Physicians And Domestic Violence: Challenges For Prevention

by Anne Flitcraft

In 1985 Surgeon General C. Everett Koop convened an unprecedented workshop on violence and public health. This conference, which focused on the use of traditional public health tools to understand violence in epidemiological terms, marked a turning point in public health officials’ involvement in domestic violence. Shelters for battered women had sprung up around the country during the 1970s, focusing the awareness of lawmakers, service providers, and researchers on the problems of women victimized by domestic violence. Not until this historic meeting, however, did an articulated strategy emerge to address violence as a public health problem. This strategy encompassed prevention and intervention tools, which then were disseminated to the public health community through regional conferences. A newly created National Center for Injury Prevention and Control within the Centers for Disease Control and Prevention (CDC) quickly expanded its emphasis on deliberate interpersonal injury to provide leadership and support for research on a wide range of issues, including domestic violence.

Federal involvement in domestic violence first took the form of model shelter programs and court-based services supported by the Law Enforcement Assistance Administration (LEAA) in the early 1970s. Hearings on domestic violence by the U.S. Commission on Civil Rights in 1978 were followed by a short-lived Office of Domestic Violence under President Carter. Hearings by the Attorney General’s Task Force and passage of the Domestic Violence Assistance Act in 1984 affirmed the federal commitment to domestic violence services. Recent federal initiatives include a “Sense of the Congress Resolution” (the so-called Morella resolution), urging courts to give presumptive child custody to victims of domestic violence, and bills to establish national and regional centers on domestic violence, to incorporate domestic violence into the medical school curriculum, and to increase funding to the CDC’s National Center for Injury Prevention and Control for research and demonstration projects on violence against women.

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The work of shelters, largely community-based, and domestic violence coalitions has forged a consensus with state and federal policymakers that (1) family violence is as serious a crime as other crimes against persons; (2) the safety of domestic violence victims and their children should be a top priority; and (3) meeting victims’ needs requires significant changes to be made to a range of traditional services. The policies that have resulted from this consensus greatly expand civil and criminal remedies to victims in many states. In law enforcement, many states have changed their arrest policies to be more supportive of the victims of domestic assault. Judicial sanctions also have been expanded to encourage incarceration of offenders as well as alternative sanctions such as “batterers’ education programs” for first-time offenders. Recent state initiatives have extended training in domestic violence to include police, court personnel, prosecutors and judges, parole and probation officers, substance abuse counselors, and child protective service workers. The interface of law enforcement and domestic violence services has expanded consistently over the past decade.

In marked contrast, the response of the health care community to domestic violence has been slow and inconsistent. By the late 1970s researchers funded by the National Institute of Mental Health (NIMH) had demonstrated the importance of domestic violence as a determinant of women’s health problems and had documented widespread failure to identify the problem in health care settings. But efforts to expand hospital-based rape crisis teams to include domestic violence were sporadic and proved difficult to sustain. Koop’s message in 1985 helped to guide the response of health professionals by targeting violence as a priority for the public health and medical care systems:

Identifying violence as a public health issue is a relatively new idea. Traditionally, when confronted by the circumstances of violence, the health professions have deferred to the criminal justice system. . . [Today] the professions of medicine, nursing, and the health-related social services must come forward and recognize violence as their issue.

Defining what it means for clinicians to “recognize violence as their issue” has proved to be difficult, particularly as this involves issues that reach beyond the physician’s office. Various rationales have evolved to explain physicians’ consistent distance-from domestic violence. One early theory suggested that identification in medical settings was difficult because battered women were reluctant to discuss the real cause of their injuries. Yet researchers have used simple interview techniques and questionnaires to uncover substantial rates of domestic violence in various medical settings, suggesting that identification was not so difficult after all. Concern then was raised that some patients would be offended by questions about violence at home; in deference, physicians were reluctant to discuss the issue.
Again, high rates of patient participation in domestic violence research have belied this concern. More recent explanations explore physicians’ projected helplessness and their belief that domestic violence is a “Pandora’s box” without solution. This rationale is inconsistent with physicians’ usual determination when faced with near-certain failure in other areas. Obviously, other factors are at work.

However much it is idealized, only a small portion of what happens in the physician/patient encounter is determined by individual physicians. The encounter is shaped by its social and cultural context, the policies and resources of health care institutions, and the beliefs, values, and professional norms of the medical community. It is naive to expect substantial changes in how victims of domestic violence are now treated by individual physicians unless there are concurrent changes in these latter areas.

In this Commentary I suggest that change is required at each of these levels-clinical practice, institutional resources, and professional norms-to link the prevention of domestic violence with appropriate care for its victims. That is, I suggest a way for physicians to recognize domestic violence as their issue.

Definition And Classification

Domestic violence is defined as the threat or infliction of physical harm among past or present social partners, irrespective of the legal or domiciliary status of the relationship in which domestic violence occurs. Physical and sexual assault may be accompanied by verbal intimidation and abuse; destruction of property; threats to significant others; stalking; and control over access to money, personal items, transportation, the telephone, and friends, family, and children. Battering is not an isolated event. One episode builds on past episodes and sets the stage for future episodes.

There is some debate about which groups to include in a clinical consideration of domestic violence. The term spouse abuse reflects an awareness that both men and women can be abused in intimate relationships, but research to date has focused on women who have been abused by male partners. We do not know to what extent current findings about battered women can be applied to the experience of men who may be abused, to violence within homosexual relationships, or to abuse among the disabled or elderly. However, within these groups, it is likely that gender-specific patterns help to shape the dynamics of an abusive relationship.

The reported clinical problems linked to domestic violence include homicide and repeated episodes of trauma, rape, substance abuse, attempted suicide, depression, child abuse, perinatal morbidity, chronic pain, and somatic complaints. Psychologically, the combination of ongoing as-
sault and coercive control may evoke symptoms of post-traumatic stress disorder, characterized by flashbacks, nightmares, hypervigilance, loss of boundaries, numbing, and chronic fear and anxiety.\(^6\)

**Prevalence.** Each year, more than 1.5 million women nationwide seek medical treatment for injuries related to abuse.\(^7\) The incidence of new cases among injury victims is relatively low—only about twenty-seven of every thousand female victims. But, because so many cases remain unresolved, the prevalence of domestic violence is quite high. For instance, domestic violence is a factor for at least 20 percent of the female patients who use emergency services for injury.\(^8\) An even more significant proportion of other populations requiring medical care are abused women: rape victims, suicide attempts, alcoholics and drug users, mothers of abused children, psychiatric patients,\(^3\) pregnant women, and those seeking care for stress-related complaints.\(^9\)

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**Clinical Violence Intervention**

The traditional public health division of primary, secondary, and tertiary prevention offers a useful way to conceptualize the merger of a preventive health perspective and a clinical perspective on domestic violence. Effective clinical violence intervention requires medical involvement at all three levels.

**Primary prevention: professional change.** In traditional public health terms, primary prevention entails lowering the number of new cases by changing behavior or environmental factors. One way for physicians to address environmental factors is to recognize ways in which the medical profession may be helping to perpetuate a harmful environment.

Following the surgeon general’s workshop in 1985 and the revelation that battering was a problem for a significant number of pregnant women, the American College of Obstetricians and Gynecologists led the way in recognizing domestic violence as a threat to women’s health and mounted a campaign to educate its members. In 1991 the American Medical Association (AMA) followed suit with a campaign to address family violence as a major health problem. The development of diagnostic and treatment guidelines on child abuse and neglect, child sexual abuse, domestic violence, and elder abuse and neglect formed the backdrop for the AMA’s organizational efforts. The AMA also played a key role in the formation of the National Coalition of Physicians against Family Violence, with institutional membership from more than seventy-five major medical organizations. The American Medical Women’s Association, the American Academy of Family Practice, and the American College of Emergency Physicians also have participated in the creation of a comprehensive medical response
to family violence. The success of these and other professional organizations in bringing these issues to the attention of their membership is significant.

Further changes to the structure of medical practice still are needed if the environment surrounding domestic violence is to be altered successfully. The status structure of medicine, its traditional male bias, and the strict hierarchical organization of medical training all have been identified as barriers to physicians’ participation in domestic violence intervention efforts. To move medicine into the mainstream of political and community life where domestic violence is unacceptable, primary prevention efforts must address both the substance of physician norms and their organizational context. At present, such efforts are rare.10

Secondary prevention: the doctor/patient encounter. Routine assessment for domestic violence is a form of health education. A physician’s acknowledgement of the problem validates the fact that battering is a threat to health. Just as routine questions regarding a patient’s smoking habits identify smoking-related problems and reinforce a patient’s decision not to smoke, routine questions about violence identify the problems of abused women, assess current safety of women who were battered in the past, and heighten the awareness of women who have not been in an abusive relationship.

Secondary prevention extends beyond identification to include appropriate early intervention. To date, specific elements of intervention generally include identification, validation, treatment of medical needs, assessment of mental health needs, clear documentation, safety assessment, and referral to law enforcement and/or community-based domestic violence services. Limited by the relative paucity of clinical experience with victims of domestic violence, current secondary prevention protocols will need to be updated based on ongoing evaluation in clinical settings.11

At first glance it seems intuitively obvious that physicians’ intervention in domestic violence must be modeled after their involvement in other abuse situations or in other criminal investigations such as homicide or rape. However, in fact, numerous issues in clinical practice overlap with law enforcement and criminal justice concerns. For instance, our current approach to alcohol and drug use, human immunodeficiency virus (HIV) disease, tuberculosis and syphilis treatment, birth control, prenatal testing, and pregnancy termination, as well as the assessment and confinement of persons who are a danger to themselves or others, all provide experience relevant to the development of models for secondary intervention strategies in domestic violence. Meanwhile, because of its emphasis on patient empowerment, domestic violence intervention converges with many contemporary challenges in medical practice—including smoking cessation, can-
cer screening, HIV prevention, occupational and environmental health, and the care of terminally ill patients—where new models of physician/patient relationships are emphasized.

Developing appropriate intervention strategies likely will involve the skills of many medical disciplines, including nursing and social work, and will call on the expertise of a broad range of clinicians. Emphasis on evaluation and research in this area is vital.

Tertiary prevention: health care organizations. The role of health care organizations in a comprehensive response to domestic violence is the least developed. In 1992 the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) expanded its guidelines on emergency departments and hospital-sponsored ambulatory care centers to encourage the development of staff education and protocols on domestic violence. Such protocols outline the responsibilities of clinical staff to identify abuse with referral to police, domestic violence services, child protective services, social services, and mental health treatment programs.

The JCAHO guidelines were part of a strategy to expand the identification of victims of domestic violence seen predominantly in emergency departments. To this extent the current guidelines are based on an extremely limited notion of what is necessary as medicine’s response to domestic violence. Protocols based on the identification of victims of domestic violence and referral to community organizations use the medical encounter largely for case finding and evidence gathering for subsequent criminal proceedings. Current protocols generally do not commit additional health care resources to victims of domestic violence, nor do they contribute to shifting resources (in alcohol treatment, intensive care unit trauma admissions, or adverse birth outcomes) to include specific domestic violence interventions.

Blue Cross/Blue Shield of Pennsylvania estimates that at least $32 million a year is spent in Pennsylvania to treat domestic violence injuries. Given the cost of health care related to violence and its associated problems, health care organizations must begin to shift resources directly into intervention services, to augment the efforts of community-based services. Research suggests that prenatal care programs, alcohol and drug treatment programs, and mental health centers routinely treat victims of domestic violence; in fact, victims of violence may consume a disproportionate amount of resources devoted to these services. Tertiary prevention of domestic violence will require health care organizations to incorporate and invest in crisis intervention, emergency hospitalization for shelter, counseling, support groups, and advocacy, rather than simple identification and referral. Such a comprehensive approach will require changes in medical practice that rival those seen in law and law enforcement practice.
Communitywide efforts to address domestic violence have grown over the past twenty years. Comprehensive community-based domestic violence services as well as expanded legal protection and enhanced law enforcement interventions thus far have provided the mainstay of interventions. Health care professionals, and physicians in particular, have joined in efforts to address domestic violence only recently. To date, physicians have concentrated on changing professional awareness and implementing changes in clinical practice, based predominantly, although not exclusively, upon case finding and documentation. In an era of rising costs and shrinking budgets, concerns about efficiency and cost-effectiveness sometimes have impeded changes in institutional policies and shifts in resource allocation to areas that meet the needs of persons victimized by domestic violence. Without such investment, the medical profession will have little to offer to victims or perpetrators of domestic violence. Ironically, if physicians’ role is essentially that of “case finder” or “mandated reporter,” women will be reluctant to tell their physician about the real cause of their injuries, and clinicians will engender the offense of patients while reaffirming their suspicion that domestic violence is indeed a “Pandora’s box.” Clearly, another role for physicians is needed.

A comprehensive medical response to domestic violence requires primary, secondary, and tertiary prevention efforts and consequent changes in the actions and programs of professional societies, physicians, and health care organizations. Only such a concerted response can fulfill Koop’s vision of a medical profession that is devoted to improving the lives of patients through its members’ efforts to combat domestic violence.

NOTES


5. Our current awareness of the violence women face within domestic relationships can be traced to the movement of “battered wives” in Britain in the 1970s, followed by the “battered women’s” movement in the United States nearly ten years later. One of the first federal initiatives in this area was the U.S. Commission on Civil Rights hearings entitled *Battered Women: Issues for Public Policy*. Ironically, with expanded funding in shelter services and the expansion of legal options to afford battered women greater safety in their communities, the term domestic violence was introduced to comply with civil rights prohibitions against gender discrimination. The emerging shelters for battered women and the battered women’s coalitions at the turn of the decade became the domestic violence services we know today.


10. Warshaw, “Limitations of the Medical Model.”

