

8.10 Preventing, Identifying & Treating Violence & Abuse

All patients may be at risk for interpersonal violence and abuse, which may adversely affect their health or ability to adhere to medical recommendations. In light of their obligation to promote the well-being of patients, physicians have an ethical obligation to take appropriate action to avert the harms caused by violence and abuse.

To protect patients' well-being, physicians individually should:

- (a) Become familiar with:
 - (i) how to detect violence or abuse, including cultural variations in response to abuse;
 - (ii) community and health resources available to abused or vulnerable persons;
 - (iii) public health measures that are effective in preventing violence and abuse;
 - (iv) legal requirements for reporting violence or abuse.
- (b) Consider abuse as a possible factor in the presentation of medical complaints.
- (c) Routinely inquire about physical, sexual, and psychological abuse as part of the medical history.
- (d) Not allow diagnosis or treatment to be influenced by misconceptions about abuse, including beliefs that abuse is rare, does not occur in "normal" families, is a private matter best resolved without outside interference, or is caused by victims' own actions.
- (e) Treat the immediate symptoms and sequelae of violence and abuse and provide ongoing care for patients to address long-term consequences that may arise from being exposed to violence and abuse.
- (f) Discuss any suspicion of abuse sensitively with the patient, whether or not reporting is legally mandated, and direct the patient to appropriate community resources.
- (g) Report suspected violence and abuse in keeping with applicable requirements. Before doing so, physicians should:
 - (i) inform patients about requirements to report;
 - (ii) obtain the patient's informed consent when reporting is not required by law. Exceptions can be made if a physician reasonably believes that a patient's refusal to authorize reporting is coerced and therefore does not constitute a valid informed treatment decision.
- (h) Protect patient privacy when reporting by disclosing only the minimum necessary information.

Collectively, physicians should:

- (i) Advocate for comprehensive training in matters pertaining to violence and abuse across the continuum of professional education.

- (j) Provide leadership in raising awareness about the need to assess and identify signs of abuse, including advocating for guidelines and policies to reduce the volume of unidentified cases and help ensure that all patients are appropriately assessed.
- (k) Advocate for mechanisms to direct physicians to community or private resources that might be available to aid their patients.
- (l) Support research in the prevention of violence and abuse and collaborate with public health and community organizations to reduce violence and abuse.
- (m) Advocate for change in mandatory reporting laws if evidence indicates that such reporting is not in the best interests of patients.

AMA Principles of Medical Ethics: I,III

Background report(s):

CEJA Report 3-A-16 Modernized *Code of Medical Ethics*

CEJA Report 6-I-07 Amendment to Opinion 2.02, Physician obligations in preventing, identifying, and treating violence and abuse

Opinion of the Judicial Council A-I-82 Abuse of children, elderly persons, and others at risk

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AMA Principles of Medical Ethics: I,III

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 6-I-07

Subject: Amendment to Opinion E-2.02, "Physicians' Obligations in Preventing, Identifying, and Treating Violence and Abuse"

Presented by: Mark A. Levine, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Jane C.K. Fitch, MD, Chair)

1 INTRODUCTION

2
3 At the request of the National Advisory Council on Violence and Abuse (NACVA), the Council on
4 Ethical and Judicial Affairs (CEJA) of the American Medical Association (AMA) has revised
5 Opinion E-2.02, "Abuse of Spouses, Children, Elderly Persons, and Others at Risk." This Opinion
6 update is intended to more thoroughly address physicians' roles in assessment, prevention, and
7 reporting of violence or abuse. Moreover, this Opinion amendment revises the scope of guidance
8 provided to physicians in order to more accurately reflect current standards of practice.
9

10 PHYSICIANS' DUTY TO DETECT AND PREVENT ABUSE

11
12 Acts of violence and abuse among patients are of significant concern to the medical community
13 because of the immediate and long-term consequences to the individuals involved. The immediate
14 consequences of violence and abuse typically involve injuries that compromise victims' health and
15 welfare. In the long term, the victims of violence or and abuse are often at risk for future
16 victimization, perpetration, and other health disorders.¹ Moreover, acts of violence also can be
17 harmful to third parties, such as children who witness domestic abuse. In general, those who are
18 subject to or are witness to violence and abuse are faced with significant risk of emotional distress
19 that may manifest in physical, psychosocial and behavioral disorders.^{2,3} Further clinical
20 consequences of violence and abuse may include depression, anxiety, substance abuse, failure to
21 keep medical appointments, and a reluctance to disclose medical information when seeking
22 treatment.^{4,5}
23

24 Physicians have an ethical obligation to promote the well-being of patients by taking appropriate
25 actions to avert the harms caused by violence and abuse (see *Principle I*). At the individual level,
26 physicians must address patients' immediate injuries, while also addressing the psychological and
27 social needs of victims.⁶ Physicians should also make all efforts to diagnose violence and abuse, or

* Reports of the Council on Ethical and Judicial Affairs are assigned to the reference committee on Constitution and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.

1 the manifestation of co-morbid conditions, so that patients may receive appropriate care.⁷ Finally,
2 physicians have a duty to protect the welfare of all members of society by working to reduce the
3 prevalence of violence and abuse among the general population (see *Principle VII*).
4 The prevention of violence requires a multi-faceted intervention strategy. Traditional means of
5 violence prevention fall within the domain of the judicial and law enforcement systems. However,
6 the public health approach to violence prevention is also effective and therefore creates the
7 opportunity for the medical community to address this pressing social issue. The foundation of the
8 public health approach to violence prevention incorporates four major steps: the framing of the
9 problem as a scientifically testable hypothesis; the identification of applicable risk and preventive
10 factors; the development and testing of prevention strategies; and the promotion and dissemination
11 of those strategies that have proven effective.⁸

12
13 This approach to violence and prevention requires substantial involvement from the medical
14 community. Physicians should honor their ethical obligations to promote public health by
15 supporting the routine assessment of all patients for symptoms of violence and abuse (see *Principle*
16 *VII*). Physicians are uniquely enabled to assess patients for exposure and the sequelae of violence
17 and abuse as the patient-physician relationship creates the opportunity to speak candidly with
18 individuals regarding their previous exposure and current risks. Furthermore, the victims of
19 violence and abuse are more likely to seek assistance from physicians than other groups, such as
20 police, clergy, or social service agencies.⁹

21
22 While physicians have long played an integral role in identifying signs of violence and abuse, they
23 have traditionally focused their attention upon the elderly, children, and women. Unfortunately,
24 this selective examination of patients means that not all at-risk patients are assessed and that signs
25 of abuse can often go unnoticed.⁵ Evidence indicates that physicians may underestimate the
26 prevalence rates of violence and abuse in the general public.¹⁰ Similarly, physicians and medical
27 staff are less likely to identify violence and abuse in patients who do not belong to population
28 groups that are traditionally believed to be at risk of abuse.¹¹ Moreover, physicians may miss
29 opportunities to identify victims when they become overly focused upon the identification of
30 clinical signs of physical abuse, and therefore fail to properly assess patients for the less overt
31 symptoms of emotional abuse or neglect.

32
33 In order to avoid missed opportunities to identify signs of violence or abuse, it is essential that
34 physicians avoid focusing their assessment efforts exclusively upon patient populations who are
35 traditionally believed to be at a high risk of victimization. Physicians must instead honor their
36 ethical obligations to protect the health of all patients in their care by routinely assessing each
37 patient for relevant physical and psychological indicators (see E-10.015, “The Patient-Physician
38 Relationship”).

39
40 To achieve universal assessment for abuse, it may be necessary to expand the scope of relevant
41 training available to physicians. Additional training at the undergraduate, graduate, and continuing
42 education levels would better prepare physicians to care for the victims of abuse. Furthermore,
43 training on violence prevention should be required for all physicians.¹²

1 Physicians should also work collectively to provide leadership in raising awareness regarding the
2 need to assess patients and identify signs of abuse.¹³ In addition, individual physicians are
3 encouraged to establish appropriate assessment and treatment protocols within their practice.
4 These protocols should also provide information and guidelines to direct physicians to external
5 community or private resources that might be available to aid patients. Through these actions,
6 physicians may reduce the volume of abuse cases that go unidentified, and consequently, help to
7 ensure that all patients receive the benefit of appropriate assessment regardless of their age, gender,
8 ethnicity, or social circumstances.

9 **CONFIDENTIALITY AND THE REPORTING OF VIOLENCE AND ABUSE**

10
11 To support the prevention of abuse it is often necessary for physicians to work in conjunction with
12 members of the public safety and law enforcement communities. Such cooperation often involves
13 the mandated reporting of any signs of violence, abuse, or suspicious injuries that a physician may
14 uncover during the clinical encounter. Many states have such mandatory reporting laws, which
15 require physicians to balance their ethical obligations to promote patients' welfare and to safeguard
16 patients' confidentiality against their duties to promote public health and comply with legal
17 requirements.

18
19 In order to facilitate discussions regarding issues of violence or abuse, it is essential that physicians
20 maintain the trust of their patients (see E-10.015, "Fundamental Elements of the Patient-Physician
21 Relationship"). Therefore, physicians must assure patients that the information shared will be held
22 in confidence, subject to legal reporting requirements (see E-5.05, "Confidentiality").

23
24 The reporting of suspected abuse without patients' prior consent represents a violation of the
25 patient's autonomy. Therefore, when reporting laws are voluntary, physicians should discuss the
26 available options with the patients. If a competent patient does not wish to report abuse, physicians
27 should generally respect this decision. In some instances a patient's wish to refrain from reporting
28 may not satisfy criteria for valid refusal, as a valid informed decision must be free of coercion. For
29 example, a patient's refusal to authorize reporting may be based upon fears for his or her own
30 health or well-being. In such situations a physician may be ethically justified in reporting
31 symptoms and sequelae of violence or abuse without the patient's consent.

32
33 Physicians' duties to protect a patient's confidentiality and autonomy are not absolute, however,
34 and the disclosure of medical information may be warranted for the protection of patients or the
35 community.¹⁴ Physicians are legally required to report suspected abuse in most states¹⁵ and such
36 reporting is considered to be protected disclosure by HIPAA.¹⁶ If reporting is mandatory,
37 physicians should notify the patient and then proceed to disclose only the minimal amount of
38 information necessary for the patient's protection (see E-5.05). Physicians should continue to
39 research issues pertaining to mandatory reporting practices and seek changes in legislation if
40 evidence indicates that mandatory reporting requirements contravene patients' best interests (see E-
41 9.025, "Advocacy for Change in Law and Policy").

1 CONCLUSION

2
3 Physicians have an ethical responsibility to engage in practices intended to identify and prevent
4 violence and abuse. Physicians should therefore make appropriate efforts to ensure that all patients
5 are routinely assessed for violence and abuse, not just those from population groups believed to be
6 at high risk. The promotion of equitable assessment may be enhanced through the incorporation of
7 additional training programs and the establishment of institutional policies on the treatment of
8 violence and abuse. Finally, physicians should comply with reporting laws in a way that minimizes
9 infringement upon the autonomy and confidentiality of patients, while seeking changes to laws that
10 do not promote patients' well-being.

11
12 RECOMMENDATION

13
14 The Council on Ethical and Judicial Affairs recommends that Opinion E-2.02, "Abuse of Spouses,
15 Children, Elderly Persons, and Others at Risk," be replaced with the following and the remainder
16 of this report be filed.

17
18 E-2.02 Physicians' Obligations in Preventing, Identifying, and Treating Violence and Abuse

19
20 Interpersonal violence and abuse were once thought to primarily affect specific high-risk
21 patient populations, but it is now understood that all patients may be at risk. The complexity
22 of the issues arising in this area requires three distinct sets of guidelines for physicians. The
23 following guidelines address assessment, prevention, and reporting of interpersonal violence
24 and abuse.

25
26 1. When seeking to identify and diagnose past or current experiences with violence and
27 abuse, physicians should adhere to the following guidelines:

28
29 A. Physicians should routinely inquire about physical, sexual, and psychological abuse as
30 part of the medical history. Physicians should also consider abuse as a factor in the
31 presentation of medical complaints because patients' experiences with interpersonal
32 violence or abuse may adversely affect their health status or ability to adhere to
33 medical recommendations.

34
35 B. Physicians should familiarize themselves with the detection of violence or abuse, the
36 community and health care resources available to abused or vulnerable persons, and
37 the legal requirements for reporting violence or abuse.

38
39 C. Physicians should not be influenced in the diagnosis and management of abuse by such
40 misconceptions as the beliefs that abuse is a rare occurrence, does not occur in
41 "normal" families, is a private problem best resolved without outside interference, or is
42 caused by the victims own actions.

43
44 2. The following guidelines are intended to guide physicians' efforts to address acts of
45 violence and abuse:

- 1 A. Physicians must treat the immediate symptoms and sequelae of violence and abuse,
2 while also providing ongoing care for patients so as to address any long-term health
3 consequences that may arise as the result of exposure.
4
- 5 B. Physicians should be familiar with current information about cultural variations in
6 response to abuse, public health measures that are effective in preventing violence and
7 abuse, and how to work cooperatively with relevant community services. Physicians
8 should help in developing educational resources for identifying and caring for victims.
9 Comprehensive training in matters pertaining to violence and abuse should be required
10 in medical school curricula and in post graduate training programs.
11
- 12 C. Physicians should also provide leadership in raising awareness regarding the need to
13 assess and identify signs of abuse. By establishing guidelines and institutional policies
14 it may be possible to reduce the volume of abuse cases that go unidentified, and
15 consequently, help to ensure that all patients receive the benefit of appropriate
16 assessment regardless of their age, gender, ethnicity, or social circumstances. The
17 establishment of appropriate mechanisms should also direct physicians to external
18 community or private resources that might be available to aid patients.
19
- 20 D. Physicians should support research in the prevention of violence and abuse and seek
21 collaboration with relevant public health authorities and community organizations.
22
- 23 3. Physicians should comply with the following guidelines when reporting evidence of
24 violence or abuse:
25
- 26 A. Physicians should familiarize themselves with any relevant reporting requirements
27 within the jurisdiction in which they practice.
28
- 29 B. When a jurisdiction mandates reporting suspicion of violence and abuse, physicians
30 should comply. However, physicians should only disclose minimal information in
31 order to safeguard patients' privacy. Moreover, if available evidence suggests that
32 mandatory reporting requirements are not in the best interests of patients, physicians
33 should advocate for changes in such laws.
34
- 35 C. In jurisdictions where reporting suspected violence and abuse is not legally mandated,
36 physicians should discuss the issue sensitively with the patient by first suggesting the
37 possibility of abuse, followed by describing available safety mechanisms. Reporting
38 when not required by law requires the informed consent of the patient. However,
39 exceptions can be made if a physician reasonably believes that a patient's refusal to
40 authorize reporting is coerced and therefore does not constitute a valid informed
41 treatment decision. (I, III)

42 (New HOD/CEJA Policy)

43
44 Issued December 1982; Updated June 1994 based on the report "Physicians and
45 Family Violence: Ethical Considerations," adopted December 1991 (JAMA. 1992;

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1 267: 3190-93); updated June 1996; updated June 2000 based on the report "Domestic
2 Violence Intervention," adopted June 1998, and updated in November 2007 based on
3 the report Physicians' Obligations in Preventing, Identifying, and Treating Violence
4 and Abuse."

Fiscal Note: Staff cost estimated at less than \$500 to implement.

ACKNOWLEDGMENTS

The Council gratefully acknowledges the members of AMA National Advisory Council on Violence and Abuse for their contributions to this Report.

REFERENCES

- ¹ AMA Council on Science and Public Health. Report 7-A-05, *Diagnosis and Management of Family Violence*. <http://www.ama-assn.org/ama/pub/category/print/1528.html> Accessed March 2007.
- ² Friedman L, Samet J, Roberts M, Hudlin M, Hans P. "Inquiry About Victimization Experiences: A Survey of Patient Preferences and Physician Practices." (1992) *Archives of Internal Medicine*, 152: 1186-1190.
- ³ Dube SR, Felitti VJ, Giles WH, Anda RF. The impact of adverse childhood experiences on health problems: evidence from four birth cohorts dating back to 1900. *Preventive Medicine*. 2003;37(3):268-77.
- ⁴ Stark E, Filcraft A. Violence among intimates" an epidemiological review. In VanHasselt VB, Morisson RL, Bellack, AS, et al., eds. *Handbook of Family Violence*. New York: Plenum Press; 1988: 293-317.
- ⁵ Family Violence Prevention Fund. *Identifying and Responding to Domestic Violence: Consensus Recommendations for Child and Adolescent Health*. Family Violence Prevention Fund: San Francisco; 2004: 37-39
- ⁶ Pellegrino ED, Thomasma DC. *For the patients good: The restoration of beneficence in health care*. New York: Oxford University Press, 1988; 10.
- ⁷ AMA Council on Ethical and Judicial Affairs. Physicians and family violence: Ethical considerations. *Journal of the American Medical Association*. 1992;267:3190-93.
- ⁸ National Centers for Injury Prevention and Control. *The Public Health Approach To Violence Prevention*. <http://www.cdc.gov/ncipc/pub-res/YVFactSheet.pdf> Accessed March 2007.
- ⁹ Mehta P, Dandrea LA. The battered woman. *American Family Physician*. 1988;37:193-9.
- ¹⁰ Stark E, Flicraft A, Frazier W. Medicine and patriarchal violence. *International Journal of Health Services*. 1979;9:461-93.
- ¹¹ Warshaw C. Limitations of the medical model in the care of battered women. *Gender Soc*. 1989;3:506-17.
- ¹² Jecker NS. Privacy beliefs and the violent family: Extending the ethical argument for physician intervention. *JAMA*. 1993;269(6):776-80.
- ¹³ Wei FS, Herbers JE. Reporting elder abuse: A medical, legal, and ethical overview. *Journal of the American Medical Women's Association*. 59(4):248-54
- ¹⁴ Gostin, L. *Public Health Law: Power, Duty, Restraint*. Berkeley, CA: University of California Press. (2000).
- ¹⁵ Salend E, Kane RA, Satz M. Elder abuse and reporting: limitations of statutes. *Gerontologist*. 1984;24:61-9.
- ¹⁶ 45 C.F.R. § 164.512 2006.

REPORTS OF JUDICIAL COUNCIL

The following reports, A-C, were presented by John H. Burkhart, M. D., Chairman:

**A. JUDICIAL COUNCIL OPINION ON ABUSE OF CHILDREN,
ELDERLY PERSONS, AND OTHERS AT RISK
(Reference Committee on Amendments to Constitution and Bylaws, page 297)**

HOUSE ACTION: ADOPTED

Report J of the Council on Scientific Affairs (1-82) presents recommendations for AMA involvement in the prevention and treatment of child abuse and neglect. All states have child abuse reporting statutes, although these statutes vary. The Judicial Council is concerned about the specific problem of child abuse as well as abuse of other persons, such as the elderly. The Judicial Council presents to the House, for its information, the Judicial Council's opinion on the ethical responsibilities of physicians regarding abuse of children, elderly persons, and others at risk.

ABUSE OF CHILDREN, ELDERLY PERSONS, AND OTHERS AT RISK. Laws that require the reporting of cases of suspected abuse of children and elderly persons 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.

Children who have been seriously injured, apparently by their parents, may nevertheless try to protect their parents by saying that the injuries were caused by an accident, such as a fall. The reason may stem from the natural parent-child relationship or fear of further punishment. Even institutionalized elderly patients who have been physically maltreated may be concerned that disclosure of what has occurred might lead to further and more drastic maltreatment by those responsible.

The physician who fails to comply with the laws requiring reporting of suspected cases of abuse of children and elderly persons and others at risk can expect that the victims could receive more severe abuse that may result in permanent bodily or brain injury or even death.

Public officials concerned with the welfare of children and elderly persons have expressed the opinion that the incidence of physical violence to these persons is rapidly increasing and that a very substantial percentage of such cases is unreported by hospital personnel and physicians. An important element that is sometimes overlooked is that a child or elderly person brought to a physician with a suspicious injury is the patient whose interests require the protection of law in the particular situation, even though the physician may also provide services from time to time to parents or other members of the family.

The obligation to comply with statutory requirements is clearly stated in the Principles of Medical Ethics. As stated at 1.02, the ethical obligation of the physician may exceed the statutory legal requirement.