



## *Resource Guide On*

# **FAMILY VIOLENCE**

# DEPARTMENT OF SOCIOECONOMIC AND STATE SOCIETY AFFAIRS

Department Fax Number:  
847/823-1309

For More Information On Family Violence  
Please Contact:

***Robert C. Fine, JD, CAE***

Department Director  
Phone: 847/384-4322  
E-mail: [fine@aaos.or](mailto:fine@aaos.or)

***Susan A. Koshy, JD, MPH***

Manager - State Society & Legislative Affairs  
Phone: 847/384-4332  
[E-mail: koshy@aaos.org](mailto:koshy@aaos.org)

***John J. (Jay) Fisher, Jr., JD***

Legislative Analyst  
Phone: 847/384-4336  
[E-mail: fisher@aaos.org](mailto:fisher@aaos.org)

***Joyce R. Knass***

***Administrative Assistant***

Phone: 847/384-4334  
[E-mail: knauss@aaos.org](mailto:knauss@aaos.org)

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## Advisory Statement

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### Physicians' Responsibilities in Regard to Violence

Violence is an enormous public health problem in the United States, both in terms of the number of lives touched, and lives lost, and in terms of the impact on the health care system. Violence in the context of this statement is defined as personal injury caused by intentional acts such as sexual abuse, abuse of children, spouses, or elderly persons, attacks related to the commission of a crime, or gang assaults. Approximately 20,000 deaths per year are attributed to intentional violence perpetrated by one person on another. Another 30,000 people die each year as a result of self-directed violence. In addition, almost 300,000 people are hospitalized every year as a result of intentional violence.

According to the U.S. Centers for Disease Control and Prevention, homicide and suicide are among the foremost causes of premature death in the United States. Together, they are the fourth leading cause of years of potential life lost to Americans under the age of 65.

Violence among family members has reached epidemic proportions. For example, more than 2 million cases of child abuse and neglect are reported annually. Between 2 and 4 million people are battered by their spouses each year. As much as 3 percent of the elderly population is abused each year.

Violence is a disease with many etiologies, and the medical community is uniquely positioned to play an important role in reducing its prevalence and the pain and suffering that results. Because the incidence of violence continues to increase, it is imperative that physicians increase their efforts to curb this epidemic.

Unlike the child abuse movement where physicians have played a vital role, physicians have had minimal involvement in addressing other forms of family violence such as sexual abuse, domestic violence, and elder abuse. Yet, as they have in the area of child abuse, physicians can make significant contributions to the advancement of knowledge, practice, and policy in this vital area.

*The American Academy of Orthopaedic Surgeons (AAOS) endorses the following principles and urges fellow members of the physician community to do likewise:*

- **Physicians must become aware of and knowledgeable about the diagnosis and treatment of family violence, and should learn what resources are available in the community for referral of victims of violence.**
- **All physicians must become familiar with applicable abuse reporting laws and other legal requirements as well as appropriate procedures for dealing with and referring suspected cases of abuse.**

- **As members of multidisciplinary teams and/or community-wide coalitions, physicians can be helpful in educating other professional groups about the physical and mental health problems that result from family violence.**
- **Physicians can play an important role by encouraging and participating in research on all forms of family violence.**
- **Physicians have a responsibility to make known their opinions about the laws, especially regarding those aspects that affect medical practice such as mandatory reporting, competency, professional judgment, patient self-determination, immunity, and liability.**

The AAOS joins the American Medical Association and other medical specialty societies in the support of the National Advisory Council on Family Violence.

The AAOS in October 1993 promulgated an "Opinion on Ethics" on the topic of "Reporting of Suspected Abuse or Neglect of Children, Disabled Adults or the Elderly." This Opinion may serve as additional guidance for the orthopaedic surgeon who encounters instances of family violence or neglect.

Portions of this statement have been adapted from the American Medical Association Report G, I-91.

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## Opinions on Ethics and Professionalism

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### Reporting of Suspected Abuse or Neglect of Children, Disabled Adults or the Elderly

#### Issues raised

What is the orthopaedic surgeon's obligation to report suspected cases of abuse or neglect of children, disabled adults or the elderly?

#### **Applicable provision of the *Principles of Medical Ethics and Professionalism in Orthopaedic Surgery***

“I. The orthopaedic profession exists for the primary purpose of caring for the patient. The physician-patient relationship is the central focus of all ethical concerns. The orthopaedic surgeon should be dedicated to providing competent medical service with compassion and respect.”

“III. The orthopaedic surgeon must respect the law, uphold the dignity and honor of the profession, and accept its self-imposed discipline. The orthopaedic surgeon also has a responsibility to seek changes in legal requirements that are contrary to the best interest of the patient.”

#### **Applicable provisions of the *Code of Medical Ethics and Professionalism for Orthopaedic Surgeons***

“I.A. The orthopaedic profession exists for the primary purpose of caring for the patient. The physician-patient relationship is the central focus of all ethical concerns.”

“II.B. The orthopaedic surgeon should conduct himself or herself morally and ethically, so as to merit the confidence of patients entrusted to the orthopaedic surgeon's care, rendering to each a full measure of service and devotion.”

“II.C. The orthopaedic surgeon should observe all laws, uphold the dignity and honor of the profession, and accept its self-imposed discipline . . .”

“III.A. The practice of medicine inherently presents potential conflicts of interest. Whenever a conflict of interest arises, it must be resolved in the best interest of the patient. If the conflict of interest cannot be resolved, the orthopaedic surgeon should notify the patient of his or her intention to withdraw from the relationship.”

## **Other references**

American Medical Association, *Current Opinions* of the Council on Ethical and Judicial Affairs,

Section 1.02 (“The Relation of Law and Ethics”)

Section 2.02 (“Abuse of Children, Elderly Persons and Others at Risk”)

## **Background**

Much has been written in recent years regarding an apparent epidemic of child abuse in the United States. A 1992 study by the National Committee for Prevention of Child Abuse showed that nearly three million children in the United States were reported as suspected victims that year. However, fewer than half those reports were found to merit further investigation.<sup>1</sup> The study found poor children were at the greatest risk, but owing to insufficient public funds, only about two-thirds of the families in which abuse or neglect was confirmed received help.<sup>1</sup>

It is impossible to determine whether the number of alleged child abuse victims is inflated with false allegations or under represents activity that is often kept secret. One widely cited figure comes from a 1985 survey showing that one in four women has suffered childhood sexual abuse.<sup>1</sup> In this survey, “Childhood” was defined as any time through age 18, and “abuse” was defined to include everything from a single glimpse of a flasher to forced intercourse. Studies limited to girls under 14, defining “abuse” as sexual contact with a man at least five years older, have shown a fairly consistent, rate of sexual abuse of 10 to 12 percent since the 1940s.<sup>1</sup>

In 1989, a U.S. congressional committee investigated the abuse and neglect of the elderly in the United States and found it to be a “national tragedy.”<sup>2</sup> Elderly abuse may take forms, including physical, sexual, and psychological abuse as well as verbal abuse, financial exploitation and/or neglect by a caregiver. A 1989 congressional study indicates that one of every 25 Americans over age 65 suffers from some serious form of abuse, neglect or exploitation.<sup>2</sup> In addition, in Illinois, an Elder Abuse Demonstration Program conducted from 1985-1987 made similar findings.<sup>2</sup>

In 1993, a national poll found that 34 percent of adults in the United States report having witnessed a man beating his wife or girlfriend and that 14 percent of women report that a husband or boyfriend has been violent with them.<sup>3</sup> Studies suggest that as many as 30 percent of women treated in emergency departments (EDs) have injuries or symptoms related to physical abuse.<sup>4</sup> A U.S. Public Health Service national objective for the year 2000 is for at least 90 percent of hospital EDs to have protocols for routinely identifying, treating, and referring victims of sexual assault and spouse abuse (objective 7.12). In addition, in 1992, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) started to recommend that accredited EDs have policies, procedures, and education in place to guide staff in the treatment of battered adults.

## **Legal considerations**

In response to the U.S. Child Abuse Prevention and Treatment Act of 1974, virtually every state has adopted legislation that requires physicians and others in authority to report suspected cases of child

abuse. In addition, a number of states have enacted legislation requiring or permitting, without legal penalty, the reporting of elder and other abuse. While the provisions of these state statutes vary, most provide a specific immunity from suit when physicians and other health care workers report suspected cases as required or permitted under the law, even if the information is obtained in the course of a treating relationship protected under the physician-patient privilege.

Illinois law is illustrative. In 1975, Illinois adopted the Abused and Neglected Child Reporting Act. The act requires physicians, school teachers and others to immediately report to the State Department of Children and Family Services a child known to them in their professional capacities who might be abused or neglected. In addition, a person required to report under the act and the medical examiner or coroner must contact the state if the child is suspected to have died as a result of abuse or neglect. A failure to report suspected child abuse or neglect will subject the physician to state disciplinary proceedings.

In 1988, Illinois adopted the Elder Abuse and Neglect Act. It provides for the permissive (not mandatory) reporting of alleged elder abuse to the State Department on Aging. The act provides that any person wishing to make a report of alleged or suspected abuse of a person 60 years of age or older will be immune from liability or professional disciplinary action on account of making the report, despite the laws of confidentiality in Illinois which would otherwise apply.

In most states, no specific laws exist that protect physicians or others who report cases of suspected abuse or neglect of adults who are disabled but who are unable to protect themselves under existing legal systems. The law presumes that once one has reached the age of majority (usually 18), one can make his or her own independent decisions and might file appropriate legal actions against those who abuse them. For example, an adult spouse who has been abused may notify the appropriate legal authorities to obtain a protective order or otherwise to stop the abusive acts. However, if the physician believes the disabled adult is being abused and is truly incapable of making his or her own decisions to report, the physician may obtain a court order to permit the reporting.

Most health care institutions have adopted policies implementing these or similar state statutes. As members of the medical staff, orthopaedic surgeons have an obligation to adhere to their institution's policies and procedures (and if they are inappropriate, to work to get them changed).

## **Ethical considerations**

State statutes that require, or that permit without penalty, the reporting of cases of suspected abuse or neglect of children, disabled adults or elderly persons may create an ethical dilemma for some orthopaedic surgeons. The parties involved, both the suspected offenders and the victims, may plead with the orthopaedic surgeon to keep the matter confidential and not to disclose or report it for investigation by public authorities. The orthopaedist, by training, will often choose to maintain as strictly confidential all information, including information about alleged abuse or neglect, obtained in the course of medical treatment.

Children who have been seriously injured, allegedly by their parents, may attempt to protect their parents by saying that the injuries were caused by an accident. The reason may stem from the natural

parent-child relationship or fear of further punishment. In addition, elderly patients who have been physically maltreated may be concerned that disclosure of what has occurred might lead to further (and possibly more drastic) maltreatment by those responsible.

However, despite the expressed wishes of the child, the disabled adult or elderly person not to report, the orthopaedic surgeon has both a legal and ethical obligation to comply with state mandatory reporting statutes and with institutional policies. Further, if an orthopaedic surgeon fails to comply with the state statutes and institutional policies requiring reporting of suspected cases of abuse or neglect, he or she may anticipate that the victims could receive more severe abuse that may result in permanent bodily, brain injury or even death.

The orthopaedic surgeon's ethical and legal obligations to comply with statutory reporting requirements are clearly stated in the Academy's *Principles of Medical Ethics and Professionalism in Orthopaedic Surgery* (Article III) and the *Code of Medical Ethics and Professionalism for Orthopaedic Surgeons* (Paragraph II.C). In addition, the ethical obligation of the orthopaedic surgeon to report suspected cases of abuse or neglect of children, disabled adults or the elderly may exceed the statutory legal requirement.

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## References

1. Shapiro L, Rosenberg D, Lauerman JF, Sparkman, R: Rush to judgment. *Newsweek*; 1993; XXI (16): 54-60.
2. Beneze L, Neighbors A: Elder abuse and neglect cases: an attorney's guide. *Ill. Bar J.*, 1991; 79: 390-394.
3. U.S. Centers for Disease Control: Emergency department response to domestic violence - California, 1992. *MMWR*; 1993; 42(32): 617-620.
4. McLeer SV, Anwar R: A study of battered women presenting in an emergency department. *Am. J. Pub. Health*; 1989; 79: 65-66.

## **STATE STATUTES**

- I. Family Violence State Statutes Chart *American Academy of Orthopaedic Surgeons*
- II. Family Violence State Statutes Description *American Academy of Orthopaedic Surgeons*
- III. State Report Card  
*Family Violence Prevention Fund*
- IV. Child Abuse and Neglect Statutes  
*National Clearinghouse on Child Abuse and Neglect Information*

# Domestic Violence State Statutes

**Statutes are often modified. Please check your state's statute for the most up to date information**

State	Training	Screening	Protocol	Mandatory Reporting
<b>Alabama</b>	None	None	None	None
<b>Alaska</b>	AS § 18.66.310 directs public employees to take continuing education in domestic violence, including all public health care professionals who are required by law to report child abuse under AS§ 47.17.020	None	AS § 18.66.300 mandates that the State Department of Health and Social Services adopt standards and procedures for the delivery of services to domestic violence victims by health care providers.	AS § 08.64.369 requires health care professionals to report burns over 5% of the body, gunshot wounds, non-accidental wounds caused by knives, axes or other sharp or pointed instruments, and all other non-accidental injuries likely to cause death
<b>Arizona</b>	None	None	None	A.R.S. § 13.3806 requires health care professionals to report gunshot wounds, knife wounds or other material injury which may have resulted from various illegal or unlawful acts
<b>Arkansas</b>	None	None	None	AS § 12-12-602 requires health care providers to report all knife or gunshot wounds which appear to be intentionally inflicted.
<b>California</b>	CA Bus & Prof. Code §2191(h) directs the Division of Medical Licensing to “consider” including a continuing education course providing training to physicians on routine screening for domestic violence  CA Penal Code § 13823.93 establishes two hospital-based training centers to train medical personnel to perform medical evidentiary examinations on domestic and sexual violence victims.	CA Health § 1233.5 requires medical clinics to screen patients for domestic violence  CA Health § 1259.5a requires acute care, acute psychiatric, and chemical dependence recovery hospitals to routinely screen patients for domestic violence.	CA Health § 1233.5 requires licensed clinic boards and medical directors to establish and adopt written policies and procedures to screen patients for domestic violence, document injuries and refer patients to available services.  CA Health § 1259.5 requires acute care, acute psychiatric, and chemical dependency recovery hospitals to establish written policies and procedures to screen patients for domestic violence, document injuries and refer patients to available services.	CA Penal Code § 11160 requires any health practitioner (as defined in Penal Code § 11165.8) employed in a health facility, clinic, physician’s office, local or state public health department, or other facility operated by a local or state public health department, to report providing medical services to a patient whom the practitioner reasonably suspects is suffering from any wound or other physical injury caused by firearms and/or assaultive or abusive conduct.
<b>Colorado</b>	None	None	None	Colo. Rev. Stat. § 12-36-135 requires physicians to report all injuries believed to have been caused by criminal acts, including domestic violence.
<b>Conn.</b>	None	None	None	Sec. 19a-490f requires hospitals and other health facilities to report to the police any injury resulting from the discharge of the firearm. The report must be made as soon as practicable and include name and address of the injured person, if known, the nature and extent of the injury and the circumstances under which the treatment was rendered.
<b>District of Columbia</b>	None	None	None	DC Code § 2-1361 requires healthcare practitioners to report all injuries caused by firearms and injuries caused by other dangerous weapons in the commission of a crime.
<b>Delaware</b>	None	None	None	DE Code Title 24 § 1762 requires physicians to report stab wounds, poisonings (other than accidental), and firearm injuries.
<b>Florida</b>	FS § 456.031 mandates a one-hour domestic violence education requirement as part of biennial relicensure or recertification for physicians, nurses, dentists, mental health providers, dental hygienists, licensed clinical social workers and other health care providers	None	None	FS § 790.24 requires health care providers to report gunshot or life threatening wounds or injuries indicating an act of violence.

<b>Georgia</b>	None	None	None	G.A.S.T. § 31-7-9 requires health care providers to report injuries inflicted by other than accidental means immediately to the head of the facility who must contact the police.
<b>Hawaii</b>	None	None	None	Haw. Rev. S § 453-14 requires health care providers to report knife wounds, gun-related wounds or any injury that would seriously maim, produce death, or has caused unconsciousness when such injury was caused by violence or sustained in an unusual or suspicious manner.
<b>Idaho</b>	None	None	None	ID S § 39-1390 requires health care providers on staff at a hospital to report injuries caused by firearms or a criminal offense.
<b>Illinois</b>	None	None	None	IL CS § 20-2630-3.2 requires medical providers to report injuries resulting from the discharge of firearms or sustained in the commission of or as a victim of a criminal offense.
<b>Indiana</b>	None	None	None	IC 35-47-7-1 provides that the physician or facility must report at once to law enforcement any injury caused by the discharge of a firearm and any injury that may cause death and is caused by any sharp or pointed instrument.
<b>Iowa</b>	None	None	Iowa Code § 135B.7 requires each hospital to establish protocols for treating victims. Under IAC 481- 51.7(3) hospitals must interview victims in privacy, ensure confidentiality, give referral information and educate emergency department staff to identify victims of domestic violence. It also specifies certain information that must be included in victims' medical records.	Iowa Code § 147.111 mandates that any person who administers any treatment to persons suffering from a gunshot, stab wound, or other serious bodily injury (defined in §702.18), which may have resulted from a criminal offense, must report to a law enforcement agency.
<b>Kansas</b>	None	None	None	KS S §21-4213 mandates that physicians report any firearm injury or wounds that is likely to or may result in death inflicted by a sharp object (knife, ice pick, or other sharp pointed instrument).
<b>Kentucky</b>	KYS § 194A.540 requires all mental health professional, primary care physicians, and nurses to take a 3-hour course on domestic violence for continued and initial licensure or certification	None	None	KY S § 209.030 requires health care providers to provide an oral or written report to the Kentucky Cabinet for Family and Children when they suspect abuse, neglect or exploitation. The Cabinet is responsible for notifying the appropriate law enforcement agency, initiating an investigation, and writing a report with recommendations for further actions.
<b>Louisiana</b>	None	None	None	None
<b>Maine</b>	None	None	None	MRSA Title 17-A § 512 requires physicians to report gunshot wounds within 24 hours.
<b>Maryland</b>	MD. Ann. Code § 19-1703 outlined the requirements, including the organization, design, and implementation of a domestic violence inservice training program for hospital emergency personnel employed by the three hospitals participating in the Pilot Domestic Violence Protocol Program. This law expired in 1998.	None	Md. Ann. Code § 19-1703 (1) required the Pilot Domestic Violence Protocol Program to develop protocols for the participating hospitals' emergency room personnel who treat victims of domestic violence. This law expired in 1998	Md. Ann. Code Art. 27 Crimes and Punishment, § 336 and 336A requires health care providers to report gunshot wounds, injuries caused by automobile or moving vessel accidents, and injuries caused by a lethal weapon.

<b>Massachusetts</b>	None	None	None	MGL Ch. 112 § 12A mandates healthcare providers to report injuries resulting from firearms, burns affecting five percent of more of the surface area of the patient, and injuries caused by a knife or pointed instrument if a crime is suspected.
<b>Michigan</b>	None	None	None	MCL § 750.41 requires health care providers to report knife, gun, and deadly weapons injuries, as well as injuries cause by “other means of violence.”
<b>Minnesota</b>	None	None	None	MNS § 626.52 requires health care providers to report bullet wounds, gunshot wounds, powder burns, or any other injury arising from, or caused by the discharge of any gun, pistol or any other firearm. Additionally, they must report any wound that has been inflicted on a perpetrator of a crime by a dangerous weapon other than a firearm.
<b>Mississippi</b>	None	None	None	MS. C. § 45-9-31 requires healthcare professions to report gunshot or knife injuries.
<b>Missouri</b>	None	None	None	RS MO § 578-350 requires healthcare professionals to report gunshot wounds.
<b>Montana</b>	None	None	None	MT Code Ann. §37-2-302 requires healthcare professionals to report gunshot and stab wounds within 24 hours of initial treatment.
<b>Nebraska</b>	None	None	None	Neb. Rev. S § 28-902 requires healthcare professionals to report all injuries of violence that appear to have been caused by a criminal offense.
<b>Nevada</b>	None	None	None	NRS § 629.041 requires healthcare providers to report injuries inflicted by a knife or firearm not under accidental circumstances; NRS § 629.045 requires health care providers to report persons with second and third degree burns consisting of 5% or more of the body area.
<b>New Hampshire</b>	NH RSA § 173-B:20 provides for a statewide coordinator to conduct educational programs for medical personnel.	None	NHRSA § 21-M:8-d requires the NH Dept of Justice to implement rules establishing standardized rape and domestic violence protocols to be used by all physicians and hospitals.	NH RSA § 631:6 requires reporting of all gunshot wounds or any other injury caused by a suspected criminal act. An exception to this is if the patient is 18 years of age or older, has been a victim of sexual assault or abuse, did not sustain a gunshot wound or other serious bodily injury, and objects to the release of information.
<b>New Jersey</b>	None	None	None	NJSA 2C:58-8(a) requires health care providers to report wounds, burns or injuries caused by firearms, destructive devices, explosives or weapons.
<b>New Mexico</b>	None	None	None	None
<b>New York</b>	NY Exec § 575 established the New York State Office for the Prevention of Domestic Violence which develops and delivers training on domestic violence to health and mental health care professionals.	NY Public Health Sect. 2137 requires the development of a protocol for screening and identification of victims who may be HIV positive or a contact of a HIV positive individual.	NY Public Health § 2803 (1)(h) requires hospitals to provide information concerning family violence victims.	NY Penal Law § 265.25 and 26 requires health care providers to report firearm wounds, knife wounds that may result in death and burns over 5 % of the body or which may result in death.
<b>North Carolina</b>	None	None	None	NCGS §. 90-21.20(b) requires health care providers to report all firearm injuries, all poisonings, and wounds caused by sharp pointed instrument, and other cases involving grave bodily harm or grave illness if they believe they arose from a criminal act.
<b>North Dakota</b>	None	None	None	NDSL § 43-17-41 requires health care professionals to report firearm and knife injuries or any other injury they suspect resulted from a criminal act.

<b>Ohio</b>	<p>ORC § 4723.25 requires the Board of Nursing to approve one or more non-mandatory continuing education courses to help assist registered and licensed nurses to recognize the sign of domestic violence and its relationship to child abuse.</p> <p>ORC § 4731.282 requires the State Medical Board to approve one or more non-mandatory continuing education courses to help assist doctors of medicine and doctors of osteopathic medicine to recognize the sign of domestic violence and its relationship to child abuse</p> <p>ORC § 4732.141 requires the State Board of Psychology to approve one or more non-mandatory continuing education courses to help assist psychologists and school psychologists to recognize the sign of domestic violence and its relationship to child abuse.</p>	None	ORC § 3727.08 requires every hospital to adopt protocols for conducting interviews with patients, separate interviews with family members who were present at the time of injury, and for creating a photographic record of injuries when domestic violence has occurred.	<p>ORC § 2921.22 requires health care professionals to report gunshot wounds, stab wounds, any serious physical harm resulting from violence, any burns resulting from violence, and all second and third degree burns from incendiary devices.</p> <p>Also, if the physician suspects the patient is a victim of domestic violence that must be noted on the patient's chart.</p>
<b>Oklahoma</b>	None	None	None	OK Statutes Sec.10-7104 requires health care professional to report injuries resulting from criminal conduct.
<b>Oregon</b>	None	None	None	OR. Rev. Stat. § 146.750 requires physicians to report non-accidental injuries caused by a knife, firearm or other deadly weapon
<b>Penn</b>	HB 2268, passed in 1998, established the "Domestic Violence Health Care Response Act." This act prescribes how certain "medical advocacy project sites" will be chosen and that each will provide comprehensive training, universal screening and domestic violence educational materials.	Includes asking patients seeking medical treatment at a hospital, health center or clinic during the course of medical examinations or treatment about the possibility of domestic violence within their relationships, regardless of whether they are suspected to be victims of domestic violence.	The medical advocacy projects shall develop and implement uniform multidisciplinary domestic violence policies and procedures which incorporate the roles and responsibilities of all staff who provide services or interact with victims of domestic violence, including the identification of victims of domestic violence through universal screening.	None
<b>Rhode Island</b>	None	None	None	RIS § 11-47-48 requires physician reporting of all firearm injuries.
<b>South Carolina</b>	None	None	None	None
<b>South Dakota</b>	None	None	None	SD Cod. Law. Ann 23-13-10 to 11 provides that an oral report shall be made as soon as possible to the county sheriff by any person treating any bullet wound, gunshot wound, powder burn, or any other injury arising from or caused by the discharge of any firearm.
<b>Tennessee</b>	None	None	None	Tenn. §36-3-621 encourages any health care practitioner, who has reasonable cause to suspect that a patient's injuries are a result of domestic violence, to report such injuries monthly to the Department of Health, Office of Health Statistics. This is a voluntary reporting statute with a two-page anonymous form. TN Code §38-1-101 requires health care providers to report injuries inflicted by a knife, firearm or other means of violence, poisonings, and suffocation.
<b>Texas</b>	None	None	TX. Family Code §91.003 requires medical professionals who suspect a patient is a victim of domestic violence to	TX Health and Safety Code § 161.041 requires health care providers to report gunshot wounds.

			provide the patient with information about the nearest shelter, document reasons for the suspicion in the patient file, and give the patient written notice that domestic violence is a crime that the victim can report it to law enforcement.	
<b>Utah</b>	None	None	None	UTC § 26-23a-2 requires health care providers to report injuries inflicted by knife, gun, pistol, explosive, infernal device, or deadly weapon, or by violation of any criminal statute.
<b>Vermont</b>	None	None	None	13 VSA § 4012 requires physicians to report injuries from firearms.
<b>Virginia</b>	None	None	None	VAC § 54.1-2967 requires health care providers to report non-self inflicted injuries from firearms, knives, and “flailing instruments.”
<b>Washington</b>	RCW §43.70.610 mandates that the Department of Health establish an ongoing domestic violence education program as an integral part of its health professions regulation to educate healthcare professional to identify, treat, and refer victims of domestic violence	None	None	
<b>West Virginia</b>	None	None	None	WVC § 61-2-27 requires health care providers to report gunshot wounds and injuries from knives or other pointed instruments that result from a criminal act.
<b>Wisconsin</b>	None	None	None	WI Statute § 146.995 requires that health care professionals report gunshot wounds, second and third degree burns over 5% of the body or any other wound that resulted from a crime.
<b>Wyoming</b>	None	None	None	None

**Compiled from data from the Family Violence Prevention Fund**

# **Family Violence Statutes in the Fifty States**

This document describes state laws dealing with physician training, screening, and protocols for treating family violence victims. It also discusses the injury reporting requirements that an orthopedic surgeon may have to comply with in the states. Please note that this document does not discuss any reporting or training requirements specific to child abuse.

## **Alaska**

Alaska law requires health care professionals to orally report gunshot wounds, no accidental wounds caused by knives, axes or other sharp or pointed instruments, and all other non-accidental injuries likely to cause death to the Department of Public Safety, a local law enforcement agency or a village public safety officer. A written report on the injury must be filed within three days with the Department of Public Safety.

## **Arizona**

Arizona law provides that a physician called upon to treat any person for gunshot wounds, knife wounds or other material injury which may have resulted from a fight, brawl, robbery or other illegal act, shall immediately notify the chief of police or the sheriff, or the nearest police officer, of the circumstances. The report shall also contain the name and description of the patient, the character of the wound and other facts which may be of use to the police in the event the condition of the patient may be due to any illegal behavior.

## **Arkansas**

All physicians that might render first aid treatment shall report all cases of knife or gunshot wounds which appear to have been intentionally inflicted, to the office of the sheriff of the county or to a city policeman. The report shall be made immediately upon the nature of the injury being ascertained, shall be by telephone if possible, otherwise by writing, and shall contain the name, age, sex, race, and location of the person so injured, together with the names of the persons bringing the patient in for treatment.

## **California**

Any physician who provides medical services to a patient that he or she knows or reasonably suspects was injured by means of a firearm or is suffering from any wound or other physical injury inflicted by assault or abusive conduct must report that fact.

A report by telephone shall be made immediately or as soon as practically possible. A written report shall be prepared and sent to a local law enforcement agency within two working days of receiving the information regarding the person. The report shall include, but shall not be limited to, the following: (A) The name of the injured person, if known. (B) The injured person's whereabouts. (C) The character and extent of the person's injuries. (D) The identity of any person the injured person alleges inflicted the wound, or other injury upon the injured person.

California law sets up two hospital-based training centers, one in northern California and one in southern California. The centers shall train medical personnel on how to perform medical evidentiary examinations for victims of sexual assault, victims of spousal abuse, and victims of elder abuse.

A licensed clinic board of directors and its medical director shall establish and adopt written policies and procedures to screen patients for purposes of detecting spousal or partner abuse. The policies shall include procedures to accomplish all of the following: (a) Identifying, as part of its medical screening, spousal or partner abuse among patients. (b) Documenting in the medical record patient injuries or illnesses attributable to spousal or partner abuse. (c) Providing to patients who exhibit signs of spousal or partner abuse a current referral list of private and public community agencies that provide, or arrange for, the evaluation, counseling, and care of persons experiencing spousal or partner abuse, including, but not limited to, hot lines, local battered women's shelters, legal services, and information about temporary restraining orders. (d) Designating licensed clinical staff to be responsible for the implementation of these guidelines.

Clinics, for purposes of satisfying these requirements, may adopt guidelines similar to those developed by the American Medical Association regarding domestic violence detection and referral.

Acute care hospitals are required to establish written policies and procedures to screen patients routinely for the purpose of detecting spousal or partner abuse. The policies shall include guidelines on all of the following:

- (a) Identifying, through routine screening, spousal or partner abuse among patients.
- (b) Documenting patient injuries or illnesses attributable to spousal or partner abuse.
- (c) Educating appropriate hospital staff about the criteria for identifying, and the procedures for handling, patients whose injuries or illnesses are attributable to spousal or partner abuse.
- (d) Advising patients exhibiting signs of spousal or partner abuse of crisis intervention services that are available either through the hospital facility or through community-based crisis intervention and counseling services.
- (e) Providing to patients who exhibit signs of spousal or partner abuse information on domestic violence and a referral list, to be updated periodically, of private and public community agencies that provide, or arrange for, evaluation of and care for persons experiencing spousal or partner abuse, including, but not limited to, hot lines, local battered women's shelters, legal services, and information about temporary restraining orders.

## **Colorado**

Physicians who treat a patient with a bullet wound, a gunshot wound, a powder burn, or any other injury arising from the discharge of a firearm, or an intentional injury caused by a knife, an ice pick, or any other sharp or pointed instrument, or any other injury that the physician has reason to believe involves a criminal act, including injuries resulting from domestic violence, must report such injury at once to the police or the sheriff.

Domestic violence is defined as an act of violence upon a person with whom the actor is or has been involved in an intimate relationship. Domestic violence also includes any other crime against a person when used as a method of coercion, control, punishment, intimidation, or revenge directed against a person with whom the actor is or has been involved in an intimate relationship.

## **District of Columbia**

Any physician having reasonable cause to believe that a person brought to him or coming before him for treatment has suffered an injury caused by a firearm, whether self-inflicted, accidental, or occurring during the commission of a crime, or has suffered injury caused by any dangerous weapon in the commission of a crime, shall report that fact.

An oral report shall be made immediately by telephone or otherwise, and followed as soon thereafter as possible by a report in writing, to the Metropolitan Police Department of the District of Columbia. Such reports shall contain, if readily available, the name, address, and age of the injured person, and shall also contain the nature and extent of the person's injuries, and any other information which the physician believes might be helpful in establishing the cause of the injuries and the identity of the person who caused the injuries.

## **Delaware**

Every physician attending or treating a stab wound, poisoning by other than accidental means, or a case of bullet wounds, gunshot wounds, powder burns or other injury arising from or caused by the discharge of a gun shall report such case as soon as possible to the appropriate police authorities. This requirement shall not apply to such wounds, poisonings or injuries received by a member of the armed forces of the United States or Delaware while engaged in the actual performance of duty.

## **Florida**

Any physician knowingly treating any person suffering from a gunshot wound or lifethreatening injury indicating an act of violence, or receiving a request for such treatment, shall report the same immediately to the sheriffs department of their county.

Physicians are required to take a one-hour CME course on domestic violence. The course shall consist of information on the number of patients in that professional's practice who are likely to be victims of domestic violence and the number who are likely to be perpetrators of domestic violence, screening procedures for determining whether a patient has any history of being either a victim or a perpetrator of domestic violence. The course also includes instruction on how to provide such patients with information on, or how to refer such patients to, resources in the local community, such as domestic violence centers and other advocacy groups, that provide legal aid, shelter, victim counseling, batterer counseling, or child protection services.

## **Georgia**

Georgia law provides that physicians having cause to believe that a patient has had physical injury inflicted upon him other than by accidental means shall make a report. An oral report shall be made immediately by telephone and shall be followed by a report in writing, if requested, to the person in charge of the medical facility or his designated delegate. The person in charge of the medical facility or his designated delegate shall then notify the local law enforcement agency having primary jurisdiction. The report shall contain the name and address of the patient, the nature and extent of the patient's injuries, and any other information that the reporting person believes might be helpful in establishing the cause of the injuries and the identity of the perpetrator.

## **Hawaii**

Every physician treating a case of knife wound, bullet wound, gunshot wound, powder burn, or any injury that would seriously maim, produce death, or has rendered the injured person unconscious, caused by the use of violence or sustained in a suspicious or unusual manner shall report such case to the chief of police of the county within 24 hours. The report shall contain the name of the injured person, description of the nature, type, and extent of the injury, together with other pertinent information that may be of use to the chief of police.

## **Idaho**

Any physician in a hospital shall notify the local law enforcement agency of that jurisdiction upon the treatment of, or request for treatment of, a person suffering an injury inflicted by means of a firearm or an injury indicating that the person may be a victim of a criminal offense.

The report provided to the law enforcement agency shall include the name and address of the injured person, the character and extent of the person's injuries, and the medical basis for making the report.

## **Illinois**

A physician must-- as soon as time permits--notify the local law enforcement upon the application for treatment of a person who is not accompanied by a law enforcement officer, when it reasonably appears that the person has received: (1) any injury resulting from the discharge of a firearm; or (2) any injury sustained in the commission of or as a victim of a criminal offense.

## **Iowa**

Under Iowa law a physician who treats any person suffering a gunshot or stab wound or other serious injury which appears to have been received in connection with the commission of a criminal offense shall at once, but not later than twelve hours thereafter, report that fact to the local law enforcement agency or if ascertainable, to the law enforcement agency in whose jurisdiction the gunshot or stab wound or other serious injury occurred. The report shall include the name of such person, the person's residence if ascertainable, and give a brief description of the gunshot or stab wound or other serious injury.

Serious injury is defined to include bodily injury that creates a substantial risk of death, causes serious permanent disfigurement, or causes protracted loss or impairment of the function of any bodily member or organ. Additionally, it includes any injury to a child that requires surgical repair and necessitates the administration of general anesthesia or skull fractures, rib fractures, and metaphysical fractures of the long bones of children under the age of four years.

Hospitals are required to establish protocols for treating victims of domestic violence. These protocols must require an interview with the victim in a place that ensures privacy, confidentiality of the person's treatment and information, sharing of information regarding the domestic abuse hotline and programs, and education of appropriate emergency department staff to assist in the identification of victims of domestic abuse.

The treatment records of victims of domestic abuse shall include: an assessment of the extent of abuse to the victim specifically describing the location and extent of the injury and reported pain, evidence that the victim was informed of the telephone numbers for the domestic abuse hot-line and domestic abuse programs and the victim's response, a record of the treatment and intervention by the health care provider, a record of the need for follow-up care and specification of the follow-up care to be given (e.g., X-rays, surgery, consultation, similar care); and the victim's statement of how the injury occurred.

## **Kansas**

Under Kansas law a physician must report to the chief of police or sheriff any treatment of an injury caused by a bullet wound, gunshot wound, powder burn or other injury arising from or caused by the discharge of

a firearm. Additionally a physician must report a wound which is likely to, or may, result in death and is apparently inflicted by a knife, ice pick, or other sharp or pointed instrument.

### **Kentucky**

A physician must report evidence of abuse, neglect or exploitation suffered by a married person. The report may be oral or written and must go to the Kentucky Cabinet for Family and Children. The report must contain the name and address of the adult, or of any other person responsible for his care; the age of the adult; the nature and extent of the abuse, neglect, or exploitation, including any evidence of previous abuse, neglect, or exploitation; the identity of the perpetrator, if known; the identity of the complainant, if possible; and any other information that the person believes might be helpful in establishing the cause of abuse, neglect, or exploitation.

### **Maine**

Physicians are required by law to report to a law enforcement officer within 24 hours of treatment a wound apparently caused by the discharge of a firearm.

### **Maryland**

A physician treating an injury caused by an automobile accident or an accident involving a boat or by a lethal weapon shall, as soon as practicable, notify either the sheriff of the county, the county police or the Department of State Police. The report shall contain the injured individual's name and address, if known, a description of the injury, and any other facts that might assist in the detection of crime. This requirement only applies in Charles, Kent, Montgomery, Talbot, Somerset, Prince George's, Wicomico, Allegany and Anne Arundel Counties.

Any physician statewide treating an injury caused by any type of gunshot must as soon as practicable, notify either the county police, the Baltimore City police, or the Department of State Police of such fact, giving the patient's name and address, if known, a description of the injury, and any other facts that might assist in the detection of crime.

### **Massachusetts**

Every physician treating a case of bullet wound, gunshot wound, powder burn or any other injury arising from the discharge of a gun, pistol, BB gun, or other air rifle or firearm, or a knife injury shall report such case at once to the colonel of the state police and to the police of the town where such physician is located. This section shall not apply to such wounds or injuries received by any member of the armed forces of the United States or of the commonwealth while engaged in the actual performance of duty.

Additionally, whenever a physician treats the victim of a sexual assault they shall report such case at once to the criminal history systems board and to the police of the town where the rape or sexual assault occurred, but shall not include the victim's name, address, or any other identifying information.

### **Michigan**

A physician treating a wound or other injury inflicted by means of a knife, gun, pistol, or other deadly weapon, or by other means of violence, has a duty to report that fact immediately, both by telephone and in writing, to the chief of police. The report shall state the name and residence of the person, if known, his or her whereabouts, and the cause, character, and extent of the injuries and may state the identification of

the perpetrator, if known.

### **Minnesota**

Under Minnesota law a physician must immediately report to the local police department or county sheriff all bullet wounds, gunshot wounds, powder burns, or any other injury arising from, or caused by the discharge of a gun, pistol, or any other firearm. Additionally, a physician must report any injury that has been inflicted on a perpetrator of a crime by a dangerous weapon other than a firearm.

The report must be made by telephone or in person, and shall be promptly supplemented by

letter, enclosed in a securely sealed, postpaid envelope, addressed to the sheriff of the county in which the wound is examined or to the city police chief.

### **Mississippi**

A physician who treats a wound or injury and who has reason to believe that the wound or injury was caused by gunshot or knifing, or receiving a request for such treatment, shall report it immediately to the municipal police department or sheriff's office.

### **Missouri**

Under Missouri law a physician who treats a person for a wound inflicted by gunshot shall immediately report to a local law enforcement official the name and address of the person, if known, and if unknown, a description of the person, together with an explanation of the nature of the wound and the circumstances under which the treatment was rendered.

### **Montana**

A physician treating the victim of a gunshot wound or stabbing shall make a report to a law enforcement officer by the fastest possible means. Within 24 hours after initial treatment or first observation of the wound, a written report shall be submitted, including the name and address of the victim, if known, and shall be sent by regular mail.

### **Nebraska**

Under Nebraska law a physician shall report every case, in which he is consulted for treatment or treats an injury of violence which appears to have been received in connection with the commission of a criminal offense, immediately to the chief of police or to the sheriff wherein the consultation or treatment occurs. Such report shall include the name of such person, the residence, if ascertainable, and a brief description of the injury.

### **Nevada**

All physicians to whom any person comes for treatment of an injury which appears to have been inflicted by means of a firearm or knife, not under accidental circumstances, shall promptly report the person's name, if known, his location and the character and extent of the injury to an appropriate law enforcement agency.

## **New Hampshire**

A physician who has treated a person for a gunshot wound or for any other injury he believes to have been caused by a criminal act, must immediately notify a law enforcement official of all the information he possesses concerning the injury. This does not apply if the person is eighteen or older and has been the victim of sexual abuse, did not sustain a gunshot wound or other serious bodily injury, and objects to the release of information.

The state government will conduct educational programs for medical personnel on domestic violence and is supposed to create protocols for physicians to use when treating domestic violence victims.

## **New Jersey**

Every case of a wound, burn or any other injury arising from or caused by a firearm, explosive or other weapon shall be reported at once to the police authorities where the person reporting is located or to the State Police by the physician consulted, attending or treating the case. This does not apply to wounds, burns or injuries received by a member of the armed forces of the United States or the State of New Jersey while engaged in the actual performance of duty.

## **New York**

Every case of a bullet wound, gunshot wound, powder burn or any other injury arising from or caused by the discharge of a gun or firearm, and every case of a wound which is likely to or may result in death and is actually or apparently inflicted by a knife, icepick or other sharp or pointed instrument, shall be reported at once to the police authorities. This shall not apply to such wounds, burns or injuries received by a member of the armed forces of the United States or the state of New York while engaged in the actual performance of duty.

The state is required to develop a protocol for identification and screening of victims of domestic violence who are HIV positive. The New York State Office for the Prevention of Domestic Violence is empowered to deliver training to health professionals on domestic violence issues.

## **North Carolina**

Physicians are required to report as soon as practicable, before, during or after completion of treatment of a person suffering from a bullet wound, gunshot wound, powder burn or any other injury arising from or caused by the discharge of a gun or firearm, every case of a wound or injury caused, or apparently caused, by a knife or sharp or pointed instrument if it appears to the physician treating the case that a criminal act was involved. Also, the physician must report every case of a wound, injury or illness in which there is grave bodily harm or grave illness if it appears to the physician treating the case that the wound, injury or illness resulted from a criminal act of violence.

The report shall be made to the police or sheriff. The report shall state the name of the wounded, ill or injured person, if known, and the age, sex, race, residence or present location, if known, and the character and extent of his injuries.

## **North Dakota**

Any physician who performs any diagnosis or treatment for any individual suffering from any wound,

injury, or other physical trauma inflicted by the individual's own act or by the act of

another by means of a knife, gun, or pistol shall as soon as practicable report the wound, injury, or trauma to a law enforcement agency in the county in which the care was rendered. Additionally, the physician must report any injury they reasonable suspect was inflicted in violation of any criminal law.

The report must state the name of the injured individual and the character and extent of the individual's injuries. When a report of domestic violence is made to a law enforcement agency the injured individual must be provided with information regarding domestic violence sexual assault.

## **Ohio**

Under Ohio law no physician shall negligently fail to report to law enforcement authorities any gunshot or stab wound that the physician treated or observed or any serious physical harm to persons that the physician knows or reasonably believes resulted from an offense of violence. Additionally, any physician who knows or reasonably believes that a patient has been the victim of domestic violence shall note that fact and the basis for it in the patient's records.

Also, Ohio law requires every hospital to adopt protocols for conducting an interview with the patient, for conducting one or more interviews, separate and apart from the interview with the patient, with any family or household member present, and for creating, whenever possible, a photographic record of the patient's injuries, in situations in which a physician knows or reasonably believes that the patient has been the victim of domestic violence.

Lastly, the state medical board must approve one or more continuing medical education courses included within the programs certified by the Ohio state medical association that assist physicians in recognizing the signs of domestic violence and its relationship to child abuse. Physicians are not required to take the courses.

## **Oklahoma**

Any physician examining, attending, or treating the victim of what appears to be criminally injurious conduct including, but not limited to, child physical or sexual abuse shall report orally or by telephone promptly to the nearest appropriate law enforcement agency in the county wherein the criminally injurious conduct occurred.

## **Oregon**

Any physician reasonably suspecting that a person coming before the physician for examination, care or treatment has had a physical injury caused by a knife, gun, pistol or other deadly weapon other than by accidental means, shall report immediately by telephone, and followed as soon thereafter as possible by a report in writing, to the appropriate medical examiner.

## **Pennsylvania**

A bill passed in 1998 creating the Domestic Violence Health Care Response Program. The Program was to set up pilot programs with certain hospitals to develop and implement a multidisciplinary, comprehensive and ongoing domestic violence education and training program. The training program shall include, but is not limited to, identifying characteristics of domestic violence, screening patients for domestic violence,

appropriately documenting the facts in the medical record and offering referral services, including domestic violence resources available in the community.

### **Rhode Island**

Every physician attending or treating a case of bullet wound, gunshot wound, powder burn, or any other injury arising from the discharge of a gun, pistol, or other firearm shall report the case at once to the police authorities where they are located. This requirement does not apply to wounds received by any member of the armed forces of the United States or of Rhode Island while engaged in the actual performance of duty.

### **Tennessee**

Any physician who knows, or reasonably suspects, that a patient's injuries are the result of domestic violence or domestic abuse, is encouraged to report to the department of health on a monthly basis. The report shall not disclose the name or identity of the patient, but should include the nature and extent of the patient's injuries, the substance in summary fashion of any statements made by the patient, including comments concerning past domestic abuse with the patient's current spouse or previous partner(s), that would reasonably give rise to suspicion of domestic abuse. The practitioner shall include any other information upon which the suspicion of domestic abuse is based.

Any physician called upon to tender aid to persons suffering from any wound or other injury inflicted by means of a knife, pistol, gun, or other deadly weapon, or by other means of violence shall report the same immediately to the chief of police or sheriff. Additionally, the physician must also report the same immediately to the district attorney general. Such report shall state the name, residence, and employer of such person, if known, such person's whereabouts at the time the report is made, the place the injury occurred, and the character and extent of such injuries.

### **Texas**

A physician who attends or treats, or who is requested to attend or treat, a bullet or gunshot wound shall report the case at once to the law enforcement authority of the municipality or county in which the physician practices.

Additionally, a physician who treats a person for injuries that the medical professional has reason to believe were caused by family violence shall:

- (1) immediately provide the person with information regarding the nearest family violence shelter center;
- (2) document in the person's medical file:
  - (A) the fact that the person has received the information provided under Subdivision (1); and
  - (B) the reasons for the medical professional's belief that the person's injuries were caused by family violence; and
- (3) give the person a written notice in substantially the following form, completed with the required information, in both English and Spanish:

## **"NOTICE TO ADULT VICTIMS OF FAMILY VIOLENCE**

"It is a crime for any person to cause you any physical injury or harm even if that person is a member or former member of your family or household.

"You may report family violence to a law enforcement officer by calling the following telephone numbers: "If you, your child, or any other household resident has been injured or if you feel you are going to be in danger after a law enforcement officer investigating family violence leaves your residence or at a later time, you have the right to: "Ask the local prosecutor to file a criminal complaint against the person committing family violence; and "Apply to a court for an order to protect you. You may want to consult with a legal aid office, a prosecuting attorney, or a private attorney. A court can enter an order that: "(1) prohibits the abuser from committing further acts of violence; "(2) prohibits the abuser from threatening, harassing, or contacting you at home; "(3) directs the abuser to leave your household; and "(4) establishes temporary custody of the children or any property.

"A VIOLATION OF CERTAIN PROVISIONS OF COURT-ORDERED PROTECTION MAY **BE A FELONY.**

"CALL THE FOLLOWING VIOLENCE SHELTERS OR SOCIAL ORGANIZATIONS IF YOU NEED PROTECTION:"

### **Utah**

Any physician who treats or cares for any person who suffers from any wound or other injury inflicted by the person's own act or by the act of another by means of a knife, gun, pistol, explosive, infernal device, or deadly weapon, or by violation of any criminal statute of this state, shall immediately report to a law enforcement agency the facts regarding the injury. The report shall state the name and address of the injured person, if known, the person's whereabouts, the character and extent of the person's injuries, and the name, address, and telephone number of the person making the report.

### **Vermont**

Every physician attending or treating a case of bullet wound, gunshot wound, powder burn, or any other injury arising from or caused by the discharge of a gun, pistol, or other firearm shall report such case at once to local law enforcement officials or the state police. The provisions of this section shall not apply to such wounds, burns or injuries received by a member of the armed forces of the United States or state of Vermont while engaged in the actual performance of duty.

### **Virginia**

Any physician who renders any medical treatment to any person for any wound which such physician knows or has reason to believe is a wound inflicted by a specified weapon and which wound such physician has reason to believe was not self-inflicted shall as soon as practicable report such fact, to the sheriff or chief of police of the county or city in which treatment is rendered. Such report must include the wounded person's name and address, if known. If such medical treatment is rendered in a hospital or similar institution, the physician shall immediately notify the person in charge of such hospital or similar institution, who shall make the report.

The weapons covered under the act are (i) any pistol, revolver, or other weapon designed or intended to propel a missile of any kind by action of an explosion of any combustible material; (ii) any dirk, bowie knife, switchblade knife, ballistic knife, razor, slingshot, spring stick, metal knuckles, or blackjack; (iii) any flailing instrument consisting of two or more rigid parts connected in such a manner as to allow them to swing freely, which may be known as a nun chahka, nun chuck, nunchaku, shuriken, or fighting chain; (iv) any disc, of whatever configuration, having at least two points or pointed blades which is designed to be thrown or propelled and which may be known as a throwing star or oriental dart; or (v) any weapon of like kind.

### **Washington**

The state government shall establish an ongoing domestic violence education program as an integral part of its health professions regulation. The purpose of the education program is to raise awareness and educate health care professionals regarding the identification, appropriate treatment, and appropriate referral of victims of domestic violence. The disciplinary authorities having the authority to offer continuing education may provide training in the dynamics of domestic violence.

### **West Virginia**

Any physician who provides medical treatment to a person suffering from a wound caused by a gunshot or a knife or other sharp or pointed instrument, under circumstances which would lead a reasonable person to believe resulted from a violation of the criminal laws shall report the same to a law-enforcement agency located within the county within which such wound is treated. The report shall be made initially by telephone and shall be followed by a written

report delivered to such agency within forty-eight hours following the initial report: Provided, That where two or more persons participate in the medical treatment of such wound, the obligation to report imposed by this section shall apply only to the attending physician or, if none, to the person primarily responsible for providing the medical treatment.

### **Wisconsin**

A physician who treats a patient suffering from a gunshot wound or any wound other than a gunshot wound if the person has reasonable cause to believe that the wound occurred as a result of a crime shall report the patient's name and the type of wound involved as soon as reasonably possible to the local police department or county sheriffs office for the area where the treatment is rendered.

This requirement does not apply if the patient is accompanied by a law enforcement officer, the patient's name and injury was previously reported, or the gunshot wound is older than thirty days.

## **WHICH STATES MAKE THE GRADE ON DOMESTIC VIOLENCE & HEALTH?**

New Report Card Examines State Laws on Screening for Domestic Violence, Training Health Care Providers, Prohibiting Insurance Discrimination and More

In a report to be released next Tuesday, August 15, the Family Violence Prevention Fund (FVPF) will evaluate which states have enacted effective laws to improve the health care response to domestic violence. The first-ever State-By-State Report Card on Health Care Laws and Domestic Violence explores state laws in five critical areas - training, screening, protocols, reporting and insurance. The Report Card grades each state based on whether it has enacted effective laws to improve the health care response to domestic violence.

Domestic violence has reached epidemic proportions in this country. Nearly one-third of American women (31 percent) report being physically or sexually abused by a husband or boyfriend at some point in their lives. Health care providers can play a critical role in helping victims of abuse and their children, if they are trained to screen for domestic violence, to recognize signs of abuse, and to intervene effectively. States can pass laws that prohibit insurance discrimination, and improve the ability of doctors, nurses and other health care providers to help victims of domestic violence. But many states have not yet done so.

The Family Violence Prevention Fund (FVPF) works to end domestic violence and help women and children whose lives are devastated by abuse, because every person has a right to live in a home free of violence. The FVPF challenges lawmakers to take domestic violence seriously, educates judges to protect all victims of abuse, advocates for laws to help battered immigrant women, helps health care providers and employers identify and aid victims of abuse, and shows Americans how to help end domestic violence.

The *State-by-State Report Card* is available online at [www.fvpf.org/statereport](http://www.fvpf.org/statereport).

## RESOURCES

### State-by-State Report Card on Health Care Laws and Domestic Violence

Posted: August 28, 2001

The Family Violence Prevention Fund's (FVPF's) State-By-State Report Card on Health Care Laws and Domestic Violence is an at-a-glance evaluation of state activity in passing laws to improve the health care response to domestic violence.

**Note:** The Family Violence Prevention Fund has developed model laws to improve the state health care response to domestic violence. If you would like a copy of these model laws, please call the Family Violence Prevention Fund at 415/252-8900, and ask to speak to a member of health team. Thank you!

[Introduction and Methodology](#)

[Grading Criteria](#)

State	Training	Screening	Protocols	Reporting	Insurance	Legislative	Total	Grade 2001	Grade 2000
<a href="#">Alaska</a>	1	0	1	0	0	0	2	C	C
<a href="#">Alabama</a>	0	0	0	0	2	0.5	2.5	C	C
<a href="#">Arkansas</a>	0	0	0	0	0	0	0	D	D
<a href="#">Arizona</a>	0	0	0	0	1	0	1	D	D
<a href="#">California</a>	1	2	2	-1	1	0.5	5.5	B	B
<a href="#">Colorado</a>	0	0	0	-1	0	0	-1	F	F
<a href="#">Connecticut</a>	0	0	0	0	0	0	0	D	D
<a href="#">Washington</a>	0	0	0	0	0	0	0	D	D
<a href="#">Delaware</a>	0	0	0	0	1	0	1	D	D
<a href="#">Florida</a>	1	0	0	1	1	0.5	3.5	B	C
<a href="#">Georgia</a>	0	0	0	0	2	0	2	C	C
<a href="#">Hawaii</a>	0	0	0	0	1	0	1	D	D
<a href="#">Iowa</a>	0	0	1	0	0	0.5	1.5	D	D
<a href="#">Idaho</a>	0	0	0	0	0	0	0	D	D
<a href="#">Illinois</a>	0	0	0	0	1	0.5	1.5	D	D
<a href="#">Indiana</a>	0	0	0	0	1	0	1	D	D
<a href="#">Kansas</a>	0	0	0	1	1	0	2	C	C
<a href="#">Kentucky</a>	1	0	0	-1	0	0.5	0.5	D	D
<a href="#">Louisiana</a>	0	0	0	0	0	0	0	D	D
<a href="#">Massachusetts</a>	0	0	0	0	1	0.5	1.5	D	D
<a href="#">Maryland</a>	0	0	0	0	0	0.5	0.5	D	B
<a href="#">Maine</a>	0	0	0	1	1	0	2	C	D
<a href="#">Michigan</a>	0	0	0	0	0	0.5	0.5	D	D
<a href="#">Minnesota</a>	0	0	0	1	0	0	1	D	D
<a href="#">Missouri</a>	0	0	0	1	0	0.5	1.5	D	D

<u>Mississippi</u>	0	0	0	0	0	0	0	0	<b>D</b>	D
<u>Montana</u>	0	0	0	0	1	0	1	1	<b>D</b>	D
<u>North Carolina</u>	0	0	0	0	0	0	0	0	<b>D</b>	D
<u>North Dakota</u>	0	0	0	0	0	0	0	0	<b>D</b>	D
<u>Nebraska</u>	0	0	0	0	2	0	2	2	<b>C</b>	C
<u>New Hampshire</u>	1	0	1	1	0	0	3	3	<b>B</b>	B
<u>New Jersey</u>	0	0	0	0	0	0	0	0	<b>D</b>	D
<u>New Mexico</u>	0	0	0	0	2	0.5	2.5	2.5	<b>C</b>	C
<u>Nevada</u>	0	0	0	0	0	0	0	0	<b>D</b>	D
<u>New York</u>	1	1	1	0	0	0.5	3.5	3.5	<b>B</b>	B
<u>Ohio</u>	1	0	1	0	0	0	2	2	<b>C</b>	C
<u>Oklahoma</u>	1	0	0	0	0	0	1	1	<b>D</b>	D
<u>Oregon</u>	0	0	0	0	1	0	1	1	<b>D</b>	D
<u>Pennsylvania</u>	1	1	1	0	1	0.5	4.5	4.5	<b>A</b>	A
<u>Rhode Island</u>	0	0	0	1	0	0	1	1	<b>D</b>	D
<u>South Carolina</u>	0	0	0	0	0	0	0	0	<b>D</b>	D
<u>South Dakota</u>	0	0	0	0	0	0	0	0	<b>D</b>	D
<u>Tennessee</u>	0	0	0	0	0	0	0	0	<b>D</b>	D
<u>Texas</u>	0	0	1	1	0	0	2	2	<b>C</b>	C
<u>Utah</u>	0	0	0	0	1	0	1	1	<b>D</b>	D
<u>Virginia</u>	0	0	0	0	1	0	1	1	<b>D</b>	D
<u>Vermont</u>	0	0	0	1	0	0	1	1	<b>D</b>	D
<u>Washington</u>	1	0	0	1	1	0	3	3	<b>B</b>	B
<u>Wisconsin</u>	0	0	0	0	1	0	1	1	<b>D</b>	D
<u>West Virginia</u>	1	0	1	0	1	0.5	3.5	3.5	<b>B</b>	B
<u>Wyoming</u>	0	0	0	0	0	0	0	0	<b>D</b>	D

## RESOURCES

# HEALTH CARE REPORT CARD 2001

### Criteria for State Grades *Training*

Just ten states have enacted laws addressing domestic violence training. They are Alaska, California, Florida, Kentucky, New Hampshire, New York, Ohio, Oklahoma, Pennsylvania and Washington state.

**Two Points:** For a state to receive two points in this category, its law must apply to all health care professionals and involve regular and comprehensive training on screening, identification and referral for domestic violence.

**One Point:** For a state to receive one point in this category, its law must do one of the following

1. Provide for training specific to domestic violence for health care professionals (can be mandatory or discretionary) at some level. May be for only public employees, all health care professionals, or another specific group. It is preferred that the training be regular (e.g. upon licensure and upon biennial re-licensure), or at specific intervals;
2. Provide one-time training only
3. Provide for establishment of training centers, or pilot programs within the state to train professionals on domestic violence;
4. Direct medical or nursing schools to develop course work to be carried out within the state; or
5. Direct a state agency to make training on domestic violence available to health care professionals;
6. Fund training centers and/or fund training efforts.

**Zero Points:** States with no laws on domestic violence training received zero points in this category.

### *Screening*

Just three states have enacted laws addressing domestic violence screening. They are California, New York and Pennsylvania.

**Two Points:** For a state to receive two points in this category, its law must require all health care facilities to establish and adopt written policies to screen patients for the purpose of detecting spousal or partner abuse.

**One Point:** For a state to receive one point in this category, its law must do one of the following:

1. Require that any or certain health care facilities establish and adopt written policies to screen patients for the purpose of detecting spousal or partner abuse, or
2. Require domestic violence screening within any special population.

**Zero Points:** States without any laws addressing domestic violence screening received zero points in this category.

### *Protocols*

Just eight states have domestic violence protocols in law. They are Alaska, California, Iowa, New Hampshire, New York, Ohio, Pennsylvania and Texas.

**Two Points:** For a state to receive two points in this category, its law must:

1. Require identification of partner abuse as part of medical screening.
2. Require documentation in the medical record of patient injuries or illnesses attributable to spousal or

partner abuse.

3. Provide referral list of appropriate services and agencies to patients.

**One Point:** For a state to receive one point in this category, its law must:

1. Require identification of partner abuse as part of medical screening;
2. Require documentation in the medical record of patent injuries or illnesses attributable to spousal or partner abuse; or
3. Provide referral list of appropriate services and agencies to patients.

**Zero Points:** States without laws on domestic violence protocols received zero points in this: category.

## **Reporting**

Thirteen states have enacted domestic violence reporting laws or reporting laws for gunshot and/or life threatening injuries only. They are California, Colorado, Florida, Kansas, Kentucky, Maine, Minnesota, Missouri, New Hampshire, Rhode Island, Texas, Vermont and Washington state.

**Two Points:** For a state to receive two points in this category, its law must:

1. Require health care professionals to report an incident of domestic violence to law enforcement only in cases of a life-threatening injury, gunshot wound, or both; 2. Prescribe procedures for working with a domestic violence advocate or with the patients directly to explain and coordinate the patient's safety planning with the health care practitioner's call to law enforcement; and
3. Allow the patient to object to the release of information to law enforcement.

**One Point:** For a state to receive one point in this category, its law must:

1. Allow for reporting of domestic violence (or non-domestic violence) cases to law enforcement or to any other governmental agency only in cases of life-threatening injury, gunshot wounds, or both; or
2. Give the patient information that would inform the patient on how to make a report to law enforcement (not require any official reporting).

**Zero Points:** States received zero points in this category if they:

1. Have failed to enact laws about reporting domestic violence crimes to law enforcement or any other governmental entity;
2. Enacted a law requiring health care professionals to notify law enforcement when the treat: any injury such as a burn, any violent crime, a knife (unless the law specifies that only life-threatening knife injuries would be included), or other "dangerous weapon," unspecified object; or injuries that are a result of any criminal "injurious conduct" or criminal activity; or an injury that would "seriously maim or render the person unconscious." Most of the laws in this category have been on the books as part of a general policy that health care professionals must report persons who had any injuries where it appeared a crime was implicated. These laws were designed to assist law enforcement in solving crimes, and not in any way specific to domestic violence;
3. Mandate the reporting of adult (elder) or child abuse.

**Negative Grade:** In this category only, a state received a negative grade if it enacted a law mandates that health care professionals report to law enforcement (or other governmental entity) any person whom he or she knows or reasonably suspects is suffering from any "wound or physical injury that is the result of abusive or assaultive conduct," without informing the victim or obtaining the victim's consent received a negative grade in this category.

## **Insurance**

Twenty-two states have enacted adequate domestic violence insurance discrimination protections. They are Alabama, Arizona, California, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Kansas, Maine, Massachusetts, Montana, Nebraska, New Mexico, Oregon, Pennsylvania, Utah, Virginia, Washington state, West Virginia and

Wisconsin.

**Two Points:** For a state to receive two points in this category, its law must:

1. Apply to all lines of health, life and disability insurance;
2. Prohibit insurers from using domestic violence as a basis for underwriting or rating insurance including: denying, canceling, limiting or excluding coverage; charging a higher premium or denying claims because and individual is, has been or is perceived to be a victim of domestic violence. (This prohibition must not be limited to actions based "solely" on domestic violence because "solely" permits actions based on domestic violence with other reasons); and
3. Prohibit insurers from underwriting or rating on the basis of mental and physical conditions or Claims resulting from domestic violence or, at a minimum, provide safeguards if insurers are permitted to consider abuse-related medical conditions and claims including written explanation to the applicant or insured. (Specific criteria for the written explanation can be obtained from the Women's Law Project or the PA Coalition Against Domestic Violence) and have at least two among items listed below as number four through seven;
5. Prohibit all of the actions outlined above because of an association with victims of domestic violence
6. including: individuals and organizations that provide shelter and other services to victims; employers and others such as family and friends;
5. Require that abuse-related information and location information be kept confidential including not transferring the information to insurance databases or other entities and that insurers develop protocols for employees, agents and contractors to ensure that interactions do not endanger the safety of the victim or result in disclosure of confidential information;
6. Provide for an enforcement mechanism that permits an individual to obtain a meaningful remedy for a single violation of the law; or 7. Provide for a private right of action.

**One Point:** For a state to receive one point in this category, its law must:

1. Apply to all lines of health, life and disability insurance; and
2. Prohibit insurers from using domestic violence as a basis for underwriting or rating insurance including: denying, canceling, limiting or excluding coverage; charging a higher premium or denying claims because and individual is, has been or is perceived to be a victim of domestic violence. This prohibition must not be limited to actions based "solely" on domestic violence because "solely" permits actions based on domestic violence with other reasons.

**Zero Points:** To receive no points in this category, a state must either:

1. Have no laws on insurance discrimination and domestic violence; or
2. Have enacted a law that fails to meet criteria one and two above. If the law discusses domestic violence and insurance discrimination, but allows for actions by insurers unless they are limited "solely" or "only" account of domestic violence, the state will get a "0" as that language is a clear loophole in the law which could allow discrimination.

**National Clearinghouse on Child Abuse  
and Neglect Information**

**Child Abuse and Neglect State Statutes  
Elements**

**Child Abuse Reporting Procedures**

<http://nccanch.acf.hhs.gov/general/legal/statutes/sag/repproc.pdf>

**Child Abuse Reporting Numbers**

<http://nccanch.acf.hhs.gov/pubs/reslist/reportnum.pdf>

**Mandatory Reporters of Child Abuse and Neglect**

<http://nccanch.acf.hhs.gov/general/legal/statutes/sag/manda.pdf>

**Definitions of Child Abuse and Neglect**

<http://nccanch.acf.hhs.gov/general/legal/statutes/sag/define.pdf>

# **ACADEMY MATERIAL**

## **1. Family Violence Resources**

*American Academy of Orthopaedic Surgeons*

## **2. Orthopaedic Aspects of Child Abuse**

*Mininder S. Kocher, MD and James R. Kasser, MD*

## **3. Letter from the Editor on Orthopaedic Aspects of Child Abuse**

*Journal of the American Academy of Orthopaedic Surgeons*

## **4. Domestic Violence: The Role of the Orthopaedic Surgeon**

*Debra A. Zillmer, MD*



American Academy of  
Orthopaedic Surgeons®

## **It's OK to Talk to Your Orthopaedic Surgeon about Family Violence**

The American Academy of Orthopaedic Surgeons is engaged in a program to heighten the awareness of orthopaedic surgeons about the issues of family violence, the ways to identify abuses and actions that can be taken.

Following is a list of national and state resources to assist victims of family violence; the telephone numbers are subject to change. This document also includes Academy initiatives to help orthopaedic surgeons learn more about the issue.

### **FAMILY VIOLENCE RESOURCES (Phone numbers subject to change without notice)**

#### **NATIONAL RESOURCES**

##### **Domestic Violence**

Violence Against Women Act

National Hotline

800-799-SAFE (7233)

TDD 800-787-3224

For emergencies, call your local police at 911

National Resource Center on Domestic Violence

800-537-2238

Family Violence Prevention Fund's Health Resource Center on Domestic Violence 888-792-2873

National Coalition Against Domestic Violence

303-839-1852 (business office)

Minnesota Program Development

Domestic Abuse Intervention Project

218-722-2781 (Victims' information and batterers' treatment program information)

Peace At Home

617-971-0131

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

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

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

Rape, Abuse, and Incest Network  
Twenty-four hour answering 800-656-4673 (800-656-HOPE)

National Center for Missing and Exploited Children  
800-843-5678  
703-274-3900

National Runaway Switchboard and Suicide Hotline  
800-621-4000

National Center for Prosecution of Child Abuse  
703-739-0321

<b>DOMESTIC VIOLENCE</b>	<b>CHILD ABUSE</b>	<b>ELDER ABUSE</b>
<p><b>ALABAMA</b> Coalition Against Domestic Violence P.O. Box 4762 Montgomery, AL 36101 (334) 832-4842</p>	<p><b>ALABAMA</b> Prevent Child Abuse Alabama 2101 Eastern Blvd. PO Box 230904 Montgomery, AL 36123 (334) 271-5105</p>	<p><b>ALABAMA</b> Family Services Division Department of Human Resources 50 Ripley Street Montgomery, AL 36130 (334) 242-9500 In-State Elder Abuse Hotline (800) 458-7214 (Domestic &amp; Institutional)</p>
<p><b>ALASKA</b> Network of Domestic and Sexual Assault 130 Seward Street, #209 Juneau, AK 99801 (907) 586-3650</p>	<p><b>ALASKA</b> Anchorage Center for Families 3745 Community Park Loop Suite 102 Anchorage, AK 99508 (907) 276-4994 In-State Hotline 800-478-4444</p>	<p><b>ALASKA</b> AK Division of Senior Services Department of Administration 3601 C Street, #310 Anchorage, AK 99503 (907) 269-3666 In-State Elder Abuse Hotline (800) 478-9996</p>
<p><b>ARKANSAS</b> Coalition Against Domestic Violence 1 Sheriff Lane, #C North Little Rock, AR 72114 (501) 812 0571</p>	<p><b>ARKANSAS</b></p>	<p><b>ARKANSAS</b> Division of Aging &amp; Adult Services AR Dept of Human Services 7<sup>th</sup> and Main Streets Little Rock, AR 72203 In-State Elder Abuse Hotline (800) 472-8049 Institutional (800) 582-4887</p>
<p><b>ARIZONA</b> Coalition Against Domestic Violence 100 W. Camelback Rd. #109 Phoenix, AZ 85013 (602) 279-2900 (800) 782-6400</p>		<p><b>ARIZONA</b> Adult Protective Service Aging &amp; Adult Administration Dept of Economic Security 1789 W. Jefferson, #950A Phoenix, AZ 85007 (602) 542-4446 In-State Elder Abuse (877) 767-2385</p>
<p><b>CALIFORNIA</b> California Alliance Against Domestic Violence 926 J St., Suite 1000 Sacramento, CA 95814 (916) 444-7163 (800) 524-4765 Statewide California Coalition for Battered Women (818) 787-0072</p>	<p><b>CALIFORNIA</b> Prevent Child Abuse California 929 J Street, Suite 717 Sacramento, CA 95814 (916) 498-8481 1 (800) CHILDREN pca-ca.org Other counties: call Sheriff's Office (916) 445-2832 Report by County</p>	<p><b>CALIFORNIA</b> Dept. of Aging 1600 K Street Sacramento, CA 95814 (916) 332-5290 Institutional (800) 231-4024</p>

<p><b>COLORADO</b> Coalition Against Domestic Violence 1600 Downing #400 P.O. Box 18902 Denver, CO 80218 (303) 831-9632</p>	<p><b>COLORADO</b> County Office of Department of Social Services Denver County (303) 727-3000 Report by County</p>	<p><b>COLORADO</b> Adult Protective Services &amp; Elder Rights Department of Social Services 1575 Sherman St. Ground Floor Denver CO 80203-1714 (303) 866-2651 In-State Elder Abuse Hotline (800) 773-1366 Institutional (800) 238-1376</p>
<p><b>CONNECTICUT</b> Coalition Against Domestic Violence 106 Pitkin St. East Hartford, CT 08106 (860) 282-7899 (800) 281-1481</p>	<p><b>CONNECTICUT</b> Prevent Child Abuse 74 East Street (Route 10) Wheeler Clinic Plainville, CT 06062 (860)793-3375 ccpa@wheelerclinic.com In-State Hotline (800) 482-2288</p>	<p><b>CONNECTICUT</b> Department of Social Services 25 Sigourney St. Hartford, CT 06106 In-State Elder Abuse Hotline (860) 424-5022 Domestic (800) 385-4225 Institutional (860) 424-5200</p>
<p><b>DELAWARE</b> Coalition Against Domestic Violence P.O. Box 847 Wilmington, DE 19899 (302) 658-2958</p>	<p><b>DELAWARE</b> Prevent Child Abuse 100 W 19th Street Suite 715 Wilmington, DE 19801 (302) 254-4611 1 (800) CHILDREN In-State Hotline (800) 292-9582</p>	<p><b>DELAWARE</b> Division of Svcs for Aging &amp; Adults w/Physical Disabilities Adult Protective Service 1901 N. Dupont Hwy. New Castle, DE 19720 (304) 577-4791 In-State Elder Abuse Hotline (800) 223-9074</p>
<p><b>DISTRICT OF COLUMBIA</b> Coalition Against Domestic Violence 513 U Street, NW Washington, DC 20001 (202) 387-5630</p>	<p><b>DISTRICT OF COLUMBIA</b> Prevent Child Abuse Metro Washington PO Box 57194 Washington, DC 20037 (202) 223-0020 pcamw@juno.com</p>	<p><b>DISTRICT OF COLUMBIA</b> Adult Protective Services Family Randall Bldg. 65 I Street, SW Washington, DC 20024 (202) 727-5947 ext. 12 Domestic (202) 727-2345 Institutional (202) 434-2140</p>
<p><b>FLORIDA</b> Florida Coalition Against Domestic Violence 308 E. Park Ave. Tallahassee, FL 32301 (850) 425-2749 (800) 500-1119</p>	<p><b>FLORIDA</b> The Family Source 433 N. Magnolia Dr. Tallahassee, FL 32308 (850) 488-5437 familysource.org In/Out of State Hotline (800) 962-2873 (Nationwide)</p>	<p><b>FLORIDA</b> Elder Protection Program Specialist Bureau of Self-Care Florida Department of Elder Affairs 4040 Esplanade Way Tallahassee, FL 32399-7000 (850) 414-2000 In-State Elder Abuse Hotline (800)962-2873 (Domestic &amp; Institutional)</p>

<p><b>GEORGIA</b> Georgia Coalition on Family Violence, Inc. 1728 Powers Ferry Rd. Bldg. 3, Suite 325 Atlanta, GA 30339 (770) 984-0085</p>	<p><b>GEORGIA</b> GA Chapter PCA America 1720 Peachtree St. NW, Suite 600 Atlanta, GA 30309 (404) 870-6565 1 (800) CHILDREN gcaa.org</p>	<p><b>GEORGIA</b> Division of Aging Services 2 Peachtree Street, NW 18th Floor Atlanta, GA 30303 (406) 657-3421 In-State Elder Abuse Hotline (800) 677-1116 Institutional (404) 657-5726 or (404) 657-4076</p>
<p><b>GUAM</b></p>	<p><b>GUAM</b></p>	<p><b>GUAM</b> In-State Elder Abuse (671) 475-0268 Domestic &amp; Institutional</p>
<p><b>HAWAII</b> State Coalition Against Domestic Violence 98-939 Moanalua Rd. Aiea, HI 96701-5012 (808) 486-5072</p>	<p><b>HAWAII</b> Prevent Child Abuse Hawaii 1575 S. Beretania St. Suite 202 Honolulu, HI 96826 (808) 951-0200 pcah@aloha.com Services 24-Hr. Hotline (808) 832-5300 or report to island police dept.</p>	<p><b>HAWAII</b> Adult &amp; Community Care Services/Program Development (ACCS/PD) DHS 810 Richard's Street, #400 Honolulu, HI 96813-2831 In-State Elder Abuse (808) 568-5701 (808) 832-5115, (808) 243-5151, (808) 241-3432, (808) 933-8820, (808) 327-6280</p>
<p><b>IDAHO</b> Coalition Against Sexual &amp; Domestic Violence 815 Park Blvd. Suite 140 Boise, ID 83712 (208) 384-0419 (888) 293-6188</p>	<p><b>IDAHO</b></p>	<p><b>IDAHO</b> Commission on Aging 3380 Americana Terrace Suite 120 Boise, ID 83720-0007 (208) 334-2423 In-State Elder Abuse Hotline (208) 334-2220</p>
<p><b>ILLINOIS</b> Coalition Against Domestic Violence 801 S. 11<sup>th</sup> St. Springfield, IL 62703-2553 (217) 789-2830</p>	<p><b>ILLINOIS</b> Prevent Child Abuse Illinois 528 S. 5<sup>th</sup> St. Suite 211 Springfield, IL 62701 voice (217) 522-1129 www.childabuse-il.org In-State Hotline (800) 252-2873</p>	<p><b>ILLINOIS</b> In-State Elder Abuse Hotline Domestic (800) 252-8966 Institutional (800) 252-4343 After hours report domestic abuse at (800) 279-0400</p>
<p><b>INDIANA</b> Domestic Violence Coalition 2511 E. 46th St. Suite N-3 Indianapolis, IN 46205 (317) 543-3908 In-State, 24-Hr. Hotline (800) 332-7385</p>	<p><b>INDIANA</b> Prevent Child Abuse Indiana 32 E. Washington St. Suite 1200 Indianapolis, IN 46204 (317) 634-9282 1 (800) CHILDREN pcain.org In-State Hotline (800) 562-2407</p>	<p><b>INDIANA</b> Bureau of Aging/In Home Services 402 W. Washington St. Indianapolis, IN 46207-7083 In-State Elder Abuse Hotline (800) 992-6978 (Domestic and Institutional) (800) 545-7763 ext. 20135</p>

<p><b>IOWA</b> Coalition Against Domestic Violence 2603 Bell Ave. Suite 100 Des Moines, IA 50321 (515) 244-8028</p>	<p><b>IOWA</b> Prevent Child Abuse Iowa 550 11<sup>th</sup> St. Suite 200 Des Moines, IA 50309 (515) 244-2200 1 (800) CHILDREN pcaiowa.org Local Office of Dept. of Human Services (800) 362-2178</p>	<p><b>IOWA</b> Adult Services Div. of Adult Children &amp; Family Services Hoover Building 5<sup>th</sup> Floor Des Moines, IA 50319 In-State Elder Abuse Hotline Domestic (800) 362-2178 Institutional (515) 281-4115</p>
<p><b>KANSAS</b> Domestic Violence Coalition 820 SE Quincy Suite 600 Topeka, KS 66612 (785) 232-9786</p>	<p><b>KANSAS</b> KS Children's Service League 3616 SW Topeka Blvd. PO Box 5268 Topeka, KS 66605-5368 (785) 274-3100 In-State Hotline (800) 922-5330</p>	<p><b>KANSAS</b> Department of Aging New England Building 503 South Kansas Topeka, KS 66603-3404 In-State Elder Abuse Hotline Domestic (800) 922-5330 Institutional (800) 842-0078</p>
<p><b>KENTUCKY</b> Domestic Violence Coalition P.O. Box 356 Frankfort, KY 40602 (502) 695-2444</p>	<p><b>KENTUCKY</b> Prevent Child Abuse Kentucky 489 E. Main St. 3<sup>rd</sup> Fl. Lexington, KY 40507 (859) 225-8879 1 (800) CHILDREN In-State Hotline (800) 752-6200</p>	<p><b>KENTUCKY</b> Office of Aging Services Cabinet for Health Services 275 E. Main St. - 5 West Frankfort, KY 40621 In-State Elder Abuse Hotline (800) 752-6200 (Domestic and Institutional)</p>
<p><b>LOUISIANA</b> Coalition Against Domestic Violence P.O. Box 77308 Baton Rouge, LA 70879 (225) 752-1296</p>	<p><b>LOUISIANA</b> Prevent Child Abuse Louisiana 733 East Airport Ave. Suite 101 Baton Rouge, LA 70806 (2254) 925-9520 1 (800) CHILDREN</p>	<p><b>LOUISIANA</b> Office of Elderly Affairs 412 N. 4<sup>th</sup> St. Baton Rouge, LA 70802 In-State Abuse Hotline (800) 259-4990 (Domestic and Institutional)</p>
<p><b>MAINE</b> Coalition for Family Crisis Services 170 Park St. Bangor, ME 04401 (207) 941-1194</p>	<p><b>MAINE</b> Prevent Child Abuse Maine PO Box 596 Portland, ME 04112 (207) 874-1175 Ext. 124 In-State Hotline (800) 452-1999</p>	<p><b>MAINE</b> Bureau of Elder &amp; Adult Services Dept. of Human Services #11 State House Station Augusta, ME 04333-0011 (207) 624-5335 In-State Elder Abuse Hotline (800) 624-8404 (Domestic and Institutional)</p>
<p><b>MARYLAND</b> Network Against Domestic Violence 6911 Laur3l Bowie Rd. #309 Bowie, MD 20715 (301) 352-4574 (800) 634-3577</p>	<p><b>MARYLAND</b> Prevent Child Abuse Maryland 2530 Riva Rd. Suite LL3 Annapolis, MD 21401 (410) 841-6599 childabuse.org/chapdir.html In-State Hotline (800) 332-6347</p>	<p><b>MARYLAND</b> Community Based Services Off. of Adult &amp; Family Svcs. Dept. of Human Resources 311 W. Saratoga St., #247 Baltimore, MD 21201 (410) 767-7639 In-State Elder Abuse Hotline (800) 91-PREVENT or (800) 917-7383 (Domestic or Institutional)</p>

<b>MASSACHUSETTS</b> Jane Doe, Inc./ Massachusetts Coalition 14 Beacon St., #507 Boston, MA 02108 (617) 248-0902	<b>MASSACHUSETTS</b> MA Citizens for Children and Youth 14 Beacon St. Suite 706 Boston, MA 02108 (617) 742-8555 1 (800) CHILDREN masskids.org In-State Hotline (800) 792-5200	<b>MASSACHUSETTS</b> Executive Office of Elder Affairs 1 Ashburton Place, 5 <sup>th</sup> Pl. Boston, MA 02108 (617) 727-7750 In-State Elder Abuse Hotline Domestic (800) 922-2275 Institutional (800) 462-5540
<b>MICHIGAN</b> Coalition Against Domestic Violence/Sexual Violence 3893 Okemos Rd. #B-2 Okemos, MI 48864 (517) 347-7000	<b>MICHIGAN</b> Michigan Children's Charter 324 North Pine Street Suite 1 Lansing, MI 48933 (517) 482-7533 childabuse.org/chapdir.html In-State Hotline (800) 942-4357	<b>MICHIGAN</b> Adult Protective Services Family Independence Agency Child and Family Svcs. 235 S. Grand Lansing, MI 48909 (517) 335-3983 In-State Elder Abuse Hotline Domestic (800) 996-6228 Institutional (800) 882-6006
<b>MINNESOTA</b> Coalition for Battered Women 450 N. Syndicate #122 St. Paul, MN 55104 (651) 616-6177 (800) 289-6177	<b>MINNESOTA</b> The Family Support Network 1821 University Ave. West Suite 302S St. Paul, MN 55104 (651) 523-0099 1 (800) CHILDREN familysupport.org In-State Hotline (612) 379-6363	<b>MINNESOTA</b> Board on Aging 444 Lafayette Rd. St. Paul, MN 55155-3843 (651) 296-2770 In-State Elder Abuse Hotline (800) 333-2433 (Domestic and Institutional)
<b>MISSISSIPPI</b> Coalition Against Domestic Violence P.O. Box 4703 Jackson, MS 39296 (601) 981-9196	<b>MISSISSIPPI</b>	<b>MISSISSIPPI</b> Division of Aging and Adult Services 750 North State Street Jackson, MS 39202 (601) 359-4929 In-State Elder Abuse Hotline Domestic (800) 222-8000 Institutional (800) 227-7308
<b>MISSOURI</b> Coalition Against Domestic Violence 415 E. McCarty Jefferson City, MO 65101 (513) 634-4161	<b>MISSOURI</b> Prevent Child Abuse Missouri 137 N. Capistrand Jefferson City, MO 65109 (573) 634-5223 childabuse.org/chapdir.html In-State Hotline (800) 392-3738	<b>MISSOURI</b> Division of Aging Dept. of Social Services 615 Howerton Court Jefferson City, MO 65102 (573) 751-3082 In-State Elder Abuse Hotline (800) 392-0210 (Domestic and Institutional)

<p><b>MONTANA</b> Coalition Against Domestic Violence P.O. Box 633 Helena, MT 59624 (406) 443-7794 (888) 404-7794</p>	<p><b>MONTANA</b> Montana Council for Families P.O. Box 7533 Helena, MT 59604-8005 127 East Main Suite 209 Missoula, MT 59807 (406) 728-9449 childabuse.org/chapdir.html In-State Hotline (800) 332-6100</p>	<p><b>MONTANA</b> Office of Aging St. LTC Division 111 Sanders St. Helena, MT 59604 (406) 444-7788 In-State Elder Abuse Hotline (800) 332-2272</p>
<p><b>NEBRASKA</b> Domestic Violence &amp; Sexual Assault Coalition 825 M. St. Suite 404 Lincoln, NE 68508 (402) 476-6256 In-State Hotline (800) 876-6238</p>	<p><b>NEBRASKA</b> In-State Hotline (800) 652-1999</p>	<p><b>NEBRASKA</b> Special Services for Children &amp; Adults NE Health and Human Services 301 Centennial Mall-South, 5<sup>th</sup> Floor Lincoln, NE 68509-5044 (402) 471-4617 In-State Elder Abuse Hotline (800) 652-1999 (Domestic and Institutional)</p>
<p><b>NEVADA</b> Network Against Domestic Violence 100 W. Grove St. Suite 315 Reno, NV 89509 (775) 828-1115 In-State Hotline (800) 230-1955</p>	<p><b>NEVADA</b> Report of Local Child Protection Agency (800) 992-5757</p>	<p><b>NEVADA</b> Department of Human Resources 340 N. 11<sup>th</sup> Street, Suite 203 Las Vegas, NV 89101 (702) 486-3545 In-State elder Abuse Hotline (800) 992-5757</p>
<p><b>NEW HAMPSHIRE</b> Coalition Against Domestic and Sexual Violence P.O. Box 353 Concord, NH 03302-0353 (603) 224-8893 (800) 852-3388</p>	<p><b>NEW HAMPSHIRE</b> Prevent Child Abuse New Hampshire 1 Tremont St. P.O. Box 607 Concord, NH 03302 (603) 225-5441 1 (800) CHILDREN Dept. of Health and Welfare- Division for Child, &amp; Youth Services (800) 894-5533/ (800) 852-3388 (after hours)</p>	<p><b>NEW HAMPSHIRE</b> Division of Elderly &amp; Adult Services 129 Pleasant St. State Office Park-South Concord, NH 03301-3857 (603) 271-4394 In-State Elder Abuse Hotline (800) 949-0470 or (603) 271-4386 Institutional (800) 442-5640 or (603)271-4396</p>
<p><b>NEW JERSEY</b> Coalition for Battered Women 2620 Whitehouse Hamilton Square Trenton, NJ 08690-2718 (609) 584-8107 In-State Hotline (800) 572-7233</p>	<p><b>NEW JERSEY</b> Prevent Child Abuse New Jersey 103 Church St. Suite 210 New Brunswick, NJ 08901 (732) 246-8060 Division of Youth and Family Services (800) 432-2075 (Nationwide, 24 hours)</p>	<p><b>NEW JERSEY</b> Department of Health and Senior Services CN-807 101 S. Broad Street Trenton, NJ 08625-0807 (609) 588-3447 In-State Elder Abuse Hotline (800) 792-8820 (Domestic &amp; Institutional)</p>

<p><b>NEW MEXICO</b> Coalition Against Domestic Violence P.O. Box 25266 Albuquerque, NM 87126 (505) 246-9240 In-State Hotline (800) 773-3645</p>	<p><b>NEW MEXICO</b> Protective Service Dept. (505) 827-8400 To Report: Local Dept. of Human Services or 24 hr (800) 797-3600</p>	<p><b>NEW MEXICO</b> State Agency of Aging La Villa Rivera Bldg., Ground Fl. 228 East Palace Ave. Santa Fe, NM 87501 (505) 827-7640 In-State Elder Abuse Hotline (800) 797-3260 (505) 841-6100 (Domestic &amp; Institutional)</p>
<p><b>NEW YORK</b> State Coalition Against Domestic Violence Women's Building, 79 Central Avenue Albany, NY 12206 (518) 432-4864 (800) 842-6906</p>	<p><b>NEW YORK</b> Prevent Child Abuse New York 134 S. Swan St. Albany, Ny 12210 (518) 445-1273 Dept. of Social Services- Division of Family &amp; Child Services (800) 342-3720</p>	<p><b>NEW YORK</b> Department of Social Services 40 N. Pearl St. Albany, NY 12243 (518) 473-6446 In-State Elder Abuse Hotline (800) 342-9871</p>
<p><b>NORTH CAROLINA</b> Coalition Against Domestic Violence 301 W. Main St. Suite 350 Durham, NC 27701 (919) 956-9124 (888) 232-9124</p>	<p><b>NORTH CAROLINA</b> Prevent Child Abuse North Carolina 3344 Hillsborough St. Suite 100D Raleigh, NC 27607 (919) 829-8009 1 (800) CHILDREN In-State Hotline (800) 354-KIDS</p>	<p><b>NORTH CAROLINA</b> APS and Guardianship Department of Human Resources 325 N. Salisbury St. Raleigh, NC 27611 (919) 733-3818</p>
<p><b>NORTH DAKOTA</b> Council on Abused Women's Services 418 E. Rosser Ave. #320 Bismarck, ND 58501 (800) 255-6240 (701) 255-6240</p>	<p><b>NORTH DAKOTA</b> Prevent Child Abuse North Dakota PO Box 1213 418 E. Rosser , Suite 303 Bismarck, ND 58502 (701)223-9052 childabuse.org/chapdir.html Dept. of Human Services Child Abuse &amp; Neglect (701) 328-2316</p>	<p><b>NORTH DAKOTA</b> Department of Human Services 600 S. 2nd Street, #1C Bismarck, ND 58504-5729 (701) 328-8910 In-State Elder Abuse (800) 755-8521 (Domestic &amp; Institutional)</p>
<p><b>OHIO</b> Action Ohio Coalition for Battered Women PO Box 15673 Columbus, OH 43215 (614) 784-0023 In-State Hotline (800) 934-9840</p>	<p><b>OHIO</b> Center for Child Abuse Prevention Timken Hall 700 Childrens Dr. Suite 130 Columbus, OH 43205 (614) 722-6800 childabuse.org/chapdir.html Child Protective Services Unit (614) 466-9824</p>	<p><b>OHIO</b> Department of Aging 50 West Broad St. 9<sup>th</sup> Fl. Columbus, OH 43215-5928 (614) 466-5500 In-State Elder Abuse Hotline (800) 282-1206</p>

<p><b>OKLAHOMA</b> Domestic Violence Network 2200 N. Classen, Suite 610 Oklahoma City, OK 73106 (405) 848-1815 24 Hr. Hotline (800) 522-9054</p>	<p><b>OKLAHOMA</b> Prevent Child Abuse Oklahoma Chapter 437 NW 12th St. Oklahoma City, OK 73103 (405) 228-0688 1 (800) CHILDREN members.aol.com/ocpca/child In-State Hotline (800) 522-3511</p>	<p><b>OKLAHOMA</b> Adult Protective Services Aging Services Division 312 NE 28<sup>th</sup> St. Oklahoma City, OK 73105 (405) 521-3660 In-State Elder Abuse Hotline (800) 522-3511 (Domestic and Institutional)</p>
<p><b>OREGON</b> Coalition Against Domestic Violence 659 Cottage St., NE Salem, OR 97301 (503) 365-9644</p>	<p><b>OREGON</b> State Office for Services to Children and Families (800) 854-3508 X 2402 (In-State, during business hours)</p>	<p><b>OREGON</b> Senior &amp; Disabled Services Division 500 Summer St. NE, 3rd Fl. Salem, OR 97310-1015 In-State Elder Abuse Hotline (800) 232-3020 (Domestic and Institutional)</p>
<p><b>PENNSYLVANIA</b> Coalition Against Domestic Violence 6400 Flank Dr. #1300 Harrisburg, PA 17112 (717) 545-6400 In-State Hotline (800) 932-4632</p>	<p><b>PENNSYLVANIA</b> Prevent Child Abuse Pennsylvania 117 South 17<sup>th</sup> St, Suite 1000 Philadelphia, PA 19103 (215) 561-5640 childabuse.org/chapdir.html In-State Hotline (800) 932-0313</p>	<p><b>PENNSYLVANIA</b> Department of Aging Forum Place 555 Walnut St., 5<sup>th</sup> Fl. Harrisburg, PA 17101-1919 (717) 783-1550 In-State Elder Abuse Hotline (800) 490-8505 Institutional (800) 254-5164</p>
<p><b>PUERTO RICO</b> Coalition Against Domestic Violence P.O. Box 11382 San Juan, Puerto Rico 00910 (787) 722-2907</p>	<p><b>PUERTO RICO</b> Dept. Of Social Services Family Services 24-Hr. Reporting (787) 749-1333 (800) 981-8333</p>	<p><b>PUERTO RICO</b> Department of Social Services P.O. Box 11398 Fernandez Juncos Station Santurce, Puerto Rico 00910 (787) 723-2127 (787) 725-9788 (787) 721-8225</p>
<p><b>RHODE ISLAND</b> Coalition on Domestic Violence 422 Post Rd., Suite 202 Warwick, RI 02888 (401) 467-9940 In-State Hotline (800) 494-8100</p>	<p><b>RHODE ISLAND</b> Prevent Child Abuse Rhode Island 500 Prospect St. Pawtucket, RI 02860 (401) 728-7920 childabuse.org/chapdir.html In-State Hotline (800) 932-0313</p>	<p><b>RHODE ISLAND</b> Department of Elderly Affairs 160 Pine Street Providence, RI 02903-3708 (401) 222-2858 In-State Elder Abuse Hotline (401) 222-2858 X321 (Domestic and Institutional)</p>
<p><b>SOUTH CAROLINA</b> Coalition Against Domestic Violence and Sexual Assault P.O. Box 7776 Columbia, SC 29202-7776 (800) 260-9293 (803) 256-2900</p>	<p><b>SOUTH CAROLINA</b> Prevent Child Abuse South Carolina 2638 Two Notch Suite 108 Columbia, SC 29204 (803) 758-1777 pcasc.org</p>	<p><b>SOUTH CAROLINA</b> Department of Social Services 1801 Main Street Columbia, SC 29202-8206 (803) 898-2501 In-State Elder Abuse Hotline (800) 868-9095 (Domestic &amp; Institutional)</p>

<p><b>SOUTH DAKOTA</b> Coalition Against Domestic Violence PO Box 141 Pierre, SD 57501 (605) 945-0869 (800) 572-9196</p>	<p><b>SOUTH DAKOTA</b> Children's Protection Services (Nationwide, during business hours) (605) 773-3227</p>	<p><b>SOUTH DAKOTA</b> Department of Social Services 700 Governor's Dr. Pierre, SD 57501-2291 (605) 773-3656 (Domestic and Institutional)</p>
<p><b>TENNESSEE</b> Task Force Against Domestic Violence P.O. Box 120972 Nashville, TN 37212-0972 (615) 386-9406 (800) 356-6767</p>	<p><b>TENNESSEE</b> Prevent Child Abuse Tennessee 333 S. Gallatin Rd., Suite 10 Nashville, TN 37115 (615) 868-4468 pcat.org</p>	<p><b>TENNESSEE</b> Commission on Aging Andrew Jackson Bldg. 500 Desderick Street 9<sup>th</sup> Fl Nashville, TN 37243-0860 (615) 741-2056 In-State Elder Abuse Hotline (888) 277-8366 (Domestic &amp; Institutional)</p>
<p><b>TEXAS</b> Council on Family Violence PO Box 161810 Austin, TX 78716 (512) 794-1133 In-State Hotline (800) 787-3224</p>	<p><b>TEXAS</b> Prevent Child Abuse Texas 12701 Research Suite 303 Austin, TX 78759 (512)250-8438 childabuse.org/chapdir.html Dept. of Human Services- Protective Services (800) 252-5400</p>	<p><b>TEXAS</b> Department of Aging 4900 North Lamar, 4<sup>th</sup> Fl. Austin, TX 78751-2316 (512) 424-6840 In-State Elder Abuse Hotline (800) 252-5400 or (512) 834-3784 (Domestic) Institutional (800) 458-9858 or (512) 438-2633</p>
<p><b>UTAH</b> Domestic Violence Advisory Council 120 North 200 West, #319 Salt Lake City, UT 84103 (801) 538-9886</p>	<p><b>UTAH</b> Prevent Child Abuse Utah 331 S. Rio Grande Suite 304 Salt Lake City, UT 84104 (801) 532-3404 pcau.org In-State Hotline (800) 678-9399 (Nationwide)</p>	<p><b>UTAH</b> Department of Social Services 120 North 200 West Salt Lake City, UT 84145-0500 In-State Elder Abuse Hotline (800) 371-7897 or (801) 264-7669</p>
<p><b>VERMONT</b> Network Against Domestic Violence and Sexual Assault P.O. Box 405 Montpelier, VT 05601 (802) 223-1302</p>	<p><b>VERMONT</b> Prevent Child Abuse Vermont Division of Social Services 94 Main St. PO Box 829 Montpelier, VT 05601 (802) 229-5724 (800) CHILDREN pcavt@together.net In-State Hotline (800) 649-5285</p>	<p><b>VERMONT</b> Department for the Aging 103 South Main Street Waterbury, VT 05671-2301 In-State Elder Abuse Hotline (802) 241-2400 (800) 564-1612 (Domestic and Institutional)</p>

<p><b>VIRGINIA</b> Virginians Against Domestic Violence 2850 Sandy Bay Rd, #101 Williamsburg, VA 23185 (800) 838-8238 (757) 221-0990</p>	<p><b>VIRGINIA</b> Prevent Child Abuse Virginia 4901 Fitzhugh Ave., Suite 200 Richmond, VA 23230 (804) 359-6166 (800) CHILDREN preventchildabuseva.org In-State Hotline (800) 552-7096</p>	<p><b>VIRGINIA</b> Department for the Aging 1600 Forest Avenue Preston Building #102 Richmond, VA 23229 (804) 662-9333 In-House Elder Abuse Hotline (888) 832-3858 or (804) 371-0896 (Domestic and Institutional)</p>
<p><b>WASHINGTON</b> Coalition Against Domestic Violence 8645 Martin Way NE, Suite 103 Olympia, WA 98516 (800) 886-2880 (360) 407-0756</p>	<p><b>WASHINGTON</b> In-State Hotline 800-562-5624</p>	<p><b>WASHINGTON</b> In-State Elder Abuse Hotline (800) 422-3263 Institutional (800) 562-6078</p>
<p><b>WEST VIRGINIA</b> Coalition Against Domestic Violence 4710 Chimney Dr. BR&gt; Charleston, WV 25302 (304) 965-3552</p>	<p><b>WEST VIRGINIA</b> Dept. of Health and Human Resources (800) 352-6513 (During business hours)</p>	<p><b>WEST VIRGINIA</b> W.VA Bureau of Senior Services 1900 Kanawha Blvd., East Holly Grove-Building 10 Charleston, WV 25305-0160 (304) 558-3317 In-State Elder Abuse Hotline (800) 352-6513 (Domestic and Institutional)</p>
<p><b>WISCONSIN</b> Coalition Against Domestic Violence 307 S. Paterson St. Suite 1 Madison, WI 53704 (608) 255-0539</p>	<p><b>WISCONSIN</b> Prevent Child Abuse Wisconsin 214 North Hamilton Madison, WI 53703 (608) 256-3374 (800) CHILDREN wcpa@juno.com Division on Children &amp; Family Services (608) 266-3036</p>	<p><b>WISCONSIN</b> Department of Health &amp; Family Services 1 West Wilson St. Madison, WI 53707-7851 In-State Elder Abuse Hotline (608) 266-2536 Institutional (800) 815-0015 or (608) 266-8944</p>
<p><b>WYOMING</b> Coalition Against Domestic and Sexual Assault 710 Garfield #242 Laramie, WY 82941 (307) 755-5481 (800) 990-3877</p>	<p><b>WYOMING</b> Prevent Child Abuse Wyoming 1902 Thomes Ave., Suite 215 Cheyenne, WY 82001 (307) 637-8622 Juvenile Services Division Child Abuse (307) 777-6079 In-State Hotline (800) 457-3659</p>	<p><b>WYOMING</b> Department of Family Services Hathaway Bldg. Third Fl. Cheyenne, WY 82002-0049 In-State Elder Abuse Hotline (307) 777-6137</p>

\*\* all 800 numbers and 24 hour numbers are for in state access only, unless otherwise noted.

**STATE TOLL-FREE CHILD ABUSE REPORTING NUMBERS**

Each state designates specific agencies to receive and investigate reports of suspected child abuse and neglect. Typically, this responsibility is carried out by child protective services (CPS) within a Department of Social Services, Department of Human Resources, or Division of Family and Children Services. In some states, police departments also may receive reports of child abuse or neglect.

Many states have an in-state toll-free number for reporting suspected abuse. Both the reporting party and the child who is allegedly being abused must reside in the same state for the following reporting numbers to be valid.

For states not listed, or when the reporting party resides in a different state than the child, please call:

**Childhelp USA National Child Abuse Hotline**

**1-800-4-A-CHILD,**

**1-800-422-4453, (option #2).**

**STATE AGENCIES ON AGING**

Designated by the Governor and state legislature, state Agencies on Aging provide leadership and guidance to the agencies and organizations serving the elderly within their state. Serving as advocates for older people, the agencies oversee a complex, statewide service system designed to complement other human service systems. State Agencies on Aging foster the expansion of community-based services and provide policy direction and technical assistance to the Area Agencies on Aging within their states.

# Orthopaedic Aspects of Child Abuse

(Vol. 8, No. 1)

*Mininder S. Kocher, MD, and James R. Kasser, MD*

Increased awareness of child abuse has led to better understanding of this complex problem. However, the annual incidence of abuse is estimated at 15 to 42 cases per 1,000 children and appears to be increasing. More than 1 million children each year are the victims of substantiated abuse or neglect, and more than 1,200 children die each year as a result of abuse. The diagnosis of child abuse is seldom easy to make and requires a careful consideration of sociobehavioral factors and clinical findings. Because manifestations of physical abuse involve the entire child, a thorough history and a complete examination are essential. Fractures are the second most common presentation of physical abuse after skin lesions, and approximately one third of abused children will eventually be seen by an orthopaedic surgeon. Thus, it is essential that the orthopaedist have an understanding of the manifestations of physical abuse, to increase the likelihood of recognition and appropriate management. There is no pathognomonic fracture pattern in abuse. Rather, the age of the child, the overall injury pattern, the stated mechanism of injury, and pertinent psychosocial factors must all be considered in each case. Musculoskeletal injury patterns suggestive of nonaccidental injury include certain metaphyseal lesions in young children, multiple fractures in various stages of healing, posterior rib fractures, and long-bone fractures in children less than 2 years old. Skeletal surveys and bone scintigraphy with follow-up radiography may be of benefit in cases of suspected abuse of younger children. The differential diagnosis of abuse includes other conditions that may cause fractures, such as true accidental injury, osteogenesis imperfecta, and metabolic bone disease. Management should be multidisciplinary, with the key being recognition, because abused children have a substantial risk of repeated abuse and death.

## Definitions

Both federal and state legislation provide definitions of child abuse. Federal law identifies a minimum set of acts that characterize mal-treatment. Each state is responsible for providing definitions of child abuse and neglect within the civil and criminal context. Civil statutes describe the conditions that obligate mandated reporters to identify known or suspected cases of abuse, and they provide definitions necessary for juvenile or family courts to take custody of an allegedly maltreated child. Criminal statutes specify the forms of maltreatment that are criminally punishable.

The Child Abuse Prevention and Treatment Act, as amended and reauthorized in October 1996 (Public Law 104-235, Section 111; 42 U.S.C. 5106g), defines child abuse and neglect as "at a minimum, any act or failure to act resulting in imminent risk of serious harm, death, serious physical or emotional harm, sexual abuse, or exploitation of a child by a parent or caretaker who is responsible for the child's welfare."

*Dr. Kocher is Pediatric Orthopaedic Surgery Fellow, Children's Hospital, Boston. Dr. Kasser is John E. Hall Professor of Orthopaedic Surgery, Harvard Medical School, and Orthopaedic Surgeon-in-Chief Children's Hospital, Boston.*

*Reprint requests: Dr. Kocher, Department of Orthopaedic Surgery, Children's Hospital, 300 Longwood Avenue, Boston, MA 02115*

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There are four major types of child maltreatment: physical abuse, neglect, sexual abuse, and emotional abuse. *Although* any of the forms of child maltreatment may be found separately, they often occur in combination. Orthopaedists are most likely to encounter physical abuse, which is the infliction of physical injury as a result of punching, beating, kicking, biting, burning, shaking, throwing, or otherwise harming a child with or without intention.

## **Epidemiology**

Inconsistencies in reporting and variations in definitions make it difficult to precisely determine the prevalence of child abuse and to track trends. In 1991, child protective services agencies in 49 states investigated 2 million reports alleging the maltreatment of almost 3 million children and determined that more than one million children were victims of substantiated child abuse or neglect. The annual incidence of child maltreatment was estimated at about 15 cases per 1,000 children younger than 18 in the general population.<sup>3</sup> A 1993 study by the National Center on Child Abuse and Neglect involving over 5,600 community professionals estimated that 42 children per 1,000 were the victims of abuse or neglect.<sup>1</sup>

The number of abused or neglected children appears to be increasing. Three national incidence studies (conducted in 1980, 1986, and 1993) surveyed community health-care professionals and social service providers. The estimated number of children who experienced harm from abuse or neglect increased from 625,100 in 1980 to 931,000 in 1986 to 1,553,800 in 1993.

Neglect is the most common form of maltreatment (52% of victims in 1995), followed by physical abuse (25%), sexual abuse (13%), emotional maltreatment (5%), medical neglect (3%), and other forms of maltreatment (2%).

Maltreatment affects children of all ages and both sexes. Among children confirmed as victims of child abuse and neglect by child protective services agencies in 1995, more than half were less than 7 years of age, and 26% were younger than 4 years old. In 1995, 52% of victims were female, and 48% were male. Children of all socioeconomic strata suffer maltreatment, but family income appears to be related to incidence rates. Children from families with annual incomes of less than \$15,000 per year were more than 25 times more likely than children from families with annual incomes above \$30,000 to have been harmed or endangered by abuse.<sup>2</sup> Demographic analysis has shown that those most at risk for maltreatment include first-born children, unplanned children, premature infants, stepchildren, and handicapped children. In addition, children of single-parent homes, drug abusing parents, parents who were themselves abused, unemployed parents, and families of lower socioeconomic status were shown to be at increased risk.

The majority of maltreated children are abused by birth parents. Fewer are maltreated by non-birth parents or parent-substitutes, such as a stepparent, foster parent, adoptive parent, or parent's separated or divorced spouse or current boyfriend or girlfriend. Of all abuse cases substantiated by child protective services agencies, 50% to 80% involved some degree of substance abuse by the child's parents.<sup>4,8</sup> More than half of all reports alleging maltreatment come from professionals, including educators, law enforcement and justice officials, medical and mental health professionals, social-service professionals, and child-care providers. About 19% of reports come from relatives of the child or from the child. Reports from professionals are more likely to be substantiated than reports from nonprofessional sources.

The exact incidence of death due to child maltreatment is unknown due to difficulties with identification and documentation. In 1995, 1,215 children were reported to have died as a result of maltreatment. Forty-six percent of these children had had prior or current contact with local child protective services agencies. Eighty-five percent of these children, were under the age of 5 years, and almost half (45%) were under the age of 1 year.<sup>9</sup> Abuse is second only to sudden infant death syndrome as a cause of mortality in infants between one and 6 months of age and is second to accidental injury in children over 1 year of age.<sup>7,10</sup>

## **Historical Background**

Violence toward children appears to be a timeless phenomenon. Writings from the first and second centuries A.D. describe afflictions of children who may have been stricken intentionally.<sup>11</sup> A pivotal paper was written in 1860 by Ambrois Tardieu, a -French professor of legal medicine. who vividly described diagnostic injuries, parental collusion, and response to removal from an abusive environment in a series of abused children.<sup>12</sup> The English Society for the Prevention of Cruel to Children was first established in Liverpool in 1883.

The first half of the 20th century witnessed a growing awareness of abuse. In 1944, neurosurgeons Ingraham and Matsc, suggested a traumatic origin for subdural hematomas in infants, rather than the more commonly recognized infectious etiology.<sup>13</sup> Skull fractures, retinal hemorrhages, and the generally poor condition and low socioeconomic background :of the affected children were noted. In 1946, John Caffey highlighted the association between multiple fractures and odural hematoma in a series of six infants. His classic papers contain the description of metaphyseal fragmentation, external cortical thickening, fractures in otherwise healthy hones, and fractures in multiple stages of healing. He clearly considered the injuries to be traumatic in origin even though a history of trauma was obscure.

In the 1950s, further association between nonaccidental injury and injuries in young children was suggested. However, medicine as a profession did not fully recognize the reality of child abuse as a distinct clinical entity until the landmark paper in 1962 by Kempe et al in the *Journal of the American Medical Association*.<sup>14</sup> Kempe coined the term "battered child syndrome" and defined a clinical condition in which young children receive serious physical abuse from a parent. He described a clinical profile of a 'young child with poor hygiene, failure to thrive, soft-tissue and bone injuries, and subdural hematoma. He pointed out the discrepancy between the injuries and the given history and noted that no new lesions appeared while the child was away from the abusive environment. That groundbreaking article was essential in attracting attention to this still neglected medical and social issue.

Within a few years after publication of that article, all states mandated reporting of suspected cases by medical professionals. Increasing public awareness and outcry resulted in the passage of the Child Abuse Prevention and Treatment Act and the establishment of the National Center on Child Abuse and Neglect in the 1970s. Strides have been made regarding the epidemiology, diagnosis, management, and societal impact of child abuse and neglect. However, the syndrome remains a major cause of death and physical and psychological disability among children.

## Clinical Features

### General Considerations

Manifestations of abuse involve the entire child. A thorough history and a concrete general and orthopaedic examination are essential (Table 1). The diagnosis of child abuse is seldom easy to make and involves a careful consideration of sociobehavioral factors and clinical findings. Ideally, a team of pediatricians, social workers, and subspecialists are involved in establishing the diagnosis; however, in many situations, the orthopaedist may be alone in the recognition and documentation of physical abuse.

**Table 1**

Clinical Findings in Child Abuse

<b><u>FACTOR OR SYSTEMS</u></b>	<b><u>FINDINGS</u></b>
History	<ul style="list-style-type: none"> <li>Delay in presenting</li> <li>History vague, lacking in detail, contradictory</li> <li>Mechanism of injury insufficient to explain injuries</li> <li>History of a fall</li> </ul>
Characteristics of child	<ul style="list-style-type: none"> <li>Less than 3 years old</li> <li>Poor household environment, drug or Physical abuse</li> <li>Overly aggressive or passive</li> <li>Behavioral problems</li> <li>Handicapped Child</li> <li>Stepchild</li> <li>Premature child</li> <li>Subnormal growth</li> </ul>
Skin	<ul style="list-style-type: none"> <li>Bruises (buttocks, perineum and genitalia, trunk, back of head and legs)</li> <li>Multiple bruises in various stages of healing</li> <li>"Bums (pattern may reflect, mechanism of bum),</li> </ul>
Head and central nervous system	<ul style="list-style-type: none"> <li>Skull fracture (multiple, bilateral, skull base, crossing suture lines, depressed fractures)</li> <li>Subdural hematoma, subarachnoid hemorrhage</li> <li>Retinal hemorrhage, hyphema, retinal detachment</li> <li>Cognitive disabilities</li> </ul>
Chest, abdomen, and pelvis	<ul style="list-style-type: none"> <li>Rib fractures (posterior, multiple), sternal fractures</li> <li>Pneumothorax, hemothorax</li> <li>Rupture of organ (liver, spleen, or pancreas laceration; bowel or bladder rupture)</li> <li>Intramural bowel hematoma</li> <li>Kidney contusion, retroperitoneal hemorrhage</li> <li>Sexual abuse</li> </ul>
Musculoskeletal system	<ul style="list-style-type: none"> <li>Multiple fractures</li> <li>Fractures in various stages of healing</li> <li>Metaphyseal corner fracture</li> <li>Long-bone fracture in child &lt; 2year</li> <li>Vertebral compression fractures, spinous process avulsion</li> <li>Scapular fracture</li> <li>Epiphyseal separation</li> </ul>

## Journal of the American Academy of Orthopaedic Surgeons

It has been estimated that 10% of *the* trauma seen in emergency departments in children under 3 years old are nonaccidental.<sup>2</sup> Although a number of risk factors for maltreatment have been identified, it must be emphasized that children of all socioeconomic status, backgrounds, and ages can be subjected to abuse.

Abused children may be either very passive or overly aggressive. They may have developmental delays, be characterized as irritable or hyperactive, or demonstrate destructive behavior. With children who are old enough to effectively communicate, care must be taken to ask age-appropriate questions and avoid leading questions. The stated history in cases of abuse is often vague and lacking in detail. There may have been a delay in seeking care. The parents may inhibit hostility or casualness to questioning. Often, they are hesitant to provide information, or they offer contradictory information. The given mechanism of injury is often insufficient to explain the physical findings, or the care-giver may deny any history of injury. Frequently, a fall is allegedly the mechanism of injury; however, it is unusual for a young child to sustain life-threatening injury from a fall alone.<sup>12</sup>

### Nonorthopaedic Features

Skin lesions, including bruises, lacerations, scars, welts, and burns, are the most common presentation of physical abuse and may be the only physical finding. Burns are present in 10% to 25% of physically abused children, and 50% to 92% demonstrate bruising. Bruising of certain locations, such as the buttocks, perineum, genitalia, trunk, back of head, and back of legs, suggests nonaccidental injury. The shape of the bruises and the pattern of the burns may reflect the instrument used. Multiple bruises are more common in older children and may be in various stages of healing.<sup>1</sup> The age of bruises and contusions can be grossly estimated by a change in color over a period of 2 to 4 weeks, with fading beginning at the periphery. The acute lesion is often blue or reddish purple; this coloration gradually changes to green and then to yellow before resolution as a brownish stain. The orthopaedist should carefully examine the patient for skin lesions before placing a cast, especially a spica cast, and should (document any lesions in the medical record.

Head trauma is the most frequent cause of morbidity and mortality in abused children. Head injuries may result from direct blows, dropping, shaking, or throwing. Multiple skull fractures, bilateral fractures, skull-base fractures, fractures crossing suture lines (Fig. 1), and depressed fractures occur more frequently in abuse than in accidental injury.<sup>13</sup> The infant brain is particularly vulnerable to acceleration-deceleration injuries. Subdural hematomas and retinal hemorrhages may be present without skull fractures in the shaken baby. Physical abuse should be suspected in any child with unexplained altered mental status, subdural hematoma, retinal hemorrhage, or skull fractures. Long-term sequelae of neurologic injuries from child abuse include cognitive disabilities, developmental delays, seizure disorders, and motor disabilities.

Visceral injuries are uncommon in child abuse, but are associated with mortality rates of 40% to 50%. When they do occur, most internal injuries are caused by direct blows from punching or kicking. Children may present with nausea, vomiting, abdominal distention, peritonitis, obstruction, and/or abdominal bruising. Injuries may include liver and spleen laceration, pancreatic rupture, intramural bowel hematoma, retroperitoneal hemorrhage, kidney contusion, bowel perforation, and bladder rupture. Mortality associated with visceral injuries is often the result of massive blood loss due to

organ or mesenteric laceration. The high death rate associated with these injuries results not only from the severity of the injuries but also from the frequent delay in seeking medical attention.

## **Orthopaedic Features**

Fractures are the second most common presentation of physical abuse, after soft-tissue bruising and burns. Approximately one third of physically abused children will require orthopaedic treatment.<sup>2</sup> The incidence of fractures in child abuse ranges from 9% to 55%, depending on the type of abuse and the methods of detecting fractures.<sup>1-5</sup>

Fractures from abuse are more common in younger children, who are at greater risk because of the diminished structural and mechanical properties of the developing skeleton and because they are demanding, defenseless, and nonverbal. Long-bone fractures in preambulatory infants in the absence of metabolic bone disease are more often inflicted than accidental. Fractures resulting from accidental accidents are more likely after the transition to ambulation. In several studies of fractures in abused children, 50% to 69% of all fractures occurred in children less than one year of age, and 75% to 85% occurred in children less than 3 years of age.<sup>15-18</sup> In reviews of the data on fractures in infants less than 1 year of age, researchers have found 45% to 56% to be associated with child abuse; of children less than 3 years old with fractures, 43% were abused.<sup>7,18-20</sup>

Multiple fractures in various stages of healing are found in more than 70% of abused children less than 1 year of age and more than 50% of all abused children. Nevertheless, many abused children present with only one fracture. In a series of 429 fractures in 189 battered children, King et al<sup>15</sup> found that 50% of the children had only a single fracture, 33% had two or three fractures, and 17% had more than three fractures. Similarly, Loder and Bookout<sup>21</sup> found that 65% of abused children had only a single fracture. Furthermore, the acute, single-diaphysis long-bone fracture that is common in accidental injury is also common in abuse. Therefore, to facilitate differentiation of accidental injuries from injuries due to abuse, rough guidelines have been established for estimating the age of fractures in children (Table 2).

In some series reporting patterns of fractures in abused children, the humerus was the most commonly fractured bone's; in others, the tibia or the femur was more common in infants and young children. The presence of a femur fracture is very suggestive of abuse (Fig. 2). In reviews of the data on children with femur fractures, 30% to 46% of fractures in children less than 5 years old were due to abuse,<sup>23-25</sup> as were 60% to 65% of fractures in children less than 1 year old.<sup>25-26</sup>

Previously, the midshaft spiral fracture had been thought to be characteristic of a violent twisting injury common in abuse. However, transverse fractures are also frequently seen in child abuse, accounting for 48% to 71% of long-bone fractures in several large series.<sup>15-16</sup> In a review of 80 femur fractures in children less than 4 years old, Beals and Tufts<sup>22</sup> found no difference in diaphyseal fracture pattern between fractures due to abuse and those resulting from accidental injury. Thus, no specific diaphyseal fracture pattern should be considered pathognomonic of child abuse.

Rib fractures are common in physical abuse and can result from anteroposterior (AP) or lateral compressive forces associated with squeezing, direct impact from striking, or oscillation and compression during violent shaking. Rib fractures from accidental injury are a marker of severe trauma in children due to the relative compliance of the rib cage and are often associated with a high risk of mortality? Even after vigorous cardiopulmonary resuscitation, rib fractures are uncommon in

children. Rib fractures have been reported in 5% to 27% of abused children.<sup>27</sup> Akbarnia et al<sup>17</sup> found rib fractures to be almost twice as prevalent in cases of abuse as fractures of any one long bone. Kleinman et al<sup>28</sup> performed postmortem radiologic and histopathologic studies on 31 abused infants and found that 51% of all fractures involved the ribs and that only 36% of the rib fractures were visible on skeletal survey. Almost 90% of abuse-related rib fractures are seen in infants less than 2 years of age, a reversal of the age distribution for accidental thoracic injuries.<sup>27</sup>



**Figure 2** Femur fracture in a **2-month-old** abused male infant

Radiographic Appearance	Early	Peak	Late
Resolution of soft-tissue swelling, days	2-5	4-10	10-
New periosteal bone, days	4-10	10-14	14-
Loss of definition of fracture line, days	10-14	14-21	21-
Presence of soft callus, days	10-14	14-21	21-
<b>Presence</b> of hard callus, days	14-21	21-42	42-
<b>Remodeling</b> of fracture, months	3	12	24

**Table 2**

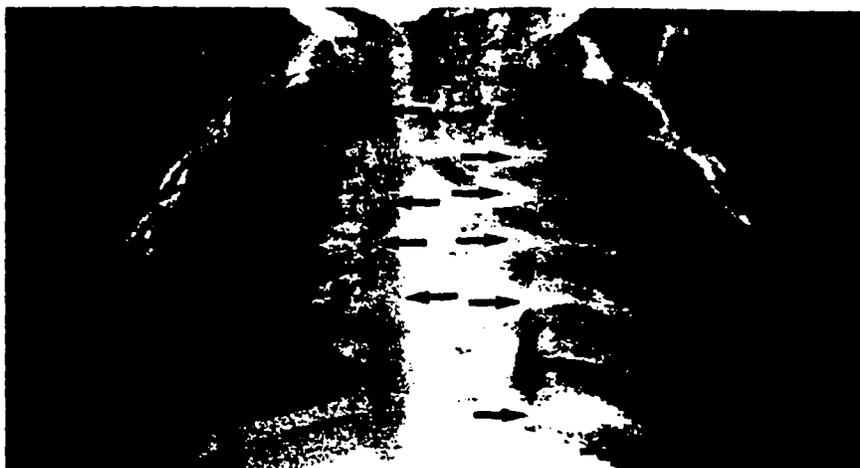
Timetable for Estimating the Age of Fractures in Children'

Adapted with permission from O'Connor JF Cohen J: Dating fractures, in Kleinman " PK (ed): Diagnostic Imaging of Child Abuse. Baltimore: Williams & Wilkins, 1987, p 6.'

Rib fractures may be difficult to detect on initial chest x-ray films; they may become radiographically apparent only later due to healing callus or may not be appreciated unless radionuclide scanning is performed. Posterior and postero-lateral rib fractures are most common and are highly specific for child abuse (Table 3). These fractures result from mechanical stress at the points of firm rib fixation adjacent to the costovertebral junction. However, fracture may occur anywhere along the arc of the rib, including the rib head and the costochondral junction (Fig. 3).

The clavicle is one of the most commonly fractured bones in accidental childhood injury; however, clavicular fractures, are relatively unusual in child abuse, detected in only 2% to 7% of abused children.<sup>17, 27</sup> Similarly, fractures of the hands and feet are common in accidental injury but fairly uncommon in abuse.

**Table 3**  
**Specificity of Musculoskeletal Radiologic Findings in Child Abuse\***



**Figure 3** Multiple bilateral posterior rib fractures (arrows) in ; 2-month-old abused male infant.

True physical fractures are uncommon in the abused child. except for transphyseal fractures of the distal humerus in children less than one year old. Physical separations are most often the result of violent traction or rotation, as opposed to shaking, and may be complicated by growth disturbance. The injury is evidenced radiographically by abundant healing callus (Fig. 4); however, early diagnosis may be difficult before the appearance of the epiphyseal ossific nucleus, necessitating the use of other imaging modalities. such as arthrography, sonography, and magnetic resonance imaging.

Metaphyseal injuries are less common than diaphyseal fractures, with an incidence in cases of child abuse varying between 5% and 44%, depending on the screening method used.<sup>8,15,16,21</sup> However, metaphyseal lesions have high specificity and are considered to be a "classic" radiographic finding in physical abuse (Fig. 5). On the basis of extensive radiologic and histopathologic postmortem examination of abused children, Kleinman et al<sup>29</sup> concluded that metaphyseal injuries are a consequence of planar fractures through the primary spongiosa, which result in a disklike fragment of bone and calcified cartilage (Fig. 6). This may appear as a transverse radiolucency within the subphyseal region of the metaphysis. On an oblique projection, this fragment has a buckethandle appearance. If the periphery of the fragment is thicker than the center of a lesion it appears as a characteristic corner fracture,

**Table 3**  
**Specificity of Musculoskeletal Radiologic Findings in Child Abuse**

**High specificity**

- Metaphyseal corner lesions
- Posterior rib fractures
- Scapular fractures
- Spinous process fractures
- Sternal fractures

### **Moderate specificity**

Multiple fractures  
Fractures of different ages  
Epiphyseal separations  
Vertebral body fractures  
Digital fractures  
Complex skull fractures

### **Common in child abuse, but low specificity**

Clavicular fractures  
Long-bone shaft fractures  
(femur, tibia, humerus)  
Linear skull fractures

'Adapted with permission from O'Connor JF, Cohen J: Dating fractures, in Kleinman PK (ed):  
Diagnostic *Imaging of Child Abuse*. Baltimore: Williams & Wilkins, 1987, p 6.



**Figure 4** Transphyseal fracture of the proximal humerus: is with abundant callus formation 3 weeks after injury in a 15month-old abused male infant.

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*Orthopaedic Aspects of Child Abuse*

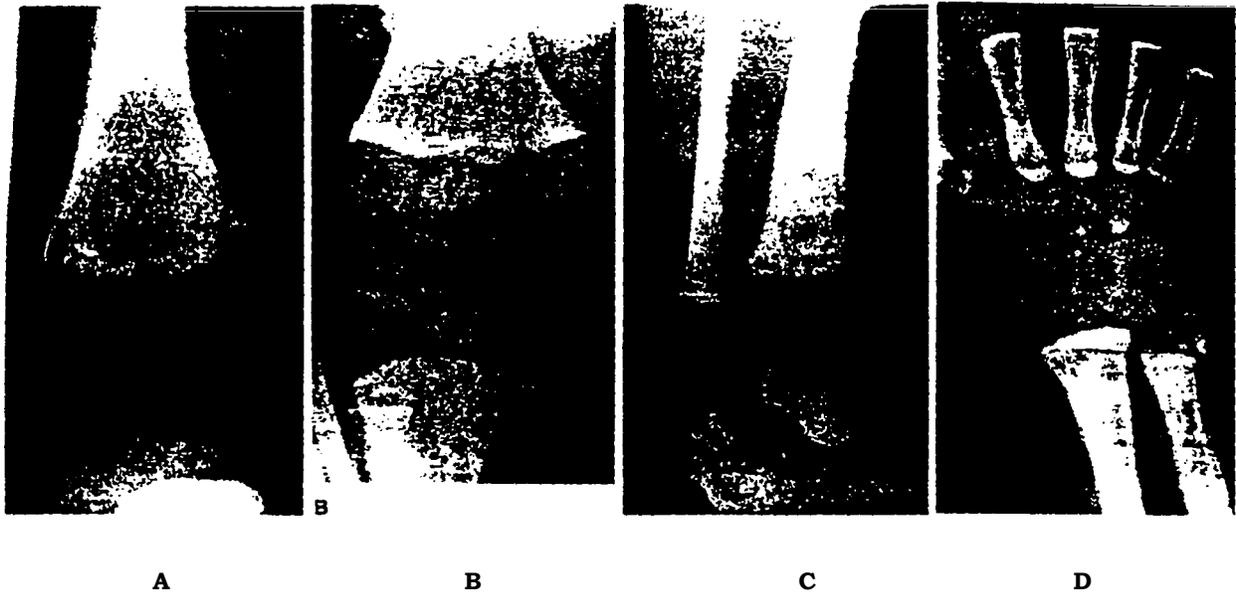


Figure 5 Metaphyseal lesions due to child abuse. A, Corner fracture of the distal femur (arrow) in a 2-month-old abused male infant. B, Medial corner fracture of the proximal tibia (arrow) in a 4-month-old abused female infant. C, Corner fractures of the distal tibia (arrows) in a 2-month-old abused male infant. D, Corner fracture of the distal ulna (arrow) in a 3-month-old abused female infant.

Periosteal avulsion and subperiosteal hemorrhage in the metaphyseal region result in new-bone formation 5 to 14 days after injury. Repetitive injury may result in widening of the radiolucent metaphyseal zone with cupping. The forces necessary to produce these lesions involve rapid acceleration deceleration or torsion-traction and thus are suggestive of violent shaking or twisting. Metaphyseal impaction injuries may result in periosteal new-bone and buckle fractures.

The incidence of spinal injuries from abuse has ranged from only 0% to 3% in large series.<sup>2-30</sup> Most spinal injuries in child abuse are asymptomatic compression fractures detected on skeletal survey in younger children (Fig. 7). Abused children rarely demonstrate significant kyphosis or neurologic abnormality from spinal injuries. Disk-space narrowing and anterior vertebral notching may be noted. Fracture or avulsion of the spinous processes is fairly specific to abuse (Table 3). Most injuries occur in the lower thoracic and upper lumbar spine, and multiple levels may be involved. The mechanism of injury is often the hyperflexion and hyperextension associated with violent shaking.

While there is no pathognomonic fracture pattern, there are a number of general patterns that may help differentiate accidental from abuse fractures. Worlock et al<sup>30</sup> compared fractures in 35 abused children with fractures in 826 nonabused children. The abused children were younger, with 80% less than 15 months of age; all were less than years of age. Only 2% of children with accidental fractures were less than 18 months old, and 86% were older than 5 years of age. In addition, abused children were more likely to have multiple fractures.

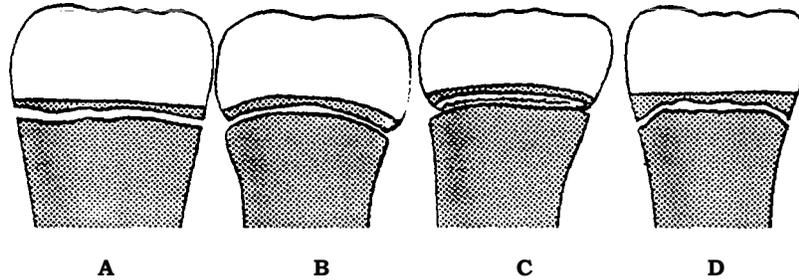


Figure 6 Metaphyseal lesions due to child abuse. A, A planar fracture through the primary spongiosa produces metaphyseal lucency. B, If the metaphysis is tipped or simply projected at an obliquity to the x-ray beam, the margin of the resultant fragment is projected with a bucket-handle appearance. C, If the peripheral fragment is substantially thicker than the central fragment and the plane of injury is viewed tangentially, a corner fracture appearance will result. D, If the metaphysis is displaced or projected at an obliquity a thicker bucket-handle appearance will result. (Adapted with permission from Kleinman PK [ed]: *Diagnostic Imaging of Child Abuser* Baltimore: Williams & Wilkins, 1987, p 113.

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Mininder S. Koeber, MD. and /antes R. Kasser, MD.



Figure 7 L4 compression fracture (arrow) in a 3-month-old abused male infant.

bruising of the head and neck, rib fractures, and spiral humeral-shaft fractures.

Comparing the findings in 52 children under 3 years of age with fractures from abuse and 145 children with accidental injuries, Leventhal et al found that abused children were more likely to sustain a midshaft or metaphyseal humerus fracture, to sustain a tibia or femur fracture if less than 1 year of age, and to have a care-giver who reported no accident but merely a change in behavior. Injuries more common with accidental injury included clavicle fractures, fractures of the distal extremities in children older than 1 year of age, supracondylar humerus fractures, and femur fractures in children over 1 year of age who had fallen while running.

In a study of 49 infants less than 12 months old with fractures, Rosenberg and Bottenfield<sup>17</sup> found that fractures of the humerus or femur with an unknown mechanism or injury were more common in cases of abuse. and clavicle fractures were more common in accidental trauma. However, these differences in injury patterns between abuse and accidental injury must be viewed in the light of studies in which no statistically significant differences were found in the incidence of long-bone fractures or in fracture pattern.<sup>20,31</sup>

### **Radiologic Imaging**

In addition to imaging of acute injuries, a skeletal survey is often used to detect the presence of additional fractures in physically abused children (Table 4). Multiple images are preferable to a single AP x-ray film of the entire infant, because of the obliquity and lack of detail often seen with this "babygram." Skeletal surveys are more useful in children less than 5 years of age who have clinical evidence of physical abuse. The American Academy of Pediatrics Section on Radiology has recommended a mandatory survey in all cases of suspected abuse in children younger than 2 years of age and individualized use of a survey' in children aged 2 to 5 years based on clinical indicators. In children over the age of years, a skeletal survey was considered to have only minimal value.<sup>32</sup> Fractures detected incidentally on skeletal survey are rarely present without clinical evidence of physical abuse by history or physical examination.<sup>2</sup> The yield of skeletal surveys in cases of neglect and sexual abuse is low. The yield of skeletal surveys in children over 3 years of age is also low because occult asymptomatic bone injuries are rare.

The use of radionuclide bone scanning as a screening procedure in physical abuse is controversial. Bone scans are more sensitive than skeletal surveys in screening for physical abuse, especially in detecting rib fractures, nondisplaced long-bone fractures, and occult bone injuries (Fig. 8).<sup>33</sup> However, disadvantages of bone scanning include cost, radionuclide exposure, lack of specificity, and limited availability and expertise. In addition, it may be difficult to detect epiphyseal-metaphyseal abnormalities (because of the normally increased activity in this region) and to date fractures. Thus, many recommend radionuclide bone scanning when skeletal surveys are negative or questionable despite a clinical suspicion of abuse.<sup>27</sup> Repeating a skeletal survey 2 to 3 weeks after the initial presentation can assist in the identification, confirmation, and dating of questionable fractures.

### **Differential Diagnosis**

The differential diagnosis of child abuse includes other conditions that can lead to fracture, periosteal elevation, or bruising in young children. The differentiation between mild forms of osteogenesis imperfecta (OI) and child abuse can be particularly vexing and deserves special mention.

**Table 4**  
**Skeletal Survey for Child Abuse\***

AP bilateral arms  
AP bilateral forearms  
AP bilateral hands  
AP bilateral thighs  
AP bilateral lower legs  
AP bilateral feet  
AP and lateral axial skeleton and trunk  
AP and lateral skull

Adapted with permission from American Academy of Pediatrics Section on Radiology: Diagnostic imaging of child abuse. *Pediatrics* 1991;**87:262-264.**

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Because OI is rare and nonaccidental injury is common, the possibility of OI may be overlooked when the child seems clearly to have suffered a nonaccidental injury. There have been sporadic high-profile cases in which children identified as victims of abuse were later found to have mild forms of OI.

Undiagnosed OI should be considered when a child presents with multiple fractures but a history of minimal trauma. Characteristics of OI that may be useful in differentiation from child abuse include blue sclerae, dental involvement, osteopenia, family history, wormian bones on skull radiographs and deformity. However, patients with milder forms of OI, such as Sillence type IV, may have normal sclerae, no dental involvement, minimal osteopenia, and due to spontaneous mutations, no family history of OI. In addition, blue sclerae can be normal in infants up to the age of 4 months.

To make the differentiation even more difficult, it must be considered that children with OI may also be the victims of abuse. In OI as in abuse, the purported mechanism of injury often seems insufficient for the resultant fracture. However, in otherwise normal bones and in the absence of features associated with OI, unexplained fractures are much more likely to represent abuse than a rare mild form of OI. Metaphyseal corner fractures, rib fractures, subdural hematoma, retinal hemorrhages, and skull fractures are not typical features of OI. Resolution of fracturing in a protected environment also supports abuse. Although the diagnosis of OI is still based on clinical and radiographic criteria, fibroblast cell culture from a skin biopsy specimen can now be used to detect molecular abnormalities of type 1 collagen in approximately 85% of the OI cases.

Osteogenesis imperfecta is but one example of the complexity of accurately diagnosing child abuse. It is essential that the physician be aware of all the possibilities that must be considered in the differential diagnosis of that protean entity (Table 5)

**Management**

The first and most vital step in the management of child abuse is to establish the diagnosis. A tactful and tempered approach should be taken at the initial encounter, as many cases of suspected abuse are found to be unsubstantiated. Nevertheless, although false suspicion of child abuse can be stigmatizing and burdensome to the family, the consequences of failure to diagnose can be fatal. It has been estimated that failure to diagnose an initial presentation of child abuse may result in a 30% to 50%

chance of repeated abuse and 5% to 10% chance of death. With reinjury, parents often seek care at a different medical facility. Physicians and other health-care providers are required by law in most states to report suspected cases of child abuse, and failure to report has increasingly resulted in sanctions, fines, exposure to liability and claims of malpractice. A reporter does not have to be certain that abuse or neglect has occurred; he or she must simply have a reasonable suspicion of maltreatment. The law affords the reporter immunity from civil or criminal liability stemming from the act of reporting such as a charge of defamation or invasion of privacy (however, malicious reporting may expose the reporter to litigation).

The management of a physically abused child ideally involves a team approach. Most hospitals that treat a substantial number of children have such a team. When in an adult hospital or a community hospital without a child abuse team, the orthopaedist should consider a telephone consultation with the emergency department of a local children's hospital or with a 24-hour child abuse assistance line, which most states have available. The role of the orthopaedist is usually in identifying or assessing the possibility of abuse given the pattern of skeletal injuries and then in managing the injuries. The child's primary-care physician should be contacted to ascertain whether there is any history or previous injuries in the child or siblings. Consultation with child protective services, the department or social services, and legal counsel is essential to investigate the possibility of child abuse, to assess the often complex family dynamics, and to provide legal and social protection for the child.

General surgical, neurosurgical, ophthalmologic, dermatologic, or gynecologic consultation may be necessary, depending on the child's injuries. Careful physical examination and appropriate imaging modalities are essential to rule out associated neurologic and visceral injuries. Hospital admission is often required to care for acute injuries and to provide a protected environment in which steps can be taken to diagnose and substantiate the abuse and arrange for appropriate disposition.

Many child abuse cases eventually involve legal proceedings for custodial action or criminal charges against the abuse perpetrator, which may require depositions, testimony, or court appearances by the treating physicians. The diagnostic evidence supporting physical abuse must be carefully and thoroughly documented in the medical record. Any conclusions or assessments should be based firmly on the clinical facts of the case. Even in the absence of an impartial witness or an admission to the act of abuse, the diagnosis of abuse remains an opinion. Thus, a statement regarding the level of certainty of abuse is essential. Legal consent is required for any actions to treat an abused child or to release information from the medical record. Court custody may be required when suspected family members refuse to cooperate with an investigation. The sensitive management of family violence requires both medical and legal input. Hospital child protective services teams will generally coordinate legal proceedings.

### **TABLE 3**

#### **Differential Diagnosis of Child Abuse**

##### **Diagnosis Factors and /or Characteristics**

Accidental Injury

Age, mechanism of injury, associated injuries, no delay in seeking care

Birth Trauma

Obstetric history, call us within 2 weeks of birth, humeral fracture, clavicle fracture, distal humeral physical separation

Osteogenesis Imperfecta	Family history, osteopenia, blue sclerae, dental involvement, wormian bones, skin-test abnormalities
Caffey Disease	Family history, diffuse periosteal elevation, mandibular involvement, irritability, inflammation, swelling stiffness
Rickets	Physal widening, metabolic abnormalities, deformity, osteopenia, Looser's lines, laboratory abnormalities
Congenital Syphilis	Metaphyseal erosions, periosteal bone formation, serologic tests, pseudoparalysis
Congenital Insensitivity To Pain history	Infection, joint destruction, neurologic abnormalities, family
Coagulation disorders (Hemophilia, von Willebrand disease)	Brusing, coagulopathy, laboratory abnormalities
Leukemia	Metaphyseal lucencies, systemic symptoms, hematologic abnormalities, bone-marrow biopsy findings
Normal Radiographic Variants	Angulation of ossifying metaphysis, cortical irregularity, spurring, juxtaphyseal variants

## Summary

Child abuse is a pervasive social and medical problem that remains a major cause of disability and death among children. The diagnosis of child abuse involves careful consideration of sociobehavioral factors and clinical findings. Fractures are the second most common presentation of physical abuse, after skin lesions. There is no pathognomonic fracture pattern in abuse, although certain metaphyseal lesions, multiple fractures in various stages of healing, posterior rib fractures, and long-bone fractures in children less than 2 years old are suggestive of nonaccidental injury. Management should be multidisciplinary, with an emphasis on recognition, because abused children have a substantial risk of repeated abuse and death.

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## References

1. McMahon P, Grossman W, Gaffney M, Stanitski C: Soft-tissue injury as an indication of child abuse. *J Bone Joint Surg Am* 1995;77:1179-1183.
2. Akbarian BA, Akbarian NO: The role of orthopedist in child abuse and neglect. *Orthop Clin North Am* 1976;7:733-742.
3. National Center on Child Abuse and Neglect: *Child Maltreatment 1995: Reports From tire States to the National Center on Child Abuse and Neglect*. Washington, DC. National Center on Child Abuse and Neglect, 1997.
4. Sedlak A, Broadhurst DD (eds): *The Third National Incidence Study of Child Abuse and Neglect: Final Report*. Washington, DC: US Department of

Health and Human Services, 1996.

5. Caffey J: Multiple fractures in the long bones of infants suffering from chronic subdural hematoma. *AIR Am J Roentgenol* 1946;56:163-173.
6. Kempe CH, Silverman FN, Steele BF, Droegemuller W, Silver HK: The battered-child syndrome. *JAMA* 1962; 181:17-24.
7. Rosenberg N, Bottenfield G: Fractures in infants: A sign of child abuse. *Ann Emerg Med* 1982;11:178-180.
8. Krishnan J, Barbour PJ, Foster BK: Patterns of osseous injuries and psychosocial factors affecting victims of child abuse. *Aust N Z J Surg* 1990;60: 447-450.
9. Lung CT, Daro D (eds): *Current Trends in Child Abuse Reporting and Fatalities: Tire Results of the 1995 Annual Fifty State Survey*. Chicago: National Committee to Prevent Child Abuse, 1996, pp 1-24.
10. McClain PW, Sacks JJ, Froehike RG, Ewigman BG: Estimates of fatal child abuse and neglect, United States, 1979 through 1988. *Pediatrics* 1993;91:338-313.
11. Lynch MA: Child abuse before Kempe: An historical literature review. *Child Abuse Negl* 1985;9:7-15.
12. Helfer RE, Slovis TL, Black M: Injuries resulting when small children fall out of bed. *Pediatrics* 1977;60:533-535.
13. Meservy CJ, Towbin R, McLaurin RL, Myers PA, Ball W: Radiographic characteristics of skull fractures resulting from child abuse. *AIR Am J Roentgenol* 1987;149:173-175.
14. Touloukian RJ: Abdominal visceral injuries in the child abuse syndrome. *Pediatr Ann* 1968;42:642-646.
15. King J, Diefendorf D, Apthorp J, Negrete VF, Carlson M: Analysis of 429 fractures in 189 battered children. *J Pediatr Orthop* 1988;8:585-589.
16. Drvaric DM, Morrell SM, Wylly JB, Miller MB, Schmitt EW: Fracture patterns in the battered child syndrome. *J South Orthop Assn* 1992;1:20-25.
17. Akbarnia B, Torg JS, Kirkpatrick J, Sussman S: Manifestations of the battered-child syndrome. *J Bone Joint Surg Am* 1974;56:1159-1166.
18. Leventhal IM, Thomas SA, Rosenfield NS, Markowitz RI: Fractures in young children: Distinguishing child abuse from unintentional injuries. *Am J Dis Child* 1993;147:87-92.
19. McClelland CO, Heiple KG: Fractures in the first year of life: A diagnostic dilemma? *Am J Dis Child* 1982;136:26-29.
20. Kowai-Fern A, Paxton TP, Ros SP, Lietz H, Fitzgerald M, Gamelli RL: Fractures in the under-3-year-old age cohort. *Clin Pediatr (Phila)* 1992;31: 653-659.
21. Loder RT, Bookout C: Fracture patterns in battered children. *J Orthop Trauma* 1991;5:428-433.
22. Beals RK, Tufts E: Fractured femur in infancy: The role of child abuse. *J Pediatr Orthop* 1983;3:583-586.
23. Dalton HJ, Slovis T, Helfer RE, Comstock J, Scheurer S, Riolo S: Undiagnosed abuse in children younger than 3 years with femoral fracture. *Am J Dis Child* 1990;144:875-878.
24. Gross RH, Stranger M: Causative factors responsible for femoral fractures in infants and young children. *J Pediatr Orthop* 1983;3:341-343.
25. Anderson WA: The significance of femoral fractures in children. *Ann Emerg Med* 1982;11:174-177.
26. Garcia VF, Gotschall CS, Eichelberger MR, Bowman LM: Rib fractures in children: A marker of severe trauma. *J Trauma* 1990;30:695-700.
27. Merten DF, Carpenter BLM: Radiologic imaging of inflicted injury in the child abuse syndrome. *Pediatr Clin North Am* 1990;37:815-837.
28. Kleinman PK, Marks SC Jr, Nimkin K, Rayder SM, Kessler SC: Rib fractures in 31 abused infants: Postmortem radiologic-histopathologic study. *Radiology* 1996;200:807-810.
29. Kleinman PK, Marks SC, Blackbourne B: The metaphyseal lesion in abused infants: A radiologic-histopathologic study. *AIR Am J Roentgenol* 1986;146: 895-905.
30. Worlock P, Stower M, Barbor P: Patterns of fractures in accidental and non-accidental injury in children: A comparative study. *BMI* 1986;293:1001-102
31. Blakemore LC, Loder RT, Hensinger RN: Role of intentional abuse in children 1 to 5 years old with isolated femoral shaft fractures. *J Pediatr Orthop* 1996;5:585-588.
32. American Academy of Pediatrics Section on Radiology: Diagnostic imaging of child abuse. *Pediatrics* 1991;87: 262-264.
33. Conway JJ, Collins M, Tanz RR, et al: The role of bone scintigraphy in detecting child abuse. *Semin Nud Med* 1993;23:321-333.
34. Ablin DS, Greenspan A, Reinhart M, Grix A: Differentiation of child abuse from osteogenesis imperfecta. *AIR Am J Roentgenol* 1990;154:1035-1046.

## **Journal of the American Academy of Orthopaedic Surgeons**

The article in this issue by M. S. Kocher and J. R. Kasser, entitled "Orthopaedic Aspects of Child Abuse," points up an ugly side of our society and serves as an important reminder of our responsibility as physicians. Although there are many theories about the etiology of domestic violence, the unfortunate fact is that it is now a common occurrence in our society. The consequences of some types of violence, such as murder and sexual assault, are flagrantly obvious. In contrast, the violence that occurs within the context of the family is often clandestine and insidious, but may be no less destructive in its effects. It is by nature covert, resistant to discovery, and difficult to deal with because it is intertwined with issues of trust and family relationships.

Violence in the home has three different faces: child abuse, spousal abuse, and elder abuse. The prevalence and estimated number of victims in the United States are staggering. National statistics suggest that more than 3 million cases of child abuse or neglect are reported each year, affecting 2.5% of all children.<sup>1</sup> More than half of abused children will have fractures, and more than half will have caretakers who have suffered abuse themselves. The incidence rates of spousal abuse and elder abuse are more difficult to pinpoint; however, 83% of Americans report that domestic violence is a very important societal issue.<sup>2</sup> A recent study of 452 women seeking emergency treatment at an obstetric gynecologic clinic found that 40.1% of them either were currently involved in or had previously been involved in an abusive relationship.<sup>3</sup> Abuse of the elderly by their caretakers is a less frequently reported phenomenon but probably has a higher incidence than has been documented. Estimates are that the incidence of elder abuse may be 1 to 2 million cases per year, but that only 1 of every 14 cases is reported to a referral agency.<sup>4</sup> At least half of the instances of elder abuse are inflicted by adult children or spouses. In all cases of domestic abuse, the violence occurs in an environment of dependency and intimacy, which may obscure or even prevent its discovery.

We are shocked by public reports of death due to abuse. However, there are other consequences of both discovered and undiscovered abuse that are also devastating and pervasive. These are not just the physical injuries but also the resultant emotional and developmental problems. It is a fact that the abused are more likely to become the abusers of the next generation, thus perpetuating the problem. In addition, abused children are more likely to become involved in criminal activity than their nonabused peers.

So what are we as physicians supposed to do? First, we have the responsibility to familiarize ourselves with the problem of domestic abuse and its various manifestations. There are numerous studies in the pediatric and radiologic literature detailing the patterns of abuse and the commonly observed fractures. This

is especially important in cases of suspected child abuse, because a significant percentage of abused children first present with a fracture. However, we must be intimately familiar with the signs of all types of abuse, not only those that most frequently affect children. Abused patients may present to anyone's practice the problem crosses all socioeconomic and ethnic lines. We also need to become familiar with the resources in our hospitals and communities and the professionals trained to handle these situations. We must have confidence that they will deal with the events that we report with discretion and finesse.

Most important, we must resist the temptation to not become involved, rationalizing that someone else will see the problem and report it. No one wants to wrongly accuse an individual or family and thus cause them embarrassment. However, we must acknowledge that we have a moral and a legal responsibility to act.

I hope that articles such as this one on child abuse and forthcoming articles on spousal and elder abuse will be a springboard for you to learn more about this problem and your responsibilities- With vigilance, the occurrence can decline, thereby decreasing the devastating impact on our society.

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-Alan M. Levine, MD  
*Editor-in-Chief*

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#### References

1. Lung CT, Daro D: *Current Trends in Child Abuse Reporting and Fatalities: The Results of the 1995 Annual Fifty State Survey*. Chicago: National Committee to Prevent Child Abuse, 1996.
2. Domestic Violence Advertising Campaign Tracking Survey: Wave III. Prepared by Lieberman Research, Inc, for The Advertising Council and the Family Violence Prevention Fund, November 1995. Available at <http://www.ama-assn.org/advocacy.htm>. Accessed January 6, 2000
3. Geary FH Jr, Wingate CB: Domestic violence and physical abuse of women: The Grady Memorial Hospital experience. *Am J Obstet Gynecol* 1999;181:S17-S21.
4. Lachs MS, Pillemer K: Abuse and neglect of elderly persons. *N Engl J Med* 1995;332:37-443.

# **Domestic Violence: The Role of the Orthopaedic Surgeon in Identification and Treatment**

*Debra A. Zillmer, MD*

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## **Abstract**

*Domestic violence is a major public health problem in the United States. As many as 35% of women visiting hospital emergency departments for trauma care are there because of injuries caused by intimate partner violence. The practicing orthopaedic surgeon may come in contact with these women in the emergency department as well as in the office setting. The ability to identify victims of abuse requires a sensitive approach and a specific set of skills. Once the victim has been identified, appropriate referral to local agencies is critical to help ensure the victim's safety. The issues surrounding identification, documentation, inquiry about safety, and activation of community services need to be incorporated into the core curriculum of resident training programs and the continuing education of the practicing orthopaedic surgeon.*

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Domestic violence, or "intimate partner violence," is the threatened or actual use of physical force against a domestic partner that either results in or has the potential to result in death, injury, or harm. It has been estimated that 8% to 12% of American women are abused by intimate partners each year.<sup>1</sup> Data from 1996 published by the Federal Bureau of Investigation indicate that 51% of all murdered women were killed by someone they knew, and 30% were slain by a husband, ex-husband, or boyfriend. In stark contrast, only 3% of all male murder victims were killed by wives, ex-wives, or girlfriends.<sup>2</sup> Nonlethal violent victimization is reported for both sexes but is eight times more frequent in women than in men.<sup>3</sup>

As many as 35% of women visiting hospital emergency departments for trauma care are there as a result of injuries caused by intimate partner violence.<sup>4</sup> A recent survey of all women aged 18 years or older who received treatment in community hospital emergency departments in two states revealed that 14.4% had suffered physical or sexual abuse during the previous year and 36.9% had been emotionally or physically abused at some time in their

Dr Zillmer is attending Orthopaedic Surgeon, Gunderson Lutheran Medical Center, LaCrosse, WI; and Adjunct Clinical Professor, University of Wisconsin-LaCrosse

Reprint requests: Dr. Zillmer, Gunderson Lutheran Sports Medicine Center, 3100 South Kinney Coulee Road, Onalaska, WI 54650

## **The Cycle of Domestic Abuse and Its Consequences**

Physical violence in a relationship generally occurs in cycles, with each cycle consisting of several phases.<sup>6</sup> In the first phase, tension escalates in the relationship. Criticism, demeaning remarks, and mild physical abuse characteristically occur. The batterer communicates dissatisfaction but is relatively controlled. The woman commonly attempts to placate the batterer with the hope of calming him down. She believes that if she behaves in just the right manner, she can control his hostility and avoid irritating him further. This may be successful for a while, with the ironic and unfortunate result that the victim comes to feel personally responsible for his moods and behavior. As the tension builds, her "control" of her partner becomes more tenuous and untenable. If she retreats and withdraws when tension is high, this may trigger him to become more aggressive. In the second phase of the cycle, the tension built up in the first phase is discharged, resulting in the first battering incident. The violent event is often accompanied by a bout of heavy alcohol intake, which law enforcement officials and even the victim may erroneously consider to be the cause of the beating, rather than merely the excuse for it. The third phase is characterized by a show of apparent remorse by the batterer with promises that the beatings will never occur again. The victim often deludes herself that this phase is a new beginning and persuades herself she should remain in the relationship to "make it work."

When the cycle repeats itself, the violence tends to become more severe, and the apology phase becomes shorter. As the batterer assumes increasing domination of the victim, he expends less and less energy in obtaining forgiveness. The victim loses self-esteem and abdicates control over her own destiny and that of her children. In this demoralized state, the victim typically finds it difficult to leave an abusive relationship, even if she has the means and the opportunity to do so.

If a woman is able to escape an abusive situation, she faces even more challenges. The Texas Council on Family Violence offers some striking statistics to characterize the experiences that await her: (1) The highest risk for serious injury or death occurs when a battered woman is leaving or has left her violent partner. (2) Of employed battered women, 74% are harassed by their abusive domestic partners at work, either in person or over the telephone. This frequently results in their being late to work or missing work altogether, and 20% eventually lose their jobs. (3) As many as 50% of all homeless women and children in this country are fleeing domestic violence. (4) Injuries that battered women receive are at least as serious as injuries suffered in 90% of violent felony crimes, yet under state laws, these injuries are almost always classified as misdemeanors.

## **Identification of Abuse and Provision of Care**

In the 1991 National Survey of Attitudes Toward Family Violence (conducted by Schulman, Lorca & Buevalos, Inc, New York, January 3-10, 1991), more than 85% of respondents stated that, if asked, they could talk to a physician if they were a victim or a perpetrator of family violence. In contrast, battered women have identified medical providers

as the least effective professional source for help, despite frequent health-care utilization.<sup>7</sup> For many abused women, the hospital emergency department is the first and sometimes the only contact they have with health-care providers.<sup>5</sup> Although orthopaedic surgeons are not traditionally considered primary-care physicians, they too may be the "first contact" physicians.

As is the case with most psychosocial problems, the physician's ability to recognize domestic abuse depends on his or her index of suspicion. It is important for physicians to recognize that a serious potential obstacle to identification of domestic abuse may be that they are unwittingly harboring some of the same common misconceptions about the phenomenon that are so prevalent in society as a whole.<sup>8</sup> Some of these misconceptions are listed in Table 1.

Domestic violence is an issue for all women. However, certain groups stand out as being at particularly high risk: (1) Women aged 19 to 29 years old in families with annual incomes below \$10,000.<sup>9</sup> (2) Pregnant women. Violence may be a more common problem for pregnant women than preeclampsia, gestational diabetes, and placenta previa.<sup>10</sup> Retrospective studies of battered women have found that 40% to 60% were abused during pregnancy-25% of them for the first time. In one study of pregnant teens, "26% were currently in a relationship with a man who was abusive; many stated that the abuse had started when they discovered they were pregnant. (3) Innercity African-American women. Homicide rates are nearly four times higher for African-American women than for white women. Furthermore, within the African-American community, the risk of violent injury for women aged 25 to 34 is 26 times higher than that for women aged 65 years or older.<sup>12</sup>

Although overt signs of abuse, such as bruises and fractures, are classic indicators, the physician must be sensitive to more subtle signs. Chronic health problems, such as headache, backache, sleep disorders, anxiety, abdominal complaints, eating disorders, depression, and chronic pain, may be related to the stress of living in a violent relationship and may be the presenting symptoms that first bring a woman into a physician's office.<sup>13</sup> When abused women are not identified, they may develop a pattern of frequent emergency department visits, hospitalizations, and increased use of outpatient health-care facilities.<sup>14,15</sup>

The ability to identify victims of abuse requires heightened awareness of the problem, a sensitive approach, and, for many physicians, a new repertoire of communication skills. The Domestic Violence Task Force of the State Medical Society of Wisconsin has summarized some practical guidelines for care delivery (Table 2).

The physician must be cognizant of the fact that women are often not the only victims in a domestic violence situation; the examiner should also inquire about any children in the home. Child abuse has been reported in 33% to 54% of families in which adult domestic violence occurred.<sup>16</sup> Nor is age a defense against violence; elderly men and women can be victims of domestic violence as well. Violence can also occur in gay and lesbian relationships. Although it is much less common, heterosexual males can be the abused partner in a relationship.

### Some Common Misconceptions About Abuse

Myth	Fact
<p><b>Battered women are always from lower Socioeconomic groups.</b></p>	<p>Inner-city emergency facilities used by women from lower Socioeconomic groups more commonly report statistics on the incidence of domestic violence than do private medical offices serving a different patient population.</p>
<p><b>Battered women must derive some satisfaction from the abuse; otherwise why would they not leave.</b></p>	<p>All studies have shown that battered women do not enjoy or seek out the violence. The reasons for staying in a violent relationship are complex. The victims live lives that are chaotic, frightening and often socially isolated.</p>
<p><b>The beating victim probably pushed her partner to the point of becoming violent.</b></p>	<p>A battered woman may get to the point where she believes that she is responsible for the recurrence of the violence, but the responsibility for the violent act resides with the batterer. Her sense that she can control the actions of her violent partner may mislead her into a false sense of security, setting her up for more severe acts of future violence.</p>
<p><b>If a woman is really a victim of abuse, she can just have the batterer arrested and put in jail.</b></p>	<p>Most women will not seek to have the batterer arrested for reasons that include financial concerns for the family, fear of violent retaliation, and the well-publicized experience of others who have gone unprotected by the law enforcement and criminal justice systems.</p>
<p><b>The simple answer to ending the violent relationship is to leave.</b></p>	<p>Abused women and their children who leave risk the possibility of more violence and even death.</p>
<p><b>If a battered woman remarries, she usually chooses another violent man</b></p>	<p>Some abused women remain single after leaving an abusive relationship, and others specifically seek out a new non-violent partner. A history of past abuse does not indicate that a woman's current relationship is abusive.</p>
<p><b>Adapted with permission from Willis M (ed): Domestic Violence: Washington DC: American College of Obstetricians and Gynecologists, technical bulletin no.1 209, 1995, pp3-4.</b></p>	

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, or are in emotional denial about, the danger they face.<sup>16</sup>

Planning for the care of domestic violence victims in advance by obtaining literature from local agencies, adequately training office staff to assist in management, and being aware of local emergency department domestic violence response plans will greatly facilitate the provision of appropriate and sensitive care when the need arises. It is important to have information readily available in the office about hotlines, shelters, legal advocacy, and other services available in the community. The National Domestic Violence Hotline (800-799-SAFE) is a 24-hour resource to help women find local shelters. In addition, local domestic

shelters and statewide domestic violence programs are frequently listed in the phone book.

Hospital emergency departments should also have this information available, as well as a response plan for providing consultation and assistance. Since 1992, the Joint Commission on Accreditation of Health Care Organizations has required that hospitals establish a plan for the identification, assessment, and treatment of abuse victims of all ages and that each emergency department maintain a current list of community-based and private agencies equipped to deal with family violence.<sup>17</sup>

Identification of victims, documentation of injuries, inquiry about safety, and activation of community services are incumbent on the orthopaedic surgeon, just as they are on all physicians. It must also be borne in mind that if a battered woman is treated by a physician who does not inquire about domestic abuse and she then returns to the same environment and sustains further injuries, the physician could potentially be held liable for those subsequent injuries.<sup>16</sup>

### **The Need for Changes in Physician Education**

The first study done to examine curricula for provision of information about adult domestic violence found that the majority of American and Canadian medical schools did not provide any instruction at all on this topic in the 1987-1988 academic year.<sup>18</sup> A 1993-1994 study found that 86% of American and Canadian medical school deans reported instruction in adult domestic violence, compared with only 57% of students. The material was presented in the preclinical years over an average of only 2 hours.<sup>7</sup>

Stand-alone lectures and teaching venues that are far removed from a student's clinical experience are often not as effective as instruction modeled on real or likely clinical encounters. Some students who have received regular and reinforced education about family violence in the preclinical years by committed and supportive faculty report that incorporating basic principles of screening, assessment, and intervention is not encouraged in clinical rotations and is actually "trained out" by residents and attendings. For example, these clinical teachers and role models may teach by negative example when they fail to routinely query about abuse or indicate to students that such inquiry is not important, will not do any good anyway, or should not be attempted, given the increasing time constraints of clinical practice.?

There currently is no information available about whether any of the 153 American orthopaedic surgery residency programs include documented teaching about domestic violence. However, there have been several questions on the topic in the American Academy of Orthopaedic Surgeons Orthopaedic In Training Examination in the past several years.

Increased awareness on the part of the practicing orthopaedic surgeon can be stimulated in orthopaedic residency training programs. A domestic violence training curriculum should include a core body of knowledge about spousal, child, and elder abuse, as well as instruction in the specific clinical skills for identification and intervention and orientation to the local community organizations that assist with victims of abuse.

The National Center for Injury Prevention and Control, a division of the Centers for Disease Control and Prevention (CDC), offers a "Guide to Training Materials and Programs for Health Care Providers" and also a system for evaluating training programs on domestic violence. The CDC can also assist in evaluating the effectiveness of training programs.<sup>19,20</sup> The addition of content on domestic abuse in continuing education courses and materials is important, so that practicing orthopaedic surgeons can be updated on the important issues of victim identification, documentation, safety, and referral. Nurses and allied health personnel also require education to increase their ability to assist in the office with victims' needs.

## **Summary**

Domestic violence is a significant public health problem in the United States. The complexity of individual human beings and their relationships makes the problem difficult to recognize and prevent. The many widely held misconceptions about this issue often interfere with identification and provision of appropriate and adequate care. Family violence occurs in all ethnic, religious, and socioeconomic groups and may be directed against children and the elderly as well as against domestic partners. The important role of the orthopaedic surgeon in dealing with victims of domestic violence lies in identification, documentation, inquiry about safety issues, and referrals to local resources trained to assist victims of domestic violence.

It is essential to improve the educational status of orthopaedic residents and practicing physicians about domestic violence. Educational efforts at the medical school level are increasing but occur primarily in the preclinical years. Although little has been done from an educational standpoint during orthopaedic residency training, opportunities exist to improve this situation.

**TABLE 2**

**Practical Guidelines for Care Delivery**

**How to Evaluate The Situation:**

- All female patients (regardless of socioeconomic status) should be evaluated for domestic violence.
- Characteristics of injuries that may suggest abuse; Injuries inconsistent with offered explanation, multiple injuries, injuries in different stages of healing, a substantial delay between onset of injury and presentation for treatment
- Patient characteristics or behavior that may suggest abuse; a flat affect, looking to the partner for approval before answering, nervousness about leaving the hospital/clinic.
- Characteristics of the spouse/partner that may suggest an abusive situation: being overly attentive, reluctance to let patient out of his sight, aggressiveness, answering questions for the patient.

**How to Interview the Patient:**

- Interview should be done outside the presence of others.
- If the patient is not a native speaker of English or is hearing or speech-impaired, a hospital translator or other neutral communication facilitator should be used instead of a family member.
- If you feel awkward introducing the subject of abuse with patients, the following approach may be useful. I see many women who require medical care because of injuries similar to yours, often injuries caused by someone they know. Did someone you know do this to you?
- Useful follow-up questions: “Do you feel safe at home?” “Did someone hit you?” “Is it safe for you to go home?” “Do you every feel you are in danger?”
- Not effective questions: “Do you get something out of the violence?” Did you do anything that caused your partner to hit you?” “Could you have done anything to avoid or defuse the situation?”

**How to Advise the Patient:**

- Victims should be advised of the option of reporting to the police.
- If the woman acknowledges abuse, listen nonjudgmentally to further assess her needs and then offer referrals to local resources.
- If the woman does not acknowledge abuse but you are still concerned, let her know of your misgivings. Sometimes a patient may listen silently without overly acknowledging what is being said. In this case, it is still helpful to offer some information about referrals and encourage her to return if she has any problems in the future.

**How to Document the Case:**

- Carefully document the abuse as it has been described to you.
- Use a body map or have photographs taken of injuries (with the patient’s permission).
- Document your opinion if the patient’s injuries are not consistent with the offered explanation.
- Disclosure of a diagnosis of abuse to any third party and reporting to the authorities should be done only with the abused woman’s knowledge and consent. The exception to this rule would be if a state has a mandatory reporting statute. Physicians should check requirements in the state in which they practice.

**Adapted with permission from materials from the Domestic Violence Task Force, State Medical Society of Wisconsin, Madison.**

**REFERENCES:**

1. Wilt S, Olson S: Prevalence of domestic violence in the United States. *J Am Med Womens Assoc* 1996;51:77-82.
2. US Department of Justice, Federal Bureau of Investigation: Uniform Crime Reports: Crime in the United States. Washington, DC: US Department of Justice, 1997.
3. Greenfield L, Rand MR, Craven D, et al (eds): Violence by intimates: Analysis of data on crimes by current or former spouses, boyfriends, and girlfriends, in *Bureau of Justice Statistics Fact book*. Washington, DC: US De-

partment of justice, document NCJ167237, 1998.

4. McLeer SV, Anwar R: A study of battered women presenting in an emergency department. *Am J Public Health* 1989;79:65-66.
5. Dearwater SR, Coben JH, Campbell JC, et al: Prevalence of intimate partner abuse in women treated at community hospital emergency departments. *JAMA* 1998;280:433-438.
6. Walker LE: *The Battered Woman Syndrome*. New York: Springer, 1984.
7. Alpert EJ, Tonkin AE, Seeherman AM, Holtz HA: Family violence curricula in U.S. medical schools. *Am J Prev Med* 1998;14:273-282.
8. Hofeller KH: *Battered Women, Shattered Lives*. Palo Alto, Calif. R & E Research Associates, 1983.
9. Bachman R, Saltzman LE: *Violence Against Women: Estimates From the Redesigned Survey*. Washington, DC: US Department of Justice, Office of Justice Programs document NCJ-154348, 1995.
10. Gazmararian JA, Lazoric S, Spitz AM, Ballard TJ, Saltzman LE, Marks JS: Prevalence of violence against pregnant women. *JAMA* 1996;275:1915-1920.
11. McFarlane J: Violence during teen pregnancy: Health consequences for mother and child, in Levy B (ed): *Dating Violence: Young Women in Danger*. Seattle: Seal Press, 1991
12. Grisse JA, Schwarz DF, Miles CG, Holmes JH: Injuries among inner-city minority women: A population-based longitudinal study. *Am J Public Health* 1996;86:67-70.
13. Worcester N: The role of health care workers in responding to battered women. *Wis Med* 1992;91:9-11.
14. Bergman B, Brismar B: A 5-year followup study of 117 battered women. *Am J Public Health* 1991;81:1486-1489.
15. Varvaro FF: Treatment of the battered woman: Effective response of the emergency department. *Am Coll Emerg Physicians* 1989;11:8-13.
16. Flitcraft A (ed): *Diagnostic and Treatment Guidelines on Domestic Violence*. Chicago: American Medical Association, 1992.
17. LaCrosse L: Domestic violence: The physician as patient advocate. *Wis Med* 1996;95:392-393.
18. Education about adult domestic violence in U.S. and Canadian medical schools, 1987-88. *MMWR Morb Mortal Wkly Rep* 1989;38:17-19.
19. Osattin A, Short LM: Intimate partner violence and sexual assault: A guide to training materials and programs for health care providers. Atlanta: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 1998.
20. Short LM, Johnson D, Osattin A: Recommended components of health care provider training programs on intimate partner violence. *Am J Prev Med* 1998;14:283-288.

## GENERAL MATERIAL

- I. Laws Mandating Reporting of Domestic Violence *JAMA*
  
- II. A Domestic Violence Working Tool for Health Care Providers  
*Susan M. Hadley, MPH*
  
- III. Building Bridges between Domestic Violence Advocates and  
Health Care Providers  
  
*National Resource Center on Domestic Violence*

<http://www.vaw.umn.edu/documents/bridges/bridges.html>

## Laws Mandating Reporting of Domestic Violence

### Do They promote Patient Well-being?

Ariella Hyman, JD; dean Schillinger, MD; Bernard Lo, MD

DOMESTIC violence is increasingly recognized as a major public health problem, affecting individuals of all ethnic and socioeconomic backgrounds. Domestic violence has been defined as a pattern of coercive control consisting of physical, sexual, and/or psychological assaults against current or former intimate partners.<sup>1</sup> Batterers also commonly use economic abuse, isolation, and intimidation to exert power over their partners. This article often refers to the battering of women, since 90% to 95% of domestic violence victims are women.<sup>2</sup> Domestic violence also can occur against men and in homosexual as well as heterosexual relationships.<sup>3,4</sup>

Approximately 4 million women are believed to be battered every year by their partners.<sup>5</sup> At least one fifth of all women will be physically assaulted by a partner or ex-partner during their lifetimes.<sup>6</sup> Domestic violence is believed to be the most common cause of serious injury to women<sup>7</sup> and accounts for more than 40% of female homicide cases.<sup>8,9</sup>

The American Medical Association<sup>1,10</sup> and three surgeons general<sup>11,12</sup> have encouraged health care providers to recognize, treat, and prevent this "silent epidemic" of family violence. The prevalence of domestic violence among patients in ambulatory care settings has been estimated to be between 20% and 30%.<sup>1-15</sup> Yet domestic violence remains vastly underdetected. Although battered women seek medical care frequently,<sup>13,15</sup> as few as one in 20 are correctly identified by the practitioners to whom they turn for help<sup>5,14,16</sup> Barriers to proper identification and intervention have recently been elucidated<sup>17,18</sup> and include practitioners' lack of knowledge and training.<sup>19</sup>

With the increasing awareness of domestic violence, attention has turned to how health care practitioners can best respond. Practitioners need to routinely inquire about domestic violence, provide sensitive and nonpunitive support, address patient safety, document the abuse, provide information about options and resources, and offer referrals.<sup>19</sup> What is less clear is what role, if any, clinicians should play in bringing cases of domestic violence to the attention of state authorities. California's recent legislation making explicit the duty to report in domestic violence cases has spawned further

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From San Francisco Neighborhood Legal Assistance Foundation' (Ms Hyman); the Department of Internal Medicine, San Francisco General Hospital (Dr Schillinger); and the Division of General Internal Medicine (Drs Schillinger and Lo), Program in Medical Ethics, the Robert Wood Johnson Clinical Scholars Program, and the Center for AIDS Prevention Studies (Dr Lo), University of California, San Francisco.  
Reprint requests to University of California, San Francisco, Room C 126, 521 Parnassus Ave, San Francisco, CA 94143-0903 (Dr Lo).

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debate around mandatory reporting.<sup>12-21</sup> The increased awareness of domestic violence may also lead to the reexamination of existing statutes mandating reports of injuries due to weapons and crimes-laws that also apply to domestic violence cases.

Mandatory reporting may fail to protect survivors of domestic violence and creates ethical dilemmas for clinicians when patients do not want their case reported. After briefly describing the various state reporting laws, this article analyzes how mandatory reporting of domestic violence may be detrimental to patients who are living with ongoing abuse and violence. We make recommendations for ensuring that future policies safeguard the well-being and autonomy of survivors of domestic violence and suggest how providers can minimize harms to the abused patient under current laws.

## **MANDATORY REPORTING LAWS AFFECTING DOMESTIC VIOLENCE**

As of March 1994, all but five states<sup>1</sup> have laws that, to varying extents, may require health practitioners to report cases of domestic violence (Table 1). Most states have general laws mandating providers to report injuries involving a weapon or criminal act. The presumed purpose of these laws is to detect crime.<sup>1,22</sup> With the growing recognition of domestic violence as a crime, these laws may be increasingly applied to domestic violence cases. A few states have adult abuse reporting laws that may be modeled after child and elder abuse reporting and derive from goals of victim protection.<sup>1,23</sup> Another purpose of reporting is data collection on domestic violence.<sup>24</sup> (We do not discuss reporting laws applicable in health facilities in the military, Department of Veterans Affairs, Native American reservations, or the territories. Also not included are laws requiring reporting of burns, poisoning, and suffocation, acts that may be common in domestic violence cases, and statutes relating only to elder or vulnerable adult abuse reporting.)

### **What Is to Be Reported?**

Almost all states mandate reporting when the patient has an injury that appears to have been caused by a gun, knife, or other deadly weapon.<sup>25</sup> States may also require reporting of injuries resulting from crimes,<sup>26</sup> acts of violence<sup>27</sup>

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Health Law and Ethics section editors: Lawrence O. Gostin, JD, the Georgetown/ Johns Hopkins Program on Law and Public Health, Washington, DC, and Baltimore, Md; Helene M. Cole, MD, Contributing Editor, *JAMA*.

**Table 1.-State Reporting Statutes**

<b><u>State</u></b>	<b><u>Statute Citation</u></b>
Alabama	No statute found
Alaska	Alaska Stat §§08.64.369-.370 (Supp 1993)
Arizona	Arz Rev Stat Ann §13-3806 (1989)
Arkansas	Ark Code Ann §§12-12-601 to 603 (Michie 1987)
California	Calif Penal Code §§11160-11163.2 (West Supp 1995)
Colorado	Colo Rev Stat Ann §12-36-135 (West 1991)
Connecticut	1993 Conn Acts 269 (Reg Sess)
Delaware	Del Code Ann tit 24, §1762 (1987)
District of Columbia	DC Code Ann §§2-1361 to 1363 (1994)
Florida	Fla Stat Ann §790.24 (West 1992)
Georgia	Ga Code Ann §31-7-9 (Harrison 1991)
Hawaii	Hawaii Rev Stat §453-14 (1985)
Idaho	Idaho Code §39-1390 (1993)
Illinois	Ill Ann Stat ch 20, 2630/3.2 (Smith-Hurd 1993)
Indiana	Ind Code Ann §§35-47-7-1 to 2 (West 1986)
Iowa	Iowa Code Ann §147.11 (West Supp 1994)
Kansas	Kan Stat Ann §21-4213 (1988)
Kentucky	Ky Rev Stat Ann §209.010-.990 (Michie/Bobbs-Merrill 1991)
Louisiana	No statute found
Maine	Me Rev Stat Ann tit 17-A, §512 (West 1983)
Maryland	Md Ann Code art 27, §§336-336A (1992)
Massachusetts	Mass Gen Laws Ann ch 112, §12A (West Supp 1994)
Michigan	Mich Comp Laws Ann §750.411 (West 1991)
Minnesota	Minn Stat Ann §§626.52-55 (West Supp 1994)
Mississippi	Miss Code Ann §45-9-31 (1972) [weapon Miss Code Ann §§93-21-1 to 25 (Supp 1993) (abuse-voluntary)
Missouri	Mo Ann Stat §§578-350-353 (Vernon Supp 1994)
Montana	Mont Code Ann §§37-2-302 to 303 (1993)
Nebraska	Neb Rev Stat §28-902 (1989)
Nevada	Nev Rev Stat Ann §§629.031-.041 (Michie 1992 & Supp 1993)
New Hampshire	NH Rev Stat Ann §631:6 (Supp 1993)
New Jersey	NJ Stat Ann §2C:58-8 (West Supp 1994)
New Mexico	NM Stat Ann §§27-7-14 to 31 (Michie 1992)
New York	NY Penal Law §265.25 (McKinney 1989)
North Carolina	NC Gen Stat §90-21.20 (1993)
North Dakota	ND Cent Code §43-17-41 (1993)
Ohio	Ohio Rev Code Ann §2921.22 (Anderson 1993)
Oklahoma	Okla Stat Ann tit 21, §§846.1-848 (West Supp 1994)
Oregon	Ore Rev Stat §§146.710-780 (1990 & Supp 1994)
Pennsylvania	18 PA Cons Stat Ann §5106 (1983) (weapon, crime) 23 Pa Cons Stat Ann §§6102, 6115 (1991) (abuse-voluntary)

Rhode Island	RI Gen Laws §11-47-48 (1981) [weapon] RI Gen Laws §12-29-9 (Supp 1993) (domestic violence)
South Carolina	No statute found
South Dakota	SD Codified Laws Ann §§23-13-10 to 14 (1988)
Tennessee	Tenn Code Ann §§38-1-101 to 103,(1991)
Texas	Tex Health and Safety Code Ann §§161.041-.042 (west 1992)
Utah	Utah Code Ann §§26-23a-1 to 3 (1989)
Vermont	Vt Stat Ann tit 13, §4012 (1974)
Virginia	Va Code Ann §54.1-2967 (Michie 1991)
Washington	No statute found
West Virginia	WVa Code Ann §61-2-27 (1992)
Wisconsin	Wis Stat Ann §146.995 (West Supp 1993)
Wyoming	No statute found

or nonaccidental acts.<sup>28</sup> Specific provisions vary from state to state, for instance, regarding the type of weapon or crime or the seriousness of the injury that mandates reporting. Laws often do not define key terms, such as what constitutes "violence," "weapon," or "grave injury." Because of state-by-state variation, practitioners should obtain a copy of their state reporting statute and can use Table 2 to guide them through its provisions.

Five states have mandatory reporting laws specifically addressing reporting where domestic violence or abuse is suspected. In California, practitioners must report to the police if they provide medical services to a patient who may be suffering from a physical injury caused by "assaultive or abusive conduct." In Kentucky, any person having reasonable cause to suspect an adult has suffered abuse, neglect, or exploitation must report it to the Cabinet for Human resources. The Cabinet must notify police investigate the complaint, and provide services where necessary, except if the adult refuses them. In New Mexico, any person having reasonable cause to believe an adult is being abused, neglected or exploited must report it. New Hampshire requires reporting of injuries believed to be caused by a criminal act, except if the injured person was a victim of abuse or sexual assault, is older than 18 years, objects to reporting, and is not being treated for a gunshot wound or other serious bodily injury. Rhode Island requires reports of domestic violence without any identifying information, for data collection purposes only.

In addition to their weapon or crime-reporting requirements, Mississippi and Pennsylvania permit any person to report abuse to the state department of public welfare or police, respectively.<sup>29</sup>

## **Who Makes the Report?**

States may require reporting by whomever is treating the injury in question,<sup>30</sup> by particular health care workers,<sup>31</sup> or by the institution, facility, or person in charge.<sup>32</sup> Some statutes require “any person” to report.<sup>33</sup> Their applicability to health providers depends on whether such laws override the state’s provider-patient privilege laws.

## **What Level of Knowledge or Suspicion Is Required of the Reporter?**

Jurisdictions differ regarding the degree of knowledge or suspicion that triggers the obligation to report. Some set forth an objective standard, requiring reports only if the practitioner has “reasonable” cause to suspect the injury was inflicted in violation of a crime<sup>34</sup> Others specify a subjective standard: providers must report only if in their opinion a criminal act was involved.<sup>35</sup> No statute requires that the patient acknowledge that the injury was caused by a weapon, crime, act of violence, or abuse.

## **Who Receives the Report and What is Their Response?**

With three exceptions,<sup>36</sup> reports are made to a criminal justice agency. Very few reporting provisions specify what is to be done with reports.<sup>37</sup> Responses to reports will vary depending on state law and local policy and practice.

## **Are There Penalties for Failing to Report?**

Most states impose penalties for failure to report. Penalties can consist of fines of as little as \$10<sup>38</sup> or as much as \$1000<sup>39</sup> and may sometimes include a jail sentence.<sup>40</sup>

## **Is Immunity From Liability Provided?**

Most states provide practitioners with immunity from civil and/or criminal liability when making reports in good faith.

## **Table 2 – Questions to Ask When Evaluating Reporting Statute**

What is the purpose of the reporting statute?  
What is to be reported?  
Who makes the report?  
What level of knowledge or suspicion is required of the reporter?  
Who receives the report and what is their response?  
Are there penalties for failing to report?  
Is immunity from liability provided?  
Are there provisions for confidentiality of reports?  
Are provider-patient privileges explicitly revoked?  
Is there case law interpreting provider liability?

### **Are There Provisions for Confidentiality of Reports?**

A few laws require reporters or report recipients not to release reports except in limited circumstances,<sup>41</sup> potentially enhancing confidentiality.

### **Are Provider-Patient Privileges Explicitly Revoked?**

Various statutes claim or have been interpreted by case law to suggest that provider-patient testimonial privileges or confidential communication provisions do not apply to the information required to be reported.<sup>42,44</sup>

### **Is There Case Law Interpreting Provider Liability?**

Health care providers may have obligations under common law and under statutes. We have not found any state appellate court cases in which a physician or hospital was prosecuted or sued for failure to report domestic violence. There is precedent, however, for holding providers liable for failure to diagnose and report child abuse, both under the state's reporting statute and under theories of negligence.<sup>45</sup> Case law in several jurisdictions also suggests that providers could be held liable for breaching confidentiality or privacy by reporting where not required by law.<sup>46</sup>

### **Implications of mandatory reporting of domestic violence**

Mandatory reporting of domestic violence can arguably serve a number of goals, such as enhancing patient safety and well-being, improving the response of the health care system to domestic violence, holding perpetrators accountable, and improving data collection and documentation on domestic violence. However, providers need to appreciate why mandatory reporting may not achieve these goals, and may in fact harm battered women.

### **Risk of Retaliation**

Mandatory reporting may put battered patients at risk of retaliation by the perpetrators. Batterers often escalate the violence if their partners increase help-seeking measures or attempt separation.<sup>47,49</sup> As many as half of batterers threaten retaliatory violence, and more than 30% may inflict further assaults during prosecution.<sup>49</sup> While mandating reports may relieve some patients of the onus of reporting the batterer, other patients may still be blamed by the perpetrator for revealing the abuse to their provider.

## **Deterrent to Seeking Care**

Many battered women believe that calling the police is not a safe or preferred response to their situation.<sup>50</sup> If they fear that reporting will place them and their children in greater danger and will be carried out despite their objections, battered women will, likely refrain from telling their providers of the abuse or from seeking care at all (Michael A. Rodriguez, MD, MPH, Pacific Center for Violence Prevention, San Francisco General Hospital, University of California, San Francisco, unpublished data, June 1994)<sup>51</sup> Some perpetrators may also prohibit access to health care once it is suspected that reports are being made.

## **May Not Improve the Care of Battered Patients**

Can a mandatory reporting law lead providers to identify more cases and improve care to battered patients? A US General Accounting Office survey<sup>52</sup> of protective services agencies suggests mandatory reporting of elder abuse detects significantly fewer cases than education about elder abuse. Similarly, provider education about domestic violence is likely a more effective means of increasing detection.

Even if cases are identified, mandatory reporting alone does little to ensure that practitioners will provide appropriate care to battered patients. Reporting without first educating providers in how to handle these cases skillfully can result in increased danger to patients. Furthermore, clinicians who rationalize that if they report, the problem will be taken care of may abdicate responsibility for ongoing care. Those providers who view reporting as detrimental may choose not to inquire about domestic violence, thereby also depriving patients of potentially beneficial care.

## **Limited Response to Reports of Abuse**

Reports by health practitioners could be used by the police and district attorneys to apprehend and prosecute perpetrators of violence. This may send a strong social message that domestic violence is a crime that will not be tolerated. However, if there is no effective response to reports of domestic violence, a mandatory reporting law may create expectations of services and protection that cannot be met,<sup>53</sup> decrease patient trust in the provider and the system, diminish patient safety, and undermine goals of punishment and deterrence.

In a national survey of 843 domestic violence organizations, 86% of respondents indicated police respond very ineffectively when restraining order violations are reported, 71% stated that prosecutors refuse to prosecute violations except in very limited circumstances, and 42% reported that violators have never been sent to jail by judges in their county.<sup>54</sup> Studies in San Francisco and New York City revealed that in 1991, only 25% to 30% of domestic violence calls to the police resulted in written reports required by law, and only 7% to 12% resulted in arrests (Victim Services, New York, (212) 577-7700, unpublished data, 1991)<sup>55</sup> Police nationwide are more likely to respond quicker, make a report, and search the scene for evidence when the offender is a stranger than when the offender is an intimate.<sup>2</sup> Even if there is successful prosecution, battered women are at higher risk of re-assault after criminal justice intervention than are other victims of violent crime.<sup>49</sup>

Some suggest that reporting to a state protective services agency may be more effective than reporting to police. However, with some exceptions,<sup>56</sup> these agencies are often overburdened and underfunded,<sup>57</sup> may lack domestic violence expertise, and may enact policies that fail to protect battered women and to enable them to protect their children.<sup>48;51</sup>

Even if reports lead to appropriate referrals, patient needs may not be met, because domestic violence community services are often unavailable or underfunded. In San Francisco, four of five battered women are turned away from shelters due to lack of space (San Francisco Commission on the Status of Women, (415) 252-2570, unpublished data, 1993 and 1994). Low-cost legal services for battered women across the country are sparse.<sup>54</sup> Battered women of color, of low income, and/or immigrants face the greatest difficulties accessing courts and social and legal services.<sup>54,58</sup> Resources for gay and lesbian survivors are severely lacking.<sup>3,4</sup>

### **Inaccurate Data Collection**

Epidemiologic data on domestic violence are essential. However, data collected through mandatory reporting may be inaccurate because of confusion about what must be reported, uneven compliance with laws, and false reporting.<sup>44</sup> Compliance with reporting laws may be low due to unawareness of laws, failure of providers to consider domestic violence, minimization or acceptance of domestic violence, belief that mandatory reporting represents an untenable intrusion into another's life, and concern that report recipients may not adequately respond.<sup>59</sup> Connecticut allowed its statute mandating reports in domestic violence cases for data collection purposes to lapse, because the data gathered were inaccurate and underestimated the prevalence of domestic violence (oral communication, Anne Menard, former executive director of the Connecticut Coalition Against Domestic Violence, May 1994).

### **Bias in Reporting**

An analysis of child abuse reporting revealed that a greater percentage of black and Hispanic families identified as abusive was reported, compared with identified white families.<sup>60</sup> Families with the lowest incomes had the highest rate of being reported. Mandatory reporting of domestic violence may similarly result in disproportionate reporting of low income and minority patients and the perpetuation of harmful stereotypes.

### **Documentation**

One potential goal of reporting may be to document the domestic violence for use in criminal and civil court cases. However, documentation in the medical record of the abuse serves this goal, while better preserving confidentiality and privacy. Such documentation also is an essential part of the patient's ongoing care.

## **ETHICAL ISSUES**

Health care providers may experience conflicts between a mandate to report cases of domestic violence, their judgment of what is in the best interests of the patient, and the patient's desire not to report the abuse. Practitioners may be caught between their obligations to society and their duties to the patient. In analyzing these dilemmas, clinicians need to keep in mind the basic ethical principles of nonmaleficence, beneficence, autonomy, and confidentiality.

## **Acting in the Best Interests of Patients**

The guideline of nonmaleficence urges practitioners to avoid causing harm and to prevent serious harm.<sup>61</sup> The related guidelines of beneficence requires practitioners to act for the benefit of patients. These guidelines provide the ethical justification for providers to intervene in domestic violence.<sup>19</sup> Providers can take steps to prevent further harm to survivors by validating the experience of the abuse, discussing options with the patient, making referrals to appropriate domestic violence agencies, and providing ongoing care.

Reporting domestic violence may, in some cases, lead to punishment of abusers and prevent further violence to the patient and others. Reporting may also serve a larger social good since the law considers domestic violence a crime against society as well as against the victim. In many cases, however, reporting may not be in the best interests of the patient. Retaliation and increased violence often occur. Battered women may not receive adequate protection. Some women may have already found that calling the police does not stop the violence and in fact may cause it to escalate. If the patient herself does not want state involvement, it is ethically troubling to override her objections on the grounds that it is in her best interests.

## **Autonomy**

According to the ethical guideline of respecting patient autonomy, competent, informed adults have the right to act in accordance with their values, goals, and life plan. Some survivors may not want domestic violence reported, believing that it will be ineffective or even counterproductive. Such refusals do not imply that the patient's decision making is impaired. The vast majority of battered women make rational decisions that others would also make, given similar circumstances.<sup>62</sup>

Paternalism has been rejected in other clinical settings when nonmaleficence and beneficence conflict with autonomy.<sup>63</sup> It is now accepted that competent, informed patients should retain the power to decide what is in their best interests. Participating in decisions increases patients' sense of control, self-determination, and adherence to care plans. In the case of domestic violence, while the clinician has a duty to counsel and refer to appropriate agencies, the patient should decide whether to accept the intervention. Although tempting, practitioners should avoid the pitfall of "rescuing" their patients. Rather, practitioners should respect a woman's assessment of when it is safe to change her life situation.<sup>5</sup> Battered women need to reclaim their own sense of control, and it is the clinician's role to facilitate this process. Thus, paternalistic requirements to report domestic violence may be particularly detrimental for survivors. They perpetuate harmful stereotypes of battered women as passive and helpless, interfere with self-determination, and may revictimize battered women, by controlling decisions in their lives.

## **Confidentiality**

Confidentiality of medical information encourages people to seek medical care and discuss sensitive issues with providers, fosters trust in the physician-patient relationship, prevents harmful consequences to patients, and respects their privacy.<sup>61</sup> Battered women often consider trust to be an essential aspect of their relationship with health care providers (Michael A. Rodriguez, MD, MPH, Pacific Center for Violence Prevention, San Francisco General Hospital, University of California, San Francisco, unpublished data, June 1994). Breaches of confidentiality undermine trust and deter patients from confiding in their

providers. Erosions of privacy may harm patients in more tangible ways. For example, some insurers have refused coverage or terminated policies of battered women.<sup>64</sup>

Exceptions to confidentiality are justified to prevent serious harm to third parties, such as those at risk for infectious diseases and to identify and protect persons who are incapable of seeking assistance on their own, such as abused children." Such exceptions are warranted only if the benefits of the intervention are substantial and if harms resulting from the breach are minimized and acceptable. In the case of domestic violence, however, the harm to third parties is unclear, battered women have intact decision-making capacity, and interventions are often ineffective.

In thinking about reporting cases of domestic violence, clinicians commonly consider similar situations, such as reporting of child abuse and elder abuse. Practitioners need to understand how these situations differ in ethically significant ways from domestic violence.

### **Child Abuse Reporting**

Reporting of child abuse has been justified on the grounds of nonmaleficence and beneficence because children are unable to make informed decisions. State intervention in this context is based on the doctrine of *parens patriae*, which grants the state the role of guardian over incompetent persons. The state accordingly takes steps to promote the child's safety by counseling the parents, providing supportive services, or removing the child from custody. Critics of mandatory child abuse reporting, however, question whether underfunded social welfare agencies are in fact able to benefit the child and the family and whether they may do more harm than good by raising false hopes.<sup>65</sup>

The analogy between child abuse and domestic violence is flawed. Although paternalism seems appropriate with children, adult survivors of domestic violence cannot be presumed to be incapable of making informed decisions about their lives.

### **Elder Abuse Reporting**

Reporting abused or neglected elders who are incapable of seeking assistance has been justified by the guidelines of nonmaleficence and beneficence. Many laws that mandate reporting of elder abuse are part of broad statutes concerning abuse of incapacitated or disabled adults and are modeled after child abuse statutes.<sup>66</sup> The hope is that reporting and intervention can provide resources that will allow the elderly person to continue to live safely at home. Elderly persons who are truly capable of making informed decisions, free of intimidation or coercion, are usually free to decline offered assistance.<sup>61,67</sup>

Many criticisms of elder abuse reporting laws may also apply to mandatory reporting of domestic violence. Critics argue that elder abuse reporting laws wrongly presume that the elderly, solely on the basis of their advanced age, are incapable of determining when they need assistance. The breach of confidentiality resulting from mandatory reporting of elder abuse may strain the physician-patient relationship and discourage older persons from seeking medical assistance because they fear institutionalization.<sup>53,57</sup> Furthermore, because adult protective services are often underfunded, reporting may not result in supportive services that might allow the abused elders to safely remain at home.

## **POLICY DIRECTIONS**

Battered women may require particular advocacy and protection because of such factors as ongoing contact with the batterer, economic dependence on the perpetrator, and a high risk of retaliatory violence.<sup>49</sup> We should strive for improved services by police, courts, protective services agencies, and the health care system and better coordination among all settings to which battered women may turn. However, the woman's decisions must be respected regarding which interventions are indicated. The role of the health care system should not be to invoke state intervention but to provide appropriate care within the health care setting, promote self-determination, and assist patients in choosing among available courses of action.

Health care providers should participate in ongoing public policy debates regarding mandatory reporting of domestic violence and challenge legislation that jeopardizes the well-being of their patients. Policy decisions should be informed by the views and experiences of battered women and their advocates.

Numerous issues need to be discussed. Although mandatory reporting in all cases of domestic violence is problematic, are some cases—such as those involving firearms—more appropriate for reporting because they may be indicators of particular danger? Or is it precisely in the most dangerous cases that a woman's autonomy must be respected to best ensure her safety? Practitioners in states with weapon or crime reporting laws need to appreciate that exempting battered women from such laws may enhance their safety and autonomy but may also diminish the significance of domestic violence by treating it differently from other crimes.<sup>68</sup>

Policy alternatives to mandatory reporting need to be considered. Health care facilities might be mandated to establish domestic violence procedures regarding screening, safety assessment, documentation, and referrals and encouraged to place posters and pamphlets in waiting and examining rooms. Compliance with existing requirements, such as those of the Joint Commission on Accreditation of Healthcare Organizations,<sup>69</sup> might be more strictly enforced. In addition, providers and facilities might be required to offer identified battered patients referrals to supportive services and the option of reporting the case to the police. However, reporting would be contingent on the patient's consent, thereby respecting her autonomy and judgments about safety and reducing the risk that she will avoid seeking care.

The mandatory reporting debate should not distract us from the need for education to be the centerpiece of efforts to combat domestic violence. A domestic violence curriculum should be a standard component of the undergraduate, graduate, and continuing education programs of all health care professionals. Health care institutions need to develop effective staff education programs on domestic violence. The systems implemented should be culturally sensitive and accessible to diverse populations. Policies mandating domestic violence education or linking it to licensure or funding eligibility may be beneficial.<sup>70</sup>

## **MINIMIZING HARM UNDER CURRENT REPORTING LAWS**

Practitioners must not let their misgivings about a reporting requirement prevent them from routinely inquiring about domestic violence in their daily work and providing appropriate care to patients. Clinicians should acknowledge the abuse, reassure the patient she is not at fault, counsel her that the violence may escalate, help assess her safety and available options, clearly document the abuse, offer her referrals to shelter, legal services and counseling, and facilitate such referrals with her consent.

Health care institutions need to provide ongoing support and encouragement to practitioners in meeting the needs of battered women. Important steps include establishing an administrative commitment to improve domestic violence services, forming a multidisciplinary working group, developing site-specific intervention strategies, compiling a referral network of domestic violence programs, instituting training, and evaluating progress.<sup>71</sup> Excellent models exist of collaboration between health care facilities and community domestic violence programs to provide advocacy and intervention within the health care setting. (Information on model programs, compiled by Daniel J. Sheridan, MSRN, board member, Nursing Network on Violence Against Women International, is available through the Family Violence Prevention Fund's Health Resource Center on Domestic Violence by calling (800) 313-1310.)

When considering making a report, clinicians should ensure that the patient feels respected, cared for, listened to, and encouraged to make her own choices to the extent allowable within the law. Practitioners should learn how local authorities respond to reports. They should discuss with the patient their legal obligations to report, explain follow-up procedures that may ensue, and address the risk of reprisal and possible need for shelter or protective orders.<sup>19</sup> The patient's needs and safety concerns should be communicated to the agency that receives the report. If the patient wants immediate help, the provider should advocate for priority assistance. If the patient believes police intervention will jeopardize her safety, the provider should work with the patient and report recipient on how best to meet the patient's safety needs. The provider should strive to maximize the role of the patient's input regarding future action. Clinicians and health care institutions must recognize that their role in the care of the abused patient goes beyond simply obeying reporting laws; they need to provide appropriate ongoing care and try to mitigate the potential harms resulting from those laws.

## CONCLUSION

There are laws in 45 states and the District of Columbia mandating reports of injuries due to weapons, crimes, violence, intentional acts, or abuse. These laws may require, to different extents, reporting in cases of domestic violence. Mandating a coercive intervention that may fail to offer adequate protection may further jeopardize the patients we are trying to help. Mandatory reporting may threaten the safety of battered women, discourage them from seeking care, fail to improve the health care of battered patients, lead to inadequate responses to reports of abuse, result in biased case identification, and violate patient autonomy and confidentiality. Health care workers and the facilities in which they practice should strive to implement policies that promote the well-being and autonomy of survivors of domestic violence and minimize the harms of existing mandatory reporting laws.

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#### References

1. Flitcraft AH, Hadley SM, Hendricks-Matthews MK, McLer SV, Warshaw C. *Diagnostic and Treatment Guidelines on Domestic Violence*. Chicago, Ill: American Medical Association; 1992.
2. Bureau of Justice Statistics. *Violence Between Intimates*. Washington, DC: Bureau of Justice Statistics, US Dept of Justice; November 1994. Publication NCJ-149259.
3. Renzetti CM. Violence in lesbian relationships: a preliminary analysis of causal factors. *J Interpersonal Violence*. 1988;3:381-399.
4. Letellier P. Identifying and treating battered gay men. *San Francisco Med*. 1994;67:16-19.
5. Sassetti MR. Domestic violence. *Prim Care*. 1993;20:289-305.
6. Straus M, Gelles R, Steinmetz SK. *Behind Closed Doors: A Survey of Family Violence in America*. New York, NY: Doubleday & Co Inc; 1980.
7. Stark E, Flitcraft A. Violence among intimates: an epidemiological review. In: Van Hasselt VB, Morrison RL, Bellack AS, Hersen M, eds. *Handbook of Family Violence*. New York, NY: Plenum Press; 1988:293-318.
8. Center for the Study and Prevention of Violence, Institute for Behavioral Science, University of Colorado, Boulder, based on data from Federal Bureau of Investigation. *Uniform Crime Reports*. Washington, DC: US Dept of Justice; 1982, 1988-1991.
9. Family Violence Prevention Fund. *A Study of Family and Domestic Violence Homicide Cases in San Francisco*. San Francisco, Calif: San Francisco Commission on the Status of Women, Family Violence Prevention Fund; October 1993.
10. Council on Scientific Affairs, American Medical Association. Violence against women: relevance for medical practitioners. *JAMA* 1992;267:3184-3189.
11. Novello AC. A medical response to domestic violence. *JAMA*. 1992;267:3132.
12. American Medical Association. *Health and Justice: Conference Proceedings*. National Conference on Family Violence; March 11-13, 1994; Washington, DC.
13. Gin NE, Rucker L, Frayne S, Cygan R, Hubbell FA. Prevalence of domestic violence among patients in three ambulatory care internal medicine clinics. *J Gen Intern Med*. 1991;6:317-322.
14. Hamberger LK, Saunders DG, Hovey M. Prevalence of domestic violence in community practice and rate of physician inquiry. *Fam Med*. 1992;24:283-287.
15. Helton AS, McFarlane J, Anderson ET. Battered and pregnant: a prevalence study. *Am J Public Health*. 1987;77:1337-1339.
16. McLer SV, Anwar R. A study of battered women presenting in an emergency department. *Am J Public Health*. 1989;79:65-66.
17. Sugg NK, Inui T. Primary care physician response to domestic violence: opening Pandora's box. *JAMA*. 1992;267:3157-3160.
18. Jecker NS. Privacy beliefs and the violent family. *JAMA*. 1993;269:776-780.
19. Council on Ethical and Judicial Affairs, American Medical Association. Physicians and domestic violence: ethical considerations. *JAMA*. 1992;267:3190-3193.
20. Family Violence Prevention Fund. *National Health Initiative on Domestic Violence National Advisory/Experts Committee Meeting Notes*. San Francisco, Calif: Family Violence Prevention Fund; January 1994.
21. Alabama, Louisiana, South Carolina, Washington, Wyoming.
22. Eg, Arkansas, Kansas.
23. Eg, Kentucky, New Mexico.
24. Eg, RI Gen Laws §12-29-9 (Supp 1993); Conn Gen Stat §46b-38c (Repealed 1991).
25. Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, West Virginia, Wisconsin.
26. Arizona, California, Colorado, District of Columbia, Idaho, Illinois, Iowa, Massachusetts, Minnesota, Nebraska, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Utah, West Virginia, Wisconsin.
27. Florida, Hawaii, Michigan, Nebraska, North Carolina, Ohio, Tennessee.
28. Alaska, Arkansas, Colorado, Georgia, Hawaii, Idaho, Nevada, Oregon.
29. Miss Code Ann §93-21-1 to 25 (Supp 1993); 23 Pa Cons Stat Ann §6102, 6115 (1991).
30. Eg, Kansas, New Hampshire, South Dakota.
31. Eg, Alaska, Colorado, Missouri, Oregon.
32. Eg, Connecticut, Massachusetts, Minnesota, Tennessee.
33. Kentucky, New Mexico.
34. Eg, North Dakota.
35. Eg, Massachusetts, New Hampshire.
36. Kentucky, New Mexico, Rhode Island Gen Laws §12-29-38.
37. Iowa, Kentucky, New Mexico, Rhode Island Gen Laws §12-29-9. See also Oregon.
38. Eg, Arkansas.
39. Eg, California.
40. Eg, California, Kentucky, Texas.
41. Eg, California, Kentucky, Oregon.
42. Eg, California, Iowa, Kentucky, Missouri, Nebraska, Oklahoma, Pennsylvania, South Dakota.
43. Karnezis KC. Physician-patient privilege as applied to physician's testimony concerning wound required to be reported to public authority. 85 *ALR3d* 1196 (1978 & Supp 1994).
44. Smith SR. Medical and psychotherapy privileges and confidentiality: on giving with one hand and removing with the other. *Ky Law J*. 1986-1987;75:473-557.
45. Eg, *Landeros v Flood*, 551 P2d 389 (Calif 1976).
46. Newman S. Privacy in personal medical information: a diagnosis. *Univ Fla Law Rev*. 1981;33:394-424.
47. Bureau of Justice Statistics. *Report to the Nation on Crime and Justice: The Data*. Washington, DC: Bureau of Justice Statistics, US Dept of Justice; October 1983. Publication NCJ-87068.
48. Hart BJ. State codes on domestic violence: analysis, commentary, and recommendations. *Juv Fam Court J*. 1992;43:79.
49. Hart BJ. Battered women and the criminal justice system. *Am Behav Scientist*. 1993;36:624-638.
50. Bowker LH. *Beating Wife-Beating*. Lexington, Mass: Lexington Books; 1983.
51. Schechter S, Mihaly LK. *Ending Violence Against Women and Children in Massachusetts Families: Critical Steps for the Next Five Years*. Boston: Massachusetts Coalition of Battered Women Service Groups; November 1992.
52. US General Accounting Office. *Elder Abuse: Effectiveness of Reporting Laws and Other Factors*. Washington, DC: US General Accounting Office; 1991. Publication HRD-91-74.
53. Faulkner IR. Mandating the reporting of suspected cases of elder abuse: an inappropriate, ineffective, and ageist response to the abuse of older adults. *Fam Law Q*. 1982;16:69-91.
54. Kinports K, Fischer K. Orders of protection in domestic violence cases: an empirical assessment of the impact of the reform statutes. *Tex J Women Law*. 1993;2:163-276.
55. California Senate Office of Research. *For Your Insight: California's Response to Domestic Violence*. Sacramento: California Senate Office of Research; July 12, 1994.
56. A Report from Kentucky Attorney General Chris Gorman. *The Health Care Professional's Role in the Reporting of Spouse and Partner Abuse: Legal Responsibilities and Liabilities*. Frankfort: Office of the Attorney General of the State of Kentucky; September 1992.
57. Brewer RA, Jones JS. Reporting elder abuse: limitations of statutes. *Ann Emerg Med*. 1989;18:1217-1221.
58. Jang DL. Caught in a web: immigrant women and domestic violence. *Clearinghouse Rev*. 1994;28:397-405.
59. Rosenberg DA. *Prevention of Family Violence: The Role of Medicine*. Prepared for American Medical Association National Conference on Family Violence: Health and Justice; March 11-13, 1994; Washington, DC.
60. Hampton RL, Newberger EH. Child abuse incidence and reporting by hospitals: significance of severity, class, and race. In: Hotaling GT, Finkelhor D, Kirkpatrick JT, Straus MA, eds. *Coping With Family Violence*. Newbury Park, Calif: Sage Publications; 1988:212-221.
61. Lo B. *Resolving Ethical Dilemmas: A Guide for Clinicians*. Baltimore, Md: Williams & Wilkins; 1994.
62. McLer SV, Anwar R. The role of the emergency room physician in the prevention of domestic violence. *Ann Emerg Med*. 1987;16:1155-1161.
63. Beauchamp TL, Childress J. *Principles of Biomedical Ethics*. 3rd ed. New York, NY: Oxford University Press Inc; 1989.
64. Seelye K. Groups seek insurability for battered women. *New York Times*. May 12, 1994:A9.
65. Newberger EH. Child physical abuse. *Prim Care*. 1993;20:317-327.
66. Costa AJ. Elder abuse. *Prim Care*. 1993;20:375-389.
67. Lachs MS, Pillemer K. Current concepts: abuse and neglect of elderly persons. *N Engl J Med*. 1995;332:437-443.
68. Maguigan H. Battered women and self-defense: myths and misconceptions in current reform proposals. *Univ Penn Law Rev*. 1991;140:379-486.
69. Joint Commission on Accreditation of Healthcare Organizations. *Accreditation Manual for Hospitals*. Oakbrook Terrace, Ill: Joint Commission on Accreditation of Healthcare Organizations; 1992.
70. Eg, Calif Bus & Prof Code §§2089, 2091.2, 2191, 2196.5, 2736.1, 2811.5, 2914, 2915, 4980.41, 4996.2, and Calif Health & Safety Code §§1233.5, 1259.5 (West 1995).
71. Warshaw C. Establishing an appropriate response to domestic violence in your practice, institution, and community. In: Lee D, Durborow N, Salber P, Heisler C, eds. *Improving Health Care Response to Domestic Violence*. San Francisco, Calif: Family Violence Prevention Fund; 1994:73-101. Draft version prepared for California pilot test training.

# A DOMESTIC VIOLENCE WORKING TOOL FOR HEALTH CARE PROVIDERS

Susan M Hadley, M.P.H.; Consultant & Educator; WomanKind Founder; 15297 Edgewater Circle, Suite L101, Minneapolis, MN 55372  
 Business (952) 440-8508 E-mail: [smchadley@aol.com](mailto:smchadley@aol.com)

**Key Concept:** Health care intervention is early intervention. Early intervention may ultimately result in prevention; of more serious injuries and symptoms, prevention of emotional and mental health issues, and prevention of abuse, violence and neglect to children.

## A. CREATE CLIMATE

1. Establish safe and secure environment
  - Ensure confidentiality, informed consent, anonymity, and patient privacy and autonomy
  - Establish respectful boundaries and private patient's space
2. Display posters, buttons, brochures, videos and publications
3. Designate domestic violence specialist in medical office, clinic or hospital
4. Develop relationships with community domestic violence services

### Health Care Provider's Role

Provide immediate and ongoing health care services and support

- Presenting problem/ chief complaint
- Review Previous and current charts
- Professional observations of patient appearance, demeanor, behavior

1. Review relevant medical, sexual, social and medication history

2. Assure concern for health & welfare
  - a. Assess for current danger and potential escalating danger
  - b. Acknowledge and validate situation
  - c. Outline brief safety plan
  - d. Offer options and referrals

Time is critical - It is important to reach patient and deliver messages, while in she/he is the medical setting.

## B. SCREEN & ASSESS

1. Institute routine screening (JCAHO Std)

*"Because abuse and violence have become so common, I ask all my patients about this problem. "*

*"Are you now, have you ever been, in a relationship where someone has hurt you physically, emotionally, sexually?"*

*"Who do you have to talk with when you need support?"*

- Injury or Trauma

*"When I see injuries like these, it's usually because someone has been hit or hurt. Did this happen to you?"*

2. Inquire in sensitive, respectful and non judgmental manner
3. Always interview patient in private

**Key Concept:** Abuse is not a Communication issue. Abuse is a control issue. The victim is afraid of, and controlled by, the abuser and cannot, really should not, talk with abuser present."

4. Be alert for "red flags, subtle signs, hidden behaviors"

## Indicators for Identification

- a. "Look for a Pattern"
- b. Behaviors: verbal and non-verbal
- c. Injury and trauma
- d. Signs and symptoms
  - Look into physiological, behavioral psychological indicators
- e. Escalating danger
- f. Subtle signs
- g. Control in relationship
- h. Signs of an abuser

## Deliver messages

1. If patient is not ready to acknowledge abuse or violence, any fear, or to ask for help
  - create a safety plan
  - provide resource numbers
  - build support system of friends, providers, neighbors, acquaintances.

## Assure patient

*"If this ever happens to you or to someone you know, remember the medical Office, clinic or hospital is a safe, confidential place to talk about the home situation".*

## State clearly to patient

*"You do not deserve to be abused. You are not responsible for the abuse. You did not cause it. You did not provoke it. You cannot fix it. What happened is a crime; it's against the law. There is help available.*

**C. INTERVENE**

***Build Trust & Provide Support***

1. Listen actively, openly, with respect
2. Assure concern for pt health/welfare
  - Assess for potential danger
  - Develop a safety plan
  - Offer information, options, resources
3. Validate patient's experiences, feelings, fears; affirm strengths
4. Respect patient's process of change, timetable and decision.

- Develop realistic expectations of patient and the process of change.
- Redefine concept of "success".

**Key Concept**

Schedule follow-up appointment.

**Ask Immediate Questions**

1. Is it safe for you to go home?
2. Do you need immediate shelter?
3. Are your children safe?
4. Is there a friend, neighbor, family member, and acquaintance to call?
5. Do you need crisis counseling now?
6. Are you aware of (and have phone numbers for) community resources or the NDVH (1-888-799-SAFE)
7. Do you have safety plan if you need to leave quickly?

**Assess Lethality –**

Danger Assessment

Campbell JC, Adapted: Danger Assessment, Anna D. Wolf Endowed Professor, The Johns Hopkins University School of Nursing, '85, 1988.

1. Threatening behavior
2. Weapons available
3. Alcohol or drug abuse
  1. Partner is violent outside of home
  2. Partner has hurt the family pet
  3. Violence increased. frequency/severity
  4. Abuse during pregnancy

**Key Concept**

***"Battering during pregnancy may be an indication of what life holds in store for the unborn child."***

**The "Dual" Process of Change**

1. The process of change - external
  - a. Observable behavior(s)
  - b. Verbal, non-verbal communication
2. The process of change - internal
  - a. Rediscover a sense of self
  - b. Build hope and reduce isolation
  - c. Develop strength and direction
  - d. Acknowledge small steps
3. "Don't judge patient (or yourself) by patient's response to you"

> Patient will remember what you have said, acknowledge the abuse, talk about fear(s), and take steps, when has information, strength and support.

**Key Concept**

Progression through the stages of behavior change is not linear, it is cyclical. Relapse or setback is a natural, expected part of progression through stages of behavior change.

**D. DOCUMENT -**

Injury, Symptoms, Statements, Diagnostic Tests, Plans, Resources and Referrals

**Medical Record should include**

1. Pt. statements, medical/social history
2. Physical examinations
  - symptoms and clinical findings
  - description & location of injuries (body map)
  - direct quotes from patients
3. Diagnostic procedures (incl. lab, x-ray) and photographs (incl. consent form)
4. Professional observations, diagnostic impressions, and potential plans
5. Community contacts/resource referrals

**E. RESOURCES, COMMUNITY RELATIONSHIPS and REFERRALS**

1. Discuss short-term and long-term goals and options
2. Explore available resources, including shelter and community services, law enforcement, legal, social, behavioral, spiritual, job and career services.

**National Domestic Violence Hotline at 1-800-799-SAFE (7233) for national, regional and local resources or services for both health provider and patient.**

**For the Article on Building Bridges between Domestic Violence Advocates and Health Care Providers please click on the following link:**

**<http://www.vaw.umn.edu/documents/bridges/bridges.html>**