and perhaps to give an opinion on whether the explanation given is consistent with the injury. With regard to such testimony, the following guidelines should be followed:

- Insist on pre-trial preparation by the attorney presenting you as a witness
- Know the facts of the case well
- If testifying as an expert witness, propose questions for the attorney to ask
- Brief the attorney on questions to ask the opposing expert
- Listen to the question asked and answer only that question

- If a question is not understood, ask that it be repeated
- Do not volunteer information
- Explain when a one-word answer is not enough
- Calmly correct an attorney who misstates prior testimony

Risk Management

Duty to the Victim

Most physicians will encounter cases of domestic abuse in their practices. Physicians must be aware of their obligations in these cases, as well as their potential liability for failing to diagnose and/or report domestic abuse. In general, doing what is medically best or most appropriate is good risk management. If an injured woman is treated by a physician who does not inquire about abuse or who accepts an unlikely explanation of the injuries and she then returns to the abusive situation and sustains further injuries, the physician could be held liable for those subsequent injuries.

The duty to the victim may arise from the special relationship between doctor and patient or from the courts' interpretations of reporting laws. The argument would be that other physicians, under the same circumstances, would have diagnosed inflicted trauma and taken appropriate management steps that would have prevented the subsequent harm.

Thus, physicians must be willing to ask all women patients about abuse, and should know how to diagnose it. *Failure to conduct the interview and examination apart from the suspected victim 's spouse or partner may interfere with an accurate diagnosis.*

Physicians also should be aware of certain “red flags” that can signal particularly dangerous situations for the woman: stalking behavior by the abuser; substance abuse by the abuser; and threatened suicide by the abuser (increased risk for a murder/suicide).

In states that have enacted mandatory reporting statutes, a physician's failure to report could give rise to liability, but since reporting laws rarely explicitly give victims such a right to sue, courts must determine whether their state's statutes implicitly contain that right. Criminal reporting statutes usually are enacted to inform the police of the occurrence of crimes rather than to protect victims of violence. In contrast, child abuse reporting statutes are usually enacted with the clear purpose of protecting abused children, and some courts have allowed abused children to sue physicians who violate a reporting statute. If a state has a specific domestic violence reporting statute, courts may be more likely to allow a suit against a physician who failed to report the abuse.

Duty to Warn

Many states recognize a legal duty that physicians have toward third parties who might be harmed by their patients. In those states, if a physician is aware of a patient's intent to harm a third party, such as the patient's spouse or partner, the physician may have a legal duty to breach the patient's confidence and to warn the third party of the impending danger. Physicians, especially therapists, should know the law where they practice.

Medical Malpractice Lawsuits

Even after taking all possible measures to handle cases correctly, physicians may still become defendants in medical malpractice suits. These physicians should:

- Not panic
- Not discuss the case with anyone until they have spoken with their attorney
- Contact their malpractice insurance carriers
- Record the circumstances involved in the serving of a summons
- Have thorough documentation

Trends in Treatment and Prevention

Living in an abusive relationship takes a tremendous toll on a woman's physical and psychological well-being. As physicians begin to ask routinely about abuse, they may feel overwhelmed by the prevalence of this problem and by the amount of pain some women experience in their intimate relationships. While maintaining doctor-patient confidentiality, it is important for physicians to discuss with supportive colleagues or others how best to respond to such encounters.

All physicians should begin to respond to the JCAHO requirements of recognition, crisis intervention and referral. Some will play a more active role by developing innovative programs, advocating for increased funding for services and for violence prevention programs, and by educating students, community groups and other physicians. There is much work to be done, but there is a great potential for improving patients' lives, especially when physicians team up with other professionals and work through local community services.

Several recent trends will improve awareness and outreach in the area of domestic violence. These include hospital-based intervention programs that link with community groups and provide ongoing support and advocacy; community-based training projects to educate physicians and other health care providers; new residency requirements and additions to medical school curricula that train physicians to recognize violence and abuse; and the addition of assessment of abuse into existing community outreach programs for women. The AMA is working to assist physicians in their efforts to reduce violence and the effects of violence in their local communities.

National Information Sources On Domestic Violence

(NB: All Numbers Subject to Change!)

Violence Against Women Act National Hotline

1-800-799-SAFE, TDD 1-800-787-3224

(24-hour, toll-free number for crisis intervention assistance, counseling, and referrals)

National Resource Center on Domestic Violence, 800-537-2238

Family Violence Prevention Fund's Health Resource Center on Domestic Violence

888-RX-ABUSE, <http://www.fvpf.org/fundlindex.html>

National Coalition Against Domestic Violence, 202-638-6388 or 303-839-1852

Duluth Domestic Abuse Intervention Project, 218-722-2781

(victims information and batterers treatment program info)

Battered Women Fighting Back! Inc., 617-482-9497

National Mental Health Association Campaign for the Prevention of Violence

"Voices VS Violence",

703-684-7722

nmhprev@aol.com

National Center on Women and Family Law, Inc., 212-674-8200

National Clearinghouse for the Defense of Battered Women, 215-351-0010

National Clearinghouse on Marital and Date Rape, 510-524-1582

Fenway Community Health Center's Victim Recovery Program, 617-267-0900

National Coalition Against Sexual Assault, 202-483-7165

The Commonwealth Fund Commission on Women's Health, 212-305-8118

Physicians for a Violence-Free Society, 214-590-8807

HELP Network, 312-880-3826, cmh-helpnet@nwu.edu (handgun safety group, information about guns and domestic violence)

State Domestic Violence Coalition Phone Numbers

Alabama 334-832-4842

Alaska 907-586-3650

Arizona 602-279-2900

Arkansas 501-812-0571

California 209-524-1888

Colorado 303-831-9632

Connecticut 203-524-5890

Delaware 302-658-2958

District of Columbia 202-783-5332

Florida 904-668-6862

Georgia 770-984-0085

Hawaii 808-486-5072

Idaho 208-384-0419

Illinois 217-789-2830

Indiana 317-543-3908

Iowa 515-244-8028

Kansas 913-232-9784

Kentucky 502-875-4132

Louisiana 504-542-4446

Maine 207-941-1194

Maryland 301-942-0900

Massachusetts 617-248-0922

Michigan 517-484-2924

Minnesota 800-646-6177

Mississippi 601-981-9196

Missouri 314-634-4161

Montana 406-443-7794

Nebraska 402-476-6256

Nevada 702-358-1171

New York 518-432-4864
New Mexico 505-246-9240
New Jersey 609-584-8107
New Hampshire 603-224-8893
North Dakota 701-255-6240
North Carolina 919-956-9124
Ohio 614-784-0023
Oklahoma 405-557-1210
Oregon 503-223-7411
Pennsylvania 717-545-6400
Puerto Rico 809-722-2907
Rhode Island 401-467-9940
South Carolina 803-750-1222
South Dakota 605-945-0869
Tennessee 615-386-9406
Texas 512-794-1133
Utah 801-538-4100
Vermont 802-223-1302
Virginia 800-221-0990
Washington 360-352-4029
West Virginia 304-765-2250
Wisconsin 608-255-0539
Wyoming 307-367-4296