REVIEW

GURJIT KAUR, DO
Department of General Internal Medicine and Women's Health Center at The Gault Women's Health and Breast Pavilion, The Cleveland Clinic Foundation

LINDA HERBERT, LISW
Department of Social Work, The Cleveland Clinic Foundation

Recognizing and intervening in intimate partner violence

ABSTRACT

Intimate partner violence is as prevalent as many conditions for which we routinely screen. Yet intimate partner violence remains underdiagnosed and undertreated. Physicians and other health care workers are in a unique position to detect it and intervene. This article reviews what we can do, what we should do, and what we legally and ethically must do.

KEY POINTS

Intimate partner violence occurs in women of all racial, ethnic, and socioeconomic groups—not just in minority or poor women.

Two simple screening questions, *"Do you ever feel unsafe at home?"* and *"Has anyone at home hit you or tried to injure you in any way?"* have a sensitivity of 71% and specificity of almost 85% in detecting violence.

A battered woman may come across as a "difficult" patient with multiple vague complaints.

The risks of serious harm and murder increase when a victim decides to leave an abusive relationship.

Physicians should familiarize themselves with the laws in their own states governing mandatory reporting to police.

Hospitals and practices should establish policies for documentation in cases of suspected intimate partner violence.

PATIENT INFORMATION
Intimate partner violence, page 425

MANY CLINICIANS feel uncomfortable addressing the topic of intimate partner violence, perhaps due to a lack of training in medical school and residency, as well as a lack of continuing medical education opportunities.

However, there are several screening tools available that can help clinicians identify patients at risk, even during a short office visit.

The goals of this article are to discuss intimate partner violence in detail and to promote screening for this important public health problem.

DEFINITION

Intimate partner violence is defined as intentional behavior to obtain power and control over a partner in an intimate relationship. The abuse can be physical, sexual, or emotional, and it eventually creates progressive social isolation and economic control. Approximately 95% of victims are women, and 95% of perpetrators are men.[1]

PREVALENCE

The true prevalence of intimate partner violence is unknown, but it is quite common, with estimates of the number of women battered or abused every year in the United States ranging from 1.5 to 4 million.[2,3] Even if we accept a number near the low end of this range, this means that a woman is beaten every 15 seconds. Approximately one of every four women will be abused by a partner in her lifetime.[2]

It is believed that 3% to 4% of adult women are victims of severe violence.[1] And

Historical perspective

VIOLENCE has long-standing cultural and historical roots in our society.

English common law allowed husbands to physically chastise their wives for disciplinary purposes, as long as they did not use a stick bigger than their thumb (hence the expression "rule of thumb").[8] The Mississippi State Supreme Court reinforced this idea in *Bradley v State* (1824) by ruling that a husband could physically chastise his wife.[9] The court also made a point that domestic issues should stay within the home and not be subjected to outside intervention.

The marriage contract also subjugated the wife to her husband's authority in that she gave up her name, moved to her husband's home, and became his dependent.[10] The marriage vow required the wife to "love, honor, and obey" her husband, which led to her economic and legal dependency.

The end of the 19th century marked a major change in the legal rights of US women when legal restrictions were eliminated and the right of a husband to chastise his wife was abolished.[9] Interestingly, until the 1970s, abuse against a spouse was considered only a misdemeanor, but the same assault against a stranger was treated as a felony.[11]

in nearly two thirds of cases of rape, physical assault, or stalking of women, the perpetrator was someone the victim knew—a current or former husband, cohabitating partner, boyfriend, or date.[3]

No universal profile of battered women…

There is no universal profile of battered women. The key point to remember is that intimate partner violence occurs in women of all racial, ethnic, and socioeconomic groups—*not* just in minority or poor women.

Young women (ages 12 to 30 years) are believed to be at the highest risk, but women of any age can be victims.[4] Younger women may be more susceptible since they are more financially vulnerable and may be more likely to suffer from low self-esteem. Other risk factors may include single marital status (or recent separation or divorce), pregnancy, witnessing or experiencing childhood violence, low socioeconomic status, and substance abuse.[5,6]

…or of their abusive partners

One particular profile does not fit all batterers, either.

In general, batterers are more likely than nonbatterers to be unemployed or have a low income level,[5,7] but higher socioeconomic groups are not excluded. They are usually single, divorced, or separated and have a lower education level.[5,7] Many of these men witnessed violence during childhood and use violence to address their own problems.[7] (Violence has long-standing roots in our culture[8–11]—see Historical perspective on this page.) They may abuse drugs or alcohol (it is estimated that drugs, alcohol, or both are involved in half of all cases of intimate partner violence).[1] They also have high levels of insecurity, anger, hostility, and jealousy and may choose to batter for fear of abandonment.

One should be wary of abusers who may be intentionally charming but are really trying to gain the health care provider's trust in order to divert any suspicion from themselves. They may also come across as being overly affectionate and may answer questions for the victim.

Victims try to deny the abuse and rationalize it by blaming themselves

CYCLE OF VIOLENCE

Walker's "cycle of violence"[12] is useful in understanding the complexities of a violent relationship.

The tension-building phase is characterized by verbal abuse and hostility, leading to degradation of the victim's self-esteem. This phase may last hours to days.

The perpetrator may verbally attack the partner for not taking care of the family or for being flirtatious with other men. He may make derogatory comments about her intelligence, appearance, or decision-making. He may also try to isolate her by controlling her contact with family and friends and her access

TABLE 1

Health sequelae of intimate partner violence

Gynecologic
- Chronic pelvic pain
- Sexually transmitted diseases
- Vaginal bleeding
- Vaginitis
- Fibroids
- Dyspareunia
- Urinary tract infections

Central nervous system
- Headaches
- Back pain
- Paresthesias
- Fainting
- Seizures

Gastrointestinal
- Chronic abdominal pain
- Irritable bowel syndrome
- Bloating
- Eating disorders
- Loss of appetite

Psychological
- Post-traumatic stress disorder
- Depression
- Anxiety
- Suicidal ideation
- Insomnia
- Substance abuse

Cardiac
- Chest pain
- Palpitations

The abuser may appear calm and collected, unlike his 'crazy' wife

to money and transportation. Minor abuse such as slapping may occur, and tension continues to increase over time.

The woman tries to deny that any abuse is occurring and rationalizes the situation by blaming herself, thereby justifying the abuser's behavior. She may try to please the abuser to prevent further abuse, but the built-up tension eventually erupts into anger and battery occurs.

Acute battering, the second phase, involves explosive physical violence and property destruction that is worse than in the first stage. This is usually the shortest phase, lasting 2 to 24 hours. Sometimes the victim may intentionally provoke the abuser into becoming violent to release tension, knowing that the abuse will end at last, and they will progress to the next phase.

If the police intervene, it is usually during this phase, depending on the severity of the attack and the injuries. The victim may be quite angry and appear hysterical to law enforcement authorities, while the abuser may portray himself as calm and collected while explaining his wife's "crazed" phases. The victim generally does not seek medical attention unless her injuries are severe, wishing to prevent repercussions of revenge, which can lead to further abuse. She may also have loyalty issues with the abuser.

Honeymoon phase. With the release of tension, the third phase is characterized by remorse and kindness by the abuser towards the victim. This phase can last from 1 day to months. The abuser apologizes for his violent behavior and promises to never become violent again. He may shower the victim with gifts and try to convince her to stay in the relationship.

These thoughtful moments and promises strengthen the victim's resolve to forgive the abuser and believe that such violence will not recur. The victim earnestly hopes that the abuser will change, but in most cases, tension starts to build again and the cycle repeats itself.

HEALTH CONSEQUENCES

Most authorities agree that intimate partner violence causes both physical and mental health problems (TABLE 1). These long-term health consequences lead to poor health, decreased quality of life, and increased use of health services.

It is estimated that intimate partner violence leads to a 50% to 70% increase in gynecologic, central nervous system, and stress-related problems.[13] Gynecologic problems can include chronic pelvic pain, sexually transmitted diseases, vaginal bleeding, vaginitis, dyspareunia, fibroids, and urinary tract infections.[14,15] Central nervous system complaints can include headaches, back pain, paresthesias, fainting, or seizures.[15,16]

Intimate partner violence can also cause significant stress, leading to gastrointestinal,

cardiac, and psychological manifestations. Gastrointestinal symptoms can present as chronic abdominal pain, irritable bowel syndrome, bloating, eating disorders, or loss of appetite.[13,15,17] Cardiac symptoms can include chest pain and palpitations.[15]

Not surprisingly, intimate partner violence leads to an increased rate of mental and psychological sequelae. One study reported an incidence of major depression of 60% and of post-traumatic stress disorder of 40% in women who were abused.[18] Victims are also more susceptible to anxiety, suicidal ideation, insomnia, and substance abuse.

The Centers for Disease Control and Prevention reported that the health care costs of intimate partner rape, physical assault, and stalking exceed $5.8 billion each year, with $4.1 billion going towards medical and mental health care services.[19]

CLINICAL FINDINGS

The most common injuries from intimate partner violence include abrasions, minor lacerations, contusions, sprains, fractures, and gunshot or knife wounds to the head, face, neck, chest, breasts, and abdomen.[20,21] These injuries exhibit a central distribution and are usually covered by clothing. Often, multiple sites are involved. On examination, one may find bruises in different stages of healing.[22] The victim may claim to be "accident-prone" when asked about the cause of her injuries.

A battered woman may come across as a "difficult" patient with multiple vague complaints for which investigation has not yielded a diagnosis. Symptoms can include generalized malaise and fatigue; headaches; chronic abdominal, pelvic, back, or chest pain; sexual dysfunction; insomnia; palpitations; depression; anxiety; and irritable bowel.[20,21] Complex problems like these should raise the clinician's suspicion and prompt screening for intimate partner violence.

Other red flags to raise one's suspicion include the partner's insistence on remaining in the examination room, answering questions for the patient, or looking sternly at the patient before she answers anything, as if to remind her not to disclose any information that might incriminate him. The patient may also appear to be uncomfortable (fidgeting, clasping hands, clammy skin) and look towards her partner before answering questions or committing to anything that involves a return visit.

THE CASE FOR SCREENING

Intimate partner violence is at least as prevalent as breast cancer, thyroid dysfunction, hypertension, or colon cancer.[23] Primary care physicians spend a lot of time screening for these other medical conditions, but very few of them screen for violence issues.

As a result, intimate partner violence is underdiagnosed, being detected in only 1 in an estimated 20 battered women.[24] Hamberger et al[24] in 1992 reported that only 6 out of 364 women were even asked about abuse. But when asked about violence, most women are willing to discuss these issues with their physicians.[25]

Criteria for a good screening test

The US Public Health Service's "Put Prevention into Practice" campaign[26] determines the utility of a screening test by analyzing the following principles originally established by Frame and Carlson[27] in 1975.

We believe that intimate partner violence fulfills each of the criteria and merits screening.

- *The condition must be significant enough to affect the quality and quantity of life*. As we have noted, abuse is serious. When a woman is abused, she may sustain injuries that can lead to an untimely death. She is generally isolated from family and friends, leading to diminished self-esteem. Long-standing abuse can also affect multiple organ systems, thereby leading to long-term health consequences.
- *Treatment must be available and acceptable*. Most communities have resources to guide women to seek help from various shelters and organizations.
- *The condition must have an asymptomatic period during which early detection and treatment substantially reduces morbidity and mortality*. By routinely screening all women, clinicians are in a unique position to help prevent injury and death by being alert to abusive patterns

The victim may claim to be 'accident-prone' when asked about her injuries

and by coming up with ways to get help (see the patient information pages that follow this article.) Early detection of abuse can preserve a woman's self-esteem and help her remain safe. She can also be educated about what to do when she decides to leave and about things she will need to start over.

- *Treatment in the asymptomatic period must provide a result better than that of delaying treatment until symptoms appear*. Unfortunately, there are no hard data from randomized trials. Indeed, some may argue that screening and intervention may *increase* the victim's risk of serious injury or death, as these events are statistically more probable after the victim decides to leave, and screening may precipitate this chain of events.

However, we believe this argument may not apply. By detecting and intervening in intimate partner violence, we are trying to stop one human being from harming another. The question touches on ethics and the law as much as it does on science. Turning a blind eye is not acceptable.

- *Testing must be available at a reasonable cost to detect the condition during the asymptomatic period*. Most questionnaires are easily administered at a negligible cost.
- *The incidence of the condition must be significant enough to justify screening costs*. As noted, intimate partner violence is much more common than some of the other conditions that are routinely screened for.

Screening tools

Several tools with easy-to-remember acronyms have been created to screen for intimate partner violence. Examples include:

- RADAR,[28] ie:

*R*outinely screen all female patients over 14 years of age
*A*sk direct questions
*D*ocument clinical findings
*A*ssess patient safety and also safety of her children
*R*eview options and referrals.

- SAFE,[29] ie:

*S*afety in one's relationships and ability to return home
*A*buse (physical or sexual)
*F*riend and family awareness of the situation and ability to help
*E*mergency plan (shelter, cash, important documents).

- HITS,[30] ie, *how often has your partner:*

*H*urt you?
*I*nsulted or talked down to you?
*T*hreatened you with harm?
*S*creamed or cursed at you?

- Two simple screening questions, "*Do you ever feel unsafe at home?*" and "*Has anyone at home hit you or tried to injure you in any way?*" have a sensitivity of 71% and specificity of almost 85% in detecting violence.[31]

Barriers to screening

Screening for intimate partner violence is an important health issue, but multiple barriers prevent universal recognition and identification.

Limited time. Most outpatient visits are only 15 to 20 minutes—not enough time to get into extensive discussions.

Physician discomfort. Fourteen percent of men and 13% of women have a personal experience with violence, which creates a barrier to addressing the topic.[32]

Misconceptions. Most clinicians do not believe intimate partner violence is a common problem, or they may feel that it occurs only in lower socioeconomic groups. They may also be afraid of offending a patient by asking about abuse.

Lack of training. A 1988 survey of US and Canadian medical schools indicated that fewer than half provided formal instruction on violence to their students.[33] In addition, very few residency and continuing medical education programs provide education on this topic.

The patient must be seen alone. The woman must not be accompanied by anyone when this discussion is conducted, as abuse can escalate once they leave the office if the abuser is present with her.

Legal obligations and court testimony. Many clinicians are unaware of their legal responsibilities and are wary of long court battles and testimony.[34]

Lack of confidence. Most clinicians are uncomfortable talking about violence since they feel ill-equipped to offer help. Additionally, male clinicians have lower screening rates than their female colleagues.[35]

Does it help? Currently, there are no

73% of domestic homicides take place after the victim leaves the perpetrator

studies demonstrating the effectiveness of screening. One recent review[36] suggested that it would be premature to recommend universal screening until more studies outline the benefits and risks to women, the appropriate screening interval, and the training needs of health professionals.

CLINICAL PRACTICE GUIDELINES

Various organizations have developed differing clinical guidelines on intimate partner violence.

Organizations that advocate screening and counseling are:

- The Family Violence Prevention Fund[37] (a national, nonprofit organization)
- The American Academy of Family Physicians[38]
- The American College of Emergency Physicians[39]
- The American College of Obstetricians and Gynecologists[40]
- The American Medical Association Council on Scientific Affairs.[41]

Organizations that recommend neither for nor against screening (due to insufficient evidence) are:

- The US Preventive Services Task Force[42]
- The Canadian Task Force on Preventive Health Care.[43]

Only California, Colorado, and Kentucky require that suspected domestic violence be reported to police

STATE REPORTING LAWS

In assessing and intervening in situations of domestic violence, it is important to understand the laws regarding reporting requirements and the resources available to victims and their children in the community. In addition, it is imperative for practitioners to be aware of liability issues associated with intervention and documentation.

Mandatory reporting

There is much controversy regarding mandatory reporting, as many service providers believe that it places a victim at greater risk of physical harm. In addition, states with mandatory reporting often do not have adequate criminal justice resources to follow up on reports or do not have mechanisms in place to protect victims.[44]

In a 2001 statement, the American College of Emergency Physicians opposed mandatory reporting of domestic violence but rather encouraged reporting to community social service and victim agencies, as well as criminal justice agencies or any resource that can provide confidential counseling and assistance to victims. It also stated that referrals should be made with the express permission of the patient.[45]

In the United States, laws regarding when a physician must report a suspected case vary from state to state.

Three states mandate that suspicion of domestic violence be reported to legal authorities: California, Colorado, and Kentucky.[46]

Forty-two states have laws that require physicians to report any injury that results from the use of a firearm, knife, or other weapon.[46] These laws are not specific to the act of domestic violence but rather encompass crimes of domestic violence under the statute. These statutes make it difficult for practitioners to understand their legal obligation and its potential for liability regarding reporting vs not reporting.[44]

Twenty-three states require that injuries resulting from crimes be reported. Seven states have statutes requiring health care providers to report injuries from domestic violence.[46] Ten states have laws addressing domestic violence training. Eight states have required domestic violence protocols. Only three states have laws addressing screening for domestic violence.[37]

Five states (Alabama, New Mexico, South Carolina, Washington, and Wyoming) have no specific requirements that health care providers report patient injuries resulting from assault-related incidents.[46]

FEDERAL LAW

The Violence Against Women Act, enacted as part of the Crime Bill of 1994, empowers the federal Department of Justice to prosecute crimes of domestic violence.[47]

This legislation allows the federal government, which has historically lacked jurisdiction over crimes of domestic violence, to prosecute offenders in certain circumstances that involve interstate travel or activity and the use of firearms.

TABLE 2

Internet resources on intimate partner violence

Family Violence Prevention Fund
http://endabuse.org

State-by-State Report Card on Health Care Laws and Domestic Violence
http://endabuse.org/statereport/list.php3

US Department of Justice
Extent, Nature, and Consequences of Intimate Partner Violence
www.ncjrs.org/pdffiles/nij/181867.pdf

World Health Organization
www.who.int/violence_injury_prevention/violence/global_campaign/en/

American College of Obstetricians and Gynecologists
Violence Against Women
www.acog.org/from_home/departments/dept_web.cfm?recno=17

American Medical Women's Association
www.amwa-doc.org/publications/wchealthbook/violenceamwa-ch10.html

American Medical Association
www.ama-assn.org/ama/pub/category/3242.html

National Institutes of Health
www.nlm.nih.gov/medlineplus/domesticviolence.html

The United States has for the most part made great strides on the federal and state levels in the fight against domestic violence and in protecting victims. It is important that criminal justice systems learn what works in victim protection and what may put victims at increased risk of harm.[47]

DOCUMENTATION IS CRITICAL

It is critical for hospitals to adopt procedures for documenting suspected domestic violence. Some states require written policies and procedures regarding documentation of verified and suspected domestic violence. Each health care organization and provider should be knowledgeable regarding his or her individual state's requirements.[48] The personnel directly involved in documentation in the patient record of any suspected abuse are physicians, registered nurses, licensed practical nurses, interns, residents, social workers, counselors, and psychologists.[48]

In states with laws regarding documentation of known or suspected abuse, the health care provider must have reasonable cause to believe that a patient has been a victim of domestic violence. Then the health care personnel must record observations, impressions, and the basis of those impressions in the patient's record.[48] Suspicion of domestic violence must be documented in a clear and objective manner. If abuse is suspected but the patient denies it, health care personnel must document the suspicions and validate them with objective observations that the injuries are inconsistent with the explanation of the patient. The patient's general demeanor should be documented, as well as any quotes from the patient. Also, use words such as "stated" and "said."[37]

Hospitals must have procedures for documenting domestic violence

Documentation should be in detail and in the patient's words. It should contain how the injuries occurred and who committed the abuse, including the abuser's name and any other identifying information. It is helpful to use a body map identifying the injury observed.[37]

A procedure regarding photographing of victims who have been abused must be written and implemented. Photos should be taken whenever possible with the patient's permission.[37] It is optimal that an uninterested party—such as the hospital photographer rather than the nurse or social worker who is involved in the intervention—take the photographs. Multiple photographs, which include a full head and body shot, should be taken, as

well as photographs of the injury from different angles. The date and time of the photograph should be included in the actual photo.[49]

Discharge plans should include any referrals and recommendations that were made for the patient's follow-up care, as well as any contacts with outside resources such as police and community agencies.[49]

Health care organizations must have a protocol for interviewing victims and their accompanying family members.[48] A patient should be interviewed privately and separately from any family members, friends, or relatives who may have accompanied the patient to the health care facility. Hospital protocol, which includes written policies and procedures, must link closely with services and resources of community police departments, the judicial system, and social service agencies.[49]

REFERRAL SOURCES

National referral sources include the National Domestic Violence Hotline at (800) 799-SAFE (7233). National Web sites (TABLE 2) include the National Coalition Against Domestic Violence at www.ncadv.org, the Family Violence Prevention Fund at www.endabuse.org, and the Office on Violence Against Women at www.ojp.usdog.gov/vawo, offering numerous resources to victims and providers of victim services. Information and referrals to batterers' intervention programs are generally made through the criminal justice system in the jurisdiction where the crime was committed.

It is important to note that once referral information is given and a victim decides to leave, her risk is increased. According to statistics, 73% of domestic violence homicides take place after the victim leaves the perpetrator.[50] Identification of and intervention in domestic violence are critical to providing comprehensive patient care. All health care personnel must be knowledgeable in the legal and medical implications of domestic violence and its impact on health care and victim safety.

ACKNOWLEDGMENT. *The authors wish to thank Ms. Diane Crouse for her assistance in preparing this manuscript.*

REFERENCES

1. **el-Bayoumi G, Borum ML, and Haywood Y.** Domestic violence in women. Med Clin North Am 1998; 82:391–401.
2. **Bachman R.** Violence Against Women: A National Crime Victimization Survey Report. Washington, DC: US Department of Justice, 1994.
3. **Tjaden P, Thoennes N.** Full Report of the Prevalence, Incidence and Consequences of Intimate Partner Violence Against Women: Findings from the National Violence Against Women Survey. Washington, DC: US Department of Justice, 2000. NCJ 183781.
4. **Bachman R, Saltzman LE.** Violence Against Women: Estimates from the Redesigned Survey. Washington, DC: US Department of Justice, Bureau of Statistics, 1995:154–348.
5. **Kyriacou DN, Anglin D, Taliaferro E, et al.** Risk factors for injury to women from domestic violence against women. N Engl J Med 1999; 341:1892–1898.
6. **Wilt S, Olson S.** Prevalence of domestic violence in the United States. J Am Med Womens Assoc 1996; 51(3):77–82.
7. **Konchak PS.** Domestic violence: a primer for the primary care physician. J Am Osteopath Assoc 1998; 98:S11–14.
8. **Blackstone W.** Commentaries of the Laws of England. St. Paul, MN: West, 1987.
9. **Erez E.** Domestic violence and the criminal justice system: an overview. Online J Issues Nurs 2002; 7:4.
10. **Dobash RE, Dobash R.** Violence Against Wives. New York: Free Press, 1979.
11. **Zorza J.** The criminal law of misdemeaner domestic violence 1970–1990. J Crim Law Criminology 1992; 83:216–272.
12. **Walker AE.** The Battered Woman. New York: Harper and Row, 1979:55–77.
13. **Campbell J, Jones AS, Dienemann J, et al.** Intimate partner violence and physical health consequences. Arch Intern Med 2002; 162:1157–1163.
14. **Letourneau EJ, Holmes M, Chasedunn-Roark J.** Gynecologic health consequences to victims of interpersonal violence. Womens Health Issues 1999; 9:115–120.
15. **Coker AL, Smith PH, Bethea L, King MR, McKeown RE.** Physical health consequences of physical and psychological intimate partner violence. Arch Fam Med 2000; 9:451–457.
16. **Diaz-Olavarrieta C, Campbell J, Garcia de la Cadena C, Paz F, Villa AR.** Domestic violence against patients with chronic neurologic disorders. Arch Neurol 1999; 56:681–685.
17. **Leserman J, Li Z, Drossman DA, Hu YJ.** Selected symptoms associated with sexual and physical abuse history among female patients with gastrointestinal disorders: the impact on subsequent health care visits. Psychol Med 1998; 28:417–425.
18. **Campbell JC, Lewandowski LA.** Mental and physical health effects of intimate partner violence on women and children. Psychiatr Clin North Am 1997; 20:353–374.
19. **Centers for Disease Control and Prevention.** National Center for Injury Prevention and Control. Costs of Intimate Partner Violence Against Women in the United States. http://www.cdc.gov/ncipc/pubres/ipv_cost/ipv.htm. Accessed May 27, 2004.
20. **Melvin SY, Rhyne MC.** Domestic violence. Adv Intern Med 1998; 43:1–25.
21. **Yeager K, Seid A.** Primary care and victims of domestic violence. Prim Care 2002; 29:125–150.
22. **Flitcraft AH, Hadley S.** Diagnostic and Treatment Guidelines on Domestic Violence. Chicago: American Medical Association, 1992.
23. **Sassetti MR.** Domestic violence. Prim Care 1993; 20:289–305.
24. **Hamberger LK, Saunders DG, Hovey M.** Prevalence of domestic violence in community practice and rate of physician inquiry. Fam Med 1992; 24:283–287.
25. **Friedman LS, Samet JH, Roberts MS, Hudlin M, Hans P.** Inquiry about victimization experiences. A survey of patient preferences and physician practices. Arch Intern Med 1992; 152:1186–1190.
26. **U.S. Public Health Service.** Put Prevention into Practice: Clinician's Handbook of Preventive Services. American Nurse's Publishing, 1994.

27. **Frame PS, Carlson SJ.** A critical review of periodic health screening using specific screening criteria. J Fam Pract 1975; 2:28–35, 123–129, 189–184, 283–288.
28. **Gerard M.** Domestic violence. How to screen & intervene. RN 2000; 63:52–56.
29. **Neufeld B.** SAFE questions: overcoming barriers to the detection of domestic violence. Am Fam Physician 1996; 53:2575– 2582.
30. **Sherin KM, Sinacore JM, Li XQ, Zitter RE, Shakil A.** HITS: a short domestic violence screening tool for use in a family practice setting. Fam Med 1998; 30:508–512.
31. **Feldhaus KM, Koziol-McLain J, Amsbury HL, Norton IM, Lowenstein SR, Abbott JT.** Accuracy of 3 brief screening questions for detecting partner violence in the emergency department. JAMA 1997; 277:1357–1361.
32. **Sugg NK, Inui T.** Primary care physicians' response to domestic violence. Opening Pandora's box. JAMA 1992; 267:3157–3160.
33. **Holtz HA, Hanes C, Safran MA, et al.** Education about domestic violence in U.S. and Canadian medical schools. MMWR 1989; 38:17–18.
34. **Kennett MR.** Domestic violence. JONAS Healthc Law Ethics Regul 2000; 2:93–101.
35. **Saunders DG, Kindy P Jr.** Predictors of physicians' responses to woman abuse: the role of gender, background, and brief training. J Gen Intern Med 1993; 8:606–609.
36. **Ramsay J, Richardson J, Carter YH, Davidson LL, Feder G.** Should health professionals screen women for domestic violence? Systematic review. BMJ 2002; 325:314.
37. **Family Violence Prevention Fund.** National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings. http://endabuse.org/programs/healthcare/files/Consensus.pdf. Accessed January 13, 2005; pp 47–50.
38. **American Academy of Family Physicians.** Violence Position Paper: AAFP Policy and Advocacy Statement. www.aafp.org/x7132.xml. Accessed January 13, 2005.
39. **American College of Emergency Physicians.** Domestic Violence. Approved October 1999. www.acep.org/1,2194,0.html. Accessed January 13, 2005.
40. **American College of Obstetricians and Gynecologists.** Technical bulletin on domestic violence. Am Fam Physician 1995; 52:2387–2391.
41. **American Medical Association, Council on Scientific Affairs.** Violence against women. Relevance for medical practitioners. JAMA 1992; 267:3184–3189.
42. **U.**S. Preventive Services Task Force. Screening for family and intimate partner violence: recommendation statement. Ann Intern Med 2004; 140:382–386.
43. **MacMillan HL, Wathen CN, The Canadian Task Force on Preventive Health Care.** Prevention and Treatment of Violence Against Women: Systematic Review & Recommendations. London, Ontario, 2001.
44. Science Blog: From University of California-San Francisco. UCSF studies abused women and state mandatory reporting law. www.scienceblog.com/community/older/2001/D/200114912.html. Accessed January 13, 2005.
45. **American College of Emergency Physicians (ACEP) policy statements.** Mandatory reporting of domestic violence to law enforcement and criminal justice agencies. Available at: www.acep.org/1,615.0.html. Accessed January 13, 2005.
46. **Houry D, Sachs CJ, Feldhaus KM, Linden J.** Violence-inflicted injuries: reporting laws in the fifty states. Ann Emerg Med 2002; 39:56–60.
47. **Groban M.** The Federal Domestic Violence Laws and the Enforcement of These Laws. www.vaw.umn.edu/documents/ffc/chapter5/chapter5.html. Accessed January 13, 2005.
48. **Adrine RB, Ruden AM.** Ohio Domestic Violence Law. Cleveland, OH: West Group, 2002.
49. **The Ohio Domestic Violence Network (ODVN) and National Health Care Standards and Campaign Committee Ohio Chapter (2003).** The Ohio Domestic Violence Protocol for Health Care Providers: Standards of Care. Available at: www.odvn.org/PDFs/NSC%20Standards%20of%20Care.pdf. Accessed January 13, 2005.
50. **National Clearinghouse for the Defense of Battered Women.** The Advocate 1998; 20(2). dpa.state.kyus/library/advocate/mar98/battered.html.

ADDRESS: *Gurjit Kaur, DO, Department of General Internal Medicine, A91, The Cleveland Clinic Foundation, 9500 Euclid Avenue, Cleveland, OH 44195; e-mail kaurg@ccf.org.*