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The Case for Mandatory Training on Screening for Domestic Violence in the Wake of the Affordable Care Act

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THE CASE FOR MANDATORY TRAINING ON SCREENING FOR DOMESTIC VIOLENCE IN THE WAKE OF THE AFFORDABLE CARE ACT

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INTRODUCTION

The legal[1] and political[2] controversy over the Patient Protection and Affordable Care Act[3] (ACA) has obscured the opportunity for the federal government and states to act collaboratively to address public health problems. In particular, state policymakers have new opportunities to combat a leading social affliction by increasing protections for the victims of

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[1] *See, e.g.*, National Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566 (2012). The Court sustained the Act's individual mandate for health insurance coverage, *id.* at 2600-01, though it struck down a penalty for States electing not to participate in the Act's expansion of Medicaid, *id.* at 2608.

[2] *See, e.g.*, David A. Fahrenthold, *House Votes to Repeal Obamacare for 37th Time*, WASH. POST (May 16, 2013), http://articles.washingtonpost.com/2013-05-16/politics/39306992_1_house-republicans-repeal-health-care-law; Jeremy W. Peters, *House to Vote Yet Again on Health Care Repeal*, N.Y. TIMES, May 14, 2013, at A14.

[3] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 21, 25, 26, 29, and 42 U.S.C.).

domestic violence. The pervasive and devastating effects of domestic violence on individuals, families, and communities have been recognized as a public health crisis.[4] As implementation of the ACA changes the healthcare landscape, a provision of the Act offers a powerful impetus for states to dramatically improve their ability to reduce the incidence of domestic violence and mitigate its impact. The Health Resources and Services Administration (HRSA) guidelines incorporated into the ACA now require insurance coverage to include routine medical domestic violence screening and counseling as a preventive service for women and adolescent girls at no additional cost.[5] This comprehensive change was buttressed by the United States Preventive Services Task Force's recommendations for medical screening for domestic violence.[6] These sweeping transformations—along with new funding under the reauthorization of the Violence Against Women Act to improve the medical community's response to victims[7]—should spur states to fill a serious gap in services by mandating that physicians have training in the complex dynamics of domestic violence. In this way, screening and referrals to community services[8] can become widespread and effective. Without such mandated training, the promise of this potentially potent tool in the effort to reduce domestic violence will not be fulfilled.

Part One of this Article describes the prevalence and dynamics of intimate partner violence. Part Two explores the formal responses of the organized medical community to this grave health issue, in particular its call for routine screening for domestic violence. By contrast, Part Three examines the low rate of physician screening that actually takes place. Against this backdrop, this Part also reviews the preventive services provisions of the Affordable Care Act and the substantial gaps in current state laws that should otherwise ensure medical professionals have the information they need to assist and protect victims. This juxtaposition points to a promising opportunity for the exercise of cooperative federalism. Part Four proposes a framework for state-driven mandatory physician training and argues that states should provide more resources for training to ensure that medical screening is effective and helpful to victims. By implementing a meaningful program of training and screening, states can bring to fruition a federal-state

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[4] *See* Jo Ann Merica, *The Lawyer's Basic Guide to Domestic Violence*, 62 TEX. B.J. 915, 915 (1999) ("Domestic violence is recognized as a public health crisis."); Amy Sisley et al., *Violence in America: A Public Health Crisis—Domestic Violence*, 46 J. TRAUMA, INJURY, INFECTION, AND CRITICAL CARE 1105, 1105 (1999); David Estes, Note, Kansas v. Hendricks *As a Paradigm for Civil Commitment of Repeat Domestic Violence Offenders*, 20 T. JEFFERSON L. REV. 167, 168 (1998) ("Statistical data indicate that domestic violence is a national public health crisis. . ."); Eleanor Simon, *Confrontation and Domestic Violence Post-*Davis*: Is There and Should There Be a Doctrinal Exception?*, 17 MICH. J. GENDER & L. 175, 183 (2011) ("Today the concept of domestic violence as a public health crisis figures prominently in societal consciousness. . .").

[5] *Women's Preventive Services Guidelines*, U.S. DEP'T HEALTH & HUMAN SERVS., HEALTH RES. & SERVS. ADMIN., http://www.hrsa.gov/womensguidelines (last visited Nov. 23, 2013) [hereinafter *Women's Preventive Services Guidelines*]. HRSA guidelines are incorporated into the ACA pursuant to section 2713. Patient Protection and Affordable Care Act § 2713(a)(3)-(4), 42 U.S.C. § 300gg-13(a)(3)-(4) (2011).

[6] The ACA requires services rated as an A or B by the U.S. Preventive Services Task Force to be covered by the insurer without any additional cost to the patient. Patient Protection and Affordable Care Act § 2713(a)(1), 42 U.S.C. § 300gg-13(a)(1) (2011). Domestic violence screening and counseling is rated B by the U.S. Preventive Services. *USPSTF A and B Recommendations*, U.S. PREV. SERVS. TASK FORCE, http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm (current as of Nov. 2013).

[7] Violence Against Women Reauthorization Act of 2013, Pub. L. No. 113-4, § 501, 127 Stat 54, 96 (2013).

[8] Research shows that offering domestic violence victims support and referrals to advocacy agencies reduces the reported levels of domestic violence. Judith M. McFarlane et al., *Secondary Prevention of Intimate Partner Violence: A Randomized Controlled Trial*, 55 NURSING RES. 52, 59 (2006).

partnership for attacking a chronic and horrific social ill.

I. THE DUAL MENACE OF DOMESTIC VIOLENCE: A PRIVATE CRIME AND PUBLIC HEALTH ISSUE

Domestic violence is a pattern of abusive behavior in an intimate relationship that typically occurs in private,[9] but in the aggregate represents a public health crisis. In most instances, domestic violence serves as a device by which "one partner [] gain[s] or maintain[s] power and control over another intimate partner."[10] Abusive behaviors can include physical, sexual, emotional, economic, or psychological abuse; stalking; and threats of abuse that injure, intimidate, manipulate, humiliate, isolate, terrorize, or coerce an intimate partner.[11] These behaviors are not peculiar to certain types of relationships; they can exist in heterosexual, lesbian, gay, bisexual, and transgender relationships.[12] Likewise, victims of domestic violence are not confined to any particular segment of the population; patterns of abuse transcend differences in race, ethnicity, class, religious affiliation, age, immigration status, and ability.[13]

While domestic violence finds victims among men as well as women,[14] women overall are much more severely affected by intimate partner abuse. Studies show that women experience domestic violence incidents more frequently than men,[15] are three times more likely to sustain

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[9] Pamela Goldberg, *Anyplace but Home: Asylum in the United States for Women Fleeing Intimate Violence*, 26 CORNELL INT'L L.J. 565, 573 (1993); Amanda Blanck, Note, *Domestic Violence as a Basis for Asylum Status: A Human Rights Based Approach*, 22 WOMEN'S RTS. L. REP. 47, 55 (2000); SHANNAN CATALANO, U.S. DEP'T OF JUST., INTIMATE PARTNER VIOLENCE IN THE UNITED STATES 1 (2007), *available at* http://www.bjs.gov/content/pub/pdf/ipvus.pdf.

[10] *Domestic Violence*, U.S. DEP'T OF JUST., http://www.ovw.usdoj.gov/domviolence.htm (last updated Mar. 2013).

[11] *Id.*

[12] Eric P. Seelau et al., *Gender and Role-Based Perceptions of Domestic Abuse: Does Sexual Orientation Matter?*, 21 BEHAV. SCI. & L. 199, 199-200 (2003) ("[D]omestic abuse is also experienced by heterosexual men, gay men, lesbians, and bisexual persons, sometimes with lethal results."); *see also* Joan C. McClennen, *Domestic Violence Between Same-Gender Partners: Recent Findings and Future Research*, 20 J. INTERPERSONAL VIOLENCE 149, 150 (2005) ("Findings from existing research reveal many similarities between same-gender and opposite-gender IPV[intimate partner violence]. The prevalence rate of approximately 25% to 35% of all partners experiencing IPV is comparable."); Kevin L. Ard & Harvey J. Makadon, *Addressing Intimate Partner Violence in Lesbian, Gay, Bisexual, and Transgender Patients*, 26 J. GEN. INTERNAL MED. 630, 630 (2011) ("The National Violence Against Women (NVAW) survey found that 21.5% of men and 35.4% of women reporting a history of cohabitation with a same-sex partner had experienced physical abuse in their lifetimes.").

[13] FAMILY VIOLENCE PREVENTION FUND, NATIONAL CONSENSUS GUIDELINES ON IDENTIFYING AND RESPONDING TO DOMESTIC VIOLENCE VICTIMIZATION IN HEALTH CARE SETTINGS 7 (2004) [hereinafter NATIONAL CONSENSUS GUIDELINES], *available at* http://www.futureswithoutviolence.org/userfiles/file/Consensus.pdf.

[14] The National Intimate Partner and Sexual Violence Survey (NIPSVS) reports that 35.6% of women and 28.5% of men have been have been victims of rape, physical violence, or stalking by an intimate partner in their lifetime. MICHELE C. BLACK ET AL., CENTERS FOR DISEASE CONTROL & PREVENTION, NATIONAL INTIMATE PARTNER AND SEXUAL VIOLENCE SURVEY: 2010 SUMMARY REPORT 2 (2011) [hereinafter CDC SURVEY], *available at* http://www.cdc.gov/violenceprevention/pdf/nisvs_report2010-a.pdf.

[15] Patricia Tjaden & Nancy Thoennes, *Prevalence and Consequences of Male-to-Female and Female-to-Male Intimate Partner Violence as Measured by the National Violence Against Women Survey*, 6 VIOLENCE AGAINST WOMEN 142, 152-53 (2000).

injuries due to domestic violence,[16] are six times more likely to require medical care for injuries from domestic violence,[17] are three times as likely to be stalked,[18] and among murder victims, are eight times more likely to have been killed by an intimate partner than men.[19] As alarming as these statistics are, they probably do not reflect the actual number of victims because researchers agree that domestic violence is chronically underreported.[20]

The phenomenon of domestic violence has invoked a range of legislative responses from the states. Although states sometimes use terms other than domestic violence, such as domestic abuse,[21] family violence,[22] family abuse,[23] interpersonal violence,[24] and cohabitant abuse,[25] "[l]egal definitions across the States generally describe specific conduct or acts that are subject to civil and criminal actions."[26] The most common acts specified are assault, sexual assault, battery, harassment, stalking, trespassing, kidnapping, and burglary or robbery.[27] Many states have enacted separately chargeable crimes of domestic violence that emphasize the relationship between the parties.[28] Other states have criminal statutes for assault and battery but have augmented the penalties for crimes involving family members.[29] All states make it possible for

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[16] *See* Centers for Disease Control & Prevention, *Adverse Health Conditions and Health Risk Behaviors Associated with Intimate Partner Violence – United States, 2005*, 57 MORBIDITY & MORTALITY WKLY. REP. 113, 113 (2008).

[17] Michael S. Kimmel, *"Gender Symmetry" in Domestic Violence: A Substantive and Methodological Research Review*, 8 VIOLENCE AGAINST WOMEN 1332, 1348 (2002).

[18] *See* CDC SURVEY, *supra* note 14, at 2.

[19] *See* CALLIE MARIE RENNISON, U.S. DEP'T OF JUST., INTIMATE PARTNER VIOLENCE, 1993-2001 (2003), *available at* http://www. bjs/content/pub/pdf/ipv01.pdf.

[20] *See, e.g.*, Enrique Garcia, *Unreported Cases of Domestic Violence Against Women: Towards an Epidemiology of Social Silence, Tolerance, and Inhibition*, 58 J. EPIDEMIOLOGY COMMUNITY HEALTH 536, 536 (2004) ("[R]eported cases of domestic violence against women (usually the most severe end of violence) and homicide of women by their intimate partners represents only the tip of the iceberg. According to this metaphor, most of the cases are submerged, allegedly invisible to society.").

[21] *See, e.g.*, ARK. CODE ANN. § 9-15-101 et seq. (2013); COLO. REV. STAT. § 26-7.5-102 (2013); HAW. REV. STAT. § 586-1 et seq. (2012).

[22] *See, e.g.*, CONN. GEN. STAT. § 46b-38a-f (2013); GA. CODE ANN. § 16-5-95 (2012); N.M. STAT. ANN. § 40-13-1 (1999).

[23] *See, e.g.*, OR. REV. STAT. § 107.700 et seq. (2011).

[24] The District of Columbia defines the terms interpersonal violence, intimate partner violence, intrafamily violence, and intrafamily offense. All of these terms are synonymous with domestic violence. D.C. CODE § 16-1001 (2012).

[25] UTAH CODE ANN. § 77-36-1 et seq. (LexisNexis 2013).

[26] CHILD WELFARE INFORMATION GATEWAY, U.S. DEP'T HEALTH & HUMAN SERVS., DEFINITIONS OF DOMESTIC VIOLENCE 1 (2011), *available at* https://www.childwelfare.gov/systemwide/laws_policies/statutes/defdomvio.pdf.

[27] *Id.* at 4.

[28] *See, e.g.*, ALA. CODE § 13A-6-130 (2013); ARIZ. REV. STAT. ANN. § 13-3601 (2013); 720 ILL. COMP. STAT. 5/12-3.2 (2012); HAW. REV. STAT. § 709-906 (2012); *but see* Deborah Tuerkheimer, *Recognizing and Remedying the Harm of Battering: A Call to Criminalize Domestic Violence*, 94 J. CRIM. L. & CRIMINOLOGY 959, 959-61 (2004) (arguing that there is a "disconnect" between the criminal laws against violence and domestic violence victims because the laws, whether they are specifically called domestic violence laws or are generic laws against battery and assault, do not capture the dynamic of power and control that is uniquely present in the crime of one intimate partner abusing another).

[29] D. KELLY WEISBERG, DOMESTIC VIOLENCE: LEGAL AND SOCIAL REALITY 280-281 (2012); *see, e.g.*, ALA.

victims of domestic violence to obtain judicial orders for protection against perpetrators, sometimes called injunctions for protection against domestic violence.[30] Federal law requires states to recognize and grant full faith and credit to protection orders issued by the courts of other states.[31]

The magnitude of domestic violence's incidence and impact makes it a major public health issue.[32] The social and individual costs of intimate partner rape, physical assault, and stalking are well documented and immense. According to estimates by the Centers for Disease Control, these crimes cost approximately $5.8 billion each year for direct medical and mental health care services and lost productivity from paid work and household chores.[33] Of this total, "nearly $4.1 billion . . . is for direct medical and mental health care services."[34] The devastating health effects of domestic violence on victims have been amply demonstrated. According to the National Center for Injury Prevention and Control, women who were victims of interpersonal or domestic violence accounted for nearly 300,000 physician visits and more than 500,000 injuries requiring medical care in 1995.[35] Government agencies and researchers have noted broad-ranging and devastating effects to victim health, including illnesses such as musculoskeletal injuries, sexually transmitted infections, gastrointestinal and gynecological conditions, asthma, diabetes, chronic pain, physical disability, complications of pregnancy, and mental illness.[36] Children who live in homes with domestic violence are also at increased risk of maltreatment and poor health outcomes.[37] Child abuse may occur in a large portion of the households that experience domestic violence,[38] and children can suffer a range of problems as a result: increased rates of health

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CODE § 13A-6-130 (2013); FLA. STAT. § 741.283 (2011); OHIO REV. CODE ANN. § 2919.25 (LexisNexis 2013).

[30] MAUREEN SHEERAN & EMILIE MEYER, NAT'L COUNCIL OF JUVENILE & FAM. COURT JUDGES, CIVIL PROTECTION ORDERS: A GUIDE FOR IMPROVING PRACTICE 2 (2010), *available at* http://www.ncjfcj.org/images/stories/dept/fvd/pdf/cpo_guide.pdf ("[A]ll 50 states, the District of Columbia, all United States territories, and many tribes have committed to safeguarding victims of domestic violence and their children by offering this civil remedy."); *see, e.g.*, ALASKA STAT. § 18.66.100 (2013); FLA. STAT. § 741.30 (2011); OHIO REV. CODE ANN. § 3113.31(E) (LexisNexis 2013).

[31] 18 U.S.C. § 2265 (2012).

[32] AMERICAN MEDICAL ASS'N, H-515.965 FAMILY AND INTIMATE PARTNER VIOLENCE, *available at* http://www.ama-assn.org/ama1/pub/upload/mm/PolicyFinder/policyfiles/HnE/H-515.965.HTM (last visited Nov. 27, 2013) ("Our AMA believes that all forms of family and intimate partner violence are major public health issues.").

[33] NAT'L CTR. FOR INJURY PREVENTION & CONTROL, CENTERS FOR DISEASE CONTROL & PREVENTION, COSTS OF INTIMATE PARTNER VIOLENCE AGAINST WOMEN IN THE UNITED STATES 2 (2003) [hereinafter COSTS], *available at* http://www.cdc.gov/violenceprevention/pdf/IPVBook-a.pdf.

[34] *Id.*; *see also,* Amy E. Bonomi et al., *Health Care Utilization and Costs Associated with Physical and Nonphysical-Only Intimate Partner Violence*, 44 HEALTH SERVS. RES. 1052, 1062 (2009) (reporting victims of domestic violence experience 42 percent to 33 percent higher health costs, depending on recency and type of abuse).

[35] COSTS, *supra* note 33, at 22.

[36] *See* CDC SURVEY, *supra* note 14, at 7-9; Jacquelyn C. Campbell, *Health Consequences of Intimate Partner Violence*, 359 THE LANCET 1331, 1331-34 (2002); Patricia A. Janssen et al., *Intimate Partner Violence and Adverse Pregnancy Outcomes: A Population-Based Study*, 188 AM. J. OBSTETRICS & GYNECOLOGY 1341, 1346-47 (2003); Stacey B. Plichta, *Intimate Partner Violence and Physical Health Consequences: Policy and Practice Implications*, 19 J. INTERPERSONAL VIOLENCE 1296, 1296 (2004).

[37] *See* Todd I. Herrenkohl et al., *Intersection of Child Abuse and Children's Exposure to Domestic Violence*, 9 TRAUMA, VIOLENCE, & ABUSE 84, 85 (2008).

[38] *See* Jeffrey L. Edleson, *Mothers and Children: Understanding the Links Between Woman Battering and Child Abuse,* MINN. CTR. AGAINST VIOLENCE & ABUSE (1995), http://www.mincava.umn.edu/documents/nij/nij.html ("The studies reviewed here suggest that in 32% to 53% of all families where women are being beaten their children are

problems, including anxiety, depression, and aggression; attempted suicide; and drug and alcohol abuse.[39]

A variety of explanations for causes of domestic violence have been offered. However, these variations should not overshadow the fact that violence in a relationship is ultimately a choice made by a perpetrator[40] and that understanding its roots in any individual case cannot erase the terrible damage that has been done. Thus, any number of often overlapping theories developed by researchers may have some role in explaining why a specific individual is violent toward an intimate partner:[41] theories of individual psychopathologies,[42] couple and family interaction

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also the victims of abuse by the same perpetrator."); K. Daniel O'Leary et al., *Co-Occurrence of Partner and Parent Aggression: Research and Treatment Implications,* 31 BEHAV. THERAPY 631, 631 (2000) ("Physical aggression toward a child and a partner within the same family occurs more frequently than once thought. In community samples, the co-occurrence rate appears to be 5% to 6%; in clinical samples, it may be more than 50%.").

[39] *See* CHILD WELFARE INFORMATION GATEWAY, U.S. DEP'T HEALTH & HUMAN SERVS., DOMESTIC VIOLENCE AND THE CHILD WELFARE SYSTEM 2-3 (2009) (noting that children who witness domestic violence experience higher levels of anger, anxiety, and depression), *available at* https://www.childwelfare.gov/pubs/factsheets/domestic_violence/domesticviolence.pdf; Melissa M. Stiles, *Witnessing Domestic Violence: The Effect on Children,* 66 AM. FAM. PHYSICIAN 2052, 2052 (2002) (stating that children exposed to domestic violence "are at greater risk for internalized behaviors such as anxiety and depression, and for externalized behaviors such as fighting, bullying, lying, or cheating."); James C. Spilsbury et al., *Clinically Significant Trauma Symptoms and Behavioral Problems in a Community-Based Sample of Children Exposed to Domestic Violence,* 22 J. FAM. VIOL. 487, 487 (2007) ("Child co-victimization increased odds of reaching clinically significant levels of traumatic symptoms compared to children who witnessed the event but were not victimized."); Christopher M. Adams, *The Consequences of Witnessing Family Violence on Children and Implications for Family Counselors,* 14 THE FAM. J. 334, 335 (2006) ("The co-occurrence of these forms of abuse also places children who witness family violence at higher risk of eating disorders, substance abuse problems, and suicide.").

[40] *See Domestic Violence: Myths & Truths*, SAFEPLACE.ORG, http://www.safeplace.org/page.aspx?pid=336 (last visited Nov. 22, 2013) ("Violent behavior is a choice. Perpetrators use it to control their victims. Domestic violence is about batterers using their control, not losing their control. Their actions are very deliberate."); DAVID ISLAND & PATRICK LETELLIER, MEN WHO BEAT THE MEN WHO LOVE THEM: BATTERED GAY MEN AND DOMESTIC VIOLENCE 2 (1991) ("Because domestic violence is a decision made by a batterer, a batterer's violent actions are premeditated."); Neil Blacklock, *Domestic Violence: Working with Perpetrators, the Community and its Institutions*, 7 ADVANCES IN PSYCHIATRIC TREATMENT 65, 69 (2001) ("[E]xamination of the actions of almost all perpetrators reveals control in the level and type of violence used and clear choices in where, to whom and in what circumstances it occurs.").

[41] *See* H. LIEN BRAGG, U.S. DEP'T OF HEALTH & HUMAN SERVS., CHILD PROTECTION IN FAMILIES EXPERIENCING DOMESTIC VIOLENCE 18 (2003) ("Psychopathology, substance abuse, poverty, cultural factors, anger, stress, and depression often are thought to cause domestic violence. While there is little empirical evidence that these factors are *direct* causes of domestic violence, research suggests that they can affect its severity, frequency, and the nature of the perpetrator's abusive behavior.").

[42] Some researchers theorize that individual maladaptations and dysfunctions result in violent and controlling behavior toward intimate partners. Some of these result from damaging childhood experiences and can be learned behaviors. *See, e.g.*, Donald G. Dutton, *Male Abusiveness in Intimate Relationships*, 15 CLINICAL PSYCHOL. REV. 567, 579 (1995) ("[P]aternal rejection and shaming are strong contributors to an Abusive Personality."); Kenneth Corvo & Pamela Johnson, *Sharpening Ockham's Razor: The Role of Psychopathology and Neuropsychopathology in the Perpetration of Domestic Violence,* 18 AGGRESSION & VIOLENT BEHAV. 175, 180 (2013) ("Domestic violence at its simplified core is a maladaptive and destructive coping strategy, symptomatic of disorders of impulsivity, neuropsychological impairment, and emotional dysfunction activated within the context of intimacy or primary relationships."); Amy Holtzworth-Munroe, et al., *Violent Versus Nonviolent Husbands: Differences in Attachment Patterns, Dependency, and Jealousy,* 11 J. FAM. PSYCHOL. 314, 320, 324 (1997) (concluding that, as compared to nonviolent groups, violent men were often less secure, less trusting, more jealous, and evidenced more abandonment

theory,[43] social learning and development theory,[44] societal structure theory,[45] and feminist theory.[46] Still, for those on the frontlines of helping victims, precise understanding of cause pales

issues).

[43] Theories also posit that couple and family interaction may provide the context for understanding an individual's violent and controlling behavior. *See* Dudley D. Cahn, *Family Violence From a Communication Perspective*, *in* FAMILY VIOLENCE FROM A COMMUNICATION PERSPECTIVE 1, 7 (Dudley D. Cahn & Sally A. Lloyd eds., 1996) ("According to the frustration-aggression hypothesis, when goal attainment is blocked frustration increases and, as a result, persons become more aggressive, increasingly more threatening, and eventually violent."); Richard E. Heyman & Peter H. Neidig, *Physical Aggression Couples Treatment*, *in* CLINICAL HANDBOOK OF MARRIAGE AND COUPLES INTERVENTION 589 (W. Kim Halford & Howard J. Markman eds., 1997); Julia C. Babcock et al., *Power and Violence: The Relation Between Communication Patterns, Power Discrepancies, and Domestic Violence*, 61 J. CONSULTING & CLINICAL PSYCHOL. 40, 40 (1993) ("[V]iolence may be compensatory behavior to make up for husbands' lack of power in other arenas of marriage."); Jorge Rodriguez-Menes & Ana Safranoff, *Violence Against Women in Intimate Relations: A Contrast of Five Theories*, 9 EUR. J. CRIMINOLOGY 584, 586 (2012) ("Exchange theory . . . focuses on women's resources *relative* to men's. In its radical form, it is indifferent to gender and analyses how resources facilitate the exertion of power by whoever has more.").

[44] Social learning and development theory posits that families, along with the larger society, support violence as acceptable behavior and allow it to continue at the individual family level. *See, e.g.*, Corvo & Johnson, *supra* note 42, at 180 ("Social learning theory-based intergenerational transmission theory, on the other hand, provides an epistemologically sound framework for empirical investigation of domestic violence perpetration. By identifying family of origin violence exposure as a risk factor for adult perpetration the groundwork is laid for developmental and ecological theorizing."); Gerald T. Hotaling & David B. Sugarman, *An Analysis of Risk Markers in Husband to Wife Violence: The Current State of Knowledge*, 1 VIOLENCE & VICTIMS 101, 101 (1986) ("Only witnessing violence in the wife's family of origin was consistently associated with being victimized by violence."); Debra Kalmus, *The Intergenerational Transmission of Marital Aggression*, 46 J. MARRIAGE & FAM. 11, 11 (1984) ("[O]bserving hitting between one's parents is more strongly related to involvement in severe marital aggression than is being hit as a teenager by one's parents."); Joan I. Vondra, *The Community Context of Child Abuse*, 15 MARRIAGE & FAM. REV. 19, 26-27 (1990) ("In the context of high-volume expression of violence in the media, the probability that child care will drift into child maltreatment no doubt increases proportionately . . . Maltreating adults appear to share a common history characterized by insecure, unstable, and/or pathological relations with their parent(s)."); Tanya Abramsky et al., *What Factors are Associated with Recent Intimate Partner Violence? Findings from the WHO Multi-Country Study on Women's Health and Domestic Violence*, 11 BMC PUB. HEALTH 109, 110-11 (2011) ("A history of abuse was strongly associated with the occurrence of IPV [intimate partner violence], with reports of abuse of the woman's mother, her partners' mother, or both . . . being associated with increased risk of IPV in all sites . . . .").

[45] The societal structure theory posits that the inequalities of the entire social structure must be examined to explain the presence of domestic violence. *See, e.g.*, THE CANADIAN PANEL ON VIOLENCE AGAINST WOMEN, CHANGING THE LANDSCAPE: ENDING VIOLENCE—ACHIEVING EQUALITY 3 (1993); EVE S. BUZAWA & CARL G. BUZAWA, DOMESTIC VIOLENCE: THE CRIMINAL JUSTICE RESPONSE 67 (3d ed. 2003) ("In a real sense, structured gender inequality existed both in the home and in the institutions designed to maintain Western cultural and family values."); DAVID LEVINSON, FAMILY VIOLENCE IN CROSS-CULTURAL PERSPECTIVE (1989) (finding that among 90 societies studied worldwide, 16 had rare or nonexistent occurrences of family violence; characteristics of these societies included natural support systems and emphasis on peaceful conflict; and sexual equality was a common factor in decision-making and lack of double standards.); M.D.A. Freeman, *Violence Against Women: Does the Legal System Provide Solutions or Itself Constitute the Problem?*, 7 BRIT. J. L. & SOC'Y. 215, 216 (1980) (suggesting that the legal system reinforces relationships and ideology that fosters violence against women.); Rekha Mirchandani, *"Hitting is Not Manly": Domestic Violence Court and the Re-Imagination of the Patriarchal State*, 20 GEND. & SOC'Y 781, 783 (2006) (pointing to research that suggests laws prescribe gender roles to women that are invasive and stereotypical.).

[46] Feminist theory is focused on systemic gender inequality and entrenched misogyny in a society that devalues and objectifies women. *See, e.g.*, Kristin L. Anderson, *Gender, Status, and Domestic Violence: An Integration of Feminist and Family Violence Approaches*, 59 J. MARRIAGE & FAM. 655, 655 (1997) ("[D]omestic violence is rooted in

next to the urgency of supplying immediate support and aid.

II. ORGANIZED MEDICINE'S RESPONSE TO DOMESTIC VIOLENCE: A CALL FOR DOMESTIC VIOLENCE SCREENING ACROSS MEDICAL PRACTICES

The American Medical Association (AMA) first supported routine medical screening of women for family violence more than two decades ago,[47] and renewed its position in 2009 for all patients.[48] Organized medicine's response to domestic violence has stemmed largely from recognition that medical professionals in a range of practice and medical settings can expect to care for patients whose lives have been affected by this form of abuse.[49] For example, emergency room staff treat victims' head trauma, organ damage, and broken bones.[50] Gynecological and obstetrical staff can be confronted with a victim's miscarriage or stillbirth from a beating.[51] Orthopedic staff may treat back and neck injuries, fractures, and torn ligaments inflicted by perpetrators.[52] Internal medicine providers may treat victims whose asthma, seizure disorder, or diabetes is exacerbated by domestic violence.[53] Ophthalmologists may treat retinal detachments

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gender and power and represents men's active attempts to maintain dominance and control over women."); Kersti A. Yllo, *Through a Feminist Lens: Gender, Power, and Violence, in* CURRENT CONTROVERSIES ON FAMILY VIOLENCE 47, 47 (Richard J. Gelles & Donileen R. Loseke eds., 1993) ("Despite this complexity, the most fundamental feminist insight into all of this is quite simple: Domestic violence cannot be adequately understood unless gender and power are taken into account."); *see also* Michael P. Johnson, *Patriarchal Terrorism and Common Couple Violence: Two Forms of Violence Against Women*, 57 J. MARRIAGE & FAM. 283, 284 (1995) ("Patriarchal terrorism, a product of patriarchal traditions of men's right to control 'their' women, is a form of terroristic control of wives by their husbands that involves the systematic use of not only violence, but economic subordination, threats, isolation, and other control tactics."); Rodriguez-Menes & Safranoff, *supra* note 43, at 599 ("[P]atriarchy-as-sexism correctly stress[es] the key role of a sexist culture that is denigratory to women as a breeding ground for violence.").

[47] American Medical Ass'n, *Diagnostic and Treatment Guideline on Domestic Violence*, 1 ARCHIVES FAM. MED. 39, 41 (1992).

[48] AMERICAN MEDICAL ASS'N, H-515.965 FAMILY AND INTIMATE PARTNER VIOLENCE, *supra* note 32.

[49] *See* American Medical Ass'n, *Diagnostic and Treatment Guideline on Domestic Violence*, *supra* note 47, at 40 ("Physicians in all practice settings routinely see the consequences of violence and abuse, but often fail to acknowledge their violent etiologies."); *see also* Elaine J. Alpert et al., *Interpersonal Violence and the Education of Physicians*, 72 ACAD. MED. S41, S41-42 (1997) (stating that "physicians in every field of practice can expect to care" for victims of domestic violence and that, since 1985, the medical community has recognized the need for violence training).

[50] George Cristian Curca et al., *Patterns of Injuries in Domestic Violence in a Romanian Population*, 27 J. INTERPERSONAL VIOLENCE 2889, 2892 (2012) ("Out of 219 patients, only 9 declared victims of DV and [sic] did not have any signs of trauma when examined; 69.5% presented head or neck lesions (152 cases), 24.2% had thoracic or abdominal lesions (53 cases), and 58.9% had traumatic lesions on the upper and/or lower limbs (129 cases)."); M. Sharon Maxwell, *Domestic Violence Training for Family Practice Residents, Institute for Family Violence Studies* 10-11 (2002) (unpublished manuscript) (on file with author).

[51] *See Intimate Partner Violence: Consequences*, CENTERS FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/violenceprevention/intimatepartnerviolence/consequences.html (last visited Nov. 23, 2013) (listing reproductive effects of intimate partner violence: as including: "Gynecological disorders, Pelvic inflammatory disease, Sexual dysfunction, Sexually transmitted infections, including HIV/AIDS, Delayed prenatal care, Preterm delivery, Pregnancy difficulties like low birth weight babies and perinatal deaths, Unintended pregnancy.").

[52] *See id.*

[53] Inst. for Women's Health, *Domestic & Sexual Violence Information*, VA. COMMW. UNIV., http://www.womenshealth.vcu.edu/outreach/domesticviolence/index.html (last visited Nov. 22, 2013) ("In addition to the immediate trauma caused by abuse, domestic violence contributes to a number of chronic health problems, including

and subconjunctival hematosis caused by such violence.[54] Psychiatric staff may treat victims' depression, suicide attempts, and substance abuse.[55] Family practitioners may treat victims' gastrointestinal complaints, anxiety, muscular pain, and a variety of chronic illnesses that include headaches and sleep disturbances.[56] Dental surgeons may treat victims' dislocated and broken jaws.[57]

The AMA's policy has also been informed by the major role that physicians can play in lessening the incidence, scope, and severity of all forms of domestic violence.[58] Research indicates that most patients welcome being questioned, assessed, or screened[59] about domestic violence by clinicians when this process is conducted in a safe, nonjudgmental, and respectful manner,[60] and that they appreciate practical information, support, and referral to services.[61] Women are also likely to disclose abuse when questioned during pediatric visits made with their children.[62] Several studies have demonstrated that an intervention by a health provider has been shown to make a positive difference for victims in their health. Women who talked to their health care provider about being abused were more likely to use an intervention[63] and many reported

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depression, alcohol and substance abu3se (sic), sexually transmitted diseases including HIV/AIDS, and often limits the ability of women to manage other chronic illnesses such as diabetes and hypertension.").

[54] L. KEVIN HAMBERGER & MARY B. PHELAN, DOMESTIC VIOLENCE SCREENING AND INTERVENTION IN MEDICAL AND MENTAL HEALTHCARE SETTINGS 128 (2004) (discussing studies of ophthalmology patients who were suspected victims of domestic violence, and which found that "[c]ontusions and lacerations were the most common presenting injuries, followed by subconjunctival hemorrhage, traumatic iritis, and hyphema.").

[55] *Intimate Partner Violence: Consequences*, *supra* note 51 ("Examples of health conditions associated with IPV include: asthma, bladder/kidney infections, circulatory conditions, cardiovascular disease, fibromyalgia, irritable bowel syndrome, chronic pain syndromes, central nervous system disorders, gastrointestinal disorders, joint disease, migraines/headaches.").

[56] *See* Leslie J. Crofford, *Violence, Stress, and Somatic Syndromes*, 8 TRAUMA, VIOLENCE, & ABUSE 299, 299 (2007) ("Exposure to the stressor of violence is likely to create a state of vulnerability for the stress-related somatic syndromes and also to contribute to symptom expression and severity.").

[57] *See* EMMA WILLIAMSON, DOMESTIC VIOLENCE AND HEALTH: THE RESPONSE OF THE MEDICAL PROFESSION 35 (2000) (citing studies showing that women victims of domestic violence reported "broken teeth" and "broken jaw[s]" as a result of their abuse).

[58] *See* AMERICAN MEDICAL ASS'N, H-515.965 FAMILY AND INTIMATE PARTNER VIOLENCE, *supra* note 32.

[59] The National Consensus Guidelines use the word "assessment," but the ACA uses "screening" to describe the routine inquiry that medical professionals are encouraged to undertake to assist women with identifying and responding to domestic violence. NATIONAL CONSENSUS GUIDELINES, *supra* note 13, at 7-8; Patient Protection and Affordable Care Act § 2713(a)(4), 42 U.S.C. § 300gg-13(a)(4) (2011).

[60] *See* Peter F. Cronholm et al., *Intimate Partner Violence*, 83 AM. FAM. PHYSICIAN 1165, 1167 (2011); L. Kevin Hamberger et al., *Physician Interaction with Battered Women: The Women's Perspective*, 7 ARCHIVES FAM. MED. 575, 580 (1998) ("Battered women reported that they value medical support that includes taking a complete history, with detailed assessment of current and past violence, but without creating an atmosphere of interrogation.").

[61] L. Kevin Hamberger et al., *supra* note 60, at 580.

[62] In one study where four different pediatric practice settings screened 435 women for domestic violence, the researchers found that 22% of the women described having experienced domestic violence at some point in their lives, 16% described abuse that occurred more than two years previously, and 6% of the total number of women screened reported experiencing abuse in the past two years. Robert M. Siegel et al., *Screening for Domestic Violence in the Pediatric Office: A Multipractice Experience*, 42 CLINICAL PEDIATRICS 599, 599 (2003). The study concluded that, if screened, women were likely to disclose domestic violence during pediatric visits. *Id.* at 602.

[63] Laura A. McCloskey et al., *Assessing Intimate Partner Violence in Health Care Settings Leads to Women's*

feeling less at risk.[64] Women who were screened for abuse and given a wallet-sized referral reported fewer assaults and threats of violence.[65] A randomized control trial found that when medical professionals screen and assess women for domestic violence, and then provide education and referrals to services, domestic violence can be reduced and victims' health status improved.[66]

Moreover, the AMA has been far from alone in the medical community in calling for routine screening. The Surgeon General has supported universal screening of female patients for intimate partner/domestic violence.[67] Many medical groups have done so as well, including the American Academy of Family Physicians,[68] the American Public Health Association,[69] the American College of Obstetricians and Gynecologists[70] the American Academy of Neurology,[71] and American College of Emergency Physicians.[72] Numerous groups representing nurses, nurse practitioners, and midwives also support screening female patients in medical settings for

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Receipt of Interventions and Improved Health, 121 PUB. HEALTH REPS. 435, 435 (2006); *see also* Panagiota V. Caralis & Regina Musialowski, *Women's Experiences with Domestic Violence and Their Attitudes and Expectations Regarding Medical Care of Abuse Victims*, 90 S. MED. J. 1075, 1075 (1997) ("The majority of the respondents believe that doctors should routinely screen for abuse. As part of treatment, all women strongly recommended that doctors provide information on community and legal resources and assistance in seeking protective services.").

[64] *See* Margo Krasnoff & Ronald Moscati, *Domestic Violence Screening and Referral Can Be Effective*, 40 ANNALS EMERGENCY MED. 485, 485 (2002) (finding that women who disclosed or were identified as being victims of intimate partner violence after screening were likely to speak to an advocate and try case management. Almost half of those women who completed three to six weeks of case management reported believing they were no longer at risk for violence.).

[65] Judith M. McFarlane et al., *supra* note 8, at 52, 59.

[66] A. Tiwari et al., *A Randomized Controlled Trial of Empowerment Training for Chinese Abused Pregnant Women in Hong Kong*, 112 BJOG: INT'L J. OBSTETRICS & GYNAECOLOGY 1249, 1254 (2005); *but see* Angela Taft et al., *Screening Women for Intimate Partner Violence in Healthcare Settings*, 4 COCHRANE DATABASE OF SYSTEMATIC REVS. 1, 2 (2013) (arguing that the existing evidence of long-term benefits is insufficient to justify universal screening of patients for domestic violence in healthcare settings); Joanne Klevens et al., *Effect of Screening for Partner Violence on Women's Quality Of Life: A Randomized Controlled Trial*, 308 J. AM. MED. ASS'N 681, 689 (2012) (citing study results that suggest the combination of computerized screening and provision of a violence resource list does not result in significant benefits to participants' general health).

[67] Antonia C. Novello et al., *A Medical Response to Domestic Violence*, 267 J. AM. MED. ASS'N 3132, 3132 (1992) (Antonia Novello was the U.S. Surgeon General at the time).

[68] *Intimate Partner Violence and Abuse of Elderly and Vulnerable Adults*, AM. ACAD. OF FAMILY. PHYSICIANS (2013), http://www.aafp.org/patient-care/clinical-recommendations/all/domestic-violence.html?cmpid=_van_280.

[69] AM. PUB. HEALTH ASS'N, DOMESTIC VIOLENCE SCREENING, IDENTIFICATION, AND REFERRAL BY DENTAL HEALTH AND EYE CARE PROFESSIONAL, POLICY NUMBER 9925 (Jan. 1, 1999), *available at* http://www.apha.org/advocacy/policy/policysearch/default.htm?id=196 (recommending health care professionals including dentists and optometrists develop skills and communication techniques for early diagnosis, intervention, and referral of DV cases); AM. PUB. HEALTH ASS'N, APHA POLICY STATEMENT 9211(PP): DOMESTIC VIOLENCE (1992).

[70] AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, COMMITTEE ON HEALTH CARE FOR UNDERSERVED WOMEN: INTIMATE PARTNER VIOLENCE, COMMITTEE OPINION NO. 518 (2012).

[71] Elliott A. Schulman & Anna DePold Hohler, *The American Academy of Neurology Position Statement on Abuse and Neglect*, 78 NEUROLOGY 433 (2012).

[72] AM. COLL. OF EMERGENCY PHYSICIANS, DOMESTIC FAMILY VIOLENCE (2007), *available at* http://www.acep.org/Clinical—-Practice-management/Domestic-Family-Violence.

domestic/intimate partner violence.[73] Moreover, in 2011 the Institute of Medicine (IOM), the health division of the National Academies,[74] issued a policy statement that medical screening for risk of interpersonal/domestic violence is "central to women's safety, as well as to addressing current health concerns and preventing future health problems."[75] The IOM recommended screening and counseling for interpersonal/domestic violence for all women and adolescent girls as part of women's preventive clinical services.[76] Screening and counseling involve "elicitation of information about current and past violence and abuse in a culturally sensitive and supportive manner to address current health concerns about safety and other current or future health problems."[77] It was because of this recommendation that Kathleen Sebelius, Secretary of the United States Department of Health and Human Services, added domestic violence screening to the preventive services for women covered under the ACA.[78]

III. THE NEW LEGAL LANDSCAPE: FEDERAL SUPPORT TO FILL PERSISTENT GAPS IN STATE LAWS

This Article's proposal that states mandate physician training on domestic violence flows from recognition of three phenomena: the unprecedented stimulus for screening afforded by the ACA, overwhelming evidence that physicians cannot be counted on to voluntarily undertake effective screening, and the manifest inadequacy of existing state regulation in this area. Like the ACA itself, however, the proposal does not seek to upset states' major role in devising and implementing health care policy. Rather, the proposal recommends that states act upon a federally created opportunity to make a large contribution to society's campaign against domestic violence.

A. Potential Impact of the Affordable Care Act's Required Coverage of Domestic Violence Screening

Passage of the Affordable Care Act has paved the way for an exponential increase in the amount of screening for intimate partner violence conducted by physicians. Signed by President

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[73] *See, e.g.*, AM. COLL. OF NURSE-MIDWIVES, POSITION STATEMENT: VIOLENCE AGAINST WOMEN (2003), *available at* http://www.midwife.org/sitefiles/position/violence_against_women_05.pdf; AM. NURSES ASS'N, VIOLENCE AGAINST WOMEN: ANA POSITION STATEMENT (Mar. 24, 2000), *available at* http://www.nursingworld.org/MainMenuCategories/Policy-Advocacy/Positions-and-Resolutions/ANAPositionStatements/Position-Statements-Alphabetically/Violence-Against-Women.html; EMERGENCY NURSES ASS'N, POSITION STATEMENT: INTIMATE PARTNER AND FAMILY VIOLENCE, MALTREATMENT, AND NEGLECT (Dec. 2006), *available at* https://www.ena.org/SiteCollectionDocuments/Position%20Statements/ViolenceIntimatePartnerFamily.pdf.

[74] "The Institute of Medicine is an independent, nonprofit organization that works outside of government to provide unbiased and authoritative advice to decision makers and the public . . . [T]he IOM is the health arm of the National Academy of Sciences, which was chartered under President Abraham Lincoln in 1863." *About the IOM*, INST. OF MED., http://www.iom.edu/About-IOM.aspx (last updated Jan. 18, 2012).

[75] INST. OF MED., CLINICAL PREVENTIVE SERVICES FOR WOMEN: CLOSING THE GAPS 2 (2011).

[76] *Id.*

[77] *Id.* at 3.

[78] *See supra* note 5; *see also* Memorandum from Lisa James, Dir. of U.S. Dep't Health & Human Servs. Nat'l Health Res. Ctr. on Domestic Violence & Sally Schaeffer, Senior Pub. Pol'y Advocate, Futures Without Violence (May 25, 2012) [hereinafter Memorandum from Lisa James], *available at* http://www.futureswithoutviolence.org/userfiles/file/HealthCare/FWV-screening_memo_Final.pdf.

Obama in 2010, the ACA covers virtually every aspect of medical care in the United States.[79] A multi-state rollout of some provisions of the plan will continue beyond 2015.[80] Because patient co-pay and cost-sharing requirements reduce the likelihood that patients will use preventive care,[81] the HRSA guidelines incorporated into the ACA include a total of eight women's preventive services that should be available for all women.[82] Screening and counseling for interpersonal and domestic violence is one of those eight primary prevention services for women.[83] This provision regarding domestic violence screening ensures that new insurance plans effective after August 1, 2012, and those plans that have not been "grandfathered in" under existing terms, must cover domestic violence screening and counseling free of co-pays under the preventive care provision.[84] In addition, beginning in 2014, the ACA prohibits insurance companies, health care providers, and health programs that receive federal financial assistance from denying coverage to women based on the "pre-existing" condition of being a domestic or sexual violence survivor.[85]

The United States Preventive Services Task Force (USPSTF), an independent group of medical experts in preventive and evidence-based medicine[86] has supplied a crucial boost to widespread screening for domestic violence. In January 2013, the USPSTF recommended that clinicians screen women of childbearing age for intimate partner violence and provide intervention services or refer women who screen positive to such services.[87] "This recommendation applies to women who do not have signs or symptoms of abuse."[88] The USPSTF focuses on maintenance of health and quality of life as the major benefits of clinical preventive services, not simply the identification of disease. Its recommendations are published in the form

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[79] *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 21, 25, 26, 29, and 42 U.S.C.).

[80] *See* Mike Dorning & Alex Wayne, *Health-Law Employer Mandate Delayed by U.S. Until 2015*, BLOOMBERG (July 3, 2013, 7:51 AM), http://www.bloomberg.com/news/2013-07-02/health-law-employer-mandate-said-to-be-delayed-to-2015.html.

[81] *See* Tammy Worth, *Taking the Copay Out of Staying Healthy*, L.A. TIMES (Jan. 24, 2011), http://articles.latimes.com/2011/jan/24/health/la-he-preventive-care-20110124.

[82] *See Women's Preventive Services Guidelines*, *supra* note 5; Patient Protection and Affordable Care Act § 2713(a)(4), 42 U.S.C. § 300gg-13(a)(4) (2010).

[83] *See Women's Preventive Services Guidelines*, *supra* note 5. The eight women's preventive services are well-woman visits, gestational diabetes screening, HPV DNA testing, STI counseling, HIV screening and counseling, contraception and contraception counseling, breastfeeding support, supplies, and counseling, and interpersonal and domestic violence screening and counseling. *Id.*

[84] *Id.*; Patient Protection and Affordable Care Act § 2713(a)(4), 42 U.S.C. § 300gg-13(a)(4) (2010).

[85] HEALTH RES. CENTER ON DOMESTIC VIOLENCE, FAMILY VIOLENCE PREVENTION FUND, HOW HEALTH REFORM MAY AFFECT VICTIMS OF DOMESTIC, SEXUAL, AND DATING VIOLENCE (JUNE 2010), *available at* http://www.futureswithoutviolence.org/userfiles/file/HealthCare/Health_Reform_Memo.pdf ("Before this protection was added, seven states allowed insurers to deny health coverage to domestic violence survivors, and only 22 states had enacted adequate domestic violence insurance discrimination protections.").

[86] U.S. PREVENTIVE SERVICES TASK FORCE, http://www.uspreventiveservicestaskforce.org (last visited Nov. 26, 2013) ("The USPSTF conducts scientific evidence reviews of a broad range of clinical preventive health care services (such as screening, counseling, and preventive medications) and develops recommendations for primary care clinicians and health systems.").

[87] *USPSTF A and B Recommendations*, U.S. PREV. SERVS. TASK FORCE, *supra* note 6.

[88] *Id.*; Virginia A. Moyer, *Screening for Intimate Partner Violence and Abuse of Elderly and Vulnerable Adults: U.S. Preventive Services Task Force Recommendation Statement*, 158 ANNALS INTERNAL MED. 478, 478 (2013).

of "recommendation statements" that are graded, and when the USPSTF recommends a service, it has concluded that the benefits of the service outweigh the harms.[89] The ACA requires that all terms or services that have received a grade of 'A'[90] or 'B' from the USPSTF be provided to patients without cost-sharing.[91] The USPSTF has graded the screening and counseling for domestic violence by medical professionals a 'B'.[92]

The historic opportunities created by the ACA to provide more preventive screening and care for domestic violence,[93] however, do not alone assure that these opportunities will be realized. Even when coupled with the increased attention by the IOM and the USPSTF to the role of physicians in identifying and addressing domestic violence, the ACA's facilitation of physician screening on a wide scale is not self-executing. On the contrary, the medical community's sparse use of existing resources or training in the past[94] strongly suggests that reliance on physicians' voluntary participation in the intensified effort to make screening for domestic violence common could prove woefully inadequate:

> Although health professionals often treat abused patients, in the vast majority of treatment situations they fail to suspect abuse. Even when abuse is identified, there is resistance to validate, document, refer, and follow up with victims of domestic violence. Often battered women treated in emergency rooms are released without any intervention or follow-up.[95]

Indeed, for at least the past two decades, the medical community on the whole has had a meager record of screening patients for domestic violence victimization.[96] In order to determine medical screening rates, researchers have employed healthcare professional surveys, patient surveys, medical case file reviews, domestic violence victim surveys, and population surveys to assess the screening rates for domestic violence. In a nationally representative household sample

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[89] *Grade Definitions*, U.S. PREV. SERVS. TASK FORCE, http://www.uspreventiveservicestaskforce.org/uspstf/grades.htm (last visited Nov. 26, 2013).

[90] Services with an A grade include screenings for high blood pressure, and colorectal and cervical cancer screening for adults. *USPSTF A and B Recommendations*, U.S. PREV. SERVS. TASK FORCE, *supra* note 6.

[91] Patient Protection and Affordable Care Act § 2713(a)(1), 42 U.S.C. § 300gg-13(a)(1) (2010).

[92] *USPSTF A and B Recommendations*, U.S. PREV. SERVS. TASK FORCE, *supra* note 6.

[93] *See* Memorandum from Lisa James, *supra* note 78, at 2 (describing the historic opportunities created under the Affordable Care Act).

[94] *See* Erica Frank et al., *Clinical and Personal Intimate Partner Violence Training Experiences of U.S. Medical Students*, 15 J. WOMEN'S HEALTH 1071, 1071 (2006) (concluding that "efforts in U.S. medical schools to increase IPV screening and prevention have not achieved saturation.").

[95] Gael Strack & Eugene Hyman, *Your Patient. My Client. Her Safety: A Physician's Guide to Avoiding the Courtroom While Helping Victims of Domestic Violence*, 11 DEPAUL J. HEALTH CARE L. 33, 40 (2007) (citing Virginia P. Tilden et al., *Factors That Influence Clinicians' Assessment and Management of Family Violence*, 84 AM. J. PUB. HEALTH 628, 628 (1994); Leslie L. Davidson, *Editorial: Preventing Injuries From Violence Toward Women*, 86 AM. J. PUB. HEALTH 12, 13 (1996)); *see also* Sana Loue, *Intimate Partner Violence: Bridging the Gap Between Law and Science*, 21 J. LEGAL MED. 1, 31 (2000) (identifying both lack of physician training and assumptions that domestic violence is a couple's problem that needs to be addressed by the parties involved as reasons for why physicians fail to identify domestic violence).

[96] *See* Ruth Klap et al., *Screening for Domestic Violence Among Adult Women in the United States*, 22 J. GEN. INTERNAL MED. 579, 579 (2007).

of 4,821 women who answered telephone surveys, only 7% "reported [that] they were ever asked about domestic violence . . . by a healthcare professional."[97] A 2008 study indicated that only 7% of patient case files in a medical setting had documentation that nurses screened patients for interpersonal violence.[98] Despite this, some pockets of higher screening rates do exist. Higher screening rates are reported for low-income women in health clinics,[99] and for pregnant women.[100] Computerized questionnaires administered to women in medical settings resulted in the vast majority of such women being screened.[101] However, victim advocates and patients prefer that questions about violence be asked in person.[102] The majority of victim advocates advise health practitioners that women should be offered a conversation about domestic violence, not an intake form and a pen.[103] Nevertheless, the National Coalition against Domestic Violence states, "less than half of reproductive health care providers regularly screen patients for domestic violence."[104]

B. Insufficiency of Current State Law

The patchwork of state laws mandating that certain medical professionals be trained on issues related to domestic violence amounts to a hodgepodge of inconsistent and sometimes baffling codes and statutes. A few states, such as Alaska, mandate training on domestic violence only for *public* employees, who are required to report child abuse on issues including the nature, extent, causes, and lethality of domestic violence, procedures to promote the safety of victims, and resources for victims and perpetrators.[105] Colorado, likewise, emphasizes the development of

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[97] *Id.* (concluding that "[s]elf-reported rates of screening . . . are low even among women at high[er] risk for abuse.").

[98] Ashli Owen-Smith et al., *Screening for Domestic Violence in an Oncology Clinic: Barriers and Potential Solutions*, 35 ONCOLOGY NURSING F. 625, 628 (2008).

[99] *See* Laura A. McCloskey et al., *Intimate Partner Violence and Patient Screening Across Medical Specialties*, 12 ACAD. EMERGENCY MED. 721, 720 (2005) (reporting that healthcare professionals were more likely to screen low-income women for domestic violence).

[100] *See* Paula Rinard Renker & Peggy Tonkin, *Women's Views of Prenatal Violence Screening: Acceptability and Confidentiality Issues*, 107 OBSTETRICS & GYNECOLOGY 348, 348 (2006) (finding nearly 61% of women indicated that they had been asked by medical professionals about domestic violence at some point during their pregnancy).

[101] Over 99% of women who completed computerized health surveys were screened for intimate partner violence, as compared to 33% of women patients who received usual care in one clinical study. Deborah E. Trautman et al., *Intimate Partner Violence and Emergency Department Screening: Computerized Screening Versus Usual Care*, 49 ANNALS OF EMERGENCY MED. 526, 526 (2007).

[102] *See* Michael A. Rodriguez et al., *The Factors Associated with Disclosure of Intimate Partner Abuse to Clinicians*, 50 J. FAM. PRAC. 338, 338 (2001) (stating that direct inquiry "appear[ed] to be one of the strongest determinants of communication with patients about partner abuse"); *see also* Rui Martins et al., *Wife Abuse: Are We Detecting It?*, 1 J. WOMEN'S HEALTH 77, 78 (1992) (suggesting that increasing domestic violence detection requires "direct questioning in a protected environment"); Jo Richardson et al., *Identifying Domestic Violence: Cross Sectional Study in Primary Care*, 324 BMJ 274, 275, 276 (2002); Kimber Paschall Richter et al., *Detecting and Documenting Intimate Partner Violence: An Intake Form Question Is Not Enough*, 9 VIOLENCE AGAINST WOMEN 458, 464 (2003).

[103] Kimber Paschall Richter et al., *supra* note 102, at 464 ("An item on an intake form . . . is not enough to achieve high rates of screening and reliable documentation.").

[104] *Pregnancy and Domestic Violence Facts*, NAT'L COALITION AGAINST DOMESTIC VIOLENCE, http://www.uua.org/documents/ncadv/dv_pregnancy.pdf (last visited Nov. 26, 2013).

[105] ALASKA STAT. § 18.66.310 (2013).

training on specific topics related to domestic violence.[106] However, it only mandates such training for a few categories of workers, specifically, those in county government; they are charged with facilitating the proper identification, screening, and assessment of past and present victims of domestic violence who apply for or participate in the Colorado works program.[107] Colorado law "encourage[s] the development of domestic abuse programs by units of local government"[108] that provide educational programs "for both [the] community at large and specialized groups such as medical personnel and law enforcement."[109] However, there is no mandate for those medical personnel to take the training.[110]

Even states that have taken concrete steps to address the paucity of screening for domestic violence fall well short of the level needed to ensure that physician training to screen for this abuse actually occurs. For example, a number of states have enacted laws to ensure that training materials on domestic violence are created for the public and healthcare professionals on the identification, treatment, reporting requirements, and referral of domestic violence victims to community resources. However, these states do not mandate that medical professionals actually take the training. For instance, New Hampshire requires that a statewide organization create educational programs on domestic violence for the general public and specialized groups like medical personnel,[111] but does not require medical personnel to attend the program.[112] In New Jersey, the Director of the Division on Women in the Department of Children and Families must "establish a domestic violence public awareness campaign in order to promote public awareness of domestic violence among the general public and health care and social services professionals . . . ."[113] New York also mandates the development of training for people in the health and mental health fields,[114] but does not require medical personnel to take it.[115] Ohio requires several state medical and professional boards for doctors, nurses, psychologists, counselors and social workers to approve continuing education courses so that these professionals can recognize the signs of domestic violence and its relationship to child abuse,[116] but such professionals are not required by statute to take the courses.[117] Other states have also encouraged

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[106] COLO. REV. STAT. § 26-2-712(8) (2013).

[107] *Id.*

[108] COLO. REV. STAT. § 26-7.5-101 (2013).

[109] COLO. REV. STAT. § 26-7.5-103(c) (2013).

[110] *See* COLO. REV. STAT. § 26-7.5-101 et seq. (2013).

[111] N.H. REV. STAT. ANN. § 173-B:20 (2013); *see also, Domestic Violence*, N.H. DEP'T HEALTH & HUMAN SERVS., http://www.dhhs.state.nh.us/dcyf/domesticviolence.htm (last visited Oct. 28, 2013) (detailing the role of training teams and the availability of training).

[112] *See* N.H. REV. STAT. ANN. § 173-B:20 (2013).

[113] N.J. STAT. ANN. § 52:27D-43.36 (West 2013).

[114] N.Y. Executive Law § 575 (McKinney 2013) (creating the New York State Office for the Prevention of Domestic Violence, which develops and delivers training on domestic violence to professionals in the health and mental health fields).

[115] *See id.*

[116] OHIO REV. CODE ANN. § 4723.25 (West 2013) (establishing requirements for nurses); OHIO REV. CODE ANN. §4731.282 (West 2013) (establishing requirements for doctors); OHIO REV. CODE ANN. §4732.141 (West 2013) (establishing requirement for psychologists); OHIO REV. CODE ANN. §4757.34 (West 2013) (establishing requirements for counselors, social workers, and therapists).

[117] *See* OHIO REV. CODE ANN. § 4723.25 (West 2013); OHIO REV. CODE ANN. §4731.282 (West 2013); OHIO REV. CODE ANN. §4732.141 (West 2013); OHIO REV. CODE ANN. §4757.34 (West 2013).

education and training in a variety of ways.[118] Again, though, however laudable these attempts to encourage training, their absence of mechanisms to assure it actually occurs leaves them half-measures at best.

Finally, the gaps left by even the most advanced state attempts to provide for physician training show the sweeping need for additional state action. Only six states—California, Connecticut, Delaware, Florida, Kentucky, and Oklahoma—have any specifically mandated professional training on domestic violence for physicians. California requires that all applicants applying for medical licensure after September 1, 1994, prove that they have received instruction and coursework in "spousal or partner abuse detection and treatment."[119] However, the California Code does not speak to the number of hours of training or education necessary,[120] and the requirement can be satisfied with a letter from an educational institution certifying that the applicant has had such training.[121] This is a one-time requirement, and there is no continuing education requirement.[122] By contrast, Kentucky specifies a three-hour training course for certain doctors—primary care physicians, psychiatrists, medical examiners, and coroners—and certain other non-physician medical professionals.[123] However, the training in Kentucky is a one-time mandate and requires no re-training for continuing education.[124] On the other hand, Connecticut and Delaware take a more ambitious approach to ensuring that physicians sustain their vigilance and skill in detecting domestic violence. Connecticut requires all medical and surgical professionals seeking license renewal to complete at least one hour of training on domestic violence "during the first renewal period in which continuing medical education is required and not less than once every six years thereafter."[125] Delaware requires those who practice medicine to complete mandatory "training on the recognition of child sexual and physical abuse,

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[118] For example, Pennsylvania created a Domestic Violence Health Care Response Program, requiring medical advocacy projects to "develop and implement a multidisciplinary, comprehensive, and ongoing domestic violence education and training program for hospital, health center, or clinic personnel . . . ." 35 PA. CONS. STAT. ANN. § 7661.3 (West 2013). Washington directed the Department of Health to create similar training, WASH. REV. CODE § 43.70.610 (2013), while West Virginia directed the Bureau for Public Health, in conjunction with public and private agencies, to publish standards, procedures, and curricula about domestic violence for health care facilities. W. VA. CODE ANN. § 48-26-503 (2013). When appropriate funds are available, South Carolina authorizes the Victim Compensation Fund to provide information, training, and technical assistance to groups that provide domestic violence victim assistance, including hospital staff. S.C. CODE ANN. § 16-3-1410(A)(1) (2012). Minnesota law requires that task forces be formed for professions that work with victims, including health professions, in order to ensure that professionals are knowledgeable about violence and abuse issues. MINN. STAT. § 135A.153 (2013) (creating The Higher Education Center on Violence and Abuse to serve as an informational resource to assist higher education in developing curricula in violence and abuse, funding projects to stimulate such curricula, and coordinating policies to ensure that professions interacting with victims have the appropriate "knowledge and skills needed to prevent and respond appropriately to the problems of violence and abuse.").

[119] CAL. BUS. & PROF. CODE § 2091.2 (West 2013).

[120] *See id.*

[121] *Id.* See *Certificate of Medical Education*, MED. BD. OF CAL., http://www.mbc.ca.gov/applicant/application_form_l2.pdf (last visited July 30, 2013), for a sample of a certificate of medical education, including training on domestic violence.

[122] CAL. BUS. & PROF. CODE § 2091.2 (West 2013). However, psychologists in California have a defined training requirement that must be completed for licensure in the state. CAL. CODE REGS. tit. 16, § 1382.5 (2013).

[123] KY. REV. STAT. ANN. § 194A.540(11) (West 2013).

[124] *See id.*

[125] CONN. GEN. STAT. § 20-10b(b) (2013).

exploitation, and domestic violence" each license renewal.[126] Conversely, Oklahoma's law is notable for the narrow scope of its application and duration—the state requires only that applicants seeking licensure as anesthesiology assistants receive one hour of training on domestic violence.[127]

Florida, the remaining state in this group, merits special attention because Florida's statute is arguably the nation's most far-reaching in its effort to train physicians on domestic violence. The state requires two hours of continuing education on domestic violence every third cycle for re-licensure or recertification for physicians and a wide range of health care professionals.[128] Thus, Florida's law couples an ongoing requirement of training with unmatched breadth of application—physicians, nurses, dental care providers, licensed clinical social workers, mental health professionals and other health care providers are all subject to the law.[129] Yet, even Florida's statute fails to ensure that the training offered is adequate. Rather, the law sets forth only broad parameters of the content of training, prescribing provision of

> information on the number of patients in that professional's practice who are likely to be victims of domestic violence and the number who are likely to be perpetrators of domestic violence, screening procedures for determining whether a patient has any history of being either a victim or a perpetrator of domestic violence, and instruction on how to provide such patients with information on, or how to refer such patients to, resources in the local community, such as domestic violence centers and other advocacy groups, that provide legal aid, shelter, victim counseling, batterer counseling, or child protection services.[130]

By comparison, Kentucky's mandate delineates several specific topics pertaining to the dynamics and effects of domestic violence on which medical providers must receive training, including legal remedies for protection, lethality and risk issues, model protocols for addressing domestic violence, available community resources and victim services, and reporting requirements.[131]

C. An Opportunity for Cooperative Federalism

Deployment of funds made available through federal legislation to advance state goals serves the values of federalism and illustrates its benefits. From a constitutional perspective, this approach meets objections to coercion of states[132] as well as to federal compulsion of

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[126] DEL. CODE ANN. tit. 24, § 1723(c) (2013) (completing training is a mandatory procedure required as part of biennial license renewal).

[127] OKLA. STAT. tit. 59, § 3206 (2013).

[128] FLA. STAT. § 456.031(1)(a) (2013).

[129] *Id.*

[130] *Id.*

[131] KY. REV. STAT. ANN. § 194A.540(10) (West 2013).

[132] Seven members of the Court in *National Federation of Independent Business* determined that the ACA's conditions for Medicaid expansion amounted to impermissible coercion. Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2601-04 (2012) (opinion of Roberts, C.J., joined by Breyer & Kagan, JJ.); *id.* at 2666-68 (Scalia, Kennedy, Thomas & Alito, JJ., dissenting).

individuals.[133] As a matter of policy, the proposal enables states to perform their historic role as "laborator[ies]... [for] social and economic experiments."[134] By encouraging—but not compelling—states to require physician training for detecting and coping with domestic violence, the federal government affords each state space to craft its own method of ensuring physicians receive appropriate training.[135] Accordingly, each state can adapt the details of this requirement to its own distinctive philosophy, traditions, and regulatory regime. At the same time, features that prove especially valuable can be emulated by other states,[136] thereby refining an urgently needed means of curbing domestic violence and its disastrous consequences.

Thus, the ACA provides a promising occasion for cooperative federalism.[137] Though this relationship may at first blush appear to be top-down direction rather than the ground-up federalism envisioned by Justice Brandeis, no conflict exists between these two models. Rather, the arrangement can be seen as a species of federalism in which federal legislation may be needed to prod states to undertake desirable experimentation.[138] Here, the exiguous steps by states to ensure adequate training in screening for intimate partner abuse offers scant prospect that states would move soon toward that goal on their own. By the same token, the ACA was consciously designed to further its aims by affording a high degree of state initiative.[139] The opportunity for

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[133] A majority of the Court in *National Federation of Independent Business* concluded that the ACA's individual mandate for health insurance coverage exceeded Congress's power under the Commerce Clause. *Id.* at 2585-94 (2012) (opinion of Roberts, C.J.); *id.* at 2644-50 (Scalia, Kennedy, Thomas, & Alito, JJ., dissenting); *but see id.* at 2594–95 (opinion of Roberts, C.J.) (sustaining the individual mandate as a valid exercise of Congress's power under the Taxing Clause).

[134] New State Ice Co. v. Liebmann, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting); *see* Edward A. Purcell, Jr., *Evolving Understandings of American Federalism: Some Shifting Parameters*, 50 N.Y.L. SCH. L. REV. 635, 672 (2006).

[135] *See* Abbe R. Gluck, *Federalism from Federal Statutes: Health Reform, Medicaid, and the Old-Fashioned Federalists' Gamble*, 81 FORDHAM L. REV. 1749, 1749-50 (2013) (describing the ACA as an example of "major federal statutes that, even as they extend federal power, entrust to the states much of their implementation and elaboration").

[136] *See* Daniel A. Farber, *Reinventing Brandeis: Legal Pragmatism for the Twenty-First Century*, 1995 U. ILL. L. REV. 163, 176 (1995); Roberta Romano, *The States As A Laboratory: Legal Innovation and State Competition for Corporate Charters*, 23 YALE J. ON REG. 209, 211 (2006) ("After some experimentation, a majority of states hone in on a specific statutory formulation to solve the problem at hand, and over time, the result is substantial uniformity across the states.").

[137] *See generally* Reza Dibadj, *From Incongruity to Cooperative Federalism*, 40 U.S.F. L. REV. 845, 864-67 (2006) (defining cooperative federalism as an opportunity for the states to implement and supplement objectives under a framework created by the federal government); Michael C. Dorf & Charles F. Sabel, *A Constitution of Democratic Experimentalism*, 98 COLUM. L. REV. 267, 419-38 (1998) (arguing for the need of "experimentalist federalism," where Congress authorizes and helps finance experimental elaboration of programs, and the state and local governments actually do the experimenting); Joshua D. Sarnoff, *Cooperative Federalism, the Delegation of Federal Power, and the Constitution*, 39 ARIZ. L. REV. 205, 213-14 (1997) (discussing Congress's rationale in enacting cooperative federalism statutes).

[138] *See* Abbe R. Gluck, *Intrastatutory Federalism and Statutory Interpretation: State Implementation of Federal Law in Health Reform and Beyond*, 121 YALE L.J. 534, 567 (2011) ("One reason that federal statutes might be necessary to jump-start state experimentation is that it is not always the case that such experimentation develops organically. States often do not conduct experiments at the levels thought ideal by policymakers.").

[139] *See* Mallory Jensen, *Is ERISA Preemption Superfluous in the New Age of Health Care Reform?*, 2011 COLUM. BUS. L. REV. 464, 492-493 (2011); Theodore W. Ruger, *"Our Federalism" Moves Indoors*, 38 J. HEALTH POL., POL'Y & L. 283, 287 (2013); Sam Solomon, Note, *Health Exchange Federalism: Striking the Balance Between State Flexibility and Consumer Protection in ACA Implementation*, 34 CARDOZO L. REV. 2073, 2090 (2013).

the federal government to jumpstart state experimentation justifies the ACA's non-coercive nudging of states to expand efforts to address the tragedy of domestic violence.

Moreover, this Article's proposal that states mandate physician training on domestic violence avoids difficulties that can arise from what Abbe Gluck has called "intrastatutory federalism"—state implementation of federal law.[140] While questions of interpretation in this context are often "messy,"[141] the proposal does not require states to resolve arcane issues of construction under the ACA. Indeed, states are not directly implicated in the application of the relevant ACA provision at all. Rather, the proposal simply urges states to take note that insurance must cover medical domestic violence screening and counseling, and to effectuate the promise of this coverage by requiring training for these vital tools in the campaign against this scourge.

IV. THE VALUE AND FEASIBILITY OF MANDATORY PHYSICIAN TRAINING ON DOMESTIC VIOLENCE

Physician training to screen for intimate partner abuse is not, of course, an end in itself but rather an invaluable resource in efforts to reduce and mitigate domestic violence. While the benefits of such training may appear self-evident, legislators considering mandatory training—especially in the face of physician resistance—might need persuasion that the value of training warrants the imposition of this requirement. An exploration of the nature of training supports this Article's argument in favor of state-prescribed routine medical screening for domestic violence as a vital and realistic strategy to help combat this destructive behavior and its effects.

A. Multiple Gains from Training Physicians to Screen

To describe the goals and philosophy of training to conduct patient screening and counseling for domestic violence is to highlight many of its benefits, for training serves both to equip physicians with necessary skills for dealing with patients and also to dispel the misunderstandings that many medical professionals may have about the dynamics of domestic violence. A notable source of guiding principles for training is the *National Consensus Guidelines for Identifying and Responding to Domestic Violence Victimization in Healthcare Settings*, created by a large multidisciplinary group in 2002 and updated in 2004.[142] Those guidelines, and the instructions provided by Futures Without Violence[143] and other groups[144] emphasize to all medical providers the importance of understanding the dynamics of domestic violence, of knowing how to ask patients about it in a safe and sensitive manner, and of being able to respond to victims with validation, harm-reduction strategies, and referrals to community resources.[145] Medical professionals are advised to focus on identifying victims early, regardless of whether symptoms are apparent.[146] Even if victims choose not to disclose their abuse, providers are

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[140] *See generally* Gluck, *supra* note 138.

[141] *Id.* at 542.

[142] NATIONAL CONSENSUS GUIDELINES, *supra* note 13.

[143] Memorandum from Lisa James, *supra* note 78, at 3.

[144] *See* TRACY WEBER & LEANNE K. LEVIN, MEDICAL PROVIDERS' GUIDE TO MANAGING THE CARE OF DOMESTIC VIOLENCE PATIENTS WITHIN A CULTURAL CONTEXT 32 (2nd ed. 2004), *available at* http://www.nyc.gov/html/ocdv/downloads/pdf/Materials_Medical_Providers_DV_Guide.pdf.

[145] NATIONAL CONSENSUS GUIDELINES, *supra* note 13, at 11-19.

[146] *Id.* at 6.

advised that they may be able to break victim isolation and link them to local advocates who can help them "understand their options, live more safely within the relationship, or safely leave the relationship."[147] There is broad agreement that providers should be trained to screen patients in a private setting—without family or friends in attendance—and to inform patients of any reporting requirements or limits to confidentiality.[148] They should also be trained on recording the inquiry and response in the patient's medical record, and to follow up in future visits.[149]

Thorough training on a variety of topics is needed to ensure that a physician abides by the fundamental rule: first, do no harm.[150] Though existing guidelines may seem straightforward or intuitive, many of the dynamics of domestic violence are quite complex. The knowledge that medical professionals should have goes far beyond a discussion of the types of violence and threats that batterers use to control victims. Training also necessitates an in-depth discussion about why victims of domestic violence may stay in a relationship.[151] A large variety of chains can bind victims to their abusers: an abuser's oaths to change; fear of retaliation; lack of financial resources, education, job skills, or transportation; fear that the abuser will harm or abduct the children; and embarrassment and shame.[152] In addition to one or more causes on this non-exhaustive list, victims may also be discouraged by their prior negative involvement with the court system.[153] A lack of understanding of these deterrents to leaving can result in the medical professional blaming the victim for the continued abuse.

Further, the single issue of co-occurring substance abuse and domestic violence is itself a complicated topic that warrants training. Many victims are forced by abusers to use drugs or alcohol.[154] Victims also commonly use substances to self-medicate and escape from the impact of the violence.[155] Here, too, training could make a difference; women's substance abuse may be

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[147] *Id.*

[148] *Id.* at 12.

[149] Cronholm et al., *supra* note 60, at 1169.

[150] *See* Jeremy A. Lazarus, Member, Bd. of Trustees, Am. Med. Ass'n, Address at the CleanMed 2008 Conference: Creating Healing Environments (May 22, 2008), http://www.ama-assn.org/ama/pub/news/speeches/do-no-harm.page ("Well, a doctor's first promise is to 'do no harm.'"). The phrase "first, do no harm" is often attributed to the Hippocratic Oath, but the Oath does not contain the exact phrase. *Greek Medicine: The Hippocratic Oath*, U.S. NAT'L LIBRARY OF MED., http://www.nlm.nih.gov/hmd/greek/greek_oath.html (last visited Nov. 27, 2013).

[151] C. Garcia-Moreno, *Dilemmas and Opportunities for an Appropriate Health-Service Response to Violence Against Women*, 359 LANCET 1509, 1511 (2002).

[152] *See* Sarah M. Buel, *Fifty Obstacles to Leaving, a.k.a., Why Abuse Victims Stay*, COLO. LAW., Oct. 1999, at 20-21, 24.

[153] Many commentators have noted that the family court system is hostile to battered women. *See, e.g.*, Ruth E. Fleury-Steiner et al., *Contextual Factors Impacting Battered Women's Intentions to Reuse the Criminal Legal System*, 34 J. COMMUNITY PSYCHOL. 327, 328 (2006) ("[Victims] had been pressured rather than supported by the criminal legal system."); MARY A. FINN, EFFECTS OF VICTIMS' EXPERIENCES WITH PROSECUTORS ON VICTIM EMPOWERMENT AND RE-OCCURRENCE OF INTIMATE PARTNER VIOLENCE, FINAL REPORT 4 (Aug. 2003), *available at* https://www.ncjrs.gov/pdffiles1/nij/grants/202983.pdf (noting that prosecutors may threaten to charge *victims* of domestic violence with crimes for not participating in the legal process).

[154] *Domestic Violence & Substance Abuse: Drugs, Alcohol, and Domestic Abuse: The Intersection*, AWOMANSPLACE.ORG, http://www.awomansplace.org/domestic-violence-101/domestic-violence-and-substance-abuse/ (last visited Nov. 27, 2013).

[155] *See, e.g.*, BRAGG, *supra* note 41, at 27, 29 (noting that alcohol and drugs are used to lessen physical and emotional pain).

linked to *less* medical screening for domestic violence in a clinical setting,[156] and women do not want doctors to blame the violence on the victim's substance abuse.[157] Other important individual and frequently hidden issues, such as a victim's cultural isolation or fear of racial or ethnic prejudice, can alone suffice to make a victim feel trapped with an abusive partner and unable to communicate her plight to a physician when seeking medical care.[158] Frequently, victims fear that medical personnel will be unsympathetic and blame them for the violence.[159]

Moreover, training could substantially relieve the anxiety felt by many physicians about their capacity to conduct screening for domestic violence. Some studies have found that physicians report feeling inadequate to screen and intervene in cases of abuse.[160] Evidence indicates that training can improve confidence and willingness to screen. In a recent study on medical students' response to rape victims, one third of the students "initially indicated that they felt uncomfortable screening for and treating patients with a history of sexual assault."[161] After training, the students indicated greater comfort with routine screening and treating victims.[162] Similarly, health care providers who had training "reported increased self-efficacy and increased comfort making appropriate community referrals" for victims of domestic violence.[163] Trained medical providers also reported a heightened valuation of health care providers and the health care system as playing a crucial role in stopping domestic violence.[164]

Mandated physician training on domestic violence and screening for domestic violence, then, would serve several purposes. First—and alone sufficient to justify mandatory training—it would give healthcare providers the knowledge, skills, and ability to screen patients in a meaningful, sensitive way. Second, it would provide healthcare professionals with the information

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[156] *See* Esther K. Choo et al., *Failure of Intimate Partner Violence Screening Among Patients with Substance Use Disorders*, 17 ACAD. EMERGENCY MED. 886, 886 (2010).

[157] L. Kevin Hamberger et al., *supra* note 60, at 579.

[158] Heidi M. Bauer et al., *Barriers to Health Care for Abused Latina and Asian Immigrant Women*, 11 J. HEALTH CARE FOR THE POOR & UNDERSERVED 33, 37 (2000) (finding that Latina participants felt "disconnected, disempowered, and mistreated" in the clinical setting and were hesitant to discuss their abusive relationships, due to racial and ethnic prejudice).

[159] Nancy S. Jecker, *Privacy Beliefs and the Violent Family: Extending the Ethical Argument for Physician Intervention*, 269 J. AM. MED. ASS'N 776, 779 (1993) ("[H]ealth professionals who receive intensive training about abuse hold stronger beliefs that battered women should be helped and attribute less personal responsibility and blame to abused persons."); James T. R. Jones, *Battered Spouses' Damage Actions Against Non-Reporting Physicians*, 45 DEPAUL L. REV. 191, 197-98 (1996) (stating physicians "may be biased against victims of domestic violence"); Carole Warshaw, *Domestic Violence: Challenges to Medical Practice*, 2 J. WOMEN'S HEALTH 73, 76-77 (1993) (explaining that difficulty empathizing can lead to blaming the victim for the violence).

[160] Barbara Gerbert et al., *Domestic Violence Compared to Other Health Risks: A Survey of Physicians' Beliefs and Behaviors*, 23 AM. J. PREVENTIVE MED. 82, 88 (2002) (highlighting physicians' feelings of inadequacy regarding victims of abuse); Linn H. Parsons et al., *Methods of and Attitudes Toward Screening Obstetrics and Gynecology Patients for Domestic Violence*, 173 AM. J. OBSTETRICS & GYNECOLOGY 381, 384 (1995) (reporting that almost half of the physicians in the study indicated feeling inadequate in handling abuse victims due to lack of training).

[161] Jennifer M. Milone et al., *The Effect of Lecture and a Standardized Patient Encounter on Medical Student Rape Myth Acceptance and Attitudes Toward Screening Patients for a History of Sexual Assault*, 22 TEACHING & LEARNING IN MED. 37, 43 (2010).

[162] *Id.*

[163] L. Kevin Hamberger et al., *Evaluation of a Health Care Provider Training Program to Identify and Help Partner Violence Victims*, 19 J. FAM. VIOLENCE 1, 1 (2004).

[164] *Id.*

they need about local resources so that they can make referrals while counseling patients. Third, training would make physicians more comfortable speaking about domestic violence as a broader public health issue, thereby encouraging them to become advocates for ending domestic violence. Finally, physicians who receive training could help keep their patients, and thus the community, healthier and safer.[165]

B. Mandatory Training as a Practicable Step Forward

A central advantage of the proposal that states mandate training on domestic violence and screening for domestic violence is that it represents a practically achievable step. In particular, it reserves the more difficult question of whether to directly require that such screening take place. Whether a healthcare provider's standard of care should include the task of reporting all suspected domestic violence to local law enforcement is controversial,[166] and the ongoing debate regarding reporting requirements counsels against creation of mandatory screening regimes. For example, while the AMA strongly supports mandatory reporting on suspected or actual child maltreatment and mandated physician reporting of elder abuse,[167] it has adopted a quite different stance on reporting domestic violence:

> [M]andatory reporting laws . . . violate the basic tenets of medical ethics unless those laws (a) do not require the inclusion of victims' identities; (b) allow competent adult victims to opt out of the reporting system if identifiers are required; (c) provide that reports be made to public health agencies for

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[165] It is true that the Joint Commission on Accreditation of Healthcare Organizations has promulgated policies that address the care of victims of domestic violence; this Article's recommendation, however, goes beyond such policies. The Joint Commission, which accredits over 20,000 medical facilities, *About the Joint Commission*, JOINT COMM'N ON ACCREDITATION OF HEALTHCARE ORG., http://www.jointcommission.org/about_us/about_the_joint_commission_main.aspx (last visited Nov. 27, 2013), created standards that require medical organizations—such as hospitals, ambulatory care, and behavioral health clinics—to have criteria for their staff to identify those patients who may be victims of physical or sexual assault, domestic abuse, elder neglect or abuse, and child neglect or abuse, and to maintain a referral list of private and public agencies for referrals and follow applicable state law. *See Comply with the Joint Commission Standard PC.01.02.09 on Victims of Abuse*, FUTURES WITHOUT VIOLENCE, http://www.futureswithoutviolence.org/section/our_work/health/_health_material/_jcaho (last visited Nov. 27, 2013). Although Futures Without Violence advises hospitals on how to meet those standards related to domestic violence, the Joint Commission includes over 200 standards for medical entities—covering everything from building egress issues, emergency power systems, pain management protocols, medical staff anti-infection measures, and fire and emergency policies and equipment. *See generally Survey Activity Guide for Health Care Organizations*, JOINT COMM'N ON ACCREDITATION OF HEALTHCARE ORG. (July 2013), http://www.jointcommission.org/assets/1/6/2013_Organization_SAG_July.pdf (last visited Nov. 27, 2013). A conspicuous gap in this system, especially as it pertains to screening for domestic violence, is that medical facilities can retain their certification without meeting all of the standards. *See* Liz Kowalczyk, *Surprise Check Faults MGH Quality of Care*, BOS. GLOBE (March 17, 2007), http://www.boston.com/news/local/articles/2007/03/17/surprise_check_faults_mgh_quality_of_care/ (reporting that accreditation was granted to Massachusetts General Hospital, despite issues with medication safety, inconsistent handwashing, and incomplete medical records); Gilbert M. Gaul, *Accreditors Blamed for Overlooking Problems*, WASH. POST, July, 25, 2005, at A1 (raising questions about the joint commission's practices, potential conflicts of interest, and the rigor of its hospital surveys).

[166] *See, e.g.*, Rebekah Kratochvil, Comment, *Intimate Partner Violence During Pregnancy: Exploring the Efficacy of a Mandatory Reporting Statute*, 10 HOUS. J. HEALTH L. & POL'Y 63, 65 (2010) ("[T]here appears to be no nationwide consensus in the way states approach reporting IPV against pregnant women or competent adult victims.")

[167] AMERICAN MEDICAL ASS'N, H-515.965 FAMILY AND INTIMATE PARTNER VIOLENCE, *supra* note 32.

surveillance purposes only; (d) contain a sunset mechanism; and (e) [include a provision to] evaluate the efficacy of those laws.[168]

Tellingly, legislators appear generally to have deferred to opposition to mandatory reporting of suspected domestic violence. While all states have some form of requirement that medical professionals report child abuse[169]—including 48 states that mandate reporting by certain professions, such as physicians[170]—relatively few expressly mandate reporting of adult domestic violence victimization. Many states compel medical professionals to report patient injuries, but some do not mandate physicians report any patient injuries to law enforcement or any other agency.[171] Statutes that require medical personnel to report when they treat specified injuries typically require reporting of injuries resulting from firearms, knives, and other dangerous weapons,[172] or injuries resulting from suspected criminal conduct.[173] In only a handful of states are physicians specifically required to report to local law enforcement that they have treated injuries resulting from suspected intimate partner or domestic violence.[174]

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[168] *Id.*

[169] CHILD WELFARE INFORMATION GATEWAY, MANDATORY REPORTERS OF CHILD ABUSE AND NEGLECT 1 (Aug. 2012), *available at* https://www.childwelfare.gov/systemwide/laws_policies/statutes/manda.pdf.

[170] *Id.* at 2; *see, e.g.*, FLA. STAT. § 39.201 (2013) (requiring any person who knows, or has reason to suspect, child abuse to report, but also requiring physicians to provide their names when reporting child abuse); NEB. REV. STAT. § 28-711 (2013) (requiring physicians with "reasonable cause" to report); 23 PA. CONS. STAT. ANN. § 6311(b) (West 2013) (requiring reporting by "any licensed physician"); *see also* 42 U.S.C. §§ 5106a(b)(1)(A), 5106a(b)(2)(B)(i) (2010) (conditioning eligibility for federal grants on the requirement that the state have a law or program for mandatory reporting of child abuse).

[171] For example, Alabama, New Mexico and Wyoming have no mandatory health care provider reporting statutes for crimes. NANCY DURBOROW ET AL., FAMILY VIOLENCE PREVENTION FUND, COMPENDIUM OF STATE STATUTES AND POLICIES ON DOMESTIC VIOLENCE AND HEALTH CARE, 2, 9, 45, 68 (2010), *available at* http://www.futureswithoutviolence.org/userfiles/file/HealthCare/Compendium%20Final.pdf.

[172] *See, e.g.*, D.C. CODE § 7-2601 (2013) (requiring physicians to report all injuries caused by firearms, even if accidental, and injuries caused by other dangerous weapons in the commission of a crime); DEL. CODE ANN. tit. 24, § 1762(a) (2013) (requiring physicians to report stab wounds, poisonings (other than accidental), and firearm injuries); KAN. STAT. ANN. § 21-6319 (2013) (criminalizing physicians' failure to report any firearm injury or wound likely to result in death and that appears to have been inflicted by a knife, ice pick, or other sharp pointed instrument); MASS. GEN. LAWS ch. 112, § 12A (2013) (mandating that healthcare providers report injuries resulting from firearms, burns affecting five percent of more of the surface area of the patient's body, and injuries caused by a knife or pointed instrument if a crime is suspected); OR. REV. STAT. §§ 146.710, 146.750(1) (2013) (requiring physicians to report non-accidental injuries caused by a knife, firearm or other deadly weapon).

[173] *See, e.g.*, IDAHO CODE ANN. § 39-1390(1) (2013) (requiring health care professional to report injuries inflicted by firearm or injuries believed to be the result of criminal offense); N.C. GEN. STAT. § 90-21.20(b) (2013) (requiring health care providers to report all firearm injuries, all poisonings, and wounds caused by sharp pointed instruments or involving grave bodily harm or illness if they believe the wounds or illnesses arose from a criminal act); MICH. COMP. LAWS §§ 750.411(1),(2) (2013) (requiring health care providers to report knife, gun, and deadly weapons injuries, as well as injuries cause by "other means of violence").

[174] *See, e.g.*, COLO. REV. STAT. § 12-36-135(1)(a) (2013) (requiring health care professional to report injuries believed to be the result of criminal conduct, including domestic violence); OKLA. STAT. tit. 22, § 58 (2013) (requiring reporting of various domestic abuse situations); *see also* CAL. PENAL CODE § 11160(a)(2) (West 2013) (requiring reporting of abusive conduct); KY. REV. STAT. ANN. § 209.030 (West 2013) (requiring reporting of adult abuse); *cf.* N.H. REV. STAT. ANN. §§ 173-B:1, 631:6 (2013) (allowing an exception to reporting requirement unless victim of abuse "is also being treated for a gunshot wound or other serious bodily injury"); TENN. CODE ANN. §§ 36-3-601, 38-1-101(e) (2013)

The resistance to and controversy over mandatory reporting is instructive in assessing the significance of physicians' reluctance to conduct screening of patients. Surveys of physicians about the barriers they perceive to their ability to screen are also revealing. Among the sources of frustration cited by physicians are victims' willingness to return to abusive partners, concerns about misdiagnosis, personal discomfort, reluctance to intrude on private family matters, and lack of 24-hour social service support.[175] A significant number of doctors have reported feeling that simply asking about violence and abuse could be painful, potentially abusive, or shameful for the victim.[176] According to some doctors, other physicians might not think to ask patients or might choose not to ask patients about the possibility of domestic violence because they feel pressured for time, lack confidence, have insufficient information about referral agencies, or are unsure how to respond to the issue if it is reported.[177] Physicians' longstanding doctor-patient relationships with victims have also been cited as a barrier to discussions on domestic violence.[178] And finally, physicians may believe that the victim's psychiatric makeup or personality contribute to the violence and to the victim's inability to leave the perpetrator.[179] Whatever the explanation in a given case, these kinds of attitudes impact patients' experiences. Some patients complain that physicians often fail to ask about abuse, and that when they do ask questions about domestic violence they do so in the presence of a third party, instead of in private.[180] Additionally, patients have reported that doctors frequently fail to acknowledge and react to victims' disclosure of abuse, or fail to link victims with available resources in the community that may help reduce the violence.[181]

As with skepticism toward mandatory reporting of domestic violence, physicians' anxiety over screening indicates attempts to enact laws to require it will likely fail. Lack of political will, however, is not the only significant reason to confine the recommendation here to mandatory training; there are sound policy reasons to approach mandatory screening with caution. Again, experience with mandatory reporting—however limited its enactment—is instructive. The balance of benefits and drawbacks entailed by mandatory reporting of domestic violence cannot be considered well established at this time. While researchers have noted a "dramatic increase in the commitment made by healthcare institutions to address domestic violence" since the adoption of California's mandatory reporting model,[182] the tension between patient protection and patient

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(designating domestic abuse as an exception to the reporting law, unless the injury was life-threatening or the result of strangulation, a knife, pistol, gun, or other deadly weapon). Tennessee repealed its domestic abuse reporting law in 2012. TENN. CODE ANN. § 36-3-621 (repealed 2012).

[175] Meghan E. McGrath et al., *Violence Against Women: Provider Barriers to Intervention in Emergency Departments*, 4 ACAD. EMERGENCY MED. 297, 297 (1997).

[176] Dawn Miller & Chrystal Jaye, *GPs' Perception of Their Role in the Identification and Management of Family Violence*, 24 FAMILY PRAC. 95, 97 (2007).

[177] *Id.*

[178] Howa Yeung et al., *Responding to Domestic Violence in General Practice: A Qualitative Study on Perceptions and Experiences*, 2012 INT'L J. OF FAM. MED., 1, 4; *but see, id.* (acknowledging that longstanding doctor-patient relationships can sometimes serve to facilitate discussion of domestic violence).

[179] David H. Gremillion & Elizabeth P. Kanof, *Overcoming Barriers to Physician Involvement in Identifying and Referring Victims of Domestic Violence*, 27 ANNALS OF EMERGENCY MED. 769, 770 (1996).

[180] Karin V. Rhodes, et al., *"You're Not a Victim of Domestic Violence, Are You?" Provider-Patient Communications about Domestic Violence*, 147 ANNALS INTERNAL MED. 620, 622 (2007).

[181] *Id.*

[182] Heidi M. Bauer et al., *California's Mandatory Reporting of Domestic Violence Injuries: Does the Law Go*

autonomy in a mandatory reporting environment remains a crucial issue. On the one hand, mandatory reporting laws tend to increase the number of healthcare providers screening for domestic violence and the number of perpetrators who are held accountable by law enforcement for their behavior, and to promote early identification of victimization.[183] Mandatory reporting for all domestic violence injuries includes risks, however, such as patients delaying care, batterers' retaliation towards victims seeking treatment, victims losing autonomy in their decision-making, compromised confidentiality, and disruption in the physician-patient relationship.[184]

It seems sensible, then, to limit reform at this stage to mandatory training on domestic violence and screening for domestic violence. Indeed, requiring screening where physicians have not yet had the opportunity to receive training might well prove counterproductive. Even in the absence of legal compulsion, however, greater screening would seem a natural outgrowth of mandatory training on screening for domestic violence. Studies in other realms of medical practice confirm the intuition that training in a skill raises the frequency of exercise of that skill.[185] In a similar vein, widespread training in detection of and response to intimate partner abuse can serve to demystify screening, thus promoting a culture in which screening evolves into a professional norm. There is room to expand the roots of such a culture in medical education. Although 91% of medical students in one study reported receiving at least some training in discussing domestic violence, only 20% reported extensive training on the topic.[186] This figure contrasts with medical school training in discussing areas such as alcohol abuse (98%), chlamydia screening (95%), cholesterol testing (99%), exercise (96%), safe sex (98%), and tobacco (98%); at least a third of the students stated that their training was extensive in those other topics.[187] The curricula of medical schools, then, could include competencies in the screening, diagnosis, and treatment of domestic violence[188] so that future doctors can learn the knowledge, skills, behaviors, and attitudes that best fit the needs of victims. According to the current Standards for Accreditation of Medical Education Programs Leading to the M.D. Degree,[189] "[t]he curriculum of a medical education program must prepare medical students for their role in addressing the medical consequences of common societal problems (e.g., provide instruction in the diagnosis,

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Too Far or Not Far Enough?, 171 WJM 118, 119 (1999).

[183] Kratochvil, *supra* note 166, at 88-89.

[184] *Id.* at 92.

[185] *See, e.g.*, Judith K. Ockene et al., *Physician Training for Patient-Centered Nutrition Counseling in a Lipid Intervention Trial*, 24 PREVENTIVE MED. 563, 563, 569 (1995) (finding that physicians' completion of a training program on dietary counseling significantly increased their use of dietary counseling steps); Suzanne C. Thompson et al., *Counseling Patients to Make Lifestyle Changes: The Role of Physician Self-Efficacy, Training and Beliefs About Causes*, 10 FAM. PRAC. 70, 70 (1993) (finding that physicians who received education in health behavior change techniques were more active counselors).

[186] Erica Frank et al., *Clinical and Personal Intimate Partner Violence Training Experiences of U.S. Medical Students*, 15 J. WOMEN'S HEALTH 1071, 1073 (2006).

[187] *Id.*

[188] *See* John C. Nelson, Panel Discussion: Domestic Violence in the Adult Years (Dec. 22, 2005), *in* 33 J.L. MED. & ETHICS 28, 29 (2005).

[189] LIAISON COMM. ON MED. EDUC., FUNCTIONS AND STRUCTURE OF A MEDICAL SCHOOL: STANDARDS FOR ACCREDITATION OF MEDICAL EDUCATION PROGRAMS LEADING TO THE M.D. DEGREE 2 (2013), *available at* http://www.lcme.org/publications/functions.pdf ("To achieve and maintain accreditation, a medical education program leading to the M.D. degree in the U.S. and Canada must meet the standards contained in this document.").

prevention, appropriate reporting, and treatment of violence and abuse)."[190]

A final, major practical advantage of mandatory training for domestic violence is the abundance of resources upon which states can draw to institute such a program. With respect to funding, Title V of the Violence Against Women Act[191] may prove especially helpful. This provision authorizes federal funding for projects that improve the response of the medical community to "domestic violence, dating violence, sexual assault, and stalking."[192] The reauthorization of VAWA specially provides for federal grants to develop and implement interdisciplinary training for health professionals, public health staff and allied professionals, and for the development of training for medical staff, nurses, and other professionals to prevent and respond to such violence in a culturally appropriate and safe manner.[193] In addition, the statute provides funding for the development and implementation of comprehensive statewide strategies to improve the response of medical facilities, hospitals, and clinics to domestic violence, dating violence, sexual assault, and stalking.[194] Money is also available for grants designed to fund training that helps a broad range of health care providers identify and supply health care services to victims—including mental or behavioral health care services and referrals to appropriate community services—for medical, psychological, dental, social work, nursing, and other health professions students, residents, fellows, or current healthcare providers.[195]

Nor is funding the only or perhaps even the principal resource available to states wishing to enact and implement mandatory training. Rather than having to devise their own standards from scratch, states can consult a rich variety of materials. In addition to the National Consensus Guidelines,[196] other general educational resources and resources and training materials have been created and published. For example, the New Hampshire Coalition Against Domestic and Sexual Violence created videos for healthcare professionals that demonstrate effective methods of screening and intervening for patients who are victims of domestic violence.[197] The *Medical Providers' Guide to Managing the Care of Domestic Violence Patients within a Cultural Context* was produced in New York to address physician time management, challenges to screening, proper screening of patients, and appropriate resonses to patient disclosures of violence.[198] Blue Cross Blue Shield of Michigan published *Reach Out: Intervening in Domestic Violence and Abuse.*[199] Clinical tools have also been published by hospitals,[200] a chapter of the American

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[190] *Id.* at 11.

[191] Violence Against Women Reauthorization Act of 2013, § 501 et seq., 42 U.S.C.A. § 280g-4 et seq. (West 2013).

[192] *Id.* at § 501(a), 42 U.S.C.A. § 280g-4(a)(2).

[193] *Id.* at 42 U.S.C.A. § 280g-4(a)(1)-(2), (b)(1)(A)(ii).

[194] *Id.* at § 280g-4(a)(3).

[195] *Id.* at § 280g-4(b)(1)(A)(i).

[196] NATIONAL CONSENSUS GUIDELINES, *supra* note 13 (providing information that states may use in developing standards).

[197] *Domestic Violence Screening Tools,* N.H. COAL. AGAINST DOMESTIC & SEXUAL VIOLENCE, http://www.nhcadsv.org/screening_tools.cfm (last visited Nov. 26, 2013).

[198] WEBER & LEVIN, *supra* note 144, at 3.

[199] BLUE CROSS BLUE SHIELD OF MICH., REACH OUT: INTERVENING IN DOMESTIC VIOLENCE AND ABUSE (2007), *available at* http://www.bcbsm.com/pdf/DV_ReferenceGuide.pdf.

[200] SEE TINA M. NAPPI ET AL., BRIGHAM AND WOMEN'S HOSPITAL, DOMESTIC VIOLENCE: A GUIDE TO SCREENING AND INTERVENTION (2004), *available at* http://www.oconnorhouse.org/ngo/tool-kit/start_dv_center (follow "Sample DV Guide to Screening and Intervention – English" hyperlink) (providing guidance for physicians, complete

College of Physicians,[201] and nonprofit organizations.[202]

A review by the Institute of Medicine of domestic violence training health professionals receive, which resulted in several recommendations for effective training, provides states with yet another useful body of information.[203] The Academy on Violence and Abuse (AVA) has developed competencies, arranged by health system, educational institution, and individual learner in its *Competencies Needed by Health Professionals for Addressing Exposure to Violence and Abuse in Patient Care*.[204] Among the health system competencies called for are physical and behavioral health delivery systems to understand the physical and mental health consequences of violence and abuse and to value profession-specific training programs on those issues.[205] Health systems could integrate understandings of violence and abuse, along with best practices and continuous quality improvements, into the training and practice of the health professions.[206] A state's law might direct its licensing board to require that physicians have training consistent with these standards.

Further, inclusion of such competencies could yield gains beyond assuring individual physicians' capacity to screen for domestic violence. Health systems, for example, might be moved to support systemic change and strong research programs on prevention and intervention programs, along with identification of protective factors that mitigate victims' adverse health effects.[207] Finally, competencies to address violence should have a beneficial impact on academic institutions such as medical and nursing schools and training programs. If they adopt the recommendations of the AVA, these institutions could partner with the community in education, intervention, and prevention; adopt an interdisciplinary approach to instruction; and develop and measure the impact of a varied-learning curriculum that includes experiential and case-based

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with a domestic violence screening algorithm and a quick reference summary).

[201] Kay M. Mitchell, *Domestic Violence: The Healthcare Provider's Role in Recognition and Referral*, FLORIDA CHAPTER, AM. COLL. PHYSICIANS (Sept. 10, 2011), http://www.acponline.org/about_acp/chapters/fl/11meeting_mitchell.pdf (including DV education and instruction for healthcare providers on how to recognize victims, assess for violence, and provide help).

[202] *See, e.g.*, *Doctors and Health Care Workers*, WOMENSLAW.ORG, www.womenslaw.org/simple.php?sitemap_id=58 (last updated June 26, 2012); *Free Online Training for Health Care Professionals*, SAFEPLACE.ORG, http://www.safeplace.org/onlinecne (last visited Nov. 26, 2013) (providing online training); *Health Care: Health Materials Index*, FUTURES WITHOUT VIOLENCE, www.futureswithoutviolence.org/section/our_work/health/_health_material (last visited Nov. 26, 2013).

[203] *See generally* COMM. ON THE TRAINING NEEDS OF HEALTH PROF'LS TO RESPOND TO FAMILY VIOLENCE, INSTITUTE OF MEDICINE, CONFRONTING CHRONIC NEGLECT: THE EDUCATION AND TRAINING OF HEALTH PROFESSIONALS ON FAMILY VIOLENCE (Felicia Cohn et al., eds., 2002) (assessing current approaches to training and making recommendations for improvement).

[204] BRUCE AMBUEL ET AL., ACAD. ON VIOLENCE & ABUSE, COMPETENCIES NEEDED BY HEALTH PROFESSIONALS FOR ADDRESSING EXPOSURE TO VIOLENCE AND ABUSE IN PATIENT CARE 6 (2011), *available at* http://www.avahealth.org/file_download/inline/f4a4e2d7-9153-45a0-8671-5a0afc57c690.

[205] The AVA competencies for individual learners include demonstrating knowledge and clinical skills about violence and trauma with a set of separate knowledge-based objectives, skill-based objectives, and attitude-based objectives. *Id.* at 11. Individual learner competencies also include being able to communicate effectively with the patient, family and the physical and behavioral health team, and knowing the ethical and legal requirements of the professional regarding violence and abuse. *Id.* at 14-15.

[206] *Id.* at 7-8.

[207] *Id.* at 8.

learning, group discussions, the perspectives of patients, and clinical skills service learning.[208]

V. CONCLUSION

Now that the ACA has been enacted and sustained, and the U.S. Preventive Services Task Force recommends screening and counseling for domestic violence, nearly all the pieces of the puzzle exist to ensure physicians can provide safe, responsive, informed, and sensitive services for victims of domestic violence. The federal government, private work groups, multidisciplinary teams, and victim advocates have created—and will continue to create—high-quality training materials. The missing piece is a mandate that physicians *be individually required* to receive the training in every state, so that they can learn to conduct screening in a way that benefits their patients. Current federal guidelines and the policy recommendations of national organizations appear to have had little impact on doctors' behavior with regard to domestic violence screening and counseling.[209] The responsibility to ensure that training takes place now lies with the states. By requiring physician training on domestic violence, states can dramatically improve the services provided to victims while communicating to citizens the gravity of this crime and social scourge.

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[208] *Id.* at 10.

[209] WEISBERG, *supra* note 29, at 511.