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Professional Responsibility in Preventing Violence and Abuse

From the Editor

Educating for Professionalism

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FROM THE EDITOR
Ending the Vicious Cycle

The guises in which abuse and violence present themselves to physicians (both in practice and in training) are as protean and plentiful as the choices these professionals make when so confronted. In this month's exploration of "Professional Responsibility in Preventing Violence and Abuse" we examine the context in which physicians' choices are made and the principles that underlie ethical decision making in these situations.

Two points deserve attention in the framing of our inquiry. First, is it pragmatically necessary to distinguish "abuse" from "violence" semantically? Many are inclined to treat these concepts as essentially interchangeable from a practical standpoint, while perhaps just as many would argue that "abuse" connotes a lesser degree of maltreatment in contrast to the visceral and physical connotations of "violence." In this issue of *Virtual Mentor*, I advocate for compromise between these views, taking the perspective that both terms fall upon, and are descriptive of, a spectrum of pathological interactions that take place between two parties. Although one may be immediately tempted to replace "two parties" with recollections of quarreling spouses, lurid crimes reported in the media, or perhaps the uncomfortable notion of child abuse, it is instructive to note these "two parties" could just as well be physician and patient, physician-educator and student, or physician and staff.

Second, what is the appropriate scope for approaching this theme? Inasmuch as this is the first *Virtual Mentor* issue dedicated to this theme, there is plenty of unexplored territory in a particularly rich realm of exploration and discussion. The scope of violence and abuse is broad, potentially encompassing myriad aspects of abuse within the medical profession, family violence (child, domestic, partner, spousal, elder), youth violence (school bullying, school shootings, gang violence), broader forms of violence (war, violent crime), and even violence against the self (self-mutilation, suicide). I've decided to focus on the aspects of violence and abuse that clinicians are most likely to encounter in their professional careers, particularly those amenable to timely detection and intervention.

It is difficult to overstate the importance of preventing violence and abuse. The Centers for Disease Control and Prevention notes that "violence is a significant problem in the United States…from infants to the elderly, it affects people in all stages of life" [1], while the World Health Organization recognizes that "violence is a leading worldwide public health problem" [2]. Physicians in many specialties are qualified to intervene and ameliorate abuse and violence propagation, in both their clinical and public health roles. Despite being largely preventable with appropriate

intervention, abuse and violence in their many forms often go undiagnosed and underreported. In 2006 alone, state and local child protective services substantiated more than 900,000 cases of child abuse or neglect [3]. That same year, more than 720,000 youths were treated in emergency rooms for injuries sustained due to violence [4]. Each year, there are nearly 8 million intimate-partner-related assaults suffered by men and women alike [5], thousands of which result in death [6]. The annual cost of lost productivity and medical expenses resulting from violence in the United States has been estimated at more than $70 billion [7].

Unchecked, violence and abuse propagate a vicious cycle, and the adage that "violence begets violence" is in fact empirically supported by numerous studies showing that those who are abused, neglected, and otherwise subjected to or exposed to violence early in life are statistically and significantly more likely to engage in a wide array of destructive behaviors and become perpetrators of violence themselves later in life [8].

Physicians have both a professional and ethical obligation to detect, prevent, and treat the results of abuse, but this obligation is not always clear-cut or easy to fulfill. On the topic of family violence, for example, the American Medical Association *Code of Medical Ethics* states that "due to the prevalence and medical consequences of family violence, physicians should routinely inquire about physical, sexual, and psychological abuse as part of the medical history" and furthermore that "physicians who are likely to have the opportunity to detect abuse in the course of their work have an obligation to familiarize themselves with protocols for diagnosing and treating abuse" [9].

At the same time, however, the code acknowledges that

> laws that require the reporting of cases of suspected abuse…often create a difficult dilemma for the physician. The parties involved, both the suspected offenders and the victims, will often plead with the physician that the matter be kept confidential and not be disclosed or reported for investigation by public authorities [9].

Clearly, the physician's professional responsibilities in the context of violence and abuse prevention are often challenged by ethical conflict. It is the physician's duty to act in the best interest of the patient, but in many cases of violence and abuse what is truly best is in question. What professional obligations are applicable in these circumstances? And what should guide rational and ethical decision making when these obligations conflict? *Virtual Mentor* examines these concerns.

Although we must be cognizant of abuse and violence in clinical practice, simultaneously we should recognize that they are present within the medical profession as well. Many would argue that organized medicine is inherently hierarchical and that such intrinsic inequalities among status holders predispose the profession to abuse. Accordingly, *Virtual Mentor* tackles abuse and violence prevention in medicine from both an intrinsic and extrinsic perspective. On the

analogy of Russian nesting dolls, (or perhaps an onion, if you happen to be more gastronomically inclined), I argue that we can describe our exploration in terms of concentric realms of responsibility, critically analyzing violence and abuse prevention within the medical profession itself, within the integral and familiar patient-physician relationship, and finally within the broader context of society at large. This approach is reflected in the scope of this month's clinical cases.

In the first case, a medical student intent on pursuing a career in surgery grapples with the attending trauma surgeon's abuse. Commentators Dan Hunt, Barbara Barzansky, and Michael Migdal discuss the national prevalence of medical student mistreatment, the culture that enables continuation of these occurrences, and the options available to medical students who have experienced mistreatment.

Turning to the encounter between patient and physician, the second clinical case presents a *sine qua non* scenario for exploring the topic of violence and abuse prevention—a pediatrician who suspects child abuse ponders the appropriate clinical approach toward her patient and the patient's family. Commentator Karen St. Claire describes the scope of child abuse and neglect and explains the medical evaluation of and response to this threat to childhood well-being.

Moving outward to the question of physicians' obligations to society, the emergency physician in the third clinical case considers what steps to take when he evaluates a teenager who has been involved in violent gang activity. Commentators Lauren K. Whiteside and Rebecca M. Cunningham outline effective screening and prevention modalities for the critical public health problem of youth violence.

The remaining articles explore violence and abuse prevention from many perspectives, enhancing our holistic understanding of these issues. In the first of two medical education articles, Ana E. Nunez, Candace J. Robertson, and Jill A. Foster outline the significance of intimate partner violence (IPV) in clinical practice and recount the experiences and development of the Women's Health Education Program at Drexel University College of Medicine in educating students about IPV. In the second medical education article, Cindy Moskovic and colleagues make the case for upholding intimate-partner-violence education as a priority and describe the components, challenges, and successes of the IPV curriculum at the David Geffen School of Medicine at UCLA.

What should physicians do when confronted with knowledge or evidence of intimate partner violence? In "Mandatory Reporting of Domestic Violence: the Law, Friend or Foe?" published in the *Mt. Sinai Journal of Medicine* in 2005, Laura Iavicoli evaluated arguments for and against mandatory reporting by physicians. In this month's journal discussion, Isac Thomas reviews Iavicoli's arguments and concludes that "the unintended tragedy of mandatory reporting may be that, instead of facilitating intervention for victims of intimate partner violence, this policy might drive victims away from those who could help." He believes that "reports of intimate partner violence to legal authorities should only be made with the victim's consent."

Recall that the second clinical case examined the medical evaluation and approach to child abuse and neglect. How do we decide what constitutes child abuse and neglect in the first place, and what criteria should be considered when deciding whether or not to report it? In the clinical pearl, Jenelle R. Shanley, Deborah Shropshire, and Barbara L. Bonner review the clinical definitions of child abuse and neglect, explore the factors that influence physicians' decisions to report suspicious injuries and findings, and offer guidelines for making that difficult decision.

How do physicians maintain the balance between law and ethics? In the health law section, Kristin E. Schleiter discusses circumstances in which patient-physician confidentiality may conflict with the law and asks, "When does public safety or preventing violence justify the erosion of the patient-physician relationship that occurs when physicians abandon the otherwise-sacred pledge of confidentiality?"

In the policy forum, Nancy Rappaport and James G. Barrett look at threat assessment in schools. The authors evaluate measures taken by certain schools in response to the threat of student violence. One Texas school district certifies teachers to carry weapons in the classroom and respond to threats with deadly force if necessary. Arguing that "arming teachers is a desperate school policy initiative," the authors outline a rational framework in which medical professionals can more appropriately manage threats of school violence.

Two medicine and society pieces examine some of the underlying themes of violence and abuse that impact society. Janet Rose Osuch decries the legacy of abuse in medicine, homing in specifically upon the "culture of silence" that has often enshrouded medical error and the public humiliation sometimes employed in medical education. Jason Schnittker directs our attention to public reception of claims about the genetic causes of human behavior—mental illness and violent behavior, in particular—and addresses the consequences, positive and negative, of this enthusiastic acceptance.

The history of medicine article places our exploration of violence and abuse prevention in context. Linda L. Dahlberg and James A. Mercy summarize the history of violence as a public health problem, highlighting relevant public health developments of the past century, as well as steps taken by organizations such as the Centers for Disease Control and Prevention and the World Health Organization in response to these challenges.

Finally, in our op-ed section, Jorge C. Srabstein argues that "health professionals have the urgent public health responsibility to become informed and raise community awareness about the nature of bullying and its link to serious health risks."

These articles and commentaries study abuse and violence from many different perspectives—clinical, ethical, professional, educational, historical, social, legal, and

policy-based. It is my sincere hope that these discussions will drive home the integral role physicians have in preventing violence and abuse and will contribute to an ongoing process of education and reflection from which the medical profession, the patient-physician relationship, and society as a whole have much to gain.

References

1. Centers for Disease Control and Prevention. Violence prevention at CDC. 2008. http://www.cdc.gov/ncipc/dvp/prevention_at_CDC.htm. Accessed January 6, 2009.
2. World Health Organization. *World Report on Violence and Health.* Geneva, Switzerland: World Health Organization; 2002.
3. US Department of Health & Human Services, Administration for Children & Families. *Child Maltreatment 2006.* Washington, DC: US Government Printing Office; 2006.
4. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS). 2009. www.cdc.gov/ncipc/wisqars. Accessed January 15, 2009.
5. Tjaden P, Thoennes N. US Department of Justice. Extent, nature, and consequences of intimate partner violence: findings from the National Violence Against Women Survey, 2000. http://www.ncjrs.gov/pdffiles1/nij/181867.pdf. Accessed January 14, 2009.
6. US Department of Justice, Bureau of Justice Statistics. Homicide trends in the United States, 2007. www.ojp.usdoj.gov/bjs/homicide/intimates.htm. Accessed January 9, 2009.
7. Corso PS, Mercy JA, Simon TR, Finkelstein EA, Miller TR. Medical costs and productivity losses due to interpersonal and self-directed violence in the United States. *Am J Prev Med*. 32(6):474-482.
8. Middlebrooks JS, Audage NC. *The Effects of Childhood Stress on Health Across the Lifespan*. Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2008.
9. American Medical Association. Opinion 2.02 Abuse of spouses, children, elderly persons, and others at risk. *Code of Medical Ethics.* Chicago, IL: American Medical Association. 2006. http://www.ama-assn.org/ama1/pub/upload/mm/Code_of_Med_Eth/opinion/opinion202.html. Accessed January 13, 2009.

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CLINICAL CASE

When Bad Things Happen in the Learning Environment

Commentary by Dan Hunt, MD, MBA, Barbara Barzansky, PhD, MHPE, and Michael Migdal, PhD

Wilson was inwardly thankful that his long day of assisting in the operating room was finally coming to an end. As a fourth-year medical student heading toward a residency in surgery, he had at first been ecstatic when he secured a rotation with Dr. Cartwright, a renowned surgeon and head of the trauma surgery service. Wilson was well-aware that Dr. Cartwright had a reputation for being difficult to work with, demanding, and scary, but, at the same time, he felt that a supportive letter from the surgeon was essential for his residency application, especially since he wanted to go into trauma surgery himself.

This first week on the service made him reconsider. Even on the first day, Dr. Cartwright had seemed aloof and uninterested, complaining openly that he had little time to deal with medical students. He was critical, abrasive, and even openly rude—not only to Wilson, but to the residents as well. Wilson could have appreciated constructive criticism; but commentary from Dr. Cartwright was far from constructive. It was usually harsh—even demeaning. When Wilson answered questions incorrectly on rounds Dr. Cartwright sighed audibly, sometimes commenting pejoratively on the caliber of medical students being admitted to the school. From conversations with the residents Wilson learned that Dr. Cartwright was well-known for his temper and verbal abuse. Yet, due to his surgical skills and eminent research status, few had been willing to make an issue of it. And, given his standing in the department, the residents were universally resigned to tough it out. After all, they were surgeons. It was to be expected, right?

On the first day that Wilson was allowed to assist in the operating room on a fairly stable case, Dr. Cartwright had seemed to be in a nastier mood than usual. He raised his voice when he thought the nurses were too slow in complying with his orders or when supplies were not immediately available. He swore audibly on most of these occasions. Wilson had earned honors in the surgery clerkship during his third year of medical school and was fairly confident in his skills. On this occasion, he couldn't do anything right apparently. Dr. Cartwright upbraided him each step of the way, constantly criticizing how Wilson was holding the retractors. He sometimes simply shoved Wilson's hands out of the way or rapped him on the knuckles with the instrument he had in hand at the time. When it came time to close up, Dr. Cartwright's patience seemed to have reached an end, and he simply pushed Wilson out of the way, finishing up the sutures himself.

Sitting in the vending machine area at the end of the day, Wilson felt miserable. He looked at his knuckles finally, which looked red and certainly ached a little bit. How was he going to get through this rotation?

Commentary

Everything that happens has a context. In this case, a medical student—Wilson—is being mistreated by a professional—Dr. Cartwright—who has been trained to be a healer. Yet we read that this "healer" is the source of the pain and suffering. How could this happen? How often does it happen? How does this student on a trauma-surgery rotation formulate an appropriate response with his hopes of a letter of recommendation on the line? What types of systems must schools have in place to deal with this issue?

Asking how such mistreatment could happen forces us to look at the context in which it occurs as a starting point for analyzing the choices available to Wilson. The first circle of players and actions in this situation comprises the residents and nurses on the service, who, we see, are equally humiliated by the surgeon. The nurses are verbally abused, and the residents are living out the myth of the stoic surgery-house officer. "After all, they were surgeons."

Make no mistake, however, this stereotypic surgical-service scenario could have played out on any floor and service. It could just as easily have taken place on a pediatric rotation or in the family medicine clinic. Regardless of the specialty field, the common factor is that the abuser has the benefit of a power differential. Dr. Cartwright's ability to confer a better grade, letter of recommendation, or supervisory relationship enables him to behave in a way that everyone objects to but many must endure.

Students like Wilson also work in a wider context of systems, however, that are or should be in place to deal with abuse. One would want to examine his school's reward system and understand the role of the promotion and tenure guidelines that may value clinical and research productivity over educational humanism. More importantly for Wilson is understanding the school's policies on mistreatment. What policies and procedures are available to assist a student—or a resident or nurse for that matter—in dealing with the actual and perceived power differential exemplified in this case? The closing image of Wilson's pondering how he will "get through this rotation" leaves us wondering just how well this school has succeeded in promoting its mistreatment policy and providing an accessible and safe venue for students to talk to someone about their options.

The feelings of isolation and helplessness that Wilson is experiencing are far too common in medical education. Each year, graduating students from the nation's accredited medical schools complete the Association of American Medical Colleges (AAMC) Graduation Questionnaire (GQ), which asks a variety of questions on topics ranging from the value of the premed courses to career choice, and, of course, includes questions specifically related to mistreatment in the learning environment.

In fact, 24 questions seek information such as how well-aware of and satisfied with their school's mistreatment policies students are, the frequency and type of mistreatment they experience, who the perpetrators are, and what the student did or did not do about the situation.

The 2008 AAMC GQ was completed by 13,269 graduating seniors, 84 percent. In general, the responses from this class about incidents of mistreatment were consistent with previous graduating classes. This is disquieting because one would like to see downward trends in the frequency of observed mistreatment and upward trends in reporting of incidents. In the graduating class of 2008, 16.7 percent of the respondents reported that they had been personally mistreated during medical school. Over the last 5 years, 50 to 55 percent of those reporting mistreatment indicated that it took the form of being publicly belittled or humiliated occasionally. Other forms of abuse, such as physical threats, punishment, or unwanted sexual advances were reported less frequently. But considering that 8 percent of those reporting mistreatment stated that they were physically threatened, and 5 to 7 percent reported unwanted sexual advances, one must conclude that the learning environment is far from ideal.

All medical schools are required by the Liaison Committee on Medical Education (LCME)—the organization that accredits undergraduate medical education programs—to have policies and procedures that address mistreatment, and the LCME looks closely at these policies when schools are up for review. When the GQ was completed by the graduating class of 2008, 22 percent of all respondents reported not being aware of the school's mistreatment policies. While it might be that this group of students never found themselves in a situation in which they needed to know about the policies, it might also mean that students were lacking a source of support, as was the student in our case. Had Wilson been familiar with his school's policies and procedures, he would have known that there was a designated "point person," a faculty member who was a knowledgeable and safe person for him to call for immediate support, and, more importantly, to help him explore the options. The LCME mandates that each school have a safe outlet and point person to help students handle such situations.

Each U.S. medical school undergoes a full LCME survey every 8 years. Of the 53 schools that underwent this in the past 3 years, nine were out of compliance with the standard related to student mistreatment. This standard is among the "top 10" in frequency of noncompliance. Uniformly, the schools that are out of compliance have policies, but their students are either unaware of them or perceive that they do not provide a safe haven for reporting incidents. This may be because the individual responsible for hearing and acting on complaints has an administrative role that students see as a conflict of interest (e.g., a position in the dean's office) or is someone who provides a grade in a relevant course.

Evidence of this student perception comes from the GQ, which goes on to inform us that, of students who reported mistreatment, 66 percent stated that they did not report

it to a designated point person who was empowered to handle complaints. When asked why they did not report the mistreatment, they indicated, among other explanations, that it did not seem important enough to report (50 percent), they feared reprisal (48 percent), or "other" (20 percent). (This question allowed multiple answers which is why the total was greater than 100 percent.)

The number of students who perceive that they have experienced abuse or humiliation in the medical education learning environment is high, as is the number of schools with inadequate ways to assist students in addressing mistreatment. In a perfect world, a student would know whom to contact for help in exploring his or her options. Those options could range from an immediate intervention to no action at all, depending on the school policies and what the student felt was appropriate. In the less-than-perfect world that Wilson inhabits, he should consult the school policies or call someone in the dean's office to find out who has responsibility for dealing with cases of student mistreatment.

What would make the world better for Wilson is creating a more responsive and collegial learning environment. The LCME expects schools to implement programs that inform students, faculty, residents, and others about expectations for appropriate treatment. Students can request that this type of education be offered so that they will never again be unsure of what to do in the rare—we hope—instance that harassment or abuse occur.

Note

The ACGME Graduation Questionnaire is available at http://www.aamc.org/data/gq. Click "All School Report."

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CLINICAL CASE
What To Do when It Might Be Child Abuse
Commentary by Karen St. Claire, MD

Dr. Peterson took a deep breath and exhaled thoughtfully as she weighed the possible approaches toward a case that was scheduled for the afternoon. For several years, she had been the primary pediatrician for Adrian, now a rambunctious 7-year-old. During the course of that time, she had developed a constructive, friendly relationship with the boy's parents, who had been fastidious regarding his care and upbringing and seemed like involved, caring parents. Dr. Peterson had enjoyed appointments with this family, trusting that visits would be routine and the boy would be healthy, allowing some time to chat with the parents, who were both executives in a large company headquartered nearby. The boy had always been in good health, and seldom needed to come in for non-routine well-child visits.

Dr. Peterson now questioned her original assumptions. For the past year, Adrian had been in to see her four or five times with a succession of injuries. Dr. Peterson noted numerous bruises and lacerations in different states of healing dispersed on the boy's knees, thighs, and buttocks. Adrian needed a couple of stitches on one occasion. The last time he came in he needed treatment for a broken leg. During all of these visits, his parents had appeared concerned and anxious, attributing the injuries to Adrian's simply being a very active youngster. They told Dr. Peterson that he'd been involved with soccer and martial arts for the past year, and usually had a sports-related explanation for every injury, though they could seldom give specific details. Dr. Peterson was aware that these parents spanked on occasion when the boy misbehaved, but they said that they only swatted lightly, never leaving a mark. Both had been working overtime to handle financial problems, and said that Adrian was often left in the care of a babysitter or aunt.

During recent visits, Dr. Peterson had often noted that Adrian seemed either visibly upset or quiet and withdrawn, behaviors that were completely natural, given his sports-related injuries. Now she had to act on her growing suspicions, but what would that do to her relationship with the family?

Commentary
The diagnostic method is the intersection of medical science with the art of medical practice. Its goal is to establish a broad framework of possible diagnoses and determine through information gathering which, if any, of these diagnoses is correct. Information gathering is chiefly dependent on history-taking but also relies on physical examination and testing. The diagnostic process ultimately leads to a medical conclusion upon which treatments and therapies are based. Child abuse and

neglect (CAN) is one of many threats to child health that strongly relies on the diagnostic method to determine whether abuse or neglect have occurred so that treatment, intervention, and protection can be provided.

The situation in which Dr. Peterson finds herself with Adrian is universally uncomfortable and rarely produces an ideal outcome. If Adrian is an abused child, and if Dr. Peterson fails to recognize or address this issue, it is likely that Adrian will continue to be abused, with possibly devastating consequences. Moreover, if abuse is occurring, other children in the home are also at risk. Alternatively, if Dr. Peterson correctly identifies and addresses the problem, Adrian and his family will have to undergo a lengthy and difficult process of evaluation, intervention, and protection, but the outcome for Adrian will almost certainly be better. If Dr. Peterson suspects abuse, initiates the evaluation, and ultimately finds that no abuse has occurred, Adrian and his family will have had to undergo the evaluation process, but its positive outcome should provide closure for the family. Families that are experiencing dysfunction or stress at the onset of the evaluation may be at particular risk for further deterioration of the family system. Although Dr. Peterson worries about her therapeutic relationship with Adrian and his family, many families who find themselves in this situation and work through the process with their primary care physician choose to remain in the care of that physician.

Physicians see children and families every day with various levels of physical, emotional, and psychosocial functioning. When one of these children or families begins to stand out because of patterns in history or physical findings, the physician must rely on both her training and instincts in determining whether to take a closer look at the situation. In Adrian's case, Dr. Peterson has had growing concerns about the possibility of abuse, and she recently added this concern to Adrian's list of diagnoses. At this point, the question facing Dr. Peterson is, "How should I proceed?"

Understanding the Problem

CAN occurs more commonly in childhood than many other serious childhood disorders. National child maltreatment statistics from the U.S. Department of Health & Human Services indicate that in 2006 there were 3.6 million reports of child maltreatment (47.8/1,000) accepted for investigation by state and local Child Protective Services (CPS) agencies [1]. From these reports, 905,000 cases of child maltreatment (12.1/1,000) were substantiated. Of them, 64.1 percent were for neglect, 16 percent for physical abuse, 8.8 percent for sexual abuse, and 6.6 percent for emotional abuse. In 74.9 percent of investigated maltreatment cases, the initial report was made by a professional. About 80 percent of identified incidents of CAN were perpetrated by a parent or close caretaker of the child. In 2006, there were 1,530 CAN fatalities, 78 percent of them in children less than 4 years of age. Child maltreatment spans all economic, social, racial, cultural, and educational strata, with risk factors that include domestic violence, substance abuse, mental illness, poverty, social isolation, and prior history of abuse. Many physically and sexually abusive

acts perpetrated on children leave no specific long-term physical findings on the child's body, making the identification difficult.

Children who experience abuse or neglect are at high risk for developing long-term emotional, physical, and medical problems related to their early traumatic experiences [2, 3]. Studies on CAN recidivism indicate that maltreated children are six times more likely to experience recurrent maltreatment than children who have never been abused [4]. The risk for recurrence is highest in the first 30 days after the index episode. Clinicians should understand that they see only a small piece of the CAN puzzle in the clinical setting, and it is often other professionals and agencies that help determine whether or not abuse or neglect has occurred. Regardless of the outcome, the evaluation process is difficult for the children and families who undergo the necessary medical, social, and legal scrutiny. Whenever possible, the physician should remain involved with the patient and family to assist in providing support and medical care during the evaluation.

Physician Responsibility in Addressing Child Abuse and Neglect
The following steps offer guidelines for physicians who may confront situations in which they have to decide how to respond to suspicions of CAN.

Step 1
Maintain training in the recognition of and response to CAN and know how to perform a basic medical evaluation. Be familiar with your state's reporting statutes as well as the agencies empowered to investigate CAN [5]. Statutes generally require that reports of suspected CAN be made to CPS, law-enforcement agencies, or both. In most states, reports made in "good faith" are exempt from civil or criminal liability, even in cases where CAN is ultimately ruled out. On the other hand, failure to report suspected CAN may have adverse legal consequences.

Step 2
Review all available medical history and physical-exam information to determine if there is a reasonable concern for CAN versus an alternative explanation. This includes prior medical records and x-rays pertaining to previous clinic or emergency room visits for injuries. Consider conferencing with an experienced colleague or a local CAN consultant.

Step 3
Obtain additional information. Meet with the family and talk separately with the caretaker(s) and child.

If the additional information substantiates your concern, talk about it honestly and thoroughly with the caretaker(s). Emphasize that you will assist them in determining whether their child has been harmed so that they can best protect him or her. Avoid accusing or assigning blame at this point, inasmuch as there may be no clear indication of who might be harming the child. Ask about the child's symptoms and prior known injuries. Request specifics to determine whether there is consistency

between reported mechanisms of injury and clinical findings. Ascertain whether anyone witnessed the injuries or heard the child talk about how they occurred. Ask about family functioning, stressors, and risk factors, as well as the child's environment at home, school, and with other care providers. In the case we are discussing, Dr. Peterson should ask about Adrian's coaches and supervision during sports-related activities.

If there has been a change in the child's affect, ask the caretaker(s) about potential causes. Explain clearly to the caretaker(s) that at some point state statutes may require the involvement of other professionals and agencies, but that you will let them know if you have reached that level of concern. Reiterate that your concern is for the health and well-being of their child, and that you want to work with them to assure their child's safety.

With permission of the caretaker(s), talk separately with the child about whether something is bothering or hurting him or her. Developmentally normal children older than 3 years of age are usually able to participate in an interview to provide reasonable responses to open-ended questions about their experiences and environment. They are also capable of offering supporting details. Dr. Peterson, for example, should ask Adrian about his sports activities and hear from him how his injuries occurred.

Step 4
Following the interview with the child, complete a comprehensive physical examination of him or her, including inspection of all skin surfaces. Ask the child who he or she would like to have present during their exam. Ask the accompanying caretaker(s) to allow the child to answer questions during the exam. Directly ask the child about any scars, marks, or bruises seen on his or her body and how these occurred. If the child is reluctant to talk in front of the caretaker(s), meet separately with him or her following the exam.

Step 5
Perform or schedule any indicated tests and studies.

Step 6
Determine if additional expertise is needed, and make referrals to a clinical social worker, child-abuse pediatrician, or psychologist as indicated. One advantage to Dr. Peterson's referring Adrian and his family to a CAN specialist is that the family can then identify the abuse issues primarily with the specialist rather than with Dr. Peterson and her primary care practice.

Step 7
Based on information from the evaluation, determine whether the concern for abuse has risen to a suspicion. If so, report to CPS, a law-enforcement agency, or both, as dictated by the state's CAN statutes. Review your conclusions and your reporting decision with the caretaker(s). If Dr. Peterson decides a report to CPS is not

necessary, she may still want to refer Adrian for mental health counseling to explore the reasons for his change in affect ("often visibly upset or quiet and withdrawn"), which may be unrelated to his sports injuries but can be directly related to the family's financial stresses.

Step 8
Address any issues related to the child's safety or mental health and emotional needs as indicated.

Conclusion
Ultimately, Dr. Peterson's responsibility is to the well-being and safety of her young patient. She should be prepared to approach the possible diagnosis of child abuse or neglect in the same manner and with the same diligence that she approaches any other disorder or disease of childhood. By providing the best medical assessment, Dr. Peterson will help to identify whether or not Adrian has been abused or neglected. If her assessment concludes that CAN is suspected and she appropriately files a report, she will help assure that Adrian's case receives the most comprehensive assessment possible; that his medical, mental health and safety needs are addressed; and his family receives support and services.

References

1. US Department of Health & Human Services, Administration for Children and Families. *Child Maltreatment 2006.* Washington, DC: US Government Printing Office; 2006.
2. Corso PS, Edwards VJ, Fang X, Mercy JA. Health-related quality of life among adults who experienced maltreatment during childhood. *Am J Public Health.* 2008;98(6):1094-1100.
3. Chapman DP, Dube SR, Anda RF. Adverse childhood events as risk factors for negative mental health outcomes. *Psychiatr Ann*. 2007;37(5):359-364.
4. Hindley N, Ramchandani PG, Jones DPH. Risk factors for recurrence of maltreatment: systemic review. *Arch Dis Child*. 2006;91(9):744-752.
5. Flaherty EG, Sege RD, Griffith J, et. al. From suspicion of physical child abuse to reporting: primary care clinician decision-making. *Pediatrics*. 2008;122(3):611-619.

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CLINICAL CASE

Youth Violence: Effective Screening and Prevention

Lauren K. Whiteside, MD, and Rebecca M. Cunningham, MD

Dr. Foster, an emergency room physician in a busy urban hospital, was called in late one Friday night to evaluate Thomas, a teenager who had been involved in a violent altercation. The young man had been brought in by his mother, and refused to divulge anything about what caused his injuries. Once in the examination room, Dr. Foster could see that Thomas wore colors, clothing, and paraphernalia clearly associated with gang members who had been treated in the emergency room. Past interactions with police officers confirmed that the gang was associated with gun and drug violence.

Upon evaluation, Thomas's injuries appeared to be both minor and superficial—he had a variety of bruises, lacerations, cuts, and scrapes—but no evident signs of significant trauma. A neurological exam revealed no focal findings, and all cranial nerves were intact. Thomas had full range of motion in all four extremities. There was no indication of internal organ damage, and, though Thomas sported quite a remarkable black eye, he had no signs of altered consciousness or physical signs consistent with concussion or intracranial hemorrhage.

Dr. Foster presumed that Thomas had most likely been involved in some sort of late-night gang fight, which was consistent with the young man's reticence in answering questions related to the incident itself, though he had been grudgingly cooperative with the physical exam. For the sake of completeness, Dr. Foster ordered a CT scan to rule out any possible head trauma. He also called for blood work and a urine drug screen, to which neither Thomas nor his mother objected.

While Thomas was upstairs for the CT scan, Dr. Foster spoke with his mother who was clearly distraught. She expressed her helplessness in controlling Thomas's behavior and said she was certain that he had been drawn into a group of bad kids. She said he was almost never home, skipped school on a regular basis, and spent all of his time hanging out with friends whom she did not know. This was not the first time that Thomas had been in a fight, she was sure. She begged Dr. Foster to get her son some help.

Dr. Foster was familiar with local gang-intervention and social programs in the area that had been remarkably effective in improving the outlook and welfare of patients. He was also aware of various applicable laws for mandatory physician reporting of criminal activity and child abuse and neglect, although he was not

entirely clear on the details. A report of injury from violence triggered involvement of the gang-intervention programs.

Dr. Foster knew the professional principles regarding patient confidentiality and that, in the absence of suspicion of criminal activity or child abuse and neglect, he had a duty to maintain the confidentiality of patient information. The reporting threshold had not yet been met in his estimation. Although intervention would probably be of great benefit to Thomas, the lack of confirmed history prevented formation of a reasonable index of suspicion, and he would, in effect, be "gaming the system," albeit ostensibly in the best interests of his patient, if he reported that Thomas's injuries had resulted from acts of violence.

Once Thomas returned from the CT scan, Dr. Foster spoke to him again, determined to gain the information necessary to confirm a course of action.

"I need you to tell me exactly what happened tonight," he said sternly. "I believe it is likely that you have been the victim of violence, and, if so, I am obligated to report this to the police, who will take appropriate further steps." This was not entirely true, Dr. Foster thought, but it would get Thomas the help he needed.

At this, Thomas seemed to be struggling not to cry. "Please don't say anything to anyone," he begged. "I'm not supposed to talk about what happened."

Commentary

There are more than 100 million emergency department (ED) visits annually in the United States of which at least 3 million are the result of violence [1]. One study in an urban pediatric emergency department found that nearly half of all visits were for injury, and half of those were the result of violent acts [2]. In 2005, more than 5,000 youth ages 15 to 24 were victims of homicide, making it the second leading cause of death of all youth in this age group regardless of race and the leading cause of death for African American males in this age group [3]. Studies show that adolescents at highest risk for youth violence (minorities and those of a lower socioeconomic status) use the ED as their primary access to the health care system due to lack of a primary care physician and routine health care, limited insurance coverage, and convenience [4, 5]. Tellingly, adolescents who seek treatment at urban EDs are more likely to die from violence than from any other illness or condition for which they seek care in the ED [6, 7].

While these youth are at high risk for injury, studies show that a majority of them are treated and released without receiving counseling or information regarding injury prevention and never have access to resources that are usually readily available on inpatient trauma units. Youth exposed to violence have a substantially higher risk for retaliatory injury than those never exposed to it. So it is no surprise that adolescents once treated for violent injuries have readmission rates for later injuries that are the result of assault [8-10]. Thomas falls within this group; he should be appropriately

screened for risk of retaliatory violence and re-injury, provided with counseling and referrals at discharge, and linked to resources that can help prevent future violence.

To address this problem, physicians should incorporate violence-prevention strategies into adolescent medical practice. Many ED physicians deal with rising volumes, extended wait times, and an overwhelmed system, making it seem impossible and impractical to add accurate violence assessment or brief intervention. It is important to note, though, that as emergency medicine and trauma physicians, we are trained to evaluate the safety-discharge plan of a woman with a black eye and an inconsistent story or to report a suspicious injury in a young child to Child Protective Services. The Joint Commission on Accreditation of Healthcare Organizations requires health care professionals in this setting to screen for domestic violence and suicide [11]. Therefore, it's easy to hypothesize that these same models and principles can be applied to youth-violence prevention.

Patients must be made to feel safe and know their answers will not be used against them. Questions should be asked in a straightforward and nonjudgmental manner. To preserve confidentiality, questioning should take place in private and without parents or visitors in the room. Health care professionals conducting the interview must assure patients that it is policy that all information is just between you, me, and the medical team here at the hospital unless they plan on hurting themselves, another person, or want protection from someone else who plans to hurt them. Physicians operate under the duty-to-warn policy which states that if a violent patient communicates intent to harm a potential victim, the physician should notify both law-enforcement officials and the intended victim [12].

There are several screening and assessment tools to assist in identifying youth at risk for violence; none, however, has been validated specifically for an ED population. A screening tool used at Children's Hospital of Pennsylvania assesses the degree of safety on all injured patients using the following questions.

1. Do you know who the person is that hurt you?
2. Do you think that the conflict that caused this incident is over?
3. Do you plan to hurt anyone because of what happened today?
4. Do you think that any of your friends or family members will hurt anyone because of what happened today?
5. Have you reported the incident to the police or other authority?

There is also the FiGHTS screen, derived from a national school-based sample and used to identify adolescents attending school who are at risk for carrying firearms. One point is assigned for each positive response on the five items listed below and a score of two or more is considered positive for carrying firearms.

1. **Fi**ghting: During the last 12 months have you been in a physical fight?
2. **G**ender: Male
3. **H**urt: During the last 12 months have you been in a fight where you were injured and had to be treated by a doctor or nurse?

4. **T**hreatened: During the last 12 months have you been threatened with a weapon (knife/gun) on school property?
5. **S**moker: Have you ever smoked cigarettes regularly (one cigarette per day for 30 days?)

The screen has a sensitivity of 82 percent, a specificity of 71 percent in a school setting [13].

Key questions when obtaining an accurate history in patients at risk for future violence include school delinquency or attendance, involvement in fighting in the past year, and drug use [14]. From Thomas's case, it is safe to assume that, after completing the Children's Hospital of Pennsylvania screening tool, he will be found to be at risk for future violence. During the interview, a thorough social history should be obtained, with attention to school performance and attendance, substance use, and illicit weapon carriage [15].

The goal of screening is to assist Thomas in preventing further violence. Research has shown that prevention strategies which use scare tactics such as gun buy-backs, boot camp, and tours of the trauma bay are ineffective. More effective prevention strategies focus on positive youth development, mentoring, and home visiting [16-19]. Two studies showed success in using a case-management approach to link young victims of violence with needed services [20, 21]. Since these resources differ from community to community, physicians should be aware of what is available in their own practice settings.

Initiating the intervention from the ED is probably the best way to identify high-risk youth and obtain information for adequate follow-up. Current strategies include using existing or additionally funded social workers, trained peer volunteers (as is done for many victims of domestic violence), and other resources such as computer- or web-based technology that require fewer personnel. Staff involved in youth-violence prevention strategies should be familiar with neighborhood characteristics including demographics, crime rates, and gang activities to understand the environment in which the injured adolescent will return. Many of these adolescents live in neighborhoods riddled with unemployment, drug use, easy access to weapons, and poor academic performance. There is no one-size-fits-all approach that works, and recognizing certain hurdles in specific neighborhoods and environments is essential to develop prevention strategies. For instance, one patient in a neighborhood with prevalent gang violence may have a stable family support system, while another in the same neighborhood may not, rendering parental involvement futile. A study conducted in an inner-city emergency department showed that referring youth to a violence-prevention web site after an ED visit provided an inexpensive way to ensure that youth receive accurate health information and neighborhood resources [22].

After taking care of the medical aspects of Thomas's injury, Dr. Foster should educate him to decrease future risk for repeat injury. As stated previously, a good

history is key, and making Thomas feel comfortable in a nonthreatening atmosphere by using nonjudgmental words is important in convincing him to talk honestly about his circumstances. Involving social work will be helpful, and referral to neighborhood resources (gang-prevention or substance-use referrals if appropriate) is also essential. In many states, referral to mental health programs and substance-use resources can occur without parental approval or knowledge. Physicians should be aware of the reporting guidelines within their state; usually, however, the decision for mandatory reporting hinges on intent for harm to self or others. With these actions, Dr. Foster can make a huge impact on Thomas's life, lessen his chances for another ED visit for repeated violence, and decrease his chances of retaliatory violence and carrying and using a weapon. While Thomas will most likely heal from the physical injury after a few days, the message he receives from the prevention efforts has the potential to be life lasting.

References

1. Mackay A, Fingerhut LA, Duran CR. *Adolescent Health Chartbook. Health, United States, 2000*. Hyattsville, MD: National Center for Health Statistics, Centers for Disease Control and Prevention; 2000: 1-197.
2. Meltzer-Lange M, Lye PS. Adolescent health care in a pediatric emergency department. *Ann Emerg Med.* 1996;27(5):633-637.
3. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS). 2009. http://www.cdc.gov/ncipc/wisqars. Accessed April 8, 2008.
4. Grumbach K, Keane D, Bindman A. Primary care and public emergency department overcrowding. *Am J Public Health.* 1993;83(3):372-378.
5. Bindman AB, Grumbach K, Keane D, Rauch L, Luce JM. Consequences of queuing for care at a public hospital emergency department. *JAMA.* 1991;266(8):1091-1096.
6. Centers for Disease Control and Prevention. *National Summary of Injury Mortality Data, 1987-1994.* Atlanta, GA: National Center for Injury Prevention and Control; 1996.
7. Prothrow-Stith DB. The epidemic of youth violence in America: using public health prevention strategies to prevent violence. *J Health Care Poor Underserved.* 1995;6(2):95-101.
8. Poole GV, Griswold JA, Thaggard VK, Rhodes RS. Trauma is a recurrent disease. *Surgery.* 1993;113(6):608-611.
9. Reiner DS, Pastena JA, Swan KG, Lindenthal JJ, Tischler CD. Trauma recidivism. *Am Surg.* 1990;56(9):556-560.
10. Dowd MD. Consequences of violence. Premature death, violence recidivism, and violent criminality. *Pediatr Clin North Am.* 1998;45(2):333-340.
11. Centers for Disease Control and Prevention. Emergency department response to domestic violence—California, 1992. *MMWR Morb Mortal Wkly Rep.* 1993;42(32):617-619.
12. Moore GP, Kao L. The combative patient. In: Marx JA. *Rosen's Emergency Medicine: Concepts and Clinical Practice*. 6th ed. Philadelphia, PA: Elsevier; 2006.
13. Hayes DN, Sege R. FiGHTS: a preliminary screening tool for adolescent firearms-carrying. *Ann Emerg Med.* 2003;42(6):798-807.

14. Sege R, Stringham P, Short S, Griffith J. Ten years after: examination of adolescent screening questions that predict future violence-related injury. *J Adolesc Health.* 1999;24(6):395-402.
15. Walton MA, Cunningham RM, Goldstein AL, et al. Rates and correlates of violent behaviors among adolescents treated in an urban ED. *J Adolesc Health.* In press.
16. US Department of Health & Human Services. *Youth Violence: A Report of the Surgeon General.* Rockville, MD: US Department of Health & Human Services, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2001.
17. Commission for the Prevention of Youth Violence. Youth and violence. 2000. http://www.ama-assn.org/ama/upload/mm/386/fullreport.pdf. Accessed April 8, 2008.
18. Dearing B, Caston RJ, Babin J. The impact of a hospital based educational program on adolescent attitudes toward drinking and driving. *J Drug Educ.* 1991;21(4):349-359.
19. Tucker JB, Barone JE, Stewart J, Hogan RJ, Sarnelle JA, Blackwood MM. Violence prevention: reaching adolescents with the message. *Pediatr Emerg Care.* 1999;15(6):436-439.
20. Zun LS, Downey LV, Rosen J. Violence prevention in the ED: linkage of the ED to a social service agency. *Am J Emerg Med.* 2003;21(6):454-457.
21. Cheng TL, Wright JL, Markakis D, Copeland-Linder N, Menvielle E. Randomized trial of a case management program for assault-injured youth: impact on service utilization and risk for reinjury. *Pediatr Emerg Care.* 2008;24(3):130-136.
22. Walton MA, Cunningham RM, Xue Y, Trowbridge M, Zimmerman M, Maio RF. Internet referrals for adolescent violence prevention: an innovative mechanism for inner-city emergency departments. *J Adolesc Health.* 2008;43(3):309-312.

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MEDICAL EDUCATION

Update on Intimate Partner Violence and Medical Education

Ana E. Nunez, MD, Candace J. Robertson, MPH, and Jill A. Foster, MD

A young woman sits in front of you in the office. Based on the statistics, there is a one-in-four chance that a serious condition may be adversely affecting her health—partner violence [1]. One quarter of women and almost 8 percent of men report sexual or physical violence by an intimate partner, which amounts to about 4.8 million women and 2.9 million men annually in the United States [2, 3]. Intimate partner violence (IPV), the preferred term, is present in every race, ethnicity, age group, class, and neighborhood in America. The problem appears worse in youth and young adults—70 to 88 percent of adolescent or college women experience at least one incident of either physical or sexual violence [4, 5]. One episode of violence also appears to put a patient at greater risk for future episodes.

Interrelationship violence can occur (1) in married or unmarried couples, (2) between couples who do not live together, (3) in heterosexual and homosexual relationships, and (4) any time after the inception of the relationship (versus pre-relationship dating), so it is more correctly termed IPV than dating violence. The Women's Health Education Program (WHEP) at Drexel University College of Medicine (DUCOM) works with Many Hands Working Together (c) [6] to promote a shift toward better integration of sexual-safety planning into delivery of clinical services [7]. Sexual-safety planning is a harm-reduction, model-based intervention to reach patients with the comorbidities of IPV and high vulnerability of HIV [7].

How Partner Violence Relates to Medicine

IPV is associated with several poor health outcomes including headaches, back pain, gastrointestinal disorders, posttraumatic stress disorder, depression, anxiety, substance use, eating disorders, cigarette smoking, sexually transmitted illness, and HIV/AIDS [2, 8-10]. It is also estimated that intimate partner violence results in 2 million injuries and 1,300 deaths annually [11]. Traumatic events from partner abuse have a devastating impact on victims, often creating deep emotional and psychological wounds. Thus, partner violence poses a significant threat to the physical and mental health of victims [12].

The central issue in intimate partner violence is control and unhealthy behaviors—it goes far beyond physical assault. Its clinical manifestations—emotional, psychological, financial, and physical—can be identified in all medical practice areas. Clinicians in primary care medicine need to be particularly alert and screen regularly. The increased risk of violence during pregnancy makes standard screening in ob-gyn imperative. Physicians in emergency medicine and orthopedic specialties

who are likely to witness the consequences of intimate partner violence must be alert to inconsistencies between an asserted mechanism of action (ran into a door) and the actual injury (orbital fracture). IPV has been found to be the most common cause of orbital fracture seen in ophthalmology [13]. Beyond accurate treatment, identification of violent cause is essential in averting future violence. A red flag for any physician should be a partner or spouse who seems overly controlling in an exam room, especially one who refuses to leave his or her partner alone in the exam room at the request of a physician or when privacy would be expected. Whether cardiologist, surgeon, or anesthesiologist, all physicians need an index of suspicion regarding partner violence.

Yet the gold standard of uniform screening is not achieved in most clinical settings. Since its inception in 1993, WHEP has been a leader in educating students about the influence of sex and gender on health care and has afforded them a venue to explore the interface of biomedicine and public health. IPV education is taught in the core curriculum, reinforced during clinical training, and practiced within system-wide extracurricular health-education service programming. The program's philosophy is to offer sex and gender health-disparities education in a discrete place with available resources and to employ integrated core curricula in addition to stand-alone interventions. This curricular framework is delineated in Table 1. Extracurricular opportunities are highlighted in Table 2.

Challenges

If primary care residency requirements include IPV screening, why isn't IPV screening a student competency? The reasons break down into three areas—perception of relevance, training opportunities, and resources.

Relevance

Physicians, like the general population, have difficulty addressing uncomfortable areas (e.g., end of life, poor prognoses, and sexual health). IPV falls into this category. Reasons to resist screening can include: "I don't have any time to do this." "What if they ask me something I can't answer?" "What if they start to cry? How do I handle that?" "I'm not a therapist or social worker—this isn't my job." "Why doesn't she just leave?" These concerns can be addressed in data-driven, clinically relevant, case-based educational interventions. Understanding the adverse health outcomes associated with IPV, developing skills to establish a safe clinical environment, and identifying multidisciplinary teams and agencies for referral can increase students' and physicians' comfort and improve outcomes.

Furthermore, the error and potential for escalating harm through misinformation (e.g., encouraging a woman to engage in couples therapy rather than find a safe place and develop a plan to leave) should be addressed and corrected. Lastly, although violence is unpleasant, students must recognize that all sections of the population—including "nice people"—can be in traumatic relationships, and that intentional blindness toward the issue results in widespread adverse health outcomes.

Training Opportunities

Perhaps the biggest reason why students don't screen is that they don't see clinicians screening. Good models and mentorship are essential for students. Effective screening practices employ a high level of expertise and integration of communication, clinical decision making, maturity, and professionalism. Physicians must be able to create safe space for a patient. Whether or not a patient divulges his or her situation, clinicians must assert that everyone deserves to be safe and invite further discussion at the next visit. Concurrent with the interchange, a physician evaluates verbal and nonverbal communication to assess risk. Will the patient be beaten up if she is caught with material about violence prevention? Has she considered where she might go if she leaves her home?

Physicians and residents often don't screen because they have not been formally trained and evaluated on IPV screening. Existing interventions such as objective structured clinical exams (OSCE) can aid in training and evaluation [14]. For example, DUCOM's WH Seminar series has trained students how to retain IPV skills despite discouraging messages from house staff when on the hospital units.

Resources

Beyond training, physicians must know how to connect with social service agencies and other health professionals so that referrals and consultations can be easily made. A senior DUCOM student is developing a tool that will put referral information close at hand.

Derived from its legacy and with support from the medical school, The Women's Health Education Program serves as a dedicated resource and connector for multidisciplinary resources. Other schools need to consider linking violence-prevention training to existing educational programs (those that support social justice, clinical skills, community experiences, multidisciplinary training, and humanism) to ensure ongoing instruction. Distance-learning video tools, such as those available at http://www.doc.com, can also serve as resources. Students with opportunities for community experiences might consider establishing connections with one of many agencies [15].

Lessons Learned

WHEP has learned the following lessons from providing training in IPV for 15 years:

- After initial exposure, students need reinforcement to develop effective skills for screening and responding to IPV.
- Problem solving using a team-based approach in a multidisciplinary format is well received. WHEPs interactive, case-based sessions for third-year students are highly rated as useful reinforcement of key objectives learned in earlier years. This refresher session allows students to ask questions and use case stories while practicing screening in diverse populations.

- Opportunities to practice improve proficiency. Whether through formative (non-graded) OSCEs or with role playing, medical students need to receive feedback on skill development.
- Identifying and supporting advocates for training are crucial to success.
- Resources—people as well as primers with clinical tips on initiating discussions and making referrals—are essential.

The Future

As health disparity markers are analyzed, the total cost of intimate partner violence both in dollars and adverse outcomes will be better delineated. Universal screening of emergent risks for all patients (e.g., identifying a man with inadequate anger management) will then be defined as a component of quality care. In addition to universal screening, regular and repeat risk assessment of groups with recognized high risk (e.g., incarcerated, dual-diagnosed, and pregnant individuals), should become policy and standard in clinical care delivery.

By incorporating trauma and health within practice, relational health may become more than an end-stage intervention; it may become an "early prevention and intervention practice" included in pediatric, adolescent, and primary care.

References and Notes

1. Whitaker DJ, Haileyesus T, Swahn M, Saltzman LS. Differences in frequency of violence and reported injury between relationships with reciprocal and nonreciprocal intimate partner violence. *Am J Public Health*. 2007;97(5):941-947.
2. Tjaden P, Thoennes N. US Department of Justice. Extent, nature, and consequences of intimate partner violence: findings from the National Violence Against Women Survey. 2000. http://www.ncjrs.gov/pdffiles1/nij/181867.pdf. Accessed January 12, 2009.
3. Arehart-Treichel J. Men shouldn't be overlooked as victims of partner violence. *Psychiatr News*. 2007;42(15):31.
4. Centers for Disease Control and Prevention. Physical dating violence among high school students, United States—2003. *MMWR Morb Mortal Wkly Rep*. 2006;55(19):532-535.
5. Smith PH, White JW, Holland LJ. A longitudinal perspective on dating violence among adolescent and college-age women. *Am J Public Health*. 2003;93(7):1104-1109.
6. Many Hands Working Together(c) is a project to help domestic-violence workers learn about HIV and STIs, and to help HIV- and STI-prevention case managers learn about domestic violence.
7. Foster J, Nunez A, Robertson CJ, Parrino T, Spencer SB. American Public Health Association. HIV and domestic violence: training to improve HIV risk reduction counseling, testing, and sexual safety planning with DV survivors. 2008. http://apha.confex.com/apha/136am/webprogram/Paper176964.html. Accessed January 12, 2009.

8. Campbell JC, Jones AS, Dienemann J, et al. Intimate partner violence and physical health consequences. *Arch Intern Med*. 2002;162(10):1157-1163.
9. Heise L, Garcia-Moreno C. Violence by intimate partners. In: Krug E, Dahlberg LL, Mercy JA, et al, eds. *World Report on Violence and Health*. Geneva, Switzerland: World Health Organization; 2002. 87-121.
10. Plichta SB. Intimate partner violence and physical health consequences: policy and practice implications. *J Interpers Violence*. 2004;19(11):1296-1323.
11. Centers for Disease Control and Prevention. Understanding teen dating violence fact sheet. 2008. www.cdc.gov/ncipc/pub-res/datingabusefactsheet-a.pdf. Accessed January 12, 2008.
12. Amar AF, Alexy EM. "Dissed" by dating violence. *Perspect Psychiatr Care*. 2005;41(4):162-171.
13. Hartzell KN, Botek AA, Goldberg SH. Orbital fractures in women due to sexual assault and domestic violence. *Ophthalmology*. 1996;103(6):953-957.
14. Moskovic C, Wyatt L, Chirra A, et al. Intimate partner violence in medical school curriculum: approaches and lessons learned. *Virtual Mentor*. 2009;11(2):130-136. http://www.ama-assn.org/2009/02/medu2-0902.html. Accessed February 2, 2009.
15. US Department of Health & Human Services. Violence against women. State domestic violence resources. 2007. http://www.4woman.gov/violence/state. Accessed January 12, 2009.

Suggested Readings

The National Coalition Against Domestic Violence. Dating violence fact sheet. 2005. http://www.ncadv.org/files/datingviolence.pdf. Accessed January 12, 2009.

Joyce E. Teen dating violence: facing the epidemic. National Center for Victims of Crime. 2003. http://www.ncvc.org/ncvc/AGP.Net/Components/documentViewer/Download.aspxnz?DocumentID=38039. Accessed January 12, 2009.

Janson J, Nunez A. Drexel University College of Medicine Women's Health Education Program. PDA IPV screening tool. In press.

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MEDICAL EDUCATION

Intimate Partner Violence in the Medical School Curriculum: Approaches and Lessons Learned

Cindy Moskovic, MSW, Lacey Wyatt, MD, MPH, Annapoorna Chirra, MD, Gretchen Guiton, PhD, Carolyn J. Sachs, MD, MPH, Heidi Schubmehl, Claudia Sevilla, and Janet P. Pregler, MD

Intimate partner violence (IPV) leads to physical assault in more than 25 percent of women and nearly 10 percent of men over the course of their lives. Its health consequences are far reaching and include acute injury and death, as well as long-term sequelae such as mental health problems and decreased self-care that can cause chronic disease and exacerbation of chronic disease. Not surprisingly, research has shown that physicians who receive specific training in IPV are more likely to screen for it—making teaching about IPV a priority for medical education [1-3].

Educating medical students about IPV presents many challenges. Because IPV is a complex psychosocial phenomenon, it does not readily fit into either discipline- or disease-based models for preclinical instruction, or into discipline-based instruction during the clinical years. With many topics competing for scarce curricular time, it is especially difficult to insert a subject that is not seen as belonging to a particular discipline. The number of students who think that knowing about IPV will be highly relevant to their practices has been shown to decrease over the course of medical school, even when IPV is part of the medical curriculum. A survey of graduating U.S. medical students revealed that, although 80 percent believed they received adequate training in IPV, only 35 percent expected that such training would be relevant to their practice [1, 3].

IPV Education at UCLA

California law requires that medical students and physicians be educated about IPV [4]. And the state's penal code requires that health practitioners report having provided medical services to a patient who they reasonably suspect is suffering from a wound or other physical injury caused by assault or abusive conduct [4].

Faculty at the David Geffen School of Medicine at UCLA have faced several challenges in their attempts to ensure adequate instruction in IPV for all students. UCLA limits contact instructional hours in the first 2 years to no more than 24 hours per week, setting a high premium on contact-hour time. During the clinical years, students train at many facilities, making it difficult to standardize the instruction all students receive as they rotate through a particular clerkship. The patient population and the medical student body are among the most racially and ethnically diverse in

the nation, which creates both opportunities and hurdles to training students about IPV.

The educational demand has been tackled in three ways, by: (1) imbedding IPV curriculum into an established course on psychosocial issues in the first 2 years, (2) promoting a strong institution-wide approach to patients affected by IPV to shape the environment of the clinical years, and (3) supporting and evaluating elective experiences in IPV for interested students.

Approach to Teaching Mandatory Reporting

Patient-physician confidentiality is an ethical and federally legislated cornerstone of medical student education. The fact that mandatory reporting in California specifically supersedes this principle often generates student inquiry. It is helpful to note that other legally mandated reporting also displaces the right to patient privacy; laws require reporting of child abuse, elder abuse, sexual assault, impaired drivers, and certain sexually transmitted and other infectious diseases [5-7]. To comply with mandatory reporting, medical workers must fill out a written report and notify law enforcement by telephone. One study of this practice demonstrated that police respond only upon telephone notification. This may allay student fears that law enforcement will act on the written report at a time that would be unpredictable to the victim and medical personnel [8].

Much controversy surrounds reporting obligations as they relate to IPV. Opponents of medical reporting surmise that it may cause injured patients to avoid seeking medical care out of fear that police involvement could anger a perpetrator and increase his or her aggression [9]. Students should also be told about the potential positive aspects of mandatory reporting; it can result in timely and appropriate law-enforcement involvement, which, when combined with social and advocate support, can prevent further injury to the patient by providing immediate perpetrator arrest or facilitating safe shelter placement for the victim.

It is key to stress that mandatory reporting of suspicious injuries applies to only the small subset of patients suffering from IPV who go to physicians for medical treatment with acute injuries. Physicians assist most IPV victims through identification, treatment, and advocacy referral without the immediate involvement of law enforcement.

Preclinical Training

At UCLA, the preclinical IPV curriculum is imbedded in the Doctoring course, which became mandatory in 1993. It teaches medical students culturally sensitive patient communication and clinical problem-solving skills, health promotion and disease prevention, implications of financial and access issues, and medical ethics. Students work in small groups with tutors who are practicing physicians or other health professionals, such as psychologists and medical social workers.

During the first year of Doctoring, all students are introduced to the IPV curriculum, which consists of a standardized patient (SP) case, discussion points, and handouts detailing the domestic violence and child-abuse reporting laws in California. The case's learning objectives are to: (1) be able to conduct a culturally sensitive, empathic history, (2) know how to help the patient develop a safety plan, (3) be aware of mandatory reporting requirements in California, (4) be aware of local resources available to survivors of violence, and (5) understand a survivor's perspective in an abusive relationship and the barriers to his or her seeking help.

Students interview an SP in front of 8 or 9 students. The SPs at UCLA are actors who memorize a script, so their answers are consistent with the learning objectives of each SP case. SPs are trained to demonstrate a reluctance to disclose violence, fears of spousal repercussions, and concerns about privacy of information. The SPs will not reveal the information unless the students both clearly address confidentiality and reporting requirements and take steps to make the SP comfortable with disclosing abuse to the interviewer.

To conduct the interview, students are presented with the case's facts—a 48-year-old female who arrives at a walk-in doctor's appointment complaining of a headache and is found to have facial contusions and an injured arm. Students have access to the patient's medical record, which documents two visits to the emergency department for injuries (hand laceration and broken ribs that the patient described as accidents) along with three prior clinic visits for vague abdominal complaints over the past 18 months.

The class discussion covers: (1) how medical records can be used to establish a pattern of violence, (2) the importance of establishing a safe environment when questioning a potential IPV survivor and honestly disclosing reporting requirements, and (3) using structured questions to gather information from the patient. Equally important, especially in a culturally diverse city such as Los Angeles, is preparing students to be culturally sensitive during the interview. Students discuss differences in culture such as who is considered head of the family, male and female roles in the family structure, potential risks in separation or divorce, and how these may differ depending on the cultural beliefs of the patient and community in which they live. The case concludes by referring the patients to the appropriate resources to remove them from the abusive situation and the students completing a report for law enforcement as mandated by California law.

Clinical Training

As is true at most medical schools, clinical training in IPV at UCLA depends on students' clinical and didactic experiences during specialty-based rotations. Primary care and emergency medicine departments have didactic training on IPV as part of regular lectures, but whether students attend them depends on whether or not they are rotating at the times that the lectures are given.

Students who encounter victims of IPV have access to cross-disciplinary resources. The UCLA Domestic Violence Committee meets quarterly to review IPV cases to improve the quality of care IPV patients receive. The committee consists of the local shelter advocates as well as volunteers from the faculty and staff of the medical center including physicians, dentists, nurses, and social workers. UCLA partners with a well-established community provider of IPV services to identify an on-call advocate who can talk with patients and go to the emergency department or medical center if the patient is in an acute crisis. Access to shelter services and immediate counseling are available through the on-call advocate.

Elective Experiences

Students have the opportunity to participate in the Adolescent Relationship Violence Prevention selective offered at the David Geffen School of Medicine at UCLA, which combines didactic training with experiential outreach training. Students are trained in the Peace Over Violence "In Touch with Teens" adolescent-dating, violence-prevention curriculum, and teach local high school teens how to prevent teen-dating violence through the use of conflict-resolution skills. The primary partner for the program is the Los Angeles Unified School District (LAUSD), the second largest school district in the nation whose student body reflects the ethnic and racial diversity of Los Angeles.

In addition to curriculum training and outreach experience, sessions address culture as it relates to domestic violence. The program provides mentoring opportunities for both trainers and participating teens.

The program evolved into a medical school selective offered for credit in 2004. From 2005 to 2006 the U.S. Department of Health & Human Services funded its implementation and evaluation at four U.S. medical schools. Results showed not only that the didactic portion of the training significantly improved students' knowledge of teen IPV issues, but also that the addition of experience as community educators improved confidence in recognizing forms of abuse, discussing the magnitude of the problem and partner abuse, helping the abused person explore his or her beliefs, and offering resources for referral [10].

As another selective, the American Medical Women's Association (AMWA) chapter organizes an annual Domestic Violence Week. Local organizations, such as Los Angeles' Peace Over Violence lecture on the psychosocial theories of IPV, epidemiological spectrum of victims, and resources available for both the victims and perpetrators of abuse. Victims give testimonials on their experiences. An estimated 150 to 200 students attend over the 5 days. The goals of the program are to educate and inspire students about IPV and the problems it causes within society.

Cultural Competency

Culture-specific factors play a significant role in IPV. As part of the selective, medical students were asked to explore potential barriers as educators and review data relevant to racial, cultural, socioeconomic, educational, and gender differences

in IPV. Students examine their own biases and stereotyping of adolescents of different cultural, socioeconomic, and racial backgrounds.

After didactic training, students demonstrated a statistically significant improvement in their understanding of disparities of care for non-English speaking patients, and the role of primary care in reducing disparities. They were also more aware of the phenomenon of increased patient satisfaction when patients were matched to physicians of the same racial and ethnic background as their own. Students showed greater knowledge of disease-specific disparities.

After the students' community experiences, they endorsed greater understanding of barriers to communication between themselves and individuals with different language and racial, ethnic, or educational status, which suggests that community experiences may help them understand culture- and ethnicity-related barriers to patient care.

Conclusions

The presence of a multidisciplinary course dedicated to teaching medical students culturally sensitive patient communication and clinical problem-solving skills, health promotion, disease prevention, implications of financial and access issues, and medical ethics has allowed UCLA to integrate information and training about IPV into its curriculum. Inclusion of information about California law on mandatory reporting has been a key part. The use of standardized patients ensures that all medical students have experience with appropriate interview and counseling techniques for patients who may be victims of IPV.

A randomized study of a selective course developed at UCLA that trains medical students to counsel adolescents about IPV prevention showed that community outreach experience improves students' confidence in dealing with IPV in clinical situations. Didactic and community experiences may also enhance their cultural sensitivity. Although students have significant resources available during clinical rotations to assist victims of IPV, and although primary care and emergency medicine departments include IPV in their postgraduate clinical curriculum, ensuring that all medical students revisit IPV issues during their clinical years remains a challenge at UCLA.

References

1. Frank E, Elon L, Saltzman LE, Houry D, McMahon P, Doyle J. Clinical and personal intimate partner violence training experiences of U.S. medical students. *J Womens Health (Larchmt)*. 2006:15(9):1071-1079.
2. Lenahan P, Shapiro J. Facilitating the emotional education of medical students: using literature and film in training about intimate partner violence. *Fam Med*. 2005:37(8):543-545.
3. Hamberger LK. Preparing the next generation of physicians: medical school and residency-based violence curriculum and evaluation. *Trauma Violence Abuse*. 2007:8(2):214-225.

4. California Attorney General's Office. Facts—fighting domestic violence: the California record highlights. 1998. http://safestate.org/index.cfm?navid=221. Accessed January 6, 2009.
5. Gupta M. Mandatory reporting laws and the emergency physician. *Ann Emerg Med.* 2007;49(3):369-376.
6. Katz SN, Howe R, McGrath M. Child neglect laws in America. *Fam Law Q.* 1975;9:1-372.
7. Brewer RA, Jones JS. Reporting elder abuse: limitation of statutes. *Ann Emerg Med.* 1989;18(11):1217-1221.
8. Lund LE. What happens when health practitioners report domestic violence injuries to the police? A study of the law enforcement response of injury reports. *Violence and Vict*. 1999;14(2):203-213.
9. Rodriguez MA, Craig AM, Mooney DR, Bauer HM. Patient attitudes about mandatory reporting of domestic violence. Implications for health care professionals. *West J Med*. 1998;169(6):337-341.
10. Moskovic CS, Guiton G, Chirra A, et al. Impact of participating in a community-based intimate partner violence prevention program on medical students: a multi-center study. *J Gen Intern Med*. 2008;23(7):1043-1047.

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JOURNAL DISCUSSION
Against the Mandatory Reporting of Intimate Partner Violence
Isac Thomas

Iavicoli LG. Mandatory reporting of domestic violence: the law, friend or foe? *Mt Sinai J Med*. 2005;72(4):228-231.

For many victims of intimate partner violence (IPV), a visit to the doctor may be the only opportunity for professional intervention. It is therefore incumbent upon health care practitioners to recognize this form of violence and act in the best interest of the patient. The physical and psychological sequelae of intimate partner abuse are profound. Beyond traumatic injuries, battered women suffer from chronic pain, frequent headaches, stomach ulcers, spastic colon, stammering, and other neurological and gastrointestinal disorders [1]. They experience a significantly higher prevalence of major depression and PTSD, along with more anxiety, insomnia, and social dysfunction than those not abused [2, 3]. The 40 to 45 percent of battered women who experience both physical and sexual abuse are at an even higher risk for a host of gynecological problems, including sexually transmitted infections, vaginal bleeding, chronic pelvic pain, and urinary-tract infections [3].

The U.S. Department of Justice found in a national survey that 25 percent of women were raped, physically assaulted, or both by a current or former spouse, cohabiting partner, or date in their lifetime, 1.5 percent of them within the year. This translates to an estimated 1.5 million women being raped or physically assaulted by an intimate partner annually. Men, too, are victims, though to a lesser degree. The same survey estimates some 834,700 men are raped, physically assaulted, or both by an intimate partner each year in the United States [4]. In response to what Surgeon General C. Everett Koop once declared a national epidemic, policy makers in six states—California, Colorado, Kentucky, New Hampshire, New Mexico, and Rhode Island—have mandated that physicians report their suspicion of intimate partner abuse to a law-enforcement agency, even over the protests of the victim involved.

Many in the medical community oppose such a mandate, arguing that reporting might not always be in the best interest of the patient, and, when mandated to act against his or her clinical judgment, the physician might end up causing more harm than good. In "Mandatory Reporting of Domestic Violence: The Law, Friend or Foe?" Laura Iavicoli, MD, summarizes the arguments and evidence for and against mandatory reporting and concludes that more research is needed on the impact of existing laws on survivors of abuse before the debate can be resolved [5]. To date, anecdotal evidence abounds on both sides, the relatively limited data are

inconsistent, and no clear consensus has been reached. In lieu of more data, a thorough analysis of the argument seems warranted.

In general, victims of intimate partner abuse in a health care setting can be grouped into one of three categories:

- Those seeking legal intervention.
- Those seeking professional advice short of legal intervention.
- Those seeking medical care only.

Victims in the first category would seem to benefit from mandatory reporting. As proponents of mandatory reporting have argued, medical documentation of injuries would strengthen the legal case against the perpetrator, aid law-enforcement officials in the prosecution of the perpetrator, and remove the responsibility of contacting law enforcement from the victim [6]. For those seeking legal intervention, these benefits can be had without instituting a policy of mandatory reporting. As Iavicoli points out, the American Medical Association proposed that mandatory reporting statutes include an opt-out clause for competent adults, thus allowing clinicians to facilitate all of the above benefits for willing patients without having to betray the wishes and confidentiality of those who do not want their cases reported.

Proponents of mandatory reporting argue, however, that it permits collection of incidence and prevalence data, improves health care providers' response to and identification of abuse, and makes clear that intimate partner violence will not be condoned [6]. While important to society, these and other benefits must not obscure the physician's duty to the health and safety of the victims. Certainly, mandatory reporting infringes on the autonomy of the victim, can strain the patient-doctor relationship, and, in some instances, can place the victim in danger of retaliatory violence from the perpetrator. Above all, mandatory reporting might result in fewer victims admitting to abuse, perhaps even fewer seeking medical care.

It can be reasonably assumed that victims in the latter two categories, those seeking professional advice short of legal intervention and those seeking medical care only, would be less inclined to admit to IPV (or even seek medical care) if mandatory reporting laws required physicians to pursue legal intervention. Particularly problematic are those who would benefit greatly from professional advice and social support services, but would nonetheless be deterred by an inflexible mandate. Ultimately, mandatory reporting might result in lost opportunities for medical intervention, if victims were to avoid disclosing abuse for fear that it might place them in an intractable situation.

Iavicoli cites a study that supports this conclusion. Gielen et al. found that, of the 202 abused and 240 nonabused women they interviewed, two-thirds felt that mandatory reporting would decrease women's likelihood of disclosing their abuse to their health care provider [7]. Of the abused women who did not disclose their abuse, 71 percent felt they would be less likely to do so under a policy of mandatory reporting.

Saliently, 74.5 percent of the abused women who did disclose IPV to their medical caregiver found it was either somewhat or entirely helpful.

Thus, the unintended tragedy of mandatory reporting may be that, instead of facilitating intervention for victims of intimate partner violence, this policy might drive victims away from those who could help. As many have noted, the medical professional is often the last resort for victims, and a victim can gain a great deal of assistance and professional counsel from this source. Education, counseling, referrals to shelters and legal services, even law enforcement, are levels of intervention that a physician can facilitate—but only if a patient is willing to disclose IPV, and the physician is flexible enough to act on sound clinical judgment. On these grounds, reports of IPV to legal authorities should only be made with the victim's consent. Preserving the chance for any level of intervention is surely better than risking no intervention at all.

References

1. 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(5):451-457.
2. Lewandowski LA. Mental and physical health effects of intimate partner violence on women and children. *Psychiatr Clin North Am.* 1997;20(2):353-374.
3. Campbell JC. Health consequences of intimate partner violence. *Lancet*. 2002;359(9314):1331-1336.
4. Tjaden P, Thoennes N. *Full Report of the Prevalence, Incidence, and Consequences of Violence against Women.* Washington, DC: US Department of Justice; 2000.
5. Iavicoli LG. Mandatory reporting of domestic violence: the law, friend or foe? *Mt Sinai J Med*. 2005;72(4):228-231.
6. Glass N, Campbell JC. Mandatory reporting of intimate partner violence by health care professionals: a policy review. *Nurs Outlook.* 1998;46(6):279-283.
7. Gielen AC, O'Campo PJ, Campbell JC, et al. Women's opinions about domestic violence screening and mandatory reporting. *Am J Prev Med*. 2000;19(4):279-285.

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CLINICAL PEARL

To Report or Not Report: A Physician's Dilemma

Jenelle R. Shanley, PhD, Deborah Shropshire, MD, and Barbara L. Bonner, PhD

Physicians often encounter childhood injuries and conditions that test their knowledge of what is considered child abuse and neglect and when to report their suspicions. Some situations pose ethical dilemmas that are not easily resolved. Understanding what constitutes child maltreatment and having a plan for making decisions about it can reduce the burden of physicians' duty to report their suspicions effectively and appropriately. In this article we discuss the definitions of child abuse and neglect and offer recommendations to help physicians determine when reporting is necessary.

To illustrate the complexity and uncertainty of reporting child abuse and neglect, consider the example of a 5-year-old boy brought to the pediatrician's office for a well-child checkup. He was accompanied by his father, mother, 7-year-old sister, and 8-year-old brother. He was reported to be healthy, but upon exam the clinician discovered a 2-centimeter linear bruise on his palm. When asked about the cause of the bruise, the father said that a few days earlier he had spanked the boy with a belt and the child had put his hand behind him, resulting in the injury. He had no other bruises. Based on this information, should the pediatrician report this case?

Before one can answer this question, it is necessary to know the definitions of child abuse and neglect as defined by the American Academy of Pediatrics (AAP) and other sources [1, 2]. Physical abuse is any physical injury to a child that is not accidental and may involve, but is not limited to, hitting, slapping, beating, biting, burning, shaking, or strangulating. As a result of these actions, a child may have bruises, broken bones, burns, or internal injuries that document the occurrence, as well as imprints of the specific object used to inflict the injury (e.g., belt buckle, hand, and knuckles). In sexual abuse, an adult or older child engages a child in sexual activities such as fondling, intercourse, oral-genital stimulation, sodomy, observing sexual acts, viewing adult genitals, and looking at, watching, or engaging in pornography. Not all children who are sexually abused are forced or threatened to participate; they may be enticed through bribery, trickery, or persuasion.

Emotional and psychological abuse exposes a child frequently and repeatedly to behaviors that impact his or her psychological well-being, including blaming, threatening, yelling at, belittling, humiliating, name calling, pointing out faults, withholding emotional support and affection, and ignoring a child. In some cases, exposure to domestic violence is considered psychological abuse. Neglect is the chronic failure to meet a child's basic needs—clothing, nutritious food, cleanliness,

educational opportunity, medical and dental care, protection, shelter, and supervision. Though the four forms of maltreatment are defined separately, they often co-occur against one child.

The number of children who are maltreated annually in the United States is difficult to document because: (1) definitions vary across tribal, state, and federal jurisdictions; (2) the standards and methods of collecting data vary considerably; and (3) many cases go unrecognized and unreported [5]. In 2006, the national rate of child maltreatment was 12.1 per 1,000 children under age 18 [2]. Previously, the highest rate was 15.3 child victims per 1,000 in 1993, after which the overall rate of substantiated cases has continued to decline. The rates for neglect have persistently increased, while sexual abuse has steadily declined. Of the nearly one million substantiated cases of maltreatment in 2006, approximately 66 percent involved neglect (586,967); 16 percent, physical abuse (142,041); 9 percent, sexual abuse (78,120); 7 percent, psychological maltreatment (58,577); and 15 percent (133,978) were classified as "other types" of maltreatment (e.g., abandonment, congenital drug addiction, and threats of harm to the child). (Since children often experience multiple forms of neglect, these percentages total more than 100 percent.) The rate of maltreatment was highest for children from birth to age 1 (24.4 per 1,000), followed by ages 1 to 3 (14.2 per 1,000), and ages 4 to 7 (13.5 per 1,000). Boys and girls were equally vulnerable to neglect and physical abuse, but girls were sexually abused four times more frequently than boys (1.7 versus 0.4 per 1,000). African American children had the highest rates of substantiated abuse—24.7 per 1,000 children [2].

Do these definitions and statistics clarify the perception of suspected abuse in the case presented? The decision to report is complicated by the ambiguity of the definitions and their inconsistency across disciplines. Furthermore, accepted cultural practices complicate the decision to report. No specific guidelines distinguish between physical abuse and physical discipline. Spanking a child is one parenting behavior that can fall into this gray area. Nor is there a defining line between neglect and inadequate parenting. For example, children with a chronic illness who miss a series of medical appointments may be victims of medical neglect. Such instances present physicians with difficult decisions.

It is not the physician's responsibility to determine the intent of the parent or caregiver, or whether abuse or neglect occurred. Their responsibility is to report their suspicions and allow trained professionals to conduct an investigation. Teams across the nation conduct the investigations and make the difficult but necessary decisions. To be substantiated, a case is first referred to a Child Protective Services (CPS) agency, subsequently investigated, and then decided one way or the other based upon the preponderance of evidence [3].

According to the most recent national statistics available (from 2006), an estimated 3.6 million reports of suspected maltreatment were received by state CPS agencies, of which approximately 905,000 were substantiated [2]. In the majority of these cases maltreatment was perpetrated by the child's caregivers. Despite the statistics,

each case of suspected abuse presents physicians with the dilemma of determining what constitutes abuse and neglect and when to report.

Many factors play a role in physicians' decisions to report. A 2008 study found that pediatricians in an office-based setting do not always report suspicious injuries [4, 5]. Physicians from two national pediatric practice-based research networks were recruited and 434 reported information from more than 15,000 injuries seen in their offices. Approximately 10 percent of all injuries (1,683 injuries) were identified as suspicious, yet only 6 percent of those (95 injuries) were reported to CPS. Among the factors that played a role in reporting or not reporting, four points were commonly mentioned by physicians as contributing to their decision about reporting an injury to CPS.

- *Relationship to the family*. Familiarity with the family and a positive history resulted in physicians being less likely to report suspicious injuries, while meeting families for the first time or having prior concerns pushed physicians toward reporting to CPS.
- *Case-specific elements*. These include presence of pattern injuries, delay in seeking care, and lack of an adequate explanation for the injury.
- *Use of available professional resources*. Physicians reported that discussing the case with a knowledgeable colleague helped them decide whether or not to report suspicious injuries.
- *The clinician's past experiences with CPS*. Clinicians who believed that CPS involvement would result in a negative outcome for the child or family were less likely to report.

This study indicates that decisions to report suspicious injuries were less tied to definitions, statistics, and reporting laws than to a variety of factors related to patient-physician relationships and experiences with CPS [4, 5].

To add to the complexity of our case of the 5-year-old boy, the physician learned that the family had a prior CPS history of neglect for a dirty house and physical abuse for spanking and bruising the children. Should this information sway the physician to report?

A week after the 5-year-old boy visited the pediatrician's office, his 8-year-old brother was brought in for follow-up of an emergency-room visit for a head injury. The father reported that the boy was playing with neighborhood children and fell, hitting his head. The father did not witness the fall but noticed a lump on the left side of his son's head. The father reported that an hour later the boy fell and lost consciousness, again not witnessed directly by the father but reported to him by the boy's playmates. In the emergency room, the boy's exam showed only a bruise to his left temple area, and a CT of the brain was negative for fracture and intracranial bleeding. At the follow-up visit, the boy reported that he had had some headaches over the last few days but they were going away. He was sullen and would not answer other questions. When asked about the falls, he said that he did not

remember. Does this injury cause suspicion of abuse or neglect? Should this added information further persuade the physician to report?

The level of suspicion required to report suspected abuse is not clearly defined. But, with the knowledge that physicians tend to underreport suspected abuse, the following recommendations are made to increase physicians' confidence in making appropriate reports:

- *Obtain continuing education regarding child maltreatment*. Routinely seeking out local and national opportunities for continuing education related to child abuse and neglect can help you maintain a current understanding of child maltreatment.
- *Know reporting laws*. Familiarizing yourself with the reporting laws and to whom reports should be made in your state (i.e., CPS or law enforcement) can lessen the ambiguity in the reporting process.
- *Consult with colleagues*. Establishing collaborative relationships with colleagues to consult with regarding difficult cases can assist in the decision-making process. Physicians in private practice who do not have colleagues readily available may want to create a referral process with local agencies that have teams who make these decisions.
- *Know your local CPS staff*. Forming relationships with your local CPS staff members can facilitate an open line of communication and establish a better sense of the guidelines used by the agency.

Conclusion

The fact that it is often difficult to decide whether to report suspected abuse does not negate one's professional and legal responsibility to protect children by doing so. Physicians are not responsible for determining whether maltreatment occurred, only for reporting reasonable suspicion. The reporting decision is complicated by ambiguous definitions that vary across disciplines and by cultural differences in acceptable parenting practices. Many factors play a role in a physician's likelihood of reporting, including the relationship with the family, details surrounding the injury, consultation with colleagues, and previous experience with CPS. Physicians may reduce their decisional burden and increase appropriate reporting by participating regularly in continuing education related to child maltreatment, familiarizing themselves with reporting laws and local CPS staff, and consulting with colleagues.

References

1. American Academy of Pediatrics. Children's health topics: child abuse & neglect. 2008. http://www.aap.org/healthtopics/childabuse.cfm. Accessed November 4, 2008.
2. U.S. Department of Health and Human Services. Administration for Children & Families. *11 Years of Reporting: Child Maltreatment 2006*. Washington, DC: US Government Printing Office; 2008.
3. Leeb RT, Paulozzi L, Melanson C, Simon TR, Arias I. *Child Maltreatment Surveillance. Uniform Definitions for Public Health and Recommended Data*

Elements. Atlanta, GA: Centers for Disease Control and Prevention. National Center for Injury Prevention and Control; 2008.
4. Jones R, Flaherty EG, Bins HJ, et al. Clinicians' description of factors influencing their reporting of suspected child abuse: report of the Child Abuse Reporting Experience Study Research Group. *Pediatrics*. 2008;122(2):259-266.
5. Flaherty EG, Sege RD, Griffith J, et al. From suspicion of physical child abuse to reporting: primary care clinician decision-making. *Pediatrics*. 2008;122(3):611-619.

Suggested Reading

US Department of Health & Human Services. *Child Maltreatment 2006.* Washington, DC: Administration on Children, Youth and Families; 2004.

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HEALTH LAW

When Patient-Physician Confidentiality Conflicts with the Law

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Patient-physician confidentiality is a fundamental tenet of medical ethics. Principle IV of the American Medical Association's *Code of Medical Ethics* states, "[a] physician shall safeguard patient confidences and privacy within the constraints of the law" [1]. This duty of confidentiality is subject to certain exceptions that are ethically justified because of overriding social considerations, such as a patient's threat to inflict serious physical harm on a specific, identified person when there is reasonable probability that the patient will carry out the threat [2].

The second part of Principle IV, "within the constraints of the law," often justifies a physician's disclosure of confidential information. Physicians are required by most state laws to disclose evidence of child abuse obtained through a physical examination or conversation with a minor child [3]. Similarly, the law may demand a physician to disclose information that indicates that a crime has occurred or may occur [3]. The code advises that when, by law, patient confidentiality must be breached, the physician should notify the patient and disclose to law-enforcement authorities the minimal amount of information required [2].

Statutory exceptions to patient-physician confidentiality for reasons relating to public health and safety have existed for decades. Most states require physicians to alert law-enforcement authorities of any violence-related injuries [4]. New York Penal Code 265.25 garnered press recently because of a Columbia Hospital's apparent failure to report its emergency room treatment of a gunshot wound self-inflicted by a national football league (NFL) player [5]. Section 265.25 makes it a Class A misdemeanor for a physician or manager to fail to report a bullet wound, gunshot wound, powder burn, or other injury resulting from the discharge of a gun or firearm [6].

Most other states have similar laws and grant immunity from civil liability to physicians who report such injuries to law-enforcement authorities [4]. Hawaii has the most far-reaching statute on required disclosures. The state mandates that a physician, osteopathic physician, or surgeon report to the chief of police a knife or gunshot wound; injury that would seriously maim, produce death, or render the person unconscious; injury caused by the use of violence or sustained in a suspicious or unusual manner; or motor-vehicle collision involving serious injury or death [7]. The physician must provide the patient's name; nature, type and extent of injury; and other pertinent information [7].

The question is, where does a physician draw the line when balancing such laws and the ethical duty to maintain confidentiality? When does public safety or preventing violence justify the erosion of the patient-physician relationship by the abandonment of the otherwise-sacred principle of confidentiality? Certainly the interest of public safety is overriding when a gunshot victim arrives at the emergency room. By alerting authorities of the incident, a physician may trigger an investigation that prevents more shootings from happening and therefore protects the public. But in the case of the NFL player, the gunshot wound was self-inflicted—albeit with an illegal handgun—without indication of a suicide attempt. Do the same public-policy considerations apply when public safety is not immediately at risk? Does it matter that a law has been broken?

Justification of a breach of patient-physician confidentiality in the interest of public safety is particularly thorny in some of the cases covered by Hawaii law [7]. The provision pertaining to motor-vehicle accidents is unlike any other state statute. The statutory duty to report any injury that has rendered the patient unconscious significantly overreaches the apparent intent of such statutes to diagnose, treat, and document violence-related injuries [4]. Further, the phrase "suspicious or unusual manner" is subject to interpretation. What is it about injuries sustained in a suspicious or unusual manner that justifies forcing a doctor to breach confidentiality? Perhaps "suspicious or unusual" is easily distinguishable from the ordinary in the eyes of a physician. Most likely, a phrase so open to interpretation makes violations of this part of Hawaii's statute difficult to enforce and subject to overreaching.

While preventing violence is inherent in physicians' duty to patients and society, so too is the duty to safeguard patient confidence. Physicians delicately walk the line between ethics and law, particularly in the face of statutory obligations to breach the sacred duty of confidentiality—all to prevent violence.

References

1. American Medical Association. Principle IV. *Code of Medical Ethics*. Chicago, IL. American Medical Association. 2001. http://www.ama-assn.org/ama1/pub/upload/mm/Code_of_Med_Eth/principles.html. Accessed January 9, 2009.
2. American Medical Association. Opinion 5.05. Confidentiality. *Code of Medical Ethics*. Chicago, IL: American Medical Association. 2007. http://www.ama-assn.org/ama1/pub/upload/mm/Code_of_Med_Eth/opinion/opinion505.html. Accessed January 8, 2009.
3. American Medical Association. Report 4 (I-06). Confidentiality. Amendment report of the Council on Ethical and Judicial Affairs. Chicago, IL: American Medical Association. 2006. http://www.ama-assn.org/ama1/pub/upload/mm/369/ceja_recs_4i06.pdf. Accessed January 9, 2009.
4. Houry D, Sachs CJ, Feldhaus KM, Linden J. Violence-inflicted injuries: reporting laws in the fifty states. *Ann Emerg Med*. 2002;39(1):56-60.

5. Brach J. Plaxico Burress shoots himself accidentally. *The New York Times*. November 20, 2008. SP1.
6. New York Penal Law 265.25. http://law.justia.com/newyork/codes/penal/pen0265.25_265.25.html.
7. Hawaii Rev. Stat. 453-14. http://www.capitol.hawaii.gov/hrscurrent/Vol10_Ch0436-0474/HRS0453/HRS_0453-0014.htm.

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POLICY FORUM
Under the Gun: Threat Assessment in Schools
Nancy Rappaport, MD, and James G. Barrett, PhD

School shootings such as the Columbine and Virginia Tech tragedies have heightened administrators' and teachers' fear that their students are capable of lethal violence. Initiatives to ensure safety have ranged from zero tolerance for weapons and expanded security measures (e.g., metal detectors or school resource police officers) to student threat assessments by multidisciplinary teams. Some schools have taken extreme measures and garnered national media attention for their response to the threat of student violence. For example, one school district in Texas certified its teachers to carry weapons in the classroom and sanctioned them to respond to a threat with deadly force if necessary [1].

Arming teachers can give schools a false sense of security and may distract staff from critical preventive efforts. Despite the amount of media attention they receive, school shootings are rare events; schools are one of the safest places for children to be. Indeed, a child has a greater chance of being hit by lightning than being shot in school [2]. Less than 1 percent of all homicides among children ages 5 to 19 years occur in and around the school [3]. Still, lethal violence occurs in American schools more often than in schools in other developed industrial countries. But a teacher's discharging a weapon in response to a student's threat creates a potentially dangerous scenario that could escalate an already volatile situation. Although it is difficult to predict with accuracy what will deter potential school assailants, many school shooters also killed themselves. In such cases an armed teacher may not have been a successful deterrent.

Arming teachers is a desperate school policy initiative, one that illustrates the degree to which some school personnel feel under siege. Frightened teachers describe walking on eggshells and waking up at night afraid of the secret volatility of students. Concerns for the safety of both students and staff should not be dismissed. Schools are struggling with the urgent and pressing need to differentiate between students who are sounding an alarm when in crisis and those who may jeopardize the safety of themselves and others.

Better Approaches to Reducing Violence in Schools
In response to the schools' needs to address possible threats to safety, it is critical to employ a multifaceted strategy that, among other approaches, makes it more difficult for students to bring weapons to school. This strategy is analogous to public health interventions for reducing traffic fatalities that put the emphasis not only on the driver but also on changing the car by, for example, improving the window strength

or the flexibility of the steering wheel. Similarly, control of firearms can improve safety in schools. A 1995 study of a nationally representative school-based sample of adolescents in grades 7 through 12 found that access to a gun at home was associated with carrying a gun to school [4]. Educational and medical organizations could advocate together for more stringent gun-control laws that restricted access and banned the sale of military-style assault weapons like those used in the Virginia Tech, Columbine, and Northern Illinois University killings.

While restricting access to guns is a critical step in reducing the threat of student violence, schools need to implement policies to identify and help students who may pose a threat to staff or students. Efforts such as infectious-disease control and mandatory immunizations have set a solid precedent. Following these models, school and medical organizations could develop consensus guidelines for safety measures that, if enacted and enforced, would reduce school violence. Schools can build on the numerous programmatic options they have already implemented, including conflict-resolution programs, bullying-prevention programs that discourage students from ostracizing others, programs that teach student bystanders to deter aggression, and incentives to encourage positive behavior [5, 6]. Yet schools have a long way to go; the implementation of sound policies is inconsistent and relies on the confidence, knowledge, and perceived self-efficacy of school personnel.

Physicians can partner effectively with schools through advocacy, encouraging preventive measures, and helping respond to individual students. Indeed, clinicians (e.g., physicians, psychiatrists, psychologists, interns) who work in or with schools may encounter students who have threatened a peer or teacher with violence, gotten into a physical fight with another student, carried a weapon to school, or thought of obtaining a weapon for self-defense. It is critical that these clinicians have guidelines for determining how to care for students who may pose a threat to others or be in danger of being the victim of violence. Some promising approaches follow for clinicians who work with or consult to schools on matters of safety.

Threat Assessment

Clinicians who work with schools have a valuable resource to offer when consulting with staff and administrators on threat and safety assessment. Staff members frequently witness a variety of behaviors from students that are cause for concern, such as a poem written in an English class that mentions harming a teacher, a message on a MySpace page threatening another student, or hallway gossip about a student's weapon in his locker. It can often be difficult for staff to differentiate between behaviors that are harmless expressions of frustration and those that pose a more serious threat. At the same time, it is unrealistic that the medical professional will "clear" the student to return to school. It is not possible for anyone to predict with certainty a student's potential for violence. Schools should have a clear understanding of both the utility and limitations of physicians' evaluations and use them as opportunities to improve the safety net for vulnerable students.

Over the last 9 years, Nancy Rappaport has supervised or examined more than 150 students who were identified as potential safety risks to help schools with decision making and accessing resources. These safety assessments include home visits; interviews with the child, parents, and teachers; and analysis of reports of the violent incidents and school records [7]. Some of the fundamental concepts of threat assessment that are particularly useful for physicians, interns, and other clinicians working with schools can also be adopted by physicians who find themselves involved in threat assessment. Pediatricians and emergency room physicians may be asked to evaluate a student who has a physical injury that occurred during a school fight. A psychiatrist in an emergency room may evaluate an explosive student who has made inflammatory threats. A medical student may have a frightened teenager confide that her ex-boyfriend is planning to bring a gun to school to "even the score."

Frameworks for Examining Threats and Aggression

A team of FBI experts created principles for conducting threat assessments based on their careful analysis of school events in which students killed multiple individuals [8]. Rather than presenting a checklist to profile students, the guidelines emphasize the *process* of evaluation, providing questions for uncovering a student's motives and goals as a means for determining the extent to which the student has the motivation, intent, and resources to carry out the threat. Currently, there are no standardized guidelines for clinicians regarding the information they should obtain before sharing responsibility with the school about the safety of a student, what kind of follow-up should be provided, and who takes responsibility for ensuring this happens. It would be useful for physicians to create such guidelines, based on a case consultation model, as a standard of medical care when working with aggressive students [9]. These standards of care would clarify expectations and responsibilities for both clinicians and schools.

While it is beyond the scope of this article to enumerate all guidelines that would be helpful, some recommendations follow for assessing situations that involve violence or threats of violence.

Distinguishing between Transient and Substantive Threats. One way to classify threats is to distinguish them as transient or substantive [10]. Transient threats are those that are made while a student is upset but has no real intent or plan. An example is the student who says, "I wish I could blow up this school" after he earns detention time. When the student is questioned about the statement, it is discovered that he has no motive to blow up the school and has no access to explosive materials. A substantive threat involves a more formalized plan with means and intent to carry it out. Here an example is the student who posts a threat online to harm a peer and, when questioned, has access to a gun and has planned how and when the attack will occur. Clearly, substantive threats require immediate action, and the clinician should work with the school to notify the parents and police for the safety of all parties involved. Most transient threats require monitoring rather than urgent intervention.

Evaluating and Treating Students with Aggressive Behavior. Clinicians are not only called upon to assess a formal threat; sometimes they are asked to evaluate a student who has a pattern of aggression to help determine risk for further dangerous behavior. When assessing such students, a distinction should be made between proactive and reactive aggression. Reactive aggression is characterized by a response to a threat or perceived threat (e.g., a student flipping over a desk when he finds out he failed a class). In contrast, proactive aggression typically involves premeditated aggression toward an intended victim (e.g., an adolescent waiting after school to "jump" a peer). Proactive aggression is of greater concern in threat assessment; students who exhibit past instances of it are considered more capable of carrying out a planned assault [11].

The student who is aggressive in school warrants a comprehensive diagnosis and treatment plan. Schools often do not have resources to contain students' aggression. At the same time, practicing clinicians rarely have the flexibility to mobilize intensive resources quickly enough to stabilize an escalating crisis. This can cause clinicians who are not familiar with school policies to feel powerless in trying help families advocate for necessary resources [12]. Accessing mental health services and community resources is often daunting even for the most savvy consumers and seasoned clinicians, but in these precarious situations where timely access is essential, it can be even more difficult to acquire appropriate, timely therapeutic support. Schools have sometimes responded with on-site services, although frequently these services do not involve necessary family treatment [13]. To successfully manage these students, communities need to develop continuity of services from easy access to clinicians, home-based family services, emergency services, and hospitalizations. Strong partnerships between schools and mental health services will improve the treatment for these vulnerable students.

Identifying At-Risk Students. In addition to assessing individual students or events, clinicians should be aware of resources for both students who are at risk for carrying out a violent act and for those at risk of being the victim of such an act. By linking students to resources, clinicians can help prevent violence or the threat of it before it occurs. Following are two programs that have demonstrated early success in helping prevent youth violence.

Gun Buyback Programs

Clinicians are afforded the opportunity to provide a confidential space where students can talk about the threats and fears they experience and the steps they take to feel safe. Some students obtain firearms as a means to feel safe or to defend themselves in their neighborhoods but later recognize the dangers of possessing an illegal firearm and do not know where to turn for help. Clinicians should be aware of resources for students to turn in weapons—one being the Boston Gun Buyback Program, which provides a location for Boston residents to turn in guns, no questions asked, in exchange for a $200 Target gift card. This program has demonstrated success in getting guns off the street; between 1993 and 1996, when the program originally ran, approximately 2,800 guns were turned in to authorities [14].

Anonymous Reporting of Threats

While many violence-prevention efforts in schools understandably focus on identifying possible offenders, students who are victims of threats or harassment and those aware of students who may threaten violence should not be overlooked. Indeed, other students are often the best source of information about possible violence perpetrated by their peers; many, however, are reluctant to notify adults of a possible threat due to fear of retaliation. Moreover, a "no snitching" culture in schools deters students from informing adult supports of threats. One innovation to combat this is the use of anonymous web- and text-message-based reporting of threats. A student can log on to a web site such as http://www.schooltipline.com and post an anonymous message alerting school officials to a potential threat. While anonymous tips present the risk of false accusations and alarms, using new technologies to offer students a safe and reliable way to report possible deadly threats has shown promise in pilot programs [15].

Publicized incidents of school violence, especially school shootings, can cause school officials to believe that they must explore every possible option for deterring violence. We believe that extreme measures, such as arming teachers, are not likely to be effective and actually may put students and staff at greater risk. Instead, a coordinated, systemic approach to responding to threats is considered the best practice, and psychiatrists, psychologists, interns, and medical students can play key roles in the process. Clinicians can be front-line defenses—identifying and classifying a threat and mobilizing resources to respond without carrying a weapon. The threat of aggression warrants a rapid and thorough response by the medical profession which mobilizes services to schools and students to guarantee safety.

References

1. McKinley JC. In Texas school, teachers carry books and guns. *New York Times*. August 29, 2008: A1.
2. Verlinden S, Hersen M, Thomas J. Risk factors in school shootings. *Clin Psychol Rev.* 2000;20(1):3-56.
3. Kachur SP, Stennies GM, Powell KE, et al. School-associated violent deaths in the United States, 1992 to 1994. *JAMA.*1996;275(22):1729-1733.
4. Swahn MH, Hammig B. Prevalence of youth access to alcohol, guns, illegal drugs, or cigarettes in the home and association with health-risk behaviors. *Ann Epidemiol.* 2000;10(7):452.
5. Olweus D. *Bullying at School. What We Know and What We Can Do*. Cambridge, MA: Blackwell; 1993.
6. Walker HM, Colvin G, Ramsey E. *Antisocial Behavior in School: Strategies and Best Practices*. Pacific Grove, California: Brooks/Cole Pub. Co.; 1995.
7. Rappaport N, Flaherty LT, Hauser ST. Beyond psychopathology: assessing seriously disruptive students in school settings. *J Pediatr.* 2006;149(2):252-256.

8. Federal Bureau of Investigation. The school shooter: a threat assessment perspective. 2000. http://www.fbi.gov/publications/school/school2.pdf. Accessed January 14, 2009.
9. Rappaport N. Survival 101: assessing children and adolescents' dangerousness in school settings. In: Esman AH, Flaherty L, Horowitz H, eds. *Adolesc Psychiatry.* 2004;28:157-181.
10. Cornell DG, Sheras PL, Kaplan S, et al. Guidelines for student threat assessment: field-test findings. *School Psych Rev.* 2004;33(4):527-546.
11. Raine A, Dodge K, Loeber R, et al. The reactive-proactive aggression questionnaire: differential correlates of reactive and proactive aggression in adolescent boys. *Aggress Behav.* 2006;32(3):159-171.
12. Hurwitz KA. A review of special education law. *Pediatr Neurol.* 2008;39(3):147-154.
13. Flaherty L, Weist MD, Warner BS. School-based mental health services in the United States: history, current models and needs. *Community Ment Health J.* 1996;32(4):341-352.
14. Smalley S. Gun buybacks make return to Boston. *Boston Globe.* May 31, 2006.
15. Web site invites kids to report bullies incognito [news release]. Salt Lake City, UT: Associated Press; October 14, 2008.

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MEDICINE AND SOCIETY

The Double Helix and Double-Edged Sword: How the Public Thinks about Genes

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In some settings, claims regarding the genetic causes of human behavior are enormously controversial. In the early 1990s, the National Institutes of Health's efforts to explore the biological and genetic antecedents of violence ignited a storm of controversy, partly in response to the suggestion that the research might help to explain why violence was especially high in poor communities [1]. Likewise, publication of *The Bell Curve* elicited a strong and divisive debate, especially surrounding its claims about the role of genes in economic inequality [2]. More recently, James Watson's statements regarding race, genes, and intelligence—in which he stated that he was "inherently gloomy" about the prospects for Africa—ultimately led to his resignation from Cold Spring Harbor Laboratory, with which he had been affiliated for nearly 40 years. In these and many other instances, genetic arguments are lightning rods for controversy—and, indeed, scandal—because of their association with a host of other concerns, including responsibility and agency; the enduring nature of a person; and the ability of societies to reduce suffering, inequality, and disadvantage.

Yet these controversies, no matter how pitched they are in science and politics, are simply not as pronounced in public opinion. Despite the lingering scientific and political disputes, the public is increasingly likely to accept genetic arguments for a variety of behaviors and traits. Most Americans, for example, accept that genes are at least somewhat important for health, mental illness, intelligence, and personality [3]. In some of these cases, public support is overwhelming. For example, more than 90 percent of Americans believe genes are important for physical illness, and 65 percent view them as important for "success in life," a measure that is clearly less immediately biological than disease. Furthermore, the public remains optimistic about the potential fruits of the genetic revolution, especially with respect to DNA testing and medical intervention. In 1996, for example, most Americans believed that genetic screening would produce more good than harm [4].

Genetic arguments are also less divisive in the public sphere. In science and politics, the disputes that surround genetic arguments stem from their seemingly conservative implications juxtaposed against the progressive leanings of many scientists and politicians. Certainly some social scientists fear that genetic research will, in the minds of policy makers, reduce social problems to genetic and, hence, deterministic abnormalities, thereby diminishing the apparent value of social interventions [5]. Yet popular support for genetic arguments is unrelated to political orientation—

endorsement is common among liberals and conservatives alike [3]. Although some link genetic attributions to prejudice and stereotyping, the public is often quick to offer nondiscriminatory interpretations of genetic causes [6, 7]. Nor is popular support more common among younger cohorts, for whom cutting-edge molecular genetics might seem less remarkable and arcane. Indeed, if anything, older Americans are more likely to embrace the role of genetic influences.

How should we understand this pervasive enthusiasm? What are its sources? And, more importantly, what are its consequences? If the public is increasingly likely to see genes as the "keys to life," are they also more tolerant of abnormality? Although science may be the authority on the role of genetics in human behavior, public opinion about genes is hardly epiphenomenal—it is influential in legislative decisions about research funding, including funding for stem-cell research. Public opinion is important in other ways as well. Physicians, for example, need to appreciate public beliefs to understand how their patients respond to genetic information and advice.

Complexity of Public Beliefs about Genes

The successful mapping of the human genome received an unusual amount of attention, and this accomplishment was merely the tip of the iceberg for popular media. The amount of news surrounding genetic research has increased over time, starting well before 2003 [8, 9]. At present, the public is exposed on a near-daily basis to reports about the discovery of "a gene for" for a variety of conditions, including depression, obesity, diabetes, alcoholism, and cancer, but also a range of behaviors and traits, such as personality, religion, political beliefs, sexual orientation, and morality. Apparently these messages are reaching their audience. Public support for genetic arguments has increased over time, as one would expect given the expanded coverage [8, 10].

Perhaps more importantly, the public appears to have absorbed the positive slant these stories often take. Most news stories about genetic research take an optimistic point of view, wherein the discovery of a gene or set of genes for disease is also linked, often prematurely, to a potential cure [11]. The public rarely hears about conflicting evidence or failures to replicate key results. And the public may be less inclined to accept them should they appear—opinion research reveals that the public often spontaneously associates genetic causes with the possibility of treatment [11].

This is not to say that the public is unduly credulous or unsophisticated. Most media consumers recognize the contribution of social causes to health and behavior and do not view genes as narrowly deterministic. For example, while endorsement of genetic explanations for mental illness has grown over time, it has not come at the expense of social explanations, like family upbringing or stress, which remain common [10]. Even when presented with a "blueprint" metaphor for genes, the public is quick to provide a nondeterministic interpretation [7]. At the same time, public enthusiasm for genes does not stretch to all potential applications of genetic research. While cautiously supportive of DNA testing, for example, the public

generally opposes selective abortion for conditions that are treatable or not especially severe, such as obesity [4, 12]. Perhaps not surprisingly, the public also remains concerned about privacy, which is, of course, entirely reasonable. In short, endorsement, while strong, is not without caution, nuance, or knowledge.

From some perspectives, this enthusiasm is a good thing. Many advocates believe that genetic arguments will foster understanding and tolerance in places where blame and fear once prevailed. Along these lines, some see a strong link between support for genetic causes and support for a traditional medical model—what's good for genetics is good for medicine. In the area of mental health, for example, some welcome the rise of a genetic model, hoping it will further cement the view that psychiatric conditions are real, severe, and deserving of treatment. The National Alliance for the Mentally Ill has been especially vocal in promoting the view that genes are responsible for mental illness. Similarly, some gay-rights activists hope that a demonstrable link between genes and sexual orientation will help to allay the stigma surrounding homosexuality by, in effect, "naturalizing" an orientation that is seen by some as a blameworthy and deviant choice. These efforts have not been entirely misplaced. There is some evidence, for example, that the growing acceptance of psychiatric medications is partly due to the public's widespread adoption of a genetic model [10].

Yet the public's endorsement of a genetic model carries a shadow, and we should not expect the wave of support for genetic explanations to have the same positive consequences when applied to all traits, behaviors, and disorders. Genetic arguments occasionally foster a more divisive view of human nature [8]. Although they situate many behaviors within the realm of the natural, genetic arguments also raise fears that genes are destiny. In a genetic framework, behaviors that were once seen as freely chosen actions or personal characteristics can, instead, be interpreted as symptoms of a genetic weakness. In this way, genetic explanations might be used by the public to identify latent predispositions and threats, even when no problems are apparent. And genetic arguments are sometimes associated with the idea that interventions, no matter how effective, can never truly "cure" behavioral problems. Acceptance of a genetic cause of mental illness, for example, increases support for use of psychiatric medications, but it does not increase the perceived effectiveness of such medications [10].

Reflecting the double-edge of genetic arguments, some medical conditions benefit from their association with a genetic framework while others suffer the consequence of provoking fatalism and fear. On the positive side, those who believe that depression is caused by genetic factors tend to be more tolerant of people with depression because genes are thought to say something about the condition's origin [14, 15]. In particular, genetic arguments dispel the idea that depression is caused by personal weakness (e.g., "He just needs to get over it"), thereby transforming what was once seen as a moral weakness into a medical condition. This is more than a small victory, given the long-standing misunderstanding that depression is no different than ordinary sadness, reflecting, as it does, the usual ups and downs of life.

On the other hand, those who believe schizophrenia is caused by genetic factors tend to be less tolerant than those who believe it is caused by environmental factors, including stress and family upbringing. Indeed, those in the former group are, on some dimensions, similar to those who believe schizophrenia is caused by bad character—both groups see people with schizophrenia as even more dangerous and suspicious because their condition reflects, albeit in different ways, inherent abnormality more than a situational response [10].

Genetic explanations have similarly complex implications when applied across the spectrum of behaviors, traits, and disorders linked to genes, implications that are likely to depend on whether the condition in question is thought to be sufficiently unusual to pose some kind of a threat. Genetic explanations for violent and aggressive behavior are likely to incite fear and intolerance by making the individual appear more distinctive, sick, and uncontrollable. As a result, should scientists conclusively demonstrate a genetic influence on crime, some will begin to perceive criminals as essentially flawed and, therefore, at risk for future criminality, even when those criminals attempt to atone for their acts. Few can be truly reformed when the origins of their deviance are believed to lie within the biological "code" of their body. When applied to abnormal but nonviolent behavior, however, genetic arguments are likely to promote greater tolerance by reducing perceived personal responsibility. Sickness is tolerated even when weakness is not. In short, the public uses genetic information in divergent ways, sometimes to explain behavior and other times to assess threat, which, of course, leads to different responses.

Conclusion

It is tempting to believe that science will eventually be the arbiter of public beliefs. Having already fostered public acceptance of genetic influences, science may further contextualize the nature of genetic influence and, in doing so, help to eliminate some of the more negative aspects of genetic arguments. If, for example, science can develop cures for genetic disorders, just as it has already discovered causes, then genetic arguments might reinforce the clinical enterprise rather than increase fear. Likewise, if science can better understand how genes and environments interact, the public might be less inclined to see genes as revealing something essential about a person, and instead, view genes as malleable in the same way that environments are malleable. Biological arguments need not be in sole service of the status quo.

Yet public opinion is not a perfect corollary of scientific understanding. Nor is scientific knowledge a perfect corollary of good policy. What a society chooses to do with genetic research and information is ultimately a social and political question [13]. In the early 20th century, support for eugenics was common among both conservatives and progressives [16]. For progressives, eugenics provided a means of improving the conditions of the working class by attacking the root cause rather than the symptoms of disadvantage. For conservatives, it offered an explanation for social problems that seemed to undermine the relevance of economic regulation and government intervention. Thus, through different rationales, both groups saw value

in selective restrictions on immigration, fertility control, and, in extreme cases, forced sterilization.

By the same token, what the public chooses to do with genetic arguments will ultimately depend on its other beliefs, attitudes, and values. The public already accepts that genes are important to life, but this acceptance will not lead, of necessity, to greater tolerance. In public opinion, as in politics, the controversy surrounding genes rests not with whether they matter at all, but rather with their implications.

References

1. Duster T. Comparative perspectives and competing explanations: taking on the newly configured reductionist challenge to sociology. *Am Sociol Rev*. 2006;71:1-15.
2. Herrnstein RJ, Murray C. *The Bell Curve: Intelligence and Class Structure in American Life.* New York, NY: Simon & Schuster; 1996.
3. Shostak S, Freese J, Link BG, Phelan JC. The politics of the gene: social status and beliefs about genetics for individual outcomes. *Soc Psychol Q*. In press.
4. Singer E, Corning A, Lamias M. Trends: genetic testing, engineering, and therapy: awareness and attitudes. *Public Opin Q.* 1998;62(10):633-664.
5. Duster T. *Backdoor to Eugenics*. 2nd ed. New York, NY: Routledge; 2003.
6. Keller J. In genes we trust: the biological component of psychological essentialism and its relationship to mechanisms of motivated social cognition. *J Pers Soc Psychol*. 2005;88(4):686-702.
7. Condit CM. How the public understands genetics: non-deterministic and non-discriminatory interpretations of the 'blueprint' metaphor. *Public Underst Sci.* 1999;8(3):169-180.
8. Nelkin D, Lindee MS. *The DNA Mystique: The Gene As a Cultural Icon*. New York, NY: Freeman; 1995.
9. Condit CM. *The Meanings of the Gene: Public Debates About Human Heredity*. Madison, WI: University of Wisconsin Press; 1999.
10. Schnittker J. An uncertain revolution: why the rise of a genetic model of mental illness has not increased tolerance. *Soc Sci Med.* 2008;67(9):1370-1381.
11. Conrad P. Genetic optimism: framing genes and mental illness in the news. *Cult Med Psychiatry*. 2001;25(2):225-247.
12. Priest SH. US public opinion divided over biotechnology? *Nat Biotechnol*. 2000;18(9):939-942.
13. Alper JS, Beckwith J. Genetic fatalism and social policy: the implications of behavior genetics research. *Yale J Biol Med.* 1993;66(6):511-524.
14. Phelan JC. Genetic bases of mental illness—a cure for stigma? *Trends Neurosci.* 2002;25(8):430-431.
15. Phelan JC, Yang LH, Cruz-Rojas R. Effects of attributing serious mental illnesses to genetic causes on orientations to treatment. *Psychiatr Serv.*

2006;57(3):382-387.
16. Kevles DJ. *In the Name of Eugenics: Genetics and the Uses of Human Heredity*. New York, NY: Knopf; 1985.

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MEDICINE AND SOCIETY

Legacy of Abuse in a Sacred Profession: Another Call for Change

Janet Rose Osuch, MD, MS

Medicine is a sacred profession. Those called to enter it are largely kind, compassionate, insightful people who understand the nature of suffering and want to live their professional lives in service to relieving it. Why, then, do I contend that there is a legacy of abuse in medicine? I will examine two specific and dominant themes to explain my position—the culture of silence that has until recently surrounded medical error, and the methods employed in medical education. Both involve the inherent asymmetry of power in relationships and misuse of that power. Both foster conditions that, if they do not actually breed abuse, certainly tolerate it.

Admitting Responsibility for Medical Error

The 2000 Institute of Medicine report, "To Err is Human," issued a compelling indictment against our profession, exposing multiple types of medical errors, and concluding that up to an estimated 100,000 patient deaths occur each year as a result of errors [1]. One of the elephants in the room of medicine had finally been exposed—that doctors, those most responsible for medical care, make mistakes. Although errors caused by carelessness, indifference, or lack of attention to detail are inexcusable to me, I recognize that most result from complex systems problems. This is not to say that we should not hold physicians, nurses, and other heath care workers accountable for errors, but that instead, we should recognize that most people who choose our field care deeply about their jobs and are devastated when a patient suffers because of a personal mistake. Rather than passing judgment but ignoring the error, blaming the person, or both, the entire team caring for the patient should be involved in discussing the error together, learning from it, and, ultimately, devising a plan to prevent a similar problem from occurring in the future.

Admitting personal responsibility for a mistake is difficult, especially when we are well-intentioned and doing the best we can. It requires honesty, humility, and courage. It also entails that we remain acutely aware of the asymmetry of knowledge and power inherent in the patient-physician relationship. When a patient suffers because something went wrong, it is human nature for that person and his or her family to want to understand what happened. Our legacy of silence in the face of medical error in medicine has been, and in many cases, continues to be a poignant example of how we misuse our superior knowledge and, hence, our status. The very least that a patient and family deserve in this setting is a compassionate and transparent explanation, sincere apology, and communication of a plan of action to ensure that the error is not repeated with future patients. Apologizing for a medical

mistake in this way is perhaps the most healing action a physician can take for the patient to whom it happened.

Abuse in Medical Education

I believe that asymmetry in relationships and the misuse of power explains another cultural phenomenon in medicine—the abuse of medical learners. In my own surgery residency, the culture of abuse was pervasive. I certainly did not feel singled out in this context; I witnessed daily infractions against my peers that often made me cringe. I took this culture for granted for years, although it saddened me a great deal. When I was a resident, I believed, naively, that this culture was peculiar to my institution, not profession-wide. As I became part of the world of academic medicine as an attending physician, however, I witnessed the abuse of medical students, residents, and patients many times, although I felt helpless to stop it. Recent publications document that the majority of students of today experience humiliation or belittlement during their medical education [2, 3]. What I am saying is that, even if we win teaching awards year after year, if we tolerate this abusive culture, we are part of the problem.

Two years ago, I took the position of assistant dean of preclinical curriculum at the College of Human Medicine at Michigan State University, causing me to reflect more seriously on the abuses that I experienced in my own education. Medical educators have written extensively about "the hidden curriculum," which I consider a euphemism for the emotional abuse of medical students. Although we tout the benefits of and expectations that students practice relationship- or patient-centered care, I contend, as have others, that taking this position is unsustainable when we simultaneously tolerate an abusive learning environment in medicine [2, 4]. Anyone who has been a medical student or resident understands the emotional devastation that this culture of abuse creates, a reality that was provocatively written about by medical students recently, and that often persists for years later [5, 6].

I care deeply about the profession of medicine and feel privileged to be a part of it. In writing these comments, I was therefore not surprised to find myself hesitating to articulate examples of what the words "culture of abuse" imply, almost as if writing the words would somehow break an expected code of silence. That this phrase represents a worse indictment of the profession than the exposure of medical mistakes is, in my opinion, an understatement. It is quite probable, in fact, that the phenomena of medical error and student abuse are deeply intertwined, as both involve abuse of power.

It is with difficulty that I articulate the often dominant teaching culture of our profession, which is adversarial and based on intimidation, public humiliation, harassment, belittlement, and fear, especially in the clinical years [4-8]. This is an international phenomenon, and one that includes not only physicians, but other professions in medicine as well [3, 9]. Students are expected to know the answers to every "pimp" question without faltering, defer to the deeply entrenched hierarchical structure even in unfair situations, and never question their superiors, even when the

latter are exhibiting overtly unprofessional behavior. The consequences of this culture are predictable—low self-confidence, anger, cynicism, emotional disconnection, and depression [4, 7, 10]. How can this fail to result in disconnection, neglect, or even abuse toward patients, those in the system who are by far the most vulnerable in the hospital hierarchy?

We all entered medical school as optimistic, compassionate people. Many of us, including me, emerged from residency with cynicism and doubt about whether medicine could be as fulfilling as we had anticipated. We have been victims of the educational culture to one extent or another, whether we admit it or not. This, however, is no excuse for continuing its legacy. Instead, we must reframe the culture in which we teach our students so that we offer them the same respect, honesty, and kindness that we expect them to extend to their patients.

This is not to suggest that we should lower our standards and expect less than excellence from the learners of our profession, but that we dedicate ourselves to creating a consistent environment of interconnectedness between students and faculty [4]. It is a great privilege to interact with the future physicians. Our learning environment should foster intellectual inquiry that supports emotional and academic growth and is mutual, recognizing that our students have much to add to our own level of knowledge. Teachers are powerful role models. The environment we create should embrace, rather than diminish the spirit of the learner.

A Moral Imperative for Medical Educators

This is a call to medical educators to take definitive steps to cease tolerating the culture of abuse in medical education and view it as unacceptable. The call has been issued previously but has not been heard loudly enough to initiate substantial change [4, 11-14]. Medical educators have a moral imperative to create a culture of caring and respect in the field and to recognize the need for organizational and institutional change [3, 13].

We must have the courage to recognize not only that we commit medical errors in our care of patients, but that, by tolerating an abusive educational system, we commit errors toward our students as well. We must have the humility to accept the power differential between students and ourselves, understand the ease with which this power can be abused, and reflect each day on our interactions with students and residents to achieve self-improvement [15].

Most people who choose to teach are passionate individuals who care deeply about medical education and have been victims of an abusive educational system. Rather than passing judgment but ignoring an abusive incident, medical educators can create both informal and formal mechanisms to function as an educational team, address the incident together, learn from it, and take steps toward preventing a similar problem for future students. Intercollegial, nonjudgmental feedback based on mutual respect and goals for change is the key to the success of this endeavor. For the aggrieved learner, a discussion of the incident and the receipt of a compassionate and sincere

apology that recognizes the learner's personhood is perhaps our most healing offering. It will require the same amount of honesty, humility, and courage that we offer patients, if not more, because our educational errors are often an indictment of our behavioral and professional, rather than our intellectual or technical shortcomings.

Personal Coda

Events from my own life illustrate these themes. Having practiced medicine as a general surgery resident or academic physician for 19 years, I believed that I understood the best and the worst of medicine when I entered the hospital in March 1998 to have neurosurgical intervention for a 6-centimeter vestibular schwannoma in my brain. I was wrong. My 19-day hospitalization taught me many lessons. Certainly the most profound of these was the depth of the vulnerability that a patient with a serious illness feels. Although encounters with kind, compassionate, technically competent, and caring people were the norm during this time, my hospitalization also included serious surgical complications, medication errors, and communications of indifference or, uncommonly, even abuse from doctors, nurses, and other members of the health care team. When I contemplate my illness, what continues to bring me the most emotional pain are not the physical complications that ended my career in surgery, but the emotional abuses that I suffered. Although they were infrequent, their impact was far from trivial. Try as I might, it has been impossible to separate the pain of those incidents from those that I suffered as a resident. The interconnectedness between patient abuse and abuses in medical education became an inescapable reality for me.

I vividly remember the conversation that I had with my attending physician and the chief neurosurgery resident about a medication error that resulted in a serious complication. Although the attending physician was professional, responsible, and apologetic during the conversation, the senior resident was not. Instead, I would characterize his exchange with me as arrogant, defensive, and dismissive. The asymmetry between us—me the debilitated patient with an intracranial hematoma who could not ambulate, and he, a towering figure in a white coat—was not lost on me. I wondered though, is it possible that his own endurance of 5 years of neurosurgery residency had taken a toll on his ability to extend a compassionate response to me? What abuses had he suffered, and how might they have made him so incapable of a kind, professional response?

In deep contrast, one of the most profound interactions I experienced during that same hospitalization was with a much younger physician whom I didn't even know. The night before my operation was a fearful, vulnerable time for me, and I had trouble falling asleep. I hesitated to call for a sedative, remembering how often my restless nights as a resident had been interrupted by a sleepless patient. I felt sure, however, that a sedative had already been ordered for me when I rang the nurse's bell close to midnight. Imagine how I felt when I found the neurosurgery resident standing at my bedside shortly thereafter. In the darkness of the room, he asked how he could help me. I told him that I must be nervous because of the upcoming surgery,

that I couldn't sleep, and that I was mortified that he was losing sleep because of my request. He took my hand and told me that he would feel better knowing that I felt better. It was a simple interaction that lasted seconds, yet it was one of the most powerful experiences that I had in the hospital, holding meaning for me even 10 years later. This compassionate resident, in contrast to the first, understood my suffering and undoubtedly felt fulfilled by my grateful response to him. It is likely, however, that he had not yet had to tolerate the years of abuse that the previous resident had suffered.

I contend that, in good conscience, we cannot let this situation continue. We must attend to, value, and preserve the compassionate qualities with which our students enter the profession. I believe that Robert Michels says it best: "The nurturance of the physician's soul is the function of medical education" [16]. The wisdom of this insight empowers us in a profound way. We must follow its imperative. Just as we expect relationship-centered care for our patients, we must engender a culture of relationship-centered learning in medical education [4].

Attempts to change any culture require commitment, continuing and sustainable leadership, and a recognition that cultural change does not come quickly. As medical educators, we must collectively provide this leadership. The future patients and learners of our sacred profession depend on it.

References

1. Kohn L, Corrigan J, Donaldson MS, eds. *To Err Is Human: Building a Safer Health System*. Institute of Medicine Report. Washington, DC: National Academy Press; 2000.
2. Frankel RM. Relationship-centered care and the patient-physician relationship. *J Gen Intern Med*. 2004;19(11):1163-1165.
3. Wilkinson TJ, Gill DJ, Fitzjohn J, Palmer CL, Mulder RT. The impact on students of adverse experiences during medical school. *Med Teach*. 2006;28(2):129-135.
4. Haidet P, Stein HF. The role of the student-teacher relationship in the formation of physicians. The hidden curriculum as process. *J Gen Intern Med*. 2006;21(Suppl 1):S16-S20.
5. Brainard AH, Brislen HC. Viewpoint: learning professionalism: a view from the trenches. *Acad Med*. 2007;82(11):1010-1014.
6. Silver HK, Glicken AD. Medical student abuse. Incidence, severity, and significance. *JAMA*. 1990;263(4):527-532.
7. Elnicki DM, Curry RH, Fagan M, et al. Medical students' perspectives on and responses to abuse during the internal medicine clerkship. *Teach Learn Med*. 2002;14(2):92-97.
8. Frank E, Carrera JS, Stratton T, Bickel J, Nora LM. Experiences of belittlement and harassment and their correlates among medical students in the United States: longitudinal survey. *BMJ*. 2006;333(7570):682.
9. Ozolins I, Hall H, Peterson R. The student voice: recognising the hidden and informal curriculum in medicine. *Med Teach*. 2008;30(6):606-611.

10. Seabrook MA. Medical teachers' concerns about the clinical teaching context. *Med Educ*. 2003;37(3):213-222.
11. Bardes CL. Teaching, digression, and implicit curriculum. *Teach Learn Med*. 2004;16(2):212-214.
12. Hafferty FW. Beyond curriculum reform: confronting medicine's hidden curriculum. *Acad Med*. 1998;73(4):403-407.
13. Suchman AL, Williamson PR, Litzelman DK, et al. Toward an informal curriculum that teaches professionalism. Transforming the social environment of a medical school. *J Gen Intern Med*. 2004;19(5 Pt 2):501-504.
14. Viggiano TR, Pawlina W, Lindor KD, Olsen KD, Cortese DA. Putting the needs of the patient first: Mayo Clinic's core value, institutional culture, and professionalism covenant. *Acad Med.* 2007;82(11):1089-1093.
15. Cassell EJ. Consent or obedience? Power and authority in medicine. *N Engl J Med*. 2005;352(4):328-330.
16. Michels R. Afterword. In: Ginzberg E. *Urban Medical Centers: Balancing Academic and Patient Care Functions*. Boulder, CO: Westview Press; 1996: 93.

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HISTORY OF MEDICINE

History of Violence as a Public Health Problem

Linda L. Dahlberg, PhD, and James A. Mercy, PhD

Violence is now clearly recognized as a public health problem, but just 30 years ago the words "violence" and "health" were rarely used in the same sentence. Several important trends contributed to a growing recognition and acceptance that violence could be addressed from a public health perspective. First, as the United States became more successful in preventing and treating many infectious diseases, homicide and suicide rose in the rankings of causes of death. Tuberculosis and pneumonia were the two leading causes of death at the turn of the 20th century. By mid-century, the incidence and mortality from these infectious diseases along with others such as yellow fever, typhus, poliomyelitis, diphtheria, and pertussis were dramatically reduced through public health measures such as sanitary control of the environment, isolation of contagious disease cases, immunization, and the application of new therapeutic and medical techniques. Since 1965, homicide and suicide have consistently been among the top 15 leading causes of death in the United States [1, 2].

There are other reasons why violence became a greater focus for public health. The risk of homicide and suicide reached epidemic proportions during the 1980s among specific segments of the population including youth and members of minority groups. Suicide rates among adolescents and young adults 15 to 24 years of age almost tripled between 1950 and 1990 [3]. Similarly, from 1985 to 1991 homicide rates among 15- to 19-year-old males increased 154 percent, a dramatic departure from rates of the previous 20 years for this age group [4]. This increase was particularly acute among young African American males. These trends raised concerns and provoked calls for new solutions.

Another important development was the increasing acceptance within the public health community of the importance of behavioral factors in the etiology and prevention of disease. It is now generally accepted that prevention of three of the leading causes of death in the United States—heart disease, cancer, and stroke—rests largely on behavioral modifications such as exercise, changes in diet, and smoking cessation. Successes in these areas encouraged public health professionals to believe that they could accomplish the same for behavioral challenges underlying interpersonal violence and suicidal behavior. Finally, the emergence of child maltreatment and intimate partner violence as recognized social problems in the 1960s and 1970s demonstrated the need to move beyond sole reliance on the criminal-justice sector in solving these problems.

Calls for Action

These trends and developments led to the publication of several landmark reports that highlighted the public health significance of violence. In 1979, the Surgeon General's Report, "Healthy People," documented the dramatic gains made in the health of the American people during the previous century and identified 15 priority areas in which, with appropriate action, further gains could be expected over the course of the next decade [5]. Among the 15 was control of stress and violent behavior. This report emphasized that the health community could not ignore the consequences of violent behavior in an effort to improve the health of children, adolescents, and young adults. The goals for violence prevention established in this report were translated into measurable objectives in "Promoting Health/Preventing Disease: Objectives for the Nation" [6]. These objectives called for substantial reductions by 1990 in: (1) the number of child-abuse injuries and deaths, (2) rate of homicide among black males 15 to 24 years of age, (3) rate of suicide among 15 to 24 year olds, (4) number of privately owned handguns, and (5) improvements in the reliability of data on child abuse and family violence. In 1985, the "Report of the Secretary's Task Force on Black and Minority Health" identified homicide as a major cause of the disparity in death rate and illness experienced by African Americans and other minorities relative to non-Hispanic whites [7]. And the 1989 "Report of the Secretary's Task Force on Youth Suicide" provided a comprehensive synthesis of the state of knowledge about youth suicide and recommended a course of action for stemming the substantial increases that had occurred over the previous 3 decades [3].

Response to the Call

The emergence of violence as a legitimate issue on the national health agenda spurred a variety of responses from the public health sector during the 1980s. In 1983, the CDC established the Violence Epidemiology Branch, which was integrated into the Division of Injury Epidemiology and Control (DIEC) 3 years later. The creation of DIEC was a direct consequence of a National Research Council (NRC) and Institute of Medicine (IOM) report, "Injury in America: A Continuing Public Health Problem" [8]. This report recommended establishing a federal center for injury control within the CDC and called for funding that would be commensurate with the size of the problem. Support for the NRC/IOM report recommendations contributed to a gradual increase in the number of staff and the size of the budget devoted to violence prevention research and programmatic activities at the CDC.

Further evidence of increased concern from the public health community during the 1980s was provided by the Surgeon General's Workshop on Violence and Public Health in 1985 [9]. This workshop was the first time that the Surgeon General clearly recognized violence as a public health problem and encouraged all health professionals to respond.

Applying the Tools of Epidemiology

During the same period, the CDC undertook a number of high-profile epidemiologic investigations, looking into a series of child murders in Atlanta and a suicide cluster

in Plano, Texas [10, 11]. These investigations helped to demonstrate that epidemiologic research methods could successfully be applied to incidents of violence. Public health professionals contributed to the understanding of violence through the use of epidemiologic methods to characterize the problem and identify modifiable risk factors. In particular, efforts were made to: (1) describe the problem of homicide and suicide as causes of death, (2) monitor public health objectives for homicide and suicide, (3) examine epidemiologic characteristics of different types of homicide, (4) characterize homicide as a cause of death in the workplace, (5) describe patterns of homicide and suicide victimization in minority populations and among children, (6) study physical child abuse, and (7) quantify the risks of homicide and suicide associated with access to firearms [12-14].

Determining What Works

Beginning in the early 1990s the public health approach to violence shifted from describing the problem to understanding what worked in preventing it. These efforts were bolstered by a number of appropriations from Congress. In 1992, the CDC received its first appropriation aimed at curbing the high rates of homicide among youth. The following year, the CDC published "The Prevention of Youth Violence: A Framework for Community Action," an influential document that outlined the steps necessary to implement a public health approach to youth violence prevention [15]. By 1993, numerous violence-prevention programs were being developed and undertaken in schools and communities across the United States. In 1993, the CDC received its second appropriation for youth violence and used it to evaluate some of the more common prevention approaches being tried across the United States. These evaluation studies were among the first randomized control trials to specifically assess the impact of programs on violence-related behaviors and injury outcomes. Overall, they helped demonstrate that significant reductions in aggressive and violent behavior were possible with applied, skill-based violence-prevention programs that address social, emotional, and behavioral competencies, as well as family environments.

The achievements made in the prevention of youth violence throughout the 1980s and 1990s were published in "Youth Violence: A Report of the Surgeon General," which provided a comprehensive synthesis of the state of knowledge about youth violence, including what was known about the different patterns of offending, risk and protective factors within and across various domains (e.g., peer, family, school, and community), and about the effectiveness of prevention programs [16]. The report also highlighted the cost effectiveness of prevention over incarceration and set forth a vision for the 21st century.

The early successes in youth-violence prevention paved the way for a public health approach to other violence problems such as intimate partner violence, sexual violence, and child maltreatment. Efforts were made to document each problem, understand the risk and protective factors associated with each type of violence, and begin building the evidence-base for prevention. In 1994, for example, the CDC and the National Institute of Justice collaborated on the first national violence-against-

women survey. Conducted over the next 2 years, the survey produced the first national data on the incidence, prevalence, and economic costs of intimate partner violence, sexual violence, and stalking [17]. In 1994, Congress passed the Violence Against Women Act (Title IV of the Violent Crime Control and Law Enforcement Act)—landmark legislation that established rape prevention and education programs across the nation, in Puerto Rico and six other U.S. territories and called for local demonstration projects to coordinate the intervention and prevention of domestic violence. The CDC was given the federal responsibility to administer both efforts. The appropriations for these programs and their subsequent reauthorization from Congress were instrumental in building the infrastructure and capacity for the prevention of intimate partner violence and sexual violence at the local and state level.

Moving Forward in a Global Context

As public health efforts to understand and prevent violence gained momentum in the United States, they garnered attention abroad. Violence was placed on the international agenda in 1996 when the World Health Assembly adopted Resolution WHA49.25, which declared violence "a leading worldwide public health problem." The resolution requested the WHO to initiate public health activities to: (1) document and characterize the burden of violence, (2) assess the effectiveness of programs, with particular attention to women and children and community-based initiatives, and (3) promote activities to tackle the problem at the international and country level. In 2000, the WHO created the Department of Injuries and Violence Prevention to increase the global visibility of unintentional injury and violence and to facilitate public health action. The organization's "World Report on Violence and Health," published in 2002, is used throughout the world as a platform for increased public health action toward preventing violence [18].

Next Steps

As we move into the 21st century, public health is placing greater emphasis on disseminating and implementing effective violence-prevention programs and policies. The need to document and monitor the problem and identify effective programs and policies through research remains critically important. Nevertheless, a strong foundation has been laid for future success.

References

1. Centers for Disease Control and Prevention. National Center for Health Statistics. Leading causes of death, 1900-1998. http://www.cdc.gov/nchs/data/dvs/lead1900_98.pdf. Accessed November 18, 2008.
2. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS). 2009. http://www.cdc.gov/ncipc/wisqars. Accessed November 18, 2008.

3. Alcohol, Drug Abuse, and Mental Health Administration. *Report of the Secretary's Task Force on Youth Suicide*. Vol. 1. Washington, DC: US Government Printing Office; 1989.
4. Centers for Disease Control and Prevention. Homicides among 15-19-year-olds Males—United States, 1963-1991. *MMWR Morb Mortal Wkly Rep*. 1994;43(40):725-727.
5. US Department of Health, Education, and Welfare. *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention.* Washington, DC: US Government Printing Office; 1979.
6. US Department of Health & Human Services. *Promoting Health/Preventing Disease; Objectives for the Nation.* Washington, DC: US Government Printing Office; 1980.
7. US Department of Health & Human Services. *Report of the Secretary's Task Force on Black and Minority Health.* Washington, DC: US Government Printing Office; 1985.
8. National Research Council & Institute of Medicine. *Injury in America: A Continuing Public Health Problem*. Washington, DC: National Academy Press; 1985.
9. US Department of Health & Human Services. US Department of Justice. *Surgeon General's Workshop on Violence and Public Health Report*. Washington, DC: Health Resources Service Administration; 1986.
10. Blaser MJ, Jason JM, Weniger BG, et al. Epidemiologic analysis of a cluster of homicides of children in Atlanta. *JAMA.* 1984;251(24):3255-3258.
11. Davidson LE, Rosenberg ML, Mercy JA, Franklin J, Simmons JT. An epidemiologic study of risk factors in two teen suicide clusters. *JAMA.* 1989;262(19):2687-2692.
12. Mercy JA, O'Carroll PW. New directions in violence prediction: the public health arena. *Violence Vict.* 1988;3(4):285-301.
13. National Center for Injury Prevention and Control. *The Prevention of Youth Violence: A Framework for Community Action*. Atlanta, GA: Centers for Disease Control and Prevention; 1993.
14. Kellermann AL, Rivara FP, Somes G, et al. Suicide in the home in relation to gun ownership. *N Engl J Med.* 1992;327(7):467-472.
15. US Department of Health & Human Services, National Center for Environmental Health and Injury Control Division of Injury Control, Office of the Assistant Director for Minority Health. *The Prevention of Youth Violence: A Framework for Community Action.* Atlanta, GA: Centers for Disease Control and Prevention; 1992.
16. US Department of Health & Human Services. *Youth Violence: A Report of the Surgeon General*. Centers for Disease Control and Prevention, Substance Abuse and Mental Health Services Administration, National Institutes of Health for the National Institute of Mental Health. Washington, DC: US Government Printing Office; 2001.
17. Tjaden P, Thoennes N. *Full Report of the Prevalence, Incidence, and Consequences of Violence Against Women: Findings from the National*

Violence Against Women Survey. Washington, DC: National Institute of Justice, Office of Justice Programs, United States Department of Justice, Centers for Disease Control and Prevention; 2000.
18. Krug EG, Dahlberg LL, Mercy JA, Zwi AB, Lozano R. *World Report on Violence and Health*. Geneva, Switzerland: World Health Organization; 2002.

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SUGGESTED READINGS AND RESOURCES

Alcohol, Drug Abuse, and Mental Health Administration. *Report of the Secretary's Task Force on Youth Suicide*. Vol. 1. Washington, DC: US Government Printing Office; 1989.

Alper JS, Beckwith J. Genetic fatalism and social policy: the implications of behavior genetics research. *Yale J Biol Med.* 1993;66(6):511-524.

Amar AF, Alexy EM. "Dissed" by dating violence. *Perspect Psychiatr Care*. 2005;41(4):162-171.

American Academy of Pediatrics. Children's health topics: child abuse & neglect. 2008. http://www.aap.org/healthtopics/childabuse.cfm. Accessed November 4, 2008.

American Medical Association. Opinion 2.02 Abuse of spouses, children, elderly persons, and others at risk. *Code of Medical Ethics.* Chicago, IL: American Medical Association. 2006. http://www.ama-assn.org/ama1/pub/upload/mm/Code_of_Med_Eth/opinion/opinion202.html. Accessed January 13, 2009.

American Medical Association. Opinion 5.05. Confidentiality. *Code of Medical Ethics*. Chicago, IL: American Medical Association. 2007. http://www.ama-assn.org/ama1/pub/upload/mm/Code_of_Med_Eth/opinion/opinion505.html. Accessed January 8, 2009.

American Medical Association. Principle IV. *Code of Medical Ethics*. Chicago, IL. American Medical Association. 2001. http://www.ama-assn.org/ama1/pub/upload/mm/Code_of_Med_Eth/principles.html. Accessed January 9, 2009.

American Medical Association. Report 4 (I-06). Confidentiality. Amendment report of the Council on Ethical and Judicial Affairs. Chicago, IL: American Medical Association. 2006. http://www.ama-assn.org/ama1/pub/upload/mm/369/ceja_recs_4i06.pdf. Accessed January 9, 2009.

Arehart-Treichel J. Men shouldn't be overlooked as victims of partner violence. *Psychiatr News*. 2007;42(15):31.

Bardes CL. Teaching, digression, and implicit curriculum. *Teach Learn Med*. 2004;16(2):212-214.

Bindman AB, Grumbach K, Keane D, Rauch L, Luce JM. Consequences of queuing for care at a public hospital emergency department. *JAMA.* 1991;266(8):1091-1096.

Blaser MJ, Jason JM, Weniger BG, et al. Epidemiologic analysis of a cluster of homicides of children in Atlanta. *JAMA.* 1984;251(24):3255-3258.

Bonafons C, Jehel L, Coroller-Bequet A. Specificity of the links between workplace harassment and PTSD: primary results using court decisions, a pilot study in France. [published online ahead of print September 29, 2008]. *Int Arch Occup Environ Health.* doi:10.1038.nm1024.

Brach J. Plaxico Burress shoots himself accidentally. *The New York Times*. November 20, 2008. SP1.

Brainard AH, Brislen HC. Viewpoint: learning professionalism: a view from the trenches. *Acad Med*. 2007;82(11):1010-1014.

Brewer RA, Jones JS. Reporting elder abuse: limitation of statutes. *Ann Emerg Med.* 1989;18(11):1217-1221.

California Attorney General's Office. Facts—fighting domestic violence: the California record highlights. 1998. http://safestate.org/index.cfm?navid=221. Accessed January 6, 2009.

Campbell JC. Health consequences of intimate partner violence. *Lancet*. 2002;359(9314):1331-1336.

Campbell JC, Jones AS, Dienemann J, et al. Intimate partner violence and physical health consequences. *Arch Intern Med*. 2002;162(10):1157-1163.

Cassell EJ. Consent or obedience? Power and authority in medicine. *N Engl J Med*. 2005;352(4):328-330.

Centers for Disease Control and Prevention. Emergency department response to domestic violence—California, 1992. *MMWR Morb Mortal Wkly Rep.* 1993;42(32):617-619.

Centers for Disease Control and Prevention. Homicides among 15-19-year-olds Males—United States, 1963-1991. *MMWR Morb Mortal Wkly Rep.* 1994;43(40):725-727.

Centers for Disease Control and Prevention. National Center for Health Statistics. Leading causes of death, 1900-1998. http://www.cdc.gov/nchs/data/dvs/lead1900_98.pdf. Accessed November 18, 2008.

Centers for Disease Control and Prevention. *National Summary of Injury Mortality Data, 1987-1994.* Atlanta, GA: National Center for Injury Prevention and Control; 1996.

Centers for Disease Control and Prevention. Physical dating violence among high school students, United States—2003. *MMWR Morb Mortal Wkly Rep*. 2006;55(19):532-535.

Centers for Disease Control and Prevention. Understanding teen dating violence fact sheet. 2008. www.cdc.gov/ncipc/pub-res/datingabusefactsheet-a.pdf. Accessed January 12, 2008.

Centers for Disease Control and Prevention. Violence prevention at CDC. 2008. http://www.cdc.gov/ncipc/dvp/prevention_at_CDC.htm. Accessed January 6, 2009.

Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS). 2009. http://www.cdc.gov/ncipc/wisqars. Accessed November 18, 2008.

Chapman DP, Dube SR, Anda RF. Adverse childhood events as risk factors for negative mental health outcomes. *Psychiatr Ann*. 2007;37(5):359-364.

Cheng TL, Wright JL, Markakis D, Copeland-Linder N, Menvielle E. Randomized trial of a case management program for assault-injured youth: impact on service utilization and risk for reinjury. *Pediatr Emerg Care.* 2008;24(3):130-136.

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(5):451-457.

Commission for the Prevention of Youth Violence. Youth and violence. 2000. http://www.ama-assn.org/ama/upload/mm/386/fullreport.pdf. Accessed April 8, 2008.

Condit CM. How the public understands genetics: non-deterministic and non-discriminatory interpretations of the 'blueprint' metaphor. *Public Underst Sci.* 1999;8(3):169-180.

Condit CM. *The Meanings of the Gene: Public Debates About Human Heredity.* Madison, WI: University of Wisconsin Press; 1999.

Conrad P. Genetic optimism: framing genes and mental illness in the news. *Cult Med Psychiatry*. 2001;25(2):225-247.

Cornell DG, Sheras PL, Kaplan S, et al. Guidelines for student threat assessment: field-test findings. *School Psych Rev.* 2004;33(4):527-546.

Corso PS, Edwards VJ, Fang X, Mercy JA. Health-related quality of life among adults who experienced maltreatment during childhood. *Am J Public Health.* 2008;98(6):1094-1100.

Corso PS, Mercy JA, Simon TR, Finkelstein EA, Miller TR. Medical costs and productivity losses due to interpersonal and self-directed violence in the United States. *Am J Prev Med*. 32(6):474-482.

Davidson LE, Rosenberg ML, Mercy JA, Franklin J, Simmons JT. An epidemiologic study of risk factors in two teen suicide clusters. *JAMA.* 1989;262(19):2687-2692.

Dearing B, Caston RJ, Babin J. The impact of a hospital based educational program on adolescent attitudes toward drinking and driving. *J Drug Educ.* 1991;21(4):349-359.

Dowd MD. Consequences of violence. Premature death, violence recidivism, and violent criminality. *Pediatr Clin North Am.* 1998;45(2):333-340.

Due P, Holstein BE. Bullying victimization among 13 to 15-year-old school children: results from two comparative studies in 66 countries and regions. *Int J Adolesc Med Health.* 2008;20(2):209-221.

Duster T. *Backdoor to Eugenics*. 2nd ed. New York, NY: Routledge; 2003.

Duster T. Comparative perspectives and competing explanations: taking on the newly configured reductionist challenge to sociology. *Am Sociol Rev*. 2006;71:1-15.

Einarsen S, Hoel H, Zapf D, Cooper C. *Bullying and Emotional Abuse in the Workplace: International Perspectives in Research and Practice*. London, England: Taylor & Francis; 2003.

Eisenberg M, Neumark-Sztainer D. Peer harassment and disordered eating. *Int J Adolesc Med Health.* 2008;20(2):155-164.

Elnicki DM, Curry RH, Fagan M, et al. Medical students' perspectives on and responses to abuse during the internal medicine clerkship. *Teach Learn Med*. 2002;14(2):92-97.

Federal Bureau of Investigation. The school shooter: a threat assessment perspective. 2000. http://www.fbi.gov/publications/school/school2.pdf. Accessed January 14, 2009.

Flaherty EG, Sege RD, Griffith J, et. al. From suspicion of physical child abuse to reporting: primary care clinician decision-making. *Pediatrics*. 2008;122(3):611-619.

Flaherty L, Weist MD, Warner BS. School-based mental health services in the United States: history, current models and needs. *Community Ment Health J.* 1996;32(4):341-352.

Foster J, Nunez A, Robertson CJ, Parrino T, Spencer SB. American Public Health Association. HIV and domestic violence: training to improve HIV risk reduction counseling, testing, and sexual safety planning with DV survivors. 2008. http://apha.confex.com/apha/136am/webprogram/Paper176964.html. Accessed January 12, 2009.

Frank E, Carrera JS, Stratton T, Bickel J, Nora LM. Experiences of belittlement and harassment and their correlates among medical students in the United States: longitudinal survey. *BMJ*. 2006;333(7570):682.

Frank E, Elon L, Saltzman LE, Houry D, McMahon P, Doyle J. Clinical and personal intimate partner violence training experiences of U.S. medical students. *J Womens Health (Larchmt)*. 2006:15(9):1071-1079.

Frankel RM. Relationship-centered care and the patient-physician relationship. *J Gen Intern Med*. 2004;19(11):1163-1165.

Gielen AC, O'Campo PJ, Campbell JC, et al. Women's opinions about domestic violence screening and mandatory reporting. *Am J Prev Med.* 2000;19(4):279-285.

Glass N, Campbell JC. Mandatory reporting of intimate partner violence by health care professionals: a policy review. *Nurs Outlook.* 1998;46(6):279-283.

Grumbach K, Keane D, Bindman A. Primary care and public emergency department overcrowding. *Am J Public Health.* 1993;83(3):372-378.

Gupta M. Mandatory reporting laws and the emergency physician. *Ann Emerg Med.* 2007;49(3):369-376.

Hafferty FW. Beyond curriculum reform: confronting medicine's hidden curriculum. *Acad Med*. 1998;73(4):403-407.

Haidet P, Stein HF. The role of the student-teacher relationship in the formation of physicians. The hidden curriculum as process. *J Gen Intern Med*. 2006;21(Suppl 1):S16-S20.

Hamberger LK. Preparing the next generation of physicians: medical school and residency-based violence curriculum and evaluation. *Trauma Violence Abuse*. 2007:8(2):214-225.

Hartzell KN, Botek AA, Goldberg SH. Orbital fractures in women due to sexual assault and domestic violence. *Ophthalmology*. 1996;103(6):953-957.

Hawaii Rev. Stat. 453-14. http://www.capitol.hawaii.gov/hrscurrent/Vol10_Ch0436-0474/HRS0453/HRS_0453-0014.htm.

Hayes DN, Sege R. FiGHTS: a preliminary screening tool for adolescent firearms-carrying. *Ann Emerg Med.* 2003;42(6):798-807.

Heise L, Garcia-Moreno C. Violence by intimate partners. In: Krug E, Dahlberg LL, Mercy JA, et al, eds. *World Report on Violence and Health*. Geneva, Switzerland: World Health Organization; 2002. 87-121.

Herrnstein RJ, Murray C. *The Bell Curve: Intelligence and Class Structure in American Life.* New York, NY: Simon & Schuster; 1996.

Hindley N, Ramchandani PG, Jones DPH. Risk factors for recurrence of maltreatment: systemic review. *Arch Dis Child*. 2006;91(9):744-752.

Houry D, Sachs CJ, Feldhaus KM, Linden J. Violence-inflicted injuries: reporting laws in the fifty states. *Ann Emerg Med*. 2002;39(1):56-60.

Hurwitz KA. A review of special education law. *Pediatr Neurol.* 2008;39(3):147-154.

Iavicoli LG. Mandatory reporting of domestic violence: the law, friend or foe? *Mt Sinai J Med*. 2005;72(4):228-231.

Janson J, Nunez A. Drexel University College of Medicine Women's Health Education Program. PDA IPV screening tool. In press.

Jones R, Flaherty EG, Bins HJ, et al. Clinicians' description of factors influencing their reporting of suspected child abuse: report of the Child Abuse Reporting Experience Study Research Group. *Pediatrics*. 2008;122(2):259-266.

Joyce E. Teen dating violence: facing the epidemic. National Center for Victims of Crime. 2003. http://www.ncvc.org/ncvc/AGP.Net/Components/documentViewer/Download.aspxnz?DocumentID=38039. Accessed January 12, 2009.

Juvonen J, Gross EF. Extending the school grounds?—Bullying experiences in cyberspace. *J Sch Health.* 2008;78(9):496-505.

Kachur SP, Stennies GM, Powell KE, et al. School-associated violent deaths in the United States, 1992 to 1994. *JAMA.*1996;275(22):1729-1733.

Katz SN, Howe R, McGrath M. Child neglect laws in America. *Fam Law Q.* 1975;9:1-372.

Keller J. In genes we trust: the biological component of psychological essentialism and its relationship to mechanisms of motivated social cognition. *J Pers Soc Psychol*. 2005;88(4):686-702.

Kellermann AL, Rivara FP, Somes G, et al. Suicide in the home in relation to gun ownership. *N Engl J Med.* 1992;327(7):467-472.

Kempe CH, Silverman FN, Steele BF, Droegemueller W, Silver HK. The battered-child syndrome. *JAMA.* 1962;181:17-24.

Kevles DJ. *In the Name of Eugenics: Genetics and the Uses of Human Heredity.* New York, NY: Knopf; 1985.

Kim YS, Leventhal B. Bullying and suicide. A review. *Int J Adolesc Med Health.* 2008;20(2):133-154.

Kivimaki M, Leino-Arjas P, Virtanen M, et al. Work stress and incidence of newly diagnosed fibromyalgia: prospective cohort study. *J Psychosom Res.* 2004;57(5):417-422.

Kivimaki M, Virtanen M, Vartia M, Elovainio M, Vahtera J, Keltikangas-Jarvinen L. Workplace bullying and the risk of cardiovascular disease and depression. *Occup Environ Med*. 2003;60(10):779-783.

Kohn L, Corrigan J, Donaldson MS, eds. *To Err Is Human: Building a Safer Health System*. Institute of Medicine Report. Washington, DC: National Academy Press; 2000.

Krug EG, Dahlberg LL, Mercy JA, Zwi AB, Lozano R. *World Report on Violence and Health*. Geneva, Switzerland: World Health Organization; 2002.

Kumpulainen K. Psychiatric conditions associated with bullying. *Int J Adolesc Med Health*. 2008;20(2):121-132.

Laflamme L, Moller J, Hallqvist J, Engstrom K. Peer victimization and intentional injuries: quantitative and qualitative accounts of injurious physical interactions between students. *Int J Adolesc Med Health.* 2008;20(2):201-208.

Leeb RT, Paulozzi L, Melanson C, Simon TR, Arias I. *Child Maltreatment Surveillance. Uniform Definitions for Public Health and Recommended Data Elements*. Atlanta, GA: Centers for Disease Control and Prevention. National Center for Injury Prevention and Control; 2008.

Lenahan P, Shapiro J. Facilitating the emotional education of medical students: using literature and film in training about intimate partner violence. *Fam Med*. 2005:37(8):543-545.

Lewandowski LA. Mental and physical health effects of intimate partner violence on women and children. *Psychiatr Clin North Am*. 1997;20(2):353-374.

Lund LE. What happens when health practitioners report domestic violence injuries to the police? A study of the law enforcement response of injury reports. *Violence and Vict*. 1999;14(2):203-213.

Mackay A, Fingerhut LA, Duran CR. *Adolescent Health Chartbook*. *Health, United States, 2000*. Hyattsville, MD: National Center for Health Statistics, Centers for Disease Control and Prevention; 2000: 1-197.

McCabe RE, Antony MM, Summerfeldt LJ, Liss A, Swinson RP. Preliminary examination of the relationship between anxiety disorders in adults and self-reported history of teasing or bullying experiences. *Cogn Behav Ther*. 2003;32(4):187-193.

McKinley JC. In Texas school, teachers carry books and guns. *New York Times*. August 29, 2008: A1.

Meltzer-Lange M, Lye PS. Adolescent health care in a pediatric emergency department. *Ann Emerg Med.* 1996;27(5):633-637.

Mercy JA, O'Carroll PW. New directions in violence prediction: the public health arena. *Violence Vict.* 1988;3(4):285-301.

Michels R. Afterword. In: Ginzberg E. *Urban Medical Centers: Balancing Academic and Patient Care Functions*. Boulder, CO: Westview Press; 1996: 93.

Middlebrooks JS, Audage NC. *The Effects of Childhood Stress on Health Across the Lifespan*. Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2008.

Moore GP, Kao L. The combative patient. In: Marx JA. *Rosen's Emergency Medicine: Concepts and Clinical Practice*. 6th ed. Philadelphia, PA: Elsevier; 2006.

Moskovic CS, Guiton G, Chirra A, et al. Impact of participating in a community-based intimate partner violence prevention program on medical students: a multi-center study. *J Gen Intern Med*. 2008;23(7):1043-1047.

Moskovic CS, Wyatt L, Chirra A, et al. Intimate partner violence in medical school curriculum: approaches and lessons learned. *Virtual Mentor*. 2009;11(2): 130-136. http://www.ama-assn.org/2009/02/medu2-0902.html. Accessed February 2, 2009.

National Center for Injury Prevention and Control. *The Prevention of Youth Violence: A Framework for Community Action*. Atlanta, GA: Centers for Disease Control and Prevention; 1993.

The National Coalition Against Domestic Violence. Dating violence fact sheet. 2005. http://www.ncadv.org/files/datingviolence.pdf. Accessed January 12, 2009.

National Research Council & Institute of Medicine. *Injury in America: A Continuing Public Health Problem*. Washington, DC: National Academy Press; 1985.

Nelkin D, Lindee MS. *The DNA Mystique: The Gene As a Cultural Icon*. New York, NY: Freeman; 1995.

New York Penal Law 265.25. http://law.justia.com/newyork/codes/penal/pen0265.25_265.25.html.

Olweus D. *Bullying at School. What We Know and What We Can Do*. Cambridge, MA: Blackwell; 1993.

Olweus D. Norway. In: Smith PK, Morita Y, Junger-Tas J, Olweus D, Catalano R, Slee P, eds. *The Nature of School Bullying. A Cross-national Perspective.* 1st ed. London: Routledge; 1999: 30-31.

Ozolins I, Hall H, Peterson R. The student voice: recognising the hidden and informal curriculum in medicine. *Med Teach*. 2008;30(6):606-611.

Paice E, Aitken M, Houghton A, Firth-Coznes J. Bullying among doctors in training: cross sectional questionnaire survey. *BMJ*. 2004;329(7467):658-659.

Phelan JC. Genetic bases of mental illness—a cure for stigma? *Trends Neurosci.* 2002;25(8):430-431.

Phelan JC, Yang LH, Cruz-Rojas R. Effects of attributing serious mental illnesses to genetic causes on orientations to treatment. *Psychiatr Serv.* 2006;57(3):382-387.

Plichta SB. Intimate partner violence and physical health consequences: policy and practice implications. *J Interpers Violence*. 2004;19(11):1296-1323.

Poole GV, Griswold JA, Thaggard VK, Rhodes RS. Trauma is a recurrent disease. *Surgery.* 1993;113(6):608-611.

Priest SH. US public opinion divided over biotechnology? *Nat Biotechnol.* 2000;18(9):939-942.

Prothrow-Stith DB. The epidemic of youth violence in America: using public health prevention strategies to prevent violence. *J Health Care Poor Underserved.* 1995;6(2):95-101.

Raine A, Dodge K, Loeber R, et al. The reactive-proactive aggression questionnaire: differential correlates of reactive and proactive aggression in adolescent boys. *Aggress Behav.* 2006;32(3):159-171.

Rappaport N. Survival 101: assessing children and adolescents' dangerousness in school settings. In: Esman AH, Flaherty L, Horowitz H, eds. *Adolesc Psychiatry.* 2004;28:157-181.

Rappaport N, Flaherty LT, Hauser ST. Beyond psychopathology: assessing seriously disruptive students in school settings. *J Pediatr.* 2006;149(2):252-256.

Reiner DS, Pastena JA, Swan KG, Lindenthal JJ, Tischler CD. Trauma recidivism. *Am Surg.* 1990;56(9):556-560.

Rodriguez MA, Craig AM, Mooney DR, Bauer HM. Patient attitudes about mandatory reporting of domestic violence. Implications for health care professionals. *West J Med.* 1998;169(6):337-341.

Schnittker J. An uncertain revolution: why the rise of a genetic model of mental illness has not increased tolerance. *Soc Sci Med.* 2008;67(9):1370-1381.

Seabrook MA. Medical teachers' concerns about the clinical teaching context. *Med Educ.* 2003;37(3):213-222.

Sege R, Stringham P, Short S, Griffith J. Ten years after: examination of adolescent screening
questions that predict future violence-related injury. *J Adolesc Health.* 1999;24(6):395-402.

Shostak S, Freese J, Link BG, Phelan JC. The politics of the gene: social status and beliefs about genetics for individual outcomes. *Soc Psychol Q.* In press.

Silver HK, Glicken AD. Medical student abuse. Incidence, severity, and significance. *JAMA.* 1990;263(4):527-532.

Singer E, Corning A, Lamias M. Trends: genetic testing, engineering, and therapy: awareness and attitudes. *Public Opin Q.* 1998;62(10):633-664.

Smalley S. Gun buybacks make return to Boston. *Boston Globe.* May 31, 2006.

Smith PH, White JW, Holland LJ. A longitudinal perspective on dating violence among adolescent and college-age women. *Am J Public Health.* 2003;93(7):1104-1109.

Smith PK, Monks CP. Concepts of bullying: developmental and cultural aspects. *Int J Adolesc Med Health.* 2008;20(2):101-112.

Sourander A, Jensen P, Ronning JA, et al. Childhood bullies and victims and their risk of criminality in late adolescence: the Finnish From a Boy to a Man Study. *Arch Pediatr Adolesc Med.* 2007;161(6):546-552.

Srabstein JC. Deaths linked to bullying and hazing. *Int J Adolesc Med Health.* 2008;20(2):223-233.

Srabstein JC, Joshi P, Due P, et al. Prevention of public health risks linked to bullying: a need for a whole community approach. *Int J Adolesc Med Health.* 2008;20(2):185-199.

Srabstein JC, McCarter RJ, Shao C, Huang ZJ. Morbidities associated with bullying behaviors in adolescents. School based study of American adolescents. *Int J Adolesc Med Health*. 2006;18(4):587-596.

Srabstein JC, Piazza T. Public health, safety and educational risks associated with bullying behaviors in American adolescents. *Int J Adolesc Med Health.* 2008;20(2):129-139.

Suchman AL, Williamson PR, Litzelman DK, et al. Toward an informal curriculum that teaches professionalism. Transforming the social environment of a medical school. *J Gen Intern Med*. 2004;19(5 Pt 2):501-504.

Swahn MH, Hammig B. Prevalence of youth access to alcohol, guns, illegal drugs, or cigarettes in the home and association with health-risk behaviors. *Ann Epidemiol.* 2000;10(7):452.

Tjaden P, Thoennes N. *Full Report of the Prevalence, Incidence, and Consequences of Violence against Women*. Washington, DC: US Department of Justice; 2000.

Tjaden P, Thoennes N. *Full Report of the Prevalence, Incidence, and Consequences of Violence Against Women: Findings from the National Violence Against Women Survey*. Washington, DC: National Institute of Justice, Office of Justice Programs, United States Department of Justice, Centers for Disease Control and Prevention; 2000.

Tjaden P, Thoennes N. US Department of Justice. Extent, nature, and consequences of intimate partner violence: findings from the National Violence Against Women Survey, 2000. http://www.ncjrs.gov/pdffiles1/nij/181867.pdf. Accessed January 14, 2009.

Tucker JB, Barone JE, Stewart J, Hogan RJ, Sarnelle JA, Blackwood MM. Violence prevention: reaching adolescents with the message. *Pediatr Emerg Care.* 1999;15(6):436-439.

US Department of Health, Education, and Welfare. *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention.* Washington, DC: US Government Printing Office; 1979.

US Department of Health & Human Services. *Promoting Health/Preventing Disease; Objectives for the Nation.* Washington, DC: US Government Printing Office; 1980.

US Department of Health & Human Services. *Report of the Secretary's Task Force on Black and Minority Health.* Washington, DC: US Government Printing Office; 1985.

US Department of Health & Human Services. Violence against women. State domestic violence resources. 2007. http://www.4woman.gov/violence/state. Accessed January 12, 2009.

US Department of Health & Human Services. *Youth Violence: A Report of the Surgeon General*. Centers for Disease Control and Prevention, Substance Abuse and Mental Health Services Administration, National Institutes of Health for the National Institute of Mental Health. Washington, DC: US Government Printing Office; 2001.

US Department of Health & Human Services, Administration for Children & Families. *11 Years of Reporting: Child Maltreatment 2006*. Washington, DC: US Government Printing Office; 2008.

US Department of Health & Human Services, Administration for Children & Families. *Child Maltreatment 2006.* Washington, DC: US Government Printing Office; 2006.

US Department of Health & Human Services, National Center for Environmental Health and Injury Control Division of Injury Control, Office of the Assistant Director for Minority Health. *The Prevention of Youth Violence: A Framework for Community Action.* Atlanta, GA: Centers for Disease Control and Prevention; 1992.

US Department of Health & Human Services, US Department of Justice. *Surgeon General's Workshop on Violence and Public Health Report*. Washington, DC: Health Resources Service Administration; 1986.

US Department of Justice, Bureau of Justice Statistics. Homicide trends in the United States, 2007. www.ojp.usdoj.gov/bjs/homicide/intimates.htm. Accessed January 9, 2009.

Verlinden S, Hersen M, Thomas J. Risk factors in school shootings. *Clin Psychol Rev*. 2000;20(1):3-56.

Viggiano TR, Pawlina W, Lindor KD, Olsen KD, Cortese DA. Putting the needs of the patient first: Mayo Clinic's core value, institutional culture, and professionalism covenant. *Acad Med.* 2007;82(11):1089-1093.

Walker HM, Colvin G, Ramsey E. *Antisocial Behavior in School: Strategies and Best Practices*. Pacific Grove, California: Brooks/Cole Pub. Co.; 1995.

Walton MA, Cunningham RM, Goldstein AL, et al. Rates and correlates of violent behaviors among adolescents treated in an urban ED. *J Adolesc Health.* In press.

Walton MA, Cunningham RM, Xue Y, Trowbridge M, Zimmerman M, Maio RF. Internet referrals for adolescent violence prevention: an innovative mechanism for inner-city emergency departments. *J Adolesc Health*. 2008;43(3):309-312.

Web site invites kids to report bullies incognito [news release]. Salt Lake City, UT: Associated Press; October 14, 2008.

Whitaker DJ, Haileyesus T, Swahn M, Saltzman LS. Differences in frequency of violence and reported injury between relationships with reciprocal and nonreciprocal intimate partner violence. *Am J Public Health*. 2007;97(5):941-947.

Wilkinson TJ, Gill DJ, Fitzjohn J, Palmer CL, Mulder RT. The impact on students of adverse experiences during medical school. *Med Teach*. 2006;28(2):129-135.

Woelfle CY, McCaffrey R. Nurse on nurse. *Nurs Forum*. 2007;42(3):123-131.

Wood DF. Bullying and harassment in medical schools. *BMJ*. 2006;333(7570):664-665.

World Health Organization. *World Report on Violence and Health.* Geneva, Switzerland: World Health Organization; 2002.

Zun LS, Downey LV, Rosen J. Violence prevention in the ED: linkage of the ED to a social service agency. *Am J Emerg Med.* 2003;21(6):454-457.

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