

## Physician awareness of domestic violence: Does continuing medical education have an impact?

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One hundred currently practicing physicians were surveyed regarding screening and management of domestic violence to determine whether mandatory continuing medical education (CME) is likely to increase awareness of and response to domestic violence. The authors surveyed 25 family physicians and 25 obstetrician/gynecologists in each of two states, Florida and New Jersey. In addition, they polled 26 family practice residents in the University of Medicine and Dentistry of New Jersey–School of Osteopathic Medicine program.

Practices with a female physician were four times more likely to screen for domestic violence than practices with all male physicians. No difference existed in screening between family physicians and obstetrician/gynecologists; physicians in Florida and those in New Jersey; or attending physicians and family practice residents. Findings indicate that Florida's mandatory CME law does not appear to have made an impact on the management of domestic violence. Practices with a female physician were more likely to screen for domestic violence.

(Key words: domestic violence, partner abuse, continuing medical education, screening, obstetrician/gynecologists, family physicians)

Domestic violence is endemic in the United States, involving every phase of human life: child neglect and abuse, date violence and rape, domestic violence, abuse of the disabled, and elder abuse. These incidents often occur in a setting of prodromal nonassaultive behaviors that can be expressed as verbal threats, emotional and psychological abuse, economic isolation, and progressive social isolation, and which can escalate at any point to sexual abuse or physical injury (or both).<sup>1</sup> Adult intimate

partner violence (AIPV) can be defined as the controlling behavior or intentional intimidation or psychological, physical, or sexual abuse or battering of adult women or men by married or unmarried partners. Women account for 90% to 95% of AIPV victims.<sup>2,3</sup>

Because the scope of domestic violence has become more apparent, some state legislatures have passed laws making domestic violence a crime. Virtually all states have laws that require physicians to some extent to report cases of domestic violence; however, provisions vary from state to state. Some states require only reporting of injuries involving weapons or criminal acts while other states base reporting on child abuse laws with the goal of victim protection. For example, California has a law requiring that healthcare providers report to the police any suspected domestic violence, whereas New Hampshire requires report-

ing unless the injured person is older than 18 years and objects to the release of this information to law enforcement. Other states have taken a more moderate stance, such as Florida, which does not mandate reporting but does require continuing medical education (CME) in an effort to increase physician awareness of domestic violence. New Jersey has attempted to criminalize domestic violence, making once socially accepted behavior such as spousal physical abuse a crime but not mandating reporting. Other states do not even have any family violence statutes in place.<sup>3</sup>

### Materials and methods

We polled 25 obstetrician/gynecologists and 25 obstetrician/gynecologists in both New Jersey and Florida regarding their practices pertaining to domestic violence. Phone numbers were obtained at random from membership lists published in 1997 and 1998 by the American Academy of Family Physicians, American College of Osteopathic Family Physicians, American College of Obstetricians and Gynecologists, and the American College of Osteopathic Obstetricians and Gynecologists. We were interested in whether a difference existed between specialists or if the Florida mandatory CME law has made an impact (or both). In addition we polled 26 family medicine residents to enable us to compare their responses with those of attending physicians. The questions used appear in *Figure 1*. We were also interested in gender differences among physicians; therefore, we inquired as to whether the physicians in the office comprised men, women, or both.

Results were compared using a two-tailed  $\chi^2$ -test.

### Results

Twenty-three percent of physicians screened for domestic violence. *Table 1* displays the results for question 1 regarding screening for domestic violence at the initial visit. No significant difference existed between obstetrician/gynecologists and family physicians, physicians practicing in Florida and those practicing in New Jersey, or attending physicians

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# Checklist

- Does your office screen for domestic violence at the initial visit?
- Do you rescreen at any subsequent visit?
- Does your office have the name of a shelter readily available should a patient so require?
- Has your office had a recent victim of domestic violence?
- Has the passage of the Florida mandatory continuing medical education (CME) statute changed your screening/referral habits?

**OR**

If a mandatory CME statute were passed in New Jersey, would it change your screening/referral habits?

Figure 1. Interview questions.

and residents. Practices with a female physician were more than four times as likely to screen for domestic violence, a statistically significant difference ( $P < .05$ ).

Table 2 shows the results for question 2 regarding subsequent screening. No significant difference existed between obstetrician/gynecologists and family physicians, physicians practicing in Florida and those in New Jersey, or male physicians and female physicians.

Table 3 shows the results for question 3 concerning the identification of a recent victim of domestic violence. Again, no difference existed between obstetrician/gynecologists and family physicians, physicians practicing in Florida and those practicing in New Jersey, or male physicians and female physicians.

Table 4 displays the results for question 4 regarding the impact of CME. No significant difference existed between physicians practicing in Florida and physicians practicing in New Jersey.

## Discussion

Primary care physicians such as family

Table 1 Response to Question: Does Your Office Screen for Domestic Violence at the Initial Visit?			
Practice variable	Yes	No	Significance*
<b>Specialty</b>			
<input type="checkbox"/> Obstetrician/gynecologists	14	36	NS
<input type="checkbox"/> Family physicians	9	41	
<b>Location</b>			
<input type="checkbox"/> Florida	3	37	NS
<input type="checkbox"/> New Jersey	0	40	
<b>Composition</b>			
<input type="checkbox"/> All-male practice	7	59	$P < .05$
<input type="checkbox"/> Female physician in practice	16	18	
<b>Other</b>			
<input type="checkbox"/> Residents	4	22	NS
<input type="checkbox"/> Attending	23	77	

\*NS = not significant.

Table 2 Response to Question: Do You Rescreen at Any Subsequent Visit?			
Practice variable	Yes	No	Significance*
<b>Specialty</b>			
<input type="checkbox"/> Obstetrician/gynecologists	7	43	NS
<input type="checkbox"/> Family physicians	5	45	
<b>Location</b>			
<input type="checkbox"/> Florida	6	44	NS
<input type="checkbox"/> New Jersey	5	45	
<b>Composition</b>			
<input type="checkbox"/> All-male practice	4	62	NS
<input type="checkbox"/> Female physician in practice	7	27	

\*NS = not significant.

physicians and obstetrician/gynecologists are frequently the first lines of defense for abused individuals. They are expected to treat the consequences of domestic violence, yet they have little or no exposure as to how best to handle the problem as it arises in their practices. Reid and Glasser<sup>4</sup> showed that 57% of physicians thought that their medical education did not prepare them adequately to deal with family violence. Currently, medical schools are expanding their curriculums to include the discussion of the role of

domestic violence, but this early training frequently is not enough (a few hours at best), and it rarely is reinforced during residency and continuing education. The same study showed that 96% of those surveyed thought that physicians should receive more education. Ironically, a large multidisciplinary community-based study funded by the Robert Wood Johnson Foundation Health Care and Family Violence Field Project published in 1990 by Cohen and colleagues<sup>5</sup> showed that physicians who do attempt to treat fam-

**Table 3**  
**Response to Question: Has Your Office Had a Recent Victim of Domestic Violence?**

Practice variable	Yes	No	Significance <sup>a</sup>
<b>■ Specialty</b>			
<input type="checkbox"/> Obstetrician/gynecologists	5	43	NS
<input type="checkbox"/> Family physicians	3	47	
<b>■ Location</b>			
<input type="checkbox"/> Florida	5	45	NS
<input type="checkbox"/> New Jersey	3	47	
<b>■ Composition</b>			
<input type="checkbox"/> All-male practice	3	63	NS
<input type="checkbox"/> Female physician in practice	6	28	

<sup>a</sup>NS = not significant

**Table 4**  
**Response to Question: Did or Would Continuing Medical Education Change Your Screening Habits?**

Practice location	Yes	No	Significance <sup>a</sup>
■ Florida	6	44	NS
■ New Jersey	7	43	

<sup>a</sup>NS = not significant



## Checklist

- Lack of knowledge of prevalence, feeling that one's patients are not at risk
- Lack of training in screening and intervention
- Lack of comfort in discussing "difficult" topics
- Lack of cultural competence— not understanding cultural attitudes toward domestic violence
- Prejudice:
  - racial
  - socioeconomic
  - sexism
- Fear of losing patients by offending them
- Need to "prove" violence before reporting it
- "Pandora's box" phenomenon—requires too much time to intervene

Figure 2. Factors affecting physician failure to detect domestic violence.

ily violence were professionally and economically ostracized.

Perhaps more important than a lack of formal education are physicians' attitudes (Figure 2). In one study, less than half of the physicians polled thought that domestic violence was a significant problem in their patient population.<sup>6</sup> These physicians may be unaware of how pervasive and insidious AIPV is and have not realized that if they are treating women, they are inevitably treating some battered women.

Besides ignorance of the scope of domestic violence, the Robert Wood Johnson study demonstrates frank elitism, racial prejudice, and sexism of physicians. Physicians frequently believe that domestic violence is more common in nonwhite or poorer communities and does not occur in "nice," "normal," fam-

ilies or in "wealthier" communities.<sup>5</sup> Physicians may perceive victims, particularly nonwhite, non-middle class victims, as "deserving" the abuse. Alternately, physicians themselves who are or who have been victims of domestic violence may choose not to deal with the issue in their practices because of their own unresolved conflicts.

Despite the efforts to increase awareness, we were disappointed to find that only 23% of family physicians and obstetrician/gynecologists screened for domestic violence. We were also disappointed that resident physicians performed no better than attending physicians.

Although our study did show that practices with female physicians were more likely to screen for domestic violence, still it was less than half (47%) of such offices that did so.

### Comment

It was hoped that the mandatory CME law passed by the Florida legislature would increase physician awareness of the human immunodeficiency virus and lead to increased screening and intervention. Unfortunately, this does not appear to be the case. Physicians in Florida are no more likely to screen than physicians in New Jersey. It would seem likely that if female physicians were more likely to screen in an initial visit, then they should also be more likely to identify recent victims of domestic violence. Our data show that indeed this identification was more likely; however, this variable did not reach statistical significance. Perhaps if we expanded our study to include more offices, we would have a greater power to see this difference.

It is disappointing that screening for domestic violence occurs so infrequently that residents who received information

regarding domestic violence very early in their medical school careers were no more likely to screen than their role models. Mandatory CME does not make a difference.

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## Case report

### Refractory torticollis after a fall

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Though multiple medical and psychiatric causes of torticollis have been described, cervical dystonias resulting from distant somatic dysfunctions have not. This article describes the treatment of a 62-year-old woman in whom refractory retro-torticollis of surmised pelvic etiology developed after a fall. Structurally, cervical dystonias have been addressed as problems that originate in the head and neck, but this limited view of the musculoskeletal component of torticollis may prevent physicians from directing osteopathic manipulative treatment to the underlying problem.

(Key words: torticollis, cervical dystonia, osteopathic manipulative treatment)

Spasmodic torticollis is a muscle dystonia characterized by a sustained movement of the head to one side. Variant dystonic states occur with the head flexed (anterocollis) or extended (retrocollis).<sup>1</sup> Though spontaneous remission occasionally occurs, torticollis is usually chronic. Current treatment of torticollis frequently includes the use of botulinum toxin and, rarely, surgery.<sup>1-3</sup> Torticollis is an indication for the use of osteopathic manipulative treatment (OMT) typically directed to cranial nerve XI (spinal accessory nerve),<sup>4,5</sup> and a recent report of OMT in the emergency room described the focus of structural intervention for torticollis as being directed toward the cervicothoracic junction.<sup>6</sup>

This article describes a patient in whom a combination retrocollis/torticollis developed after a fall. The clinical history and treatment regimen are described, and the manipulative assessment and treatment of cervical dystonia is discussed.

#### Report of case

A 62-year-old female presented to the clinic complaining of right-sided neck and shoulder pain with restricted motion of 3 weeks' duration. The pain began gradually over a few days after a fall that occurred when the patient stepped into a 3-inch-deep hole with her left foot. The patient described falling forward with her left knee bent, arms outstretched. The left arm and shoulder received the brunt of the impact. She reported mild to moderate soreness in the left upper arm and shoulder, which steadily improved over the time that the right-sided neck and shoulder pain developed, and mild swelling and bruising of the left tibial tuberosity. By 96 hours after the fall, the patient had a constant pain that she described as dull and achy, but worsening in intensity upon flexion, left sidebending, or right rotation of the head. The pain radiated from the left occipital base, laterally to the left acromion. There was also mild pain on palpation of the

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