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UNHEARD VOICES OF DOMESTIC VIOLENCE VICTIMS: A CALL TO REMEDY PHYSICIAN NEGLECT

KAREN OEHME*, EMBER URBACH**, AND NAT STERN***

INTRODUCTION

> *I am seven months pregnant and he's assaulting me. My doctor has never asked me about domestic violence. My husband never leaves me alone during my doctor visits—[he]is always by my side.*[1]

In 1992, the American Medical Association (AMA) recommended that physicians screen patients for domestic violence victimization;[2] yet, over two decades later, actual screening rates remain low.[3] Two of the authors of this Article have argued elsewhere that recent changes in healthcare legal landscape,

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1. *Voices of Victims: Dataset*, INST. FOR FAM. VIOLENCE STUDIES 1, http://familyvio.csw.fsu.edu/wp-content/uploads/2013/08/VOV-QualtitativeDataAnalysis.pdf (last visited Aug. 30, 2013).

2. AM. MED. ASS'N, DIAGNOSTIC AND TREATMENT GUIDELINE ON DOMESTIC VIOLENCE, 1 ARCHIVES FAM. MED. 39, 41 (1992) [hereinafter AMA DIAGNOSTIC].

3. Research on screening for domestic violence has resulted in disparate results. For example, surveys indicate that from eighteen percent to 38.7% of medical professionals report routinely screening patients in the OBGYN setting. The highest rates of screening are when medical professionals suspect abuse. However, studies indicate that far fewer medical professionals report screening all women patients routinely. *See, e.g.*, *Three In Four Domestic Violence Victims Go Unidentified In Emergency Rooms, Penn Study Shows*, PENN MED. (Mar. 16, 2011), http://www.uphs.upenn.edu/news/News_Releases/2011/03/emergency-room-domestic-violence-identification/; Iris Borowsky & Marjorie Ireland, *Prenatal Screening for Intimate Partner Violence by Pediatricians and Family Physicians*, 110 PEDIATRICS 509, 509-16 (2002); CENTERS FOR DISEASE CONTROL AND PREVENTION, RURAL HEALTH-CARE PROVIDERS' ATTITUDES, PRACTICES, AND TRAINING EXPERIENCE REGARDING INTIMATE PARTNER VIOLENCE, 47 MORBIDITY AND MORTALITY WEEKLY REPORT 670, 670-73 (1998); Linda Chamberlain & Katherine Perham-Hester, *The Impact of Perceived Barriers on Primary Care Physicians' Screening Practices for Female Partner Abuse*, 35 WOMEN & HEALTH 55, 55-69 (2002); Tonji Durant et al., *Opportunities for Intervention: Discussing Physical Abuse During Prenatal Care Visits*, 19.4 AM. J. OF PREVENTATIVE MED. 238, 238-44 (2000); Barbara Gerbert et al., *Domestic Violence Compared to Other Health Risks: A Survey of Physician Beliefs and Behaviors*, 23 AM. J. OF PREVENTATIVE MED. 82, 82-90 (2002); Deborah L. Horan et al., *Domestic Violence Screening Practices of Obstetricians-Gynecologists*, 92.4 OBSTETRICS & GYNECOLOGY 785, 785-89 (1998); Meghan E. McGrath et al., *A Prevalence Survey of Abuse and Screening for Abuse in Urgent Care Patients*, 91.4 OBSTETRICS & GYNECOLOGY 511, 511-14 (1998); Paula Renker & Peggy Tonkin, *Women's Views of Prenatal Violence Screening: Acceptability and Confidentiality Issues*, 107.2 OBSTETRICS AND GYNECOLOGY 348, 348-54 (2006); Michael A. Rodriguez et al., *Screening and Intervention for Intimate Partner Abuse: Practices and Attitudes of Primary Care Physicians*, 282 JOURNAL OF THE AM. MED. ASS'N 468, 468-74 (1999).

including mandates in the Patient Protection and Affordable Care Act (ACA),[4] should spur state legislation mandating physician training on domestic violence and domestic violence screening.[5] That recommendation was rooted in the premise that such training and enhanced screening would address a conspicuous shortcoming in current medical practice. This Article supports that premise with empirical data showing widespread physician inattention to the voices of domestic violence victims. In particular, this Article reports a new set of qualitative data, drawn from a study conducted in conjunction with the National Hotline on Domestic Violence,[6] on the experiences of victims in the healthcare setting. These voices inject a compelling sense of urgency into the call for physicians to better understand the needs of victims and to guide them to health and safety. As the federal government funds development of strategies to strengthen the medical community's response to domestic violence,[7] states should take account of the voices of survivors/victims[8] in enacting their own legislation on physician training.

Part One of this Article describes the dynamics and prevalence of domestic violence, the largely unheeded calls for screening for domestic violence by leaders of the medical community, and prior research on victims' impressions of

4. The Health Resources and Services Administration (HRSA) guidelines were incorporated into the ACA pursuant to section 2713. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2713(a), 124 Stat. 119 (codified at 42 U.S.C.A. § 300gg-13 (West, Westlaw through 2014)). *See also Women's Preventive Services Guidelines*, HEALTH RES. & SERV. ADMIN., http://www.hrsa.gov/womensguidelines/ (last visited Aug. 14, 2013). 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) (West, Westlaw through 2014). Domestic violence screening and counseling is rated B by the Task Force. U.S. PREVENTIVE SERVICES TASK FORCE, USPSTF A AND B RECOMMENDATIONS, http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm (last visited Aug. 14, 2013).

5. Karen Oehme & Nat Stern, *The Case for Mandatory Training on Screening for Domestic Violence in the Wake of the Affordable Care Act*, 17 U. PA. J. L. & SOC. CHANGE 1 (2014).

6. *About Us*, THEHOTLINE.ORG, http://www.thehotline.org/about-support/ (last visited Aug. 14, 2013). The National Domestic Violence Hotline is a non-profit organization that provides crisis intervention, information, and referrals to victims of domestic violence as a component of the 1996 Violence Against Women Act (VAWA). *Id.*

7. *See* NAT'L COAL. AGAINST DOMESTIC VIOLENCE, COMPARISON OF VAWA 1994, VAWA 2000 AND VAWA 2005 REAUTHORIZATION BILL (2006), *available at* http://www.ncadv.org/files/VAWA_94_00_05.pdf. Provisions included $1.6 billion in funds allocated from 1994-2000 including grants to encourage arrest policies, rural domestic violence and child abuse enforcement grants, Services and Training for Officers and Prosecutors (STOP) grants, National Stalker and Domestic Violence Reduction funds, civil legal assistance for victims of violence, shelter services for battered women and children, National Domestic Violence Hotline, Federal Victims' counselors, court-appointed special advocate program, child abuse training programs, rape prevention and education, and community initiatives. *Id.*

8. The term "victims" is used throughout this article to emphasize the need for immediate action and the often-ongoing nature of the crime in patients' lives. However, those who experience violence in their intimate relationships are commonly referred to in the literature as either victims or survivors. Some researchers and advocates make a distinction between the agency of the victim/survivor and the ongoing nature of abuse. *See* Jennifer L. Dunn, *"Victims" and "Survivors": Emerging Vocabularies of Motive for "Battered Women Who Stay,"* 75 SOCIOLOGICAL INQUIRY 1, 1 (2005) (discussing use of terms 'victim' and 'survivor').

how screening should take place. Part Two describes the recent Victim Voices Dataset study[9] conducted in conjunction with the National Hotline on Domestic Violence. In that study, victims who called the Hotline for assistance were offered an opportunity to comment on their prior experiences with medical professionals in a clinical setting. This Article concludes that meaningful change in the medical system depends on state action that is responsive to the voices and needs of victims. Finally listening to victims will justify and inform physician training on the distressingly common crime of domestic violence and help to end the decades-long physician neglect of victims' needs.

I. THE PERVASIVE SCOURGE OF DOMESTIC VIOLENCE: A LIMITED RESPONSE FROM THE MEDICAL COMMUNITY

The information from the Victim Voices Dataset study was gathered to help address this nation's chronic and pervasive domestic violence. Domestic violence amounts to both devastation to individual victims and a grievously persistent social ill. Calling domestic violence an "unacknowledged epidemic," Health and Human Services Secretary Donna Shalala pledged in 1994 that the Clinton Administration would fight the problem as "terrorism in the home."[10] Since that time, much effort has been dedicated to stemming the tide of this violence.[11] Still, its prevalence has been recognized as a public health crisis[12] destructive to victims and their families alike.[13]

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9. *See infra* text accompanying notes 121-202 for a discussion of the Victim Voices Dataset and its methodology.

10. Lynne Marek, *U.S. Joining War on Domestic Violence*, CHI. TRIB. (Mar. 12, 1994), *available at* http://articles.chicagotribune.com/1994-03-12/news/9403120068_1_domestic-violence-shalala-domestic-partner (quoting Human Services Secretary Donna Shalala).

11. *See* U.S. ATT'Y OFFICE W. DIST. OF TENN, FEDERAL DOMESTIC VIOLENCE LAWS: ISSUES AND ANSWERS, http://www.justice.gov/usao/tnw/brochures/federaldomesticviolencelaws.html. In 1994, Congress passed the Violence Against Women Act. *Id.* In 1994 and 1996, Congress modified the Gun Control Act, barring abusers from possessing guns under certain circumstances. *Id.* Since 1994, forty-three states have enacted protections against insurance discrimination for domestic violence victims. NANCY DURBOROW ET AL., FAMILY VIOLENCE PREVENTION FUND, COMPENDIUM OF STATE STATUTES AND POLICIES ON DOMESTIC VIOLENCE AND HEALTH CARE 5 (2010), http://www.futureswithoutviolence.org/userfiles/file/HealthCare/Compendium%20Final.pdf. Domestic violence fatality review teams were formed under statute to convene to address the dynamics of domestic violence within states and local communities. *Id.* at 1.

12. *See, e.g.*, 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 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) ("[T]oday the concept of domestic violence as a public health crisis figures prominently in societal consciousness . . . . ").

13. CDC, NATIONAL INTIMATE PARTNER AND SEXUAL VIOLENCE SURVEY: 2010 SUMMARY REPORT 7-9 (2010), *available at* http://www.cdc.gov/violenceprevention/pdf/nisvs_report2010-a.pdf [hereinafter CDC SURVEY] (reveals that victims of domestic violence may experience musculoskeletal injuries,

A. THE NATURE AND FREQUENCY OF DOMESTIC VIOLENCE

Domestic violence is a pattern of behavior in which a person employs a variety of tactics—including but not limited to physical violence, threats of violence, intimidation, sexual coercion, isolation, and emotional abuse—to control an intimate partner.[14] Such violence crosses lines of ethnicity, race, socio-economic status, religion, and national origin.[15] The scale of domestic violence is well-documented and chilling: the Centers for Disease Control (CDC) reports that more than one in three women (thirty-five percent) and one in four men (twenty-eight percent) in the United States are raped, assaulted, or stalked by intimate partners in their lifetimes.[16] Approximately one in four women (twenty-four percent) and one in seven men (thirteen percent) have experienced severe physical violence by an intimate partner.[17] Roughly ten percent of women and two percent of men have been stalked by an intimate partner in their lifetime.[18] Although victims include both women and men, studies show that women generally experience more chronic and severe physical assaults by intimate partners than men.[19] Especially troubling is the far greater frequency with which domestic violence is lethal for women.[20] Of women murdered in the United States, about forty-five percent are killed by an intimate partner;[21] by contrast, only about five percent of men who are murdered die as a result of violence by their intimate partners.[22]

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sexually transmitted infections, gastrointestinal and gynecological conditions, asthma, diabetes, chronic pain, and physical disability linked to abuse); Jacquelyn C. Campbell, *Health Consequences of Intimate Partner Violence*, 359 LANCET 1331, 1333-34 (2002) (reveals that victims of domestic violence may be subject to higher rates of mental illness); Patricia A. Janssen et al., *Intimate Partner Violence and Adverse Pregnancy Outcomes: A Population-Based Study*, 188 AM. J. OBSTETRICS & GYNECOLOGY 1341, 1341 (2003) (reveals that victims of domestic violence may experience complications during pregnancy).

14. AM. BAR ASS'N, TOOL FOR ATTORNEYS TO SCREEN FOR DOMESTIC VIOLENCE 1 (2005), http://www.americanbar.org/content/dam/aba/migrated/domviol/screeningtoolcdv.authcheckdam.pdf.

15. *Id.*

16. CDC SURVEY, *supra* note 13, at 2.

17. *Id.*

18. *Id.*

19. *See* MURRAY A. STRAUS ET AL., BEHIND CLOSED DOORS: VIOLENCE IN THE AMERICAN FAMILY (1980); Glenda K. Kantor & Murray A. Straus, *The "Drunken Bum" Theory of Wife Beating*, 34 SOCIAL PROBLEMS 213, 219 (1987); Michael S. Kimmel, *"Gender Symmetry" in Domestic Violence: A Substantive and Methodological Research Review*, 8 VIOLENCE AGAINST WOMEN 1332, 1348 (2002) (citing Neil Frude, *Marital Violence: An Interactional Perspective, in* MALE VIOLENCE 153 (John Archer ed., 1994)); Daniel G. Saunders, *Are Assaults by Wives and Girlfriends a Major Social Problem?: A Review of the Literature*, 8 VIO. AGAINST WOM. 12, 1424, 1436 (2002); Jan E. Stets & Murray A. Straus, *Gender Differences in Reporting Marital Violence and its Medical and Psychological Consequences, in* PHYSICAL VIOLENCE IN AMERICAN FAMILIES 151 (Murray A. Straus & Richard J. Gelles eds., 1990).

20. Judith Wolfer, *Top Ten Myths about Domestic Violence*, 42 MD. BAR J. 38, 38-39 (May/June 2009).

21. ALEXIA COOPER & ERICA L. SMITH, U.S. DEP'T OF JUSTICE, HOMICIDE TRENDS IN THE UNITED STATES, 1980-2008 at 18 (2011), *available at* http://www.bjs.gov/content/pub/pdf/htus8008.pdf.

22. *Id.*

B. THE PERSONAL AND SOCIETAL DEVASTATION FROM DOMESTIC VIOLENCE

The medical community has acknowledged that physicians and medical professionals in every medical specialty encounter patients who have been victimized by domestic violence.[23] The short- and long-term health consequences of this violence go well beyond specific physical injuries like broken bones, cuts, and tissue damage.[24] Rather, the effects of domestic violence also include a range of other, less tangible medical problems for victims: chronic pain, anxiety, physical disability, post-traumatic stress disorder, depression, gastrointestinal problems, and asthma.[25] Because of the sexual coercion and assault that often occur within domestic violence,[26] an increased risk of unplanned or early pregnancies[27] and sexually transmitted diseases (including HIV/AIDS)[28] is also associated with domestic violence. As trauma victims, women are at an increased risk of substance abuse,[29] alcoholism, and suicide attempts,[30] and are three times more likely to have gynecological problems than non-abused women.[31] Domestic violence also has a highly destructive effect on the children of victims. Children who live in homes with domestic violence are at an increased risk of

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23. *See* FAMILY VIOLENCE PREVENTION FUND, IDENTIFYING AND RESPONDING TO DOMESTIC VIOLENCE: CONSENSUS RECOMMENDATIONS FOR CHILD AND ADOLESCENT HEALTH 4 (2004), *available at* http://www.futureswithoutviolence.org/userfiles/file/HealthCare/pediatric.pdf (stating that because IPV occurs in every community, "all health care settings and professionals are affected by intimate partner violence."); AMA DIAGNOSTIC, *supra* note 2, at 39-40 ("Physicians in all practice settings routinely see the consequences of violence and abuse, but often fail to acknowledge their violent etiologies."). Domestic violence is the leading cause of non-lethal injury among women in the United States. Sunita Sapkita, *Violence Against Women—Focus on Domestic Violence*, 10 HEALTH PROSPECT 48, 50 (2012). Violence against women is also associated with STIs, unintended pregnancy, abortion, and adverse pregnancy outcomes, substance abuse, depression, PTSD, eating disorders, headaches, back pain, abdominal pain, fibromyalgia, chronic disorders, poor overall health. *Id.*

24. CDC, INTIMATE PARTNER VIOLENCE: CONSEQUENCES, http://www.cdc.gov/violenceprevention/intimatepartnerviolence/consequences.html (last visited Sept. 26, 2012) (noting that some effects of domestic violence can be the direct result of abuse (bruising, cuts, broken bones, concussions and traumatic brain injuries, back/pelvic pain, and headaches), while "[o]ther conditions are the result of the impact of intimate partner violence on the cardiovascular, gastrointestinal, endocrine and immune systems through chronic stress or other mechanisms.").

25. *Health Effects of Domestic Violence*, THE ADVOCATES FOR HUMAN RIGHTS (last updated Sept. 10, 2003), http://www.stopvaw.org/health_effects_of_domestic_violence.

26. AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, COMMITTEE ON HEALTH CARE FOR UNDERSERVED WOMEN: INTIMATE PARTNER VIOLENCE, COMMITTEE OPINION NO. 518, at 1-2 (2012); Judith McFarlane et al., *Intimate Partner Sexual Assault Against Women: Frequency, Health Consequences, and Treatment Outcomes*, 105 AM. C. OBSTETRICIANS & GYNECOLOGISTS 99, 99 (2005).

27. Ann L. Coker, *Does Physical Intimate Partner Violence Affect Sexual Health?: A Systematic Review*, 8 TRAUMA, VIOLENCE, & ABUSE 149, 150 (2007); Ann M. Moore et al., *Male Reproductive Control of Women Who Have Experienced Intimate Partner Violence in the United States*, 70 SOC. SCI. & MED. 1737, 1737 (2010).

28. AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, COMMITTEE ON HEALTH CARE FOR UNDERSERVED WOMEN: REPRODUCTIVE AND SEXUAL COERCION, COMMITTEE OPINION NO. 554, at 2 (2013); Coker, *supra* note 27, at 150; Moore et al., *supra* note 27, at 1737.

29. *Health Effects of Domestic Violence*, *supra* note 25.

30. INTIMATE PARTNER VIOLENCE: CONSEQUENCES, *supra* note 24.

31. *Violence Against Women: Effects on Reproductive Health*, 20 OUTLOOK, no. 1, Sept. 2002, at 3.

maltreatment and poor health outcomes.[32] In addition, children can suffer a range of problems as a result of witnessing domestic violence: e.g., anxiety, depression, aggression, attempted suicide, and drug and alcohol abuse.[33] Studies also indicate that thirty to sixty percent of perpetrators of violence against intimate partners also abuse children in the household.[34] It is no surprise, then, that child abuse occurs in a large portion of households that experience domestic violence.[35]

Moreover, the sheer economic cost of domestic violence in the United States—amounting to over 8.3 billion dollars—is staggering.[36] Domestic violence results in over thirteen million days of lost productivity from paid work each year.[37] The treatment of injuries by domestic violence adds up to more than four billion dollars annually.[38] Nearly two million injuries and 1,300 deaths result each year from domestic violence.[39] More than a half-million injuries require

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

33. *See* CHILD WELFARE INFORMATION GATEWAY, DOMESTIC VIOLENCE AND THE CHILD WELFARE SYSTEM 2-3 (2009), *available at* https://www.childwelfare.gov/pubs/factsheets/domestic_violence/domesticviolence.pdf (finding that children who witness domestic violence experience higher levels of anger, anxiety, and depression); Christopher M. Adams, *The Consequences of Witnessing Family Violence on Children and Implications for Family Counselors,* 14 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."); 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."); 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").

34. Jeffrey L. Edleson, *The Overlap Between Child Maltreatment and Woman Battering* (1999), 5 VIO. AGAINST WOM., 134, 136 http://www.unicef.org/protection/files/BehindClosedDoors.pdf.

35. *See* 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%."); Jeffery 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 also the victims of abuse by the same perpetrator."); UNICEF, BEHIND CLOSED DOORS: THE IMPACT OF DOMESTIC VIOLENCE ON CHILDREN 7 (2006), http://www.unicef.org/protection/files/BehindClosedDoors.pdf. ("There is a common link between domestic violence and child abuse. Among victims of child abuse, 40 percent report domestic violence in the home.").

36. Wendy Max et al., *The Economic Toll of Intimate Partner Violence Against Women in the United States*, 19 VIOLENCE AND VICTIMS 259, 259 (2004).

37. CTRS. FOR DISEASE CONTROL AND PREVENTION, COSTS OF INTIMATE PARTNER VIOLENCE AGAINST WOMEN IN THE UNITED STATES 19 (2003), *available at* http://www.cdc.gov/violenceprevention/pdf/IPVBook-a.pdf [hereinafter CDC, COSTS].

38. *Id.*

39. *Id.*

medical attention, and over 145,000 injuries require hospitalization.[40] By some estimates, between twenty-two and thirty-five percent of women patients seen in emergency departments are there for injuries related to domestic violence,[41] and more than twenty-five percent of women victims of domestic violence need medical attention due as a result of their injuries.[42] Over eighteen million mental health visits also result from domestic violence.[43]

C. THE LIMITED RESPONSE OF THE MEDICAL COMMUNITY

In response to the magnitude of domestic violence and its ruinous effects, prominent organizations and groups within the medical community have recommended that medical professionals screen their patients for domestic violence. Most notably, the American Medical Association (AMA) first recommended in 1992 that physicians screen patients for domestic violence.[44] Because of the presence and impact of domestic violence, the AMA recommended "physicians should routinely inquire about family violence, especially when treating women, elderly persons, and children mature enough to be interviewed in private."[45] In addition, physicians who encounter evidence of possible abuse during practice "have an obligation to familiarize themselves with 1) protocol for diagnosing and treating family violence, 2) the state reporting requirements and protective services, and 3) community resources for victims of abuse."[46]

A year after the AMA recommendations were issued, the incoming President of the AMA testified that the organization was "very active in efforts to address the issues of family violence in general and violence against women in particular."[47] He spoke about sensitizing members of the medical community to the needs of victims, and explained that half of his requests to speak on issues had arisen from the problem of family violence.[48] Numerous other organizations have echoed the AMA's call for screening.[49]

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40. *Id.*

41. Teri Randall, *Domestic Violence Intervention Calls for More Than Treating Injuries*, 264 J. AM. MED. ASS'N 939, 939 (1990).

42. Michele C. Black, *Intimate Partner Violence and Adverse Health Consequences: Implications for Clinicians*, 5 AM. J. OF LIFESTYLE MED. 428, 429 (2011).

43. CDC, COSTS, *supra* note 37, at 19.

44. AMA DIAGNOSTIC, *supra* note 2, at 39.

45. AM. MED. ASS'N, PHYSICIANS AND FAMILY VIOLENCE: ETHICAL CONSIDERATIONS, CEJA REPORT B–I-91 10 (1992), *available at* http://www.ama-assn.org/resources/doc/ethics/ceja_bi91.pdf.

46. *Id.* at 11.

47. *Examining the Rise of Violence Against Women in the State of Maine and in Other Rural Areas: Hearing Before the S. Comm. on the Judiciary*, 103rd Cong. 8 (1993) (statement of Dr. Robert McAfee, President-elect, American Medical Association).

48. *Id.*

49. These organizations include the American Academy of Family Physicians, American Academy of Neurology, American College of Emergency Physicians, American College of Nurse-Midwives, American College of Obstetricians and Gynecologists, American Nurses Association, Emergency Nurses Association, American Medical Association, and the American Academy of Orthopaedic Surgeons. AM. ACAD. OF FAM. PHYSICIANS, INTIMATE PARTNER VIOLENCE AND ABUSE OF ELDERLY AND

In the two decades since President-elect McAfee addressed the Senate Judiciary Committee, an array of resources and materials have been developed to improve the medical community's response to victims of domestic violence.[50] Nevertheless, medical professionals' alertness and response to indicia of abuse have not appreciably improved over this period. Although healthcare professionals often treat patients who have been abused, "in the vast majority of treatment situations they fail to suspect abuse. Even when abuse is identified, there is resistance to validating and documenting the abuse and to referring and following up with victims."[51] Indeed, despite changes to federal guidelines, few members of the medical community have changed their screening practices.[52] Studies of patients[53] and physicians[54] indicate that only a fraction of patients are actually screened for domestic violence by their physicians.

In light of doctors' chronic failure to screen for domestic violence, the AMA in 2009 repeated its call for screening of all patients. The AMA "supports the inclusion of questions on family violence issues on licensure and certification" as

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VULNERABLE ADULTS (2013), http://www.aafp.org/patient-care/clinical-recommendations/all/domestic-violence.html?cmpid=_van_280; AM. ACAD. OF NEUROLOGY, THE AMERICAN ACADEMY OF NEUROLOGY POSITION STATEMENT ON ABUSE AND NEGLECT, 78 NEUROLOGY 433, 433 (2012); AM. COLL. OF EMERGENCY PHYSICIANS BD. OF DIR., DOMESTIC FAMILY VIOLENCE, AM. COLL. OF EMERGENCY PHYSICIANS (Oct. 2007), http://www.acep.org/Clinical–Practice-management/Domestic-Family-Violence/; AM. COLL. OF NURSE-MIDWIVES BD. OF DIR., POSITION STATEMENT: VIOLENCE AGAINST WOMEN, AM. COLL. OF NURSE-MIDWIVES (2013), *available at* http://midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/000000000091/Violence-Against-Women-Sept-2013.pdf; AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, COMMITTEE ON HEALTH CARE FOR UNDERSERVED WOMEN: INTIMATE PARTNER VIOLENCE, COMMITTEE OPINION NO. 518 (2012); *Violence Against Women: ANA Position Statement*, AM. NURSES ASS'N (2000), http://www.nursingworld.org/MainMenuCategories/Policy-Advocacy/Positions-and-Resolutions/ANAPositionStatements/Position-Statements-Alphabetically/Violence-Against-Women.html (last visited Aug. 15, 2013); *Position Statement: Intimate Partner Violence*, EMERGENCY NURSES ASS'N (Aug. 2013), https://www.ena.org/SiteCollectionDocuments/Position%20Statements/IPV.pdf; AMA DIAGNOSTIC, *supra* note 2, at 39-40; AM. ACAD. OF ORTHOPAEDIC SURGEONS, CHILD ABUSE OR MALTREATMENT, ELDER MALTREATMENT, AND INTIMATE PARTNER VIOLENCE (IPV): THE ORTHOPAEDIC SURGEON'S RESPONSIBILITIES IN DOMESTIC AND FAMILY VIOLENCE (MAR. 2007), http://www.aaos.org/about/papers/advistmt/1030.asp.

50. *See, e.g.*, *Doctors and Health Care Workers*, WOMENSLAW.ORG, www.womenslaw.org/simple.php?sitemap_id=58 (last updated Feb. 10, 2014).

51. 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).

52. D. KELLY WEISBERG, DOMESTIC VIOLENCE: LEGAL AND SOCIAL REALITY 511 (2012).

53. Jean Abbott et al., *Domestic Violence Against Women: Incidence and Prevalence in an Emergency Department Population*, 273 J. AM. MED. ASS'N 1763, 1763 (1995); Panagiota 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); Meghan E. McGrath et al., *A Prevalence Survey of Abuse and Screening for Abuse in Urgent Care Patients*, 91 OBSTETRICS & GYNECOLOGY 511, 511 (1998).

54. *See* Lorrie Elliott et al., *Barriers to Screening for Domestic Violence*, 17 J. GEN. INTERNAL MED. 112, 112 (2002); Deborah L. Horan et al., *Domestic Violence Screening Practices of Obstetricians-Gynecologists*, 92 OBSTETRICS & GYNECOLOGY 785, 785 (1998); Meghan E. McGrath et al., *Violence Against Women: Provider Barriers to Intervention in Emergency Departments*, 4 ACAD. EMERGENCY MED. 297 (1997); Michael A. Rodriguez et al., *Screening and Intervention for Intimate Partner Abuse: Practices and Attitudes of Primary Care Physicians*, 282 J. AM. MED. ASS'N 468, 468 (1999).

well as the development of curricula that include information on diagnosis, treatment, and the reporting of domestic violence.[55] The AMA specified:

> [T]o improve clinical services as well as the public health, our AMA encourages physicians to: (a) Routinely inquire about the family violence histories of their patients as this knowledge is essential for effective diagnosis and care; (b) Upon identifying patients currently experiencing abuse or threats from intimates, assess and discuss safety issues with the patient before he or she leaves the office, working with the patient to develop a safety or exit plan for use in an emergency situation and making appropriate referrals to address intervention and safety needs as a matter of course; (c) After diagnosing a violence-related problem, refer patients to appropriate medical or health care professionals and/or community-based trauma-specific resources as soon as possible; (d) Have written lists of resources available for victims of violence, providing information on such matters as emergency shelter, medical assistance, mental health services, protective services and legal aid . . . .[56]

D. THE CALL FOR SCREENING FEMALE PATIENTS FOR DOMESTIC VIOLENCE

Notwithstanding these gains, however, there is little evidence to suggest that absent legislative action physicians will obtain training to increase victim safety. Calls from medical community leaders and a wealth of instructional resources have done remarkably little to increase the quantity and quality of screening for domestic violence. The Patient Protection and Affordable Care Act (ACA),[57] however, may provide a necessary prod to enhance screening practices and regularity among physicians and medical professionals.

Based on the IOM policy statement, which recommends medical screening for risk of domestic violence, the Health Resources and Services Administration (HRSA) announced provisions that recommend screening for domestic violence.[58] The IOM states that screening[59] all women and adolescent girls is "central to women's safety, as well as to addressing current health concerns and

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55. *H-515.965 Family and Intimate Partner Violence*, AM. MED. ASS'N, http://www.ama-assn.org/ama1/pub/upload/mm/PolicyFinder/policyfiles/HnE/H-515.965.HTM (last visited Aug. 15, 2013).

56. *Id.*

57. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (codified as amended in scattered sections of 26 and 42 U.S.C.).

58. "The Institute of Medicine is an independent, nonprofit organization that works outside of government to provide 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 visited Aug. 15, 2013).

59. The term 'screening,' according to the IOM, means obtaining information about current and past abuse and violence from the patient in a manner that is culturally relevant, supportive, and promotes safety and wellness. INST. OF MED., REPORT BRIEF: CLINICAL PREVENTIVE SERVICES FOR WOMEN: CLOSING THE GAPS 1, 2 (July 2011).

preventing future health problems."[60] Based on this recommendation, the ACA includes a provision (recommended by HRSA) that was designed to provide women with screening and counseling services on domestic violence in clinical settings at no additional cost.[61] The eight services include well-woman visits, gestational diabetes screening, human papillomavirus testing, STI counseling, HIV screening and counseling, contraception and contraception counseling, breastfeeding support, and domestic violence screening and counseling.[62] Likewise, the U.S. Preventive Services Task Force (USPSTF), an independent group of medical experts in prevention and evidence-based medicine, recommended coverage of these services.[63] The provision regarding domestic violence screening requires that new insurance plans effective after August 1, 2012—and thus governed by the ACA—and those plans that have not been "grandfathered in" under existing terms cover domestic violence screening and counseling free of co-pays under the preventive care provision.[64] These substantial changes in the medical landscape make it crucial that medical professionals conduct screening informed by the needs, fears, and experiences of the patients they serve.

E. A FOUNDATION TO BUILD ON: PRIOR RESEARCH INTO PATIENT PERSPECTIVES ON SCREENING

It should give physicians confidence that this shift in approach will not start from scratch; considerable data already exist on the experiences of victims of domestic violence in medical settings. Research on these experiences began in the 1990s, using focus groups of battered women and individual interviews with victims to explore their interaction with medical professionals in both emergency and routine care settings.[65] While these earlier studies tended to have fewer participants than the current study,[66] they show that nearly all study participants believed that medical professionals should ask female patients about domestic

60. *Id.*

61. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2713(a)(4), 124 Stat 119, 131 (2010) (codified at 42 U.S.C.A. § 300gg-13(a)(4) (West, Westlaw through 2014)). HRSA guidelines are incorporated into the ACA pursuant to section 2713. *See also Women's Preventive Services Guidelines*, *supra* note 4.

62. *Women's Preventive Services Guidelines*, *supra* note 4.

63. U.S. PREVENTIVE SERVICES TASK FORCE, http://USPreventiveServicesTaskForce.org (last visited July 24, 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.").

64. Patient Protection and Affordable Care Act, *supra* note 61. *See also Women's Preventive Services Guidelines*, *supra* note 4.

65. *See infra* notes 67-79.

66. *See infra* notes 68-76, 78-79.

violence[67]—alone, if at all possible[68]—and help create a plan for safety.[69] Only a fraction of the participants, however, had actually been asked about abuse by their physicians.[70] Participants in the studies suggested that medical professionals ask about such violence in a nonjudgmental way,[71] listen to patients,[72] create an atmosphere of safety, provide access to resources, raise patient and community awareness about domestic violence,[73] and demonstrate empathy and compassion.[74] Moreover, those studies indicated that victims want to be validated, given control over ultimate decision-making and options, and followed up with after the professional takes an active role in response to the disclosure of domestic violence.[75] A common complaint by participants in these studies was that physicians "too easily accepted" false explanations offered by perpetrators or victims for injuries.[76]

In addition to gaining a better understanding of victims' experiences and opinions, physicians can also learn from specific comments offered by victims to researchers about screening. Studies indicate that most women are too embarrassed or afraid to raise the issue of domestic violence, but would feel relieved to talk about it with medical professionals if they were asked in a compassionate, direct manner.[77] Most participants also felt more comfortable responding to direct rather than indirect questions[78] and wanted to be offered resources—not

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67. Caralis & Musialowski, *supra* note 53, at 1075 (162 participants who identified as victims);. Andrea C. Gielen et al., *Women's Opinions about Domestic Violence Screening and Mandatory Reporting*, 19 AM. J. PREVENTIVE MED. 279, 279 (2000) (202 participants who identified as victims).

68. Therese M. Zink & Jeff Jacobson, *Screening for Intimate Partner Violence when Children Are Present: The Victim's Perspective*, 18 J. INTERPERSONAL VIOLENCE 872, 872 (2003) (thirty-two participants who identified as victims).

69. Barbara Gerbert et al., *How Health Care Providers Help Battered Women: The Survivor's Perspective*, 29 WOMEN & HEALTH 115, 115-16 (1999) (twenty-five participants who identified as victims).

70. *See* Abbott et al., *supra* note 53, at 1763; Caralis & Musialowski, *supra* note 53, at 1075; McGrath et al., *supra* note 53, at 511.

71. Jeanne E. Hathaway et al., *Listening to Survivors' Voices: Addressing Partner Abuse in the Health Care Setting*, 8 VIOLENCE AGAINST WOMEN 687, 714 (2002) (forty-nine participants who identified as victims).

72. Sandra K. Burge et al., *Patients' Advice to Physicians About Intervening in Family Conflict*, 3 ANNALS OF FAM. MED. 248, 250-51 (2005) (fifty participants who identified as victims).

73. Melanie Lutenbacher et al., *Do We Really Help? Perspectives of Abused Women*, 20 PUB. HEALTH NURSING 56, 63 (2003) (twenty-four participants who identified as victims).

74. Judy C. Chang et al., *Asking about intimate partner violence: advice from female survivors to health care providers*, 59 PATIENT EDUC. & COUNSEL. 141, 141, 143 (2005) (forty-one participants who identified as victims).

75. Jacqueline Dienemann et al., *Survivor Preferences for Response to IPV Disclosure*, 14 CLINICAL NURSING RES. 215, 215 (2005) (twenty-six participants who identified as victims).

76. L. Kevin Hamberger et al., *Physician Interaction with Battered Women: The Women's Perspective*, 7 ARCHIVES FAM. MED. 575, 576, 578 (1998) (115 participants who identified as victims).

77. Loraine Bacchus et al., *Experiences of Seeking Help From Health Professionals in a Sample of Women Who Experienced Domestic Violence*, 11 HEALTH & SOC. CARE CMTY. 10, 10 (2003); Maria A. Rodriguez et al., *Breaking the Silence: Battered Women's Perspectives on Medical Care*, 5 ARCHIVES FAM. MED. 153, 156 (1996).

78. Bacchus et al., *supra* note 77, at 13-14 (sixteen participants who identified as victims).

simply instructed to leave the abusive partner.[79] The women who did not discuss domestic violence with their physicians reported fear as a barrier to leaving; they felt threatened both by the prospect of retribution against themselves and family and friends[80] and by the perpetrator's constant presence around the medical providers.[81] In many of the instances where victims were screened, they reported that doctors appeared uninterested, uncaring, or uncomfortable,[82] and did not offer follow-up care and options to the victims.[83] Still, despite such barriers to effective screening for domestic violence, these studies show that physicians can overcome barriers when they understand the social context of domestic violence and strive to recognize and meet victims' needs with direct questioning in compassionate, informed conversations with their patients.[84]

F. THE RISING RECOGNITION OF VICTIM RIGHTS

From a historical perspective, the importance of considering the needs and participation of victims of crime is a relatively recent concept in American society. It developed first through the idea that victims should be compensated for the crimes committed against them. The initial victim compensation programs began in California in 1965[85] and soon caught national attention.[86] In the ensuing years, non-governmental organizations that included survivors and their advocates[87] developed many services for victims.[88] These organizations included the Crime Victims' Legal Advocacy Institute[89] and the National Organization for Victim Assistance.[90] In 1982, Congress enacted the Victim and Witness

79. Barbara Gerbert et al., *Experiences of Battered Women in Health Care Settings: A Qualitative Study*, 24 WOMEN & HEALTH 1, 6, 13 (1997) (thirty-eight participants who identified as victims).

80. Lutenbacher et al., *supra* note 73, at 62.

81. *Id.* at 60.

82. *Id.*

83. *Id.*

84. *See, e.g.*, Rodriguez et al., *supra* note 77, at 156.

85. CAL. VICTIM COMP. & GOV'T CLAIMS BD., CALIFORNIA VICTIM COMPENSATION PROGRAM (2010), *available at* http://vcgcb.ca.gov/docs/resources/VCPOverview_CURRENT.pdf. The California Victims' Compensation Program was established in 1965, the first program of its kind. *Id.*

86. *Crime Victim Compensation: An Overview*, NAT'L ASS'N CRIME VICTIM COMPENSATION BOARDS, http://www.nacvcb.org/index.asp?bid=14 (last visited Mar. 1, 2014). Within seven years, eight other states had victim compensation programs. Presently, close to $500 million is distributed to nearly a quarter of a million victims annually. *Id.*

87. Joanna Tucker Davis, *The Grassroots Beginnings of the Victims' Rights Movement*, NAT'L CRIME VICTIM L. INST. (Spring–Summer 2005), *available at* https://www.lclark.edu/live/files/6453-the-grassroots-beginnings-of-the-victims-rightsorg/index.asp?bid=14. Advocates and survivors led the charge on increasing victims' rights and amplifying their voices. *Id.*

88. *The History of Crime Victims' Rights in America*, MD. CRIME VICTIMS' RESOURCE CENTER, http://www.mdcrimevictims.org/laws-and-policies/history-of-crime-victims-rights-in-america/ (last visited Mar. 1, 2014).

89. *Victims' Assistance Legal Organization, Inc.*, NAT'L SEXUAL VIOLENCE RESOURCE CENTER, http://www.nsvrc.org/organizations/113 (last visited Mar. 1, 2014). The Crime Victims' Legal Advocacy Institute was later renamed Victims' Assistance Legal Organization.

90. *NOVA Overview*, NAT'L ORG. OF VICTIM ASSISTANCE, http://www.trynova.org/about-us/overview/ (last visited Mar. 1, 2014).

Protection Act, the first federal crime victims' rights legislation.[91] The law marked a major step in correcting the history that "the innocent victims of crime have been overlooked, their pleas for justice have gone unheeded, and their wounds—personal, emotional, financial—have gone unattended."[92] Two years later, Congress passed the Victims of Crimes Act (VOCA) to provide victim compensation and assistance,[93] and in 1988 amended the Act to establish the Office for Victims of Crime, which administers legal assistance and victim notification grants.[94]

Judicial recognition of the needs and rights of victims also evolved in the late twentieth century. In 1973, the Supreme Court decision in *Linda R.S. v. Richard D.* found that "a private citizen [lacked] a judicially cognizable interest in the prosecution or non-prosecution of another" when a crime has been committed.[95] By 1991 the Court in *Payne v. Tennessee* recognized that crime victims are not nameless, faceless non-participants in the criminal justice system.[96] In his concurrence in *Payne*, Justice Scalia acknowledged "a public sense of justice keen enough that it has found voice in a nationwide 'victims' rights' movement."[97] This ruling by the Court underscored national recognition of the importance of victims' voices, and overturned previous rulings regarding victim impact statements.[98] Courts had previously held that victim impact statements often distracted a jury from focusing on the defendant,[99] whereas since *Payne* victim statements have been viewed as valuable and acceptable.[100]

During this period, the feminist movement has intersected with the victim rights movement, helping to shape notable changes in social and legal attitudes toward domestic violence. These included recognition of domestic violence as a

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91. *History of Victims' Rights*, NAT'L CRIME VICTIM L. INST., http://law.lclark.edu/centers/national_crime_victim_law_institute/about_ncvli/history_of_victims_rights/ (last visited Mar. 1, 2014).

92. Victim and Witness Protection Act of 1982, Pub. L. No. 97-29, 96 Stat. 1248 (1982) (codified as amended in scattered sections of Title 18 of the U.S. Code). *See* LOIS HAIGHT HERRINGTON ET AL., PRESIDENT'S TASK FORCE ON VICTIMS OF CRIME, FINAL REPORT ii (1982).

93. 42 U.S.C.A. §§ 10601-10608 (West, Westlaw through 2014).

94. *Id.*

95. Linda R.S. v. Richard D., 410 U.S. 614, 619 (1973) (holding that that the mother of an illegitimate child did not have standing to instigate a criminal prosecution against the child's father, who did not pay child support, because state law allowing such action only applied to parents who had been married when the child was born).

96. 501 U.S. 808 (1991) (holding that the Eighth Amendment does not create a *per se* bar to the use of victim impact evidence at a capital sentence hearing).

97. *Id.* at 834 (Scalia, J., concurring).

98. *See* Cait Clarke & Thomas Block, *Victims' Voices and Constitutional Quandaries: Life After Payne v. Tennessee*, 8 ST. JOHN'S J.L. COMMENT. 35, 42 (1992), *available at* http://scholarship.law.stjohns.edu/cgi/viewcontent.cgi?article=1495&context=jcred/. The Court turned over the decision to the states to decide whether to include victim impact evidence in capital sentencing cases, where previous cases had not allowed for the admission of victim impact statements. *Id.*

99. *Id.* at 40.

100. Clarke & Block, *supra* note 98.

crime, the development of services for victims,[101] and improvements in the criminal justice system's[102] response to crimes against women. Initial federal legislation to provide direct services to victims of domestic violence came in 1984 in the form of The Family Violence Prevention and Services Act (FVPSA), and was designed to assist child and adult victims of domestic violence.[103] Congress incorporated the law as a part of the reauthorization of the Child Abuse Prevention and Treatment Act of 2010.[104] While the Act's primary focus is on mistreatment of children, the relationship between domestic violence and child welfare issues was not lost on legislators; congressional findings include the importance of integrating "the work of . . . domestic violence services" to address the issues of abuse and neglect.[105] The Act calls for training of law enforcement, social services professionals, and mental health professionals on domestic violence issues;[106] collection of data on the intersection of domestic violence and child abuse and neglect;[107] collaboration of domestic violence and child protection service providers;[108] and "linkages among child protective service agencies and public health, mental health, substance abuse, developmental disabilities, and domestic violence service agencies."[109]

Following authorization of the Family Violence Prevention and Services Act in 1984, the landmark legislation addressing domestic violence—the Violence Against Women Act of 1994 (VAWA)—was enacted.[110] VAWA laid the path for further legislation over the past two decades and has provided invaluable support for victims of domestic violence. Since its enactment, VAWA has become the most comprehensive piece of legislation on domestic violence. It has expanded to include violence prevention programs, protection for evicted victims, funding for rape crisis centers and hotlines, services for immigrant and minority women,

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101. *See Grant Programs*, U.S. DEP'T JUSTICE: OFF. VIOLENCE AGAINST WOMEN, http://www.ovw.usdoj.gov/ovwgrantprograms.htm#17In (last visited Apr. 2012). The STOP Program provides formula grants to encourage multidisciplinary approach to enhancing advocacy and improving the criminal justice system's response to violent crimes against women. *Id.* Grant programs include development and improvement of law enforcement approaches to violent crimes against women, and the development and improvement of advocacy/services for victims. *Id.*

102. *Id.*

103. *Family Violence Prevention & Services Act*, NAT'L NETWORK TO END DOMESTIC VIOLENCE, http://nnedv.org/policy/issues/fvpsa.html (last visited Mar. 1, 2014).

104. *Id.*

105. ADMIN. ON CHILDREN, U.S. DEP'T OF HEALTH & HUMAN SERVS., THE CHILD ABUSE PREVENTION AND TREATMENT ACT 5 (2010), http://www.acf.hhs.gov/sites/default/files/cb/capta2010.pdf.

106. *Id.* at 8.

107. *Id.* at 9.

108. *Id.* at 10.

109. *Id.* at 15.

110. *See generally*, *Family Violence Prevention and Services Act*, NATIONAL NETWORK TO END DOMESTIC VIOLENCE, http://nnedv.org/policy/issues/fvpsa.html; *Violence Against Women Act*, NATIONAL NETWORK TO END DOMESTIC VIOLENCE, http://nnedv.org/policy/issues/vawa.html; *Laws on Violence Against Women*, OFFICE ON WOMEN'S HEALTH, U.S. DEP'T OF HEALTH & HUMAN SERVS., http://womenshealth.gov/violence-against-women/laws-on-violence-against-women/#a (last visited Mar. 2, 2014).

programs for disabled victims, legal aid for victims, and more services for teens and children.[111] The National Domestic Violence Hotline was established under VAWA and is funded primarily by U.S. Health and Human Service's Family Violence Prevention Services Office.[112] The National Domestic Violence Hotline furnishes assistance to immigrant victims and LGBT victims, and provides $222 million annually through grants for programs that promote policies and legislation to enhance the response to domestic violence.[113] The Act also addresses dating violence, sexual violence, and stalking,[114] promotes the development of sexual assault response teams,[115] improves the judicial process for victims,[116] increases the response to male victims,[117] and strengthens the response to backlogs of sexual assault evidence kits.[118] Then-Senator Joseph Biden, in an effort to collect information on violence against women to develop policy, sat on committees, "heard from scores of women who have suffered violence,"[119] and developed the report that influenced the writing and passage of the Violence Against Women Act of 1994.[120] Victims' voices have informed legislation and strengthened services; physicians, too, can provide better-informed services by listening to their patients' voices.

II. THE VICTIM VOICES DATASET: FRESH EVIDENCE OF THE URGENT NEED FOR TRAINING

A recent collection of qualitative data on domestic violence victims, the *Victim Voices Dataset* ("the Dataset"),[121] offers new information about victims' experiences and perspectives from which legislatures can draw in crafting policies on physician training on screening for abuse. As President Obama observed in 2009, "Knowledge is widely dispersed in society, and public officials

111. *Id.*

112. *About Us*, NAT'L DOMESTIC VIOLENCE HOTLINE, http://www.thehotline.org/about-us/ (last visited Mar. 2, 2014).

113. *VAWA 2013 Summary: Changes to OVW-Administered Grant Programs*, OFFICE ON VIOLENCE AGAINST WOMEN (2013), *available at* http://www.justice.gov/sites/default/files/ovw/legacy/2014/06/16/VAWA-2013-grant-programs-summary.pdf.

114. *Id.*

115. *Id.*

116. *Id.*

117. *Id.*

118. *Id.*

119. *Id.* In his preface, Biden describes the process of examining flaws in the legal system to assist victims of violence, and the necessity of a federal law to protect women. In the creation of this report, victims' voices were heard and used to guide legislation to protect victims and potential victims. *Id.* at 2-6.

120. MAJORITY STAFF OF THE SENATE JUDICIARY COMM., THE RESPONSE TO RAPE: DETOURS ON THE ROAD TO EQUAL JUSTICE 6 (1993), *available at* http://niwaplibrary.wcl.american.edu/reference/additional-materials/vawa-legislative-history/violence-against-women-act-hearings-and-reports/vawa-related-hearings-and-reports-1993/Majority%20Staff%20Report-%20May%201993.pdf.

121. *Voices of Victims: Dataset*, *supra* note 1. The complete dataset is available online at http://familyvio.csw.fsu.edu/wp-content/uploads/2013/08/VOV-QualtitativeDataAnalysis.pdf.

benefit from having access to that dispersed knowledge."[122]As far back as New England town hall meetings,[123] it has been recognized that citizens' information and opinions are vital to the creation of effective policies.[124] Those who will be affected by policies and laws, including non-state actors and marginalized groups in communities, must participate in the creation of those laws and rules.[125] Researchers have noted flawed outcomes when legislators fail to reach out to members of affected groups to receive their input.[126] Rational, defensible decisions are more likely to result when a broad group of citizens who will be affected by policies weighs in on facts, ideas, and issues that might otherwise not be considered.[127]

A. THE VICTIM VOICES DATASET STUDY'S ORIGIN, METHOD, AND EMPIRICAL FOUNDATION

Here, the data and views contained in the Dataset were drawn from the "Hotline Study,"[128] a larger quantitative study administered to people who called the National Domestic Violence Hotline ("the Hotline") over a six-week period between December 2012 and January 2013.[129] The Hotline[130] is a nonprofit organization providing crisis intervention and information to victims of domestic violence, perpetrators, friends, and families.[131] Trained victim advocates answer calls to the Hotline.[132] Only callers who were at least eighteen years old, self-identified as victims of domestic violence, and spoke English or Spanish

122. Transparency and Open Government: Memorandum for the Heads of Executive Departments and Agencies, 74 Fed. Reg. 4685 (Jan. 26, 2009).

123. Lisa B. Bingham, *The Next Generation of Administrative Law: Building the Legal Infrastructure for Collaborative Governance*, 2010 WIS. L. REV. 297, 316 (2010).

124. Dragan Golubovic, *An Enabling Framework for Citizen Participation in Public Policy: An Outline of Some of the Major Issues Involved*, 12 INT'L J. NOT-FOR-PROFIT L. 38, 38-39 (2010).

125. UNITED NATIONS ENV'T PROGRAMME, INTEGRATED POLICYMAKING FOR SUSTAINABLE DEVELOPMENT: A REFERENCE MANUAL, 28 (2009), *available at* http://www.unep.ch/etb/publications/IPSD%20manual/UNEP%20IPSD%20final.pdf.

126. Karen Syma Czapanskiy & Rashida Manjoo, *The Right of Public Participation in the Law-Making Process and the Role of Legislature in the Promotion of This Right*, 19 DUKE J. COMP. & INT'L L. 1, 29-33 (2008) (noting that rule-making authorities in one U.S. county reached a conclusion that failed to improve the economic situation of low-income mothers without ever hearing from such women).

127. Stephen M. Johnson, *Good Guidance, Good Grief!*, 72 MO. L. REV. 695, 734-35 (2007).

128. For a description of the larger Hotline Study, see *The National Hotline Healthcare Provider Screening Questions Survey*, INST. FOR FAM. VIOLENCE STUDIES, http://familyvio.csw.fsu.edu/wp-content/uploads/2013/08/VOV-NatlHotlineSurveyQuestions.pdf (last visited Sept. 24, 2013) [hereinafter *Survey*].

129. *About Us*, NAT'L DOMESTIC VIOLENCE HOTLINE, http://www.thehotline.org/about-support/ (last viewed Aug. 18, 2013).

130. *Id.* (explaining that the Hotline was created in 1996 as a component of the Violence Against Women Act passed by Congress).

131. *Id.*

132. *Support the Hotline: Volunteering*, NAT'L DOMESTIC VIOLENCE HOTLINE, http://www.thehotline.org/support-the-national-domestic-violence-hotline/volunteering/ (last visited Aug. 27, 2013).

were invited to answer the survey.[133] After the call was completed—and the advocate provided services such as appropriate referrals, answers to questions, and safety plans—advocates asked callers if they would like to participate in a brief, anonymous survey seeking to collect a snapshot of healthcare professionals' screening behavior in regard to domestic violence.[134] The survey asked if callers had been to see a medical professional in the last twelve months.[135] Additionally, advocates offered participants an opportunity to provide comments and other statements on their experiences with healthcare professionals with regard to domestic violence screening.[136] This study explores the 207 callers' statements made in the unstructured open-ended comment section of the survey.[137]

Legislators weighing the Dataset's value in drafting standards for physician screening should take note that the analysis employed a traditional methodology for analyzing qualitative data, including organizing the data into categories and themes to ensure consistency and to minimize bias, and were assisted by computer software designed to organize such data.[138]

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133. Callers under eighteen years old or who were calling for a friend or family member and were not themselves victims were not eligible to answer the survey. Human subjects review and approval was provided by the Institutional Research Board at Florida State University. Before each survey was administered by hotline advocates, verbal consent was obtained from the caller, and the terms of anonymity and confidentiality were explained to each participant. *Survey*, *supra* note 128, at 3-4, 14.

134. *Survey*, *supra* note 128.

135. *Id.* at 9.

136. *Voices of Victims: Dataset*, *supra* note 1, at 1-23.

137. Hotline advocates were trained in three sessions by the researchers and recorded the answers. The training hours for the hotline advocates were funded through the Verizon Foundation. The Verizon Foundation did not fund the research project, only the training hours for Hotline advocates. The views and conclusions expressed in this article are not reflective of those of the Verizon Foundation. The study received approval from the Human Subjects Committee at Florida State University. Advocates asked Hotline callers' questions about whether they had been screened for domestic violence by medical professionals and whether a partner or former partner had prevented them from seeking healthcare. The responses by the participants were given in an open-ended, unprompted format.

138. *See* Gery W. Ryan & H. Russell Bernard, *Techniques to Identify Themes in Qualitative Data*, http://www.analytictech.com/mb870/readings/ryan-bernard_techniques_to_identify_themes_in.htm (describing theme identification in qualitative analysis and mentioning different types of computer assisted qualitative data analysis). Researchers who analyzed this set of data first extracted a total of 275 caller statements from the Hotline Study to form the dataset. Researchers read each response. 68 were eliminated from the data set due to irrelevancy to the study; the 68 eliminated items did not relate to screening or physician/medical professional interactions. Thus, 207 statements remained for analysis. Any discrepancies about the relevance of statements were discussed and resolved by the researchers, who used standard qualitative analysis to explore the dataset. Frequencies and means were calculated using Microsoft Excel. For a discussion of qualitative research methods, see Mita K. Giacomini & Deborah J. Cook, *Users' Guides to the Medical Literature XXIII. Qualitative Research in Health Care A. Are the Results of the Study Valid?*, 284 J. AM. MED. ASS'N 357, 357 (2000); Nicholas Mays & Catherine Pope, *Qualitative Research in Health Care: Assessing Quality in Qualitative Research*, 320 BRIT. MED. J. 50, 50 (2000). Researchers then used various methods to interpret and organize the data into categories and themes to ensure consistency and to minimize bias. For example, two researchers and research assistants analyzed the raw data, triangulated coding, and provided checks against the other researchers' analysis. Researchers reviewed the responses and identified multiple codes and keywords relevant to the responses. Researchers and research assistants individually reviewed the statements and identified trends

The responses in the victim statement dataset reflect a reasonable cross-sample with respect to gender, age, race, sexual orientation, and residence.[139] 95.2% of participants were women and 4.8% were men.[140] This number is comparable to the demographics of all hotline callers.[141] A large portion of the participants (36.7%) was between the ages of twenty-five and thirty-five years old.[142] With respect to race as self-identified by respondents, the majority of the participants were white (Anglo/Caucasian): 55.1% identified as white, 23.7% as black/African American, 1.4% as Asian, 13.5% as Hispanic, and 6.3% as other.[143] As to sexual orientation, 89.4% of participants identified as heterosexual, 3.4% as lesbian females, 1% as gay males, and 2.9% as bisexual.[144] The calls in the dataset came from forty-three states and the District of Columbia.[145]

B. PARTICIPANT RESPONSES: A DISCOURAGING REPORT ON PHYSICIAN SCREENING

As the four tables below show in detail, participants who elected to contribute open-ended responses[146] provided insight into their experiences with physicians and other healthcare professionals. Victims' responses can be characterized as falling into two overall categories: participant identification of barriers to effective screening for domestic violence and advice for medical professionals. The barriers identified by participants were created by a variety of forces: victims' own circumstances, their awareness of stigma surrounding victimiza-

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and keywords. The keywords identified by the researchers and research assistants were discussed and were agreed upon. ATLAS.ti qualitative data analysis software was used to organize the individual responses, code the individual responses, group codes into uniform themes, and compare coded responses for developing conclusions. Researchers used ATLAS.ti. Version 7. [Computer software] (2012) Berlin, Scientific Software Development. This software is one of the commonly used tools for computer-assisted qualitative data analysis. Coding proceeded until saturation was reached. Researchers used ATLAS.ti. Version 7. [Computer software] (2012) Berlin, Scientific Software Development. This software is one of the commonly used tools for computer assisted qualitative data analysis. After the individual analysis, researchers reviewed coding, and differences in coding were discussed and a final categorization was chosen.

139. *Voices of Victims: Dataset*, *supra* note 1.

140. *See infra* Table 1.

141. E-mail from Norma Mazzaei, Operations Director, National Domestic Violence Hotline, to Karen Oehme, Director, Florida State University Institute for Family Violence Studies (Sept. 24, 2013) (on file with authors) (containing information that ninety-five percent of callers to the Hotline are women and five percent are men).

142. *See infra* Table 1.

143. *Id.*

144. *Id.* 1.9% identified as something else, 0.5% preferred not to answer, and 1.9% of participants were not asked. *Id.*

145. *Voices of Victims: Dataset, supra* note 1. Only the states of Alaska, Connecticut, Idaho, Iowa, Utah, West Virginia, and Wyoming were not represented among the respondents. *Id.*

146. The Victim Voices Dataset is comprised of unprompted, unstructured, and open-ended statements that victims offered when asked a series of close-ended questions. The significance of these responses should not be limited to the number of responses of a particular issue related to domestic violence screening in the medical setting. Readers should consider that these responses were unprompted by further questions and were provided in an unstructured format. The fact that these responses echo current and past research is of utmost importance when examining the role of the victim in policy making.

Table 1. Demographics of 207 Participants					
Gender	***n***	**Percentage**	**Race and Ethnicity**	***n***	**Percentage**
Male	10	4.8%	Anglo/Caucasian	114	55.1%
Female	197	95.2%	Black/African American	49	23.7%
Transgender	0	0.0%	Hispanic	28	13.5%
Gender Identity	***n***	**Percentage**	Native Am./Alaska Native	3	1.4%
Female	190	91.8%	Multiracial	8	3.9%
Male	10	4.8%	Asian	3	1.4%
Transgender	2	1.0%	Unknown	2	1.0%
Not Asked	5	2.4%	**Sexual Identity**	***n***	**Percentage**
Age	***n***	**Percentage**	Bisexual	6	2.9%
18-24	26	12.6%	Gay Male	2	1.0%
25-35	76	36.7%	Heterosexual/Straight	185	89.4%
36-45	58	28.0%	Lesbian	7	3.4%
46-54	28	13.5%	Not Asked	4	1.9%
55-64	11	5.3%	Prefer Not to Answer	1	0.4%
65 and over	1	0.5%	Something Else	2	1.0%
No Answer	7	3.4%			

tion, behaviors by the abusers as reported by participants, and actions of the medical professionals as perceived by participants. In addition, some participants offered their own advice for successful patient-medical professional interactions. The section below includes summaries of the statements, and selected direct quotations in italics.

1. The Emotional Experience of Victims in Healthcare Settings

A distinctive contribution of the Victim Voices Dataset is the insight afforded into the emotions of victims as they face the stigma of domestic violence in healthcare settings. In particular, participants' statements reflect how they felt being asked if they were experiencing domestic violence. As shown below, some reported feelings of embarrassment and shame about their victimization. A substantial number of participants reported fear or uncertainty simply about being questioned on this topic: they feared retribution by the abuser or were uncertain what the medical professional would do if they acknowledged the violence.[147] In some instances, victims stated that they felt judged by the medical professional in the clinical setting; in others, they felt that their needs were

147. *Voices of Victims: Dataset*, *supra* note 1.

unimportant to the treating clinician.[148] Some suggested that they would have come forward about the abuse if health care professionals had asked them.[149] Several stated that they volunteered information regarding their injuries or domestic violence without being asked.[150] At the same time, only a single victim stated that she did not want to be asked about the source of her injuries.[151]

Table 2. Victim Circumstances, Behaviors, and Attitudes	
Victim expressed fear/uncertainty about being asked about domestic violence (example: retribution by abuser, arrest of abuser, unsure of what medical professionals would do in response to disclosure)	32
Victim expressed embarrassment/shame over being victimized	11
Victim felt unimportant or judged by the medical professional	9
Victim volunteered information about abuse before being asked	8
Victim lied about how injury was obtained	5
Victim stated he/she wished medical professional would have asked about abuse	2
Victim felt comfortable talking to the medical professional	1
Victim did not want to be asked about the source of injuries	1

Comments from participants related to their feelings about screening include:

- "No, I didn't feel comfortable telling them. They sent [the abuser] out of the room. I still didn't say what happened because he was out there and I knew they would ask him about it."[152]
- "I was asked if I felt safe at home at the emergency room. I lied and said yes. I was asked if I was happy at home by my physical therapist. I lied and said yes. I was scared to say no. I didn't know what would happen then."[153]
- "I feel I am judged because I am gay."[154]
- "[P]hysicians can be very patronizing without meaning to be and see DV 'like a movie.'"[155]

148. *Id.*
149. *Id.* at 1, 2, 4, 6, 8.
150. *Id.* at 2, 6, 15-16.
151. *Id.* at 8.
152. *Id.*
153. *Id.* at 10.
154. *Id.* at 5.
155. *Id.* at 10.

2. Abusers' Interference with Victims' Medical Care

Many participants offered insight into their predicament by describing abusers' obstruction of their attempts to seek medical help. Such hindrance took a number of forms: for example, preventing victims from seeking medical care, insisting on being present at medical appointments, and using a position of authority or controlling behavior to disrupt victim-provider interaction.[156] Participants reported that abusers prevented the victims from seeking health care and described abusers' outright refusal to bring the wounded victim to medical care.[157] In one instance, an abusive husband merely gave a wounded victim an ice pack and told her she did not need medical attention.[158] Some participants also reported that abusers exploited victims' financial vulnerability. For example, an abuser might exercise financial control over the victim by forbidding the victim to pay for co-pays, prescriptions, or services, or manipulating insurance arrangements to drop the victim from the plan altogether.[159] In some cases, abusers went so far as to threaten physical harm to the victim for seeking medical attention.[160]

Even when victims were able to find healthcare providers, abusers sometimes undermined the quality of care victims received. Some victims reported that their abusers controlled the medical experience through force of their authority over the victim or by employing certain tactics. For example, participants recounted abusers speaking for the victim, verbally abusing the victim while at the healthcare visit, claiming that they were actually the victim of abuse to deflect attention from the true victim's injuries, and ridiculing the patient for seeking care.[161] One participant stated that the abuser made the injury appear to be the victim's fault when talking with healthcare providers.[162] Another participant's partner falsely reported that the victim was suicidal; she was subsequently held in a psychiatric hospital against her will.[163] One abuser mocked a participant in the presence of medical staff for being on anti-depressants.[164] More subtly, but potently, the very presence of the abuser with the victim in a medical setting often chilled effective victim-physician interaction.[165] Many participants stated that the abuser's presence there compromised their willingness to candidly answer questions regarding domestic violence as well as their ability to fully disclose the extent of their physical and psychological injuries.[166]

156. *Voices of Victims: Dataset*, *supra* note 1.
157. *Id.*
158. *Id.*
159. *See, e.g.*, *id.* at 1, 2, 5, 6, 8, 10, 12, 14-17.
160. *Id.* at 12, 13, 15, 17.
161. *Id.* at 2, 10, 14.
162. *Id.* at 18.
163. *Id.* at 16.
164. *Id.* at 23.
165. *Voices of Victims: Dataset*, *supra* note 1.
166. *Id.*

Table 3. Participant Statements about Abuser Behaviors	
Prevented from seeking care by abuser (includes being kept from routine care and from emergency care)	45
Stated abuser was present at visit	28
Abuser used authority to control the victim's medical visit	4
Abuser used control tactics to affect the victim's medical visit	8

Statements from participants related to abuser behaviors include:

- "I'm disabled and need surgery because of a cervical spine injury. She [the abuser] would keep my phone from me so the doctor could not reach me to schedule my surgery. They ended up discharging me as a patient. She would never let me go to the doctor alone because she is very controlling and jealous."[167]
- "[The abusive partner] never lets me go to the doctor. He says if I work and get my own health insurance, then I can go to the doctor; he refuses to pay my co-pays and for medicine."[168]
- "[He] would say [we] could not afford $3 co-pay for insulin even though he was buying alcohol, drugs, and other things."[169]
- "I had a miscarriage because of the domestic violence. [The abuser] tried to be in the emergency room with me; he didn't want to leave me alone with doctor."[170]
- "My [abusive] husband, who is a doctor, would always make sure he was with me at my doctor appointments and would never leave me alone with any doctor."[171]

3. Physicians' Deficient Screening for Domestic Violence

A recurrent theme among participants who were actually screened was how poorly the screening was performed. The quality of screening evoked a variety of criticisms. For example, several participants complained that the physician allowed someone else to be present at the time the physician asked questions about domestic violence: e.g., the perpetrator of abuse, family or friends of either the victim or perpetrator.[172] Other participants reported that they were not asked

167. *Id.* at 8.
168. *Id.* at 10.
169. *Id.* at 1.
170. *Id.* at 10.
171. *Id.* at 13.
172. *Voices of Victims: Dataset*, *supra* note 1.

specifically about domestic violence, but instead more vaguely whether they felt "safe at home" or a similar variant.[173]

Other statements reflect the inattentiveness or indifference participants felt they encountered from physicians and other medical personnel.[174] Some pointed to severe, frequent beatings whose effects went unnoticed by emergency room doctors.[175] One participant reported that the perpetrator had verbally abused her at the hospital with no reaction from the staff.[176] Yet another caller stated that the staff did not ask her about domestic violence, even though it appeared that the staff could tell she had been abused.[177] In some instances, participants complained that the doctor appeared to miss obvious physical or non-physical signs of abuse and either did not screen for abuse or dismissed the behavior.[178] Among these overlooked symptoms were bruising, broken bones, sexual assault wounds, bite marks, and marks from attempted strangulation.[179] As one sign of physicians' lack of concern for their plight, a few participants stated that another (unrelated) patient present in the clinical setting needed to raise the issue of domestic violence with a healthcare professional in order for the victim to receive assistance.[180]

Even where physician screening occurred and elicited participants' disclosure

Table 4. Medical Professional Behaviors	
Medical professional asked about abuse	57
Medical professional did not ask about abuse	43
Medical professional lacked education on domestic violence	21
Medical professional did not follow up after asking about abuse/abuse was disclosed	18
Medical professional missed what patient felt were obvious signs of abuse	17
Medical professional asked about domestic violence when someone else (abuser/family/friends) was in the room	14
Medical professional asked if victim felt "safe at home" without further defining the question	11
Only a written medical form asked about patient's domestic violence	6

173. *Id.*
174. *Id.* at 2, 7, 9-10.
175. *Id.* at 9, 17.
176. *Id.* at 4.
177. *Id.* at 11.
178. *Id.* at 4, 14, 17.
179. *Id.* at 9, 15.
180. *Id.* at 13.

of domestic violence, victims could not be assured of a meaningful response. A number of participants complained that physicians did not provide follow-up after they disclosed abuse after being screened.[181] In one case, notation of the participant's affirmative response to questions about abuse was the only action taken, as was a prescription for anti-depressants in another case.[182] One participant said it would have helped her a great deal "if [someone] had asked" about the abuse.[183]

Statements from participants related to medical professional behaviors include:

- "He [the abuser] threw me down the stairs, so we went to the ER. He said to tell them I fell on the coffee table. The doctors and nurses kept asking me[,] "[A]re you sure?[,]" when I told them that. They knew that didn't happen. I kept telling them I was sure because he was there."[184]
- "I am seven months pregnant and he's assaulting me. My doctor has never asked me about domestic violence. My husband never leaves me alone during my doctor visits—[he] is always by my side."[185]
- "My husband . . . would always make sure he was with me at my doctor appointments and would never leave me alone with any doctor. When they would ask at the gynecologist's office "do you feel safe at home," they would just ask in passing, looking down at their paper."[186]
- "I have never been asked by a healthcare [professional] about DV . . . . When I have gone to the hospital because of a DV-related injury I had to beg the hospital to put me somewhere where [the perpetrator] could not find me, because he disregards law [enforcement]"[187]
- "[The doctor] minimized domestic violence and referred to it as stress."[188]
- "The doctors didn't believe me, they believed my husband."[189]
- "The ob-gyn's response was "All relationships are horrible."[190]

181. *Id.* at 4.
182. *Id.* at 5.
183. *Id.* at 16.
184. *Id.* at 18.
185. *Id.* at 1.
186. *Id.* at 13.
187. *Id.* at 3.
188. *Id.*
189. *Id.* at 10.
190. *Id.* at 14.

- "[The doctor was] just rushing through the form. [I] also felt it would have been helpful for him to define domestic violence."[191]
- "[The victim] volunteered information about the DV to her doctor and he told her to reconcile [with her abuser]. The abuser called numerous times in front of the doctor and the doctor said to answer [the] phone and reconcile."[192]

4. Victims' Advice on Improving Physician Screening

As described in Table Three, some participants used the opportunity to comment on domestic violence screening to provide recommendations for healthcare professionals. Though the number of responses in this vein was relatively small, they implicitly reflect the same dissatisfaction with physician screening directly expressed elsewhere. The two leading suggestions reflect unhappiness with physician failure even to ask about domestic violence and with physician understanding of domestic violence.[193] Research has indicated that using clear, plain language and asking directly about domestic violence increases the rate of identification of abused women.[194] Studies of victims have concluded that physicians should use direct language[195] and that victims would be more likely to respond honestly to direct questions.[196] The Victim Dataset reveals that patients prefer to be asked about domestic violence in a clear, direct manner.

Despite the gloomy picture painted by the data and comments above, not all participants reported unsatisfying responses from physicians. A few participants provided responses indicating that medical professionals asked about domestic violence and acted to increase their safety.[197] One participant stated that once she was separated from the abuser, a protective order was filed and the abuser was banned from the hospital.[198] Another said that while she had to "beg" the hospital staff, she was ultimately placed in a room away from the perpetrator to increase safety.[199] In three instances, medical professionals gave participants information on the National Domestic Violence Hotline.[200] Another participant reported that she was happy her doctor asked about domestic violence in response to her

191. *Id.* at 15.
192. *Id.* at 11.
193. *Voices of Victims: Dataset*, *supra* note 1.
194. Susan V. McLeer & Rebecca Anwar, *A Study of Battered Women Presenting in an Emergency Department*, 79 AM. J. PUB. HEALTH 65, 66 (1989); Laurie J. Morrison et al., *Improving the Emergency Department Detection Rate of Domestic Violence Using Direct Questioning*, 19 J. EMERGENCY MED. 117, 121 (2000); Michael A. Rodriguez et al., *The Factors Associated with Disclosure of Intimate Partner Abuse to Clinicians*, 50 J. FAM. PRAC. 338, 342 (2001).
195. Bacchus et al., *supra* note 77, at 14; Hathaway et al., *supra* note 71, at 714; Rodriguez et al., *supra* note 77, at 156.
196. Bacchus et al., *supra* note 77, at 14.
197. *Voices of Victims: Dataset*, *supra* note 1.
198. *Id.* at 12.
199. *Id.* at 3.
200. *Id.* at 1, 15, 18.

Table 5. Participant Recommendations to Medical Professionals about Screening for Domestic Violence	
Ask patients about domestic violence	6
Get more training and education on domestic violence	6
Ask patients about domestic violence in private—without others around	4
Ask in a clear manner. Explain clearly what domestic violence is	3
Explain what illnesses can be caused by domestic violence	1
Avoid asking vague questions that are confusing	3
Ask about sexual identity—it may be important	1

abnormally high blood pressure.[201] One participant stated that nurses created a safe environment for her to talk about the otherwise uncomfortable topic of domestic violence.[202] While the relatively low number of responses describing helpful physician behavior obviously leaves vast room for improvement, these positive experiences demonstrate the potential benefit of medical assistance to victims of domestic violence when the will—and the understanding—exist.

CONCLUSION

Recognition of the vital role of voices of domestic violence victims is part of a larger current in evolving attitudes toward victims of crime. Despite those gains and the fact that physicians have had access to crucial information about domestic violence and screening for nearly two decades, the blight of domestic violence continues to go undetected in thousands of emergency rooms and doctors' offices. The authors of this study do not presume to explain why so many medical professionals still allow domestic abuse to go undetected on their watch. Healthcare professionals no doubt want to help victims of violence. However, the evidence cited here leaves no room for doubt that many physicians still allow untold myriad victims to slip out of their care without offering them access to help. The accounts of victims gathered in the Victim Voices Dataset demonstrate the fundamental need for mandatory training of physicians on domestic violence and domestic violence screening. Such training will enable doctors to sensitively and safely identify victims and to help them learn about community resources and assistance. Within the criminal justice system, commentators have argued that a truly effective response must allow for victim participation because victim voices are important in assessing the safety

201. *Id.* at 14.
202. *Id.* at 13.

implications of a criminal case or civil order for protection.[203] Just as victims' voices are important in criminal justice, so too are they a critical component of domestic violence treatment by healthcare professionals.

If physicians fail to recognize the voices of victims, they will be unable to provide proper safeguards against future violence. This would be tragic—in no small part because it is entirely avoidable. Mandatory domestic violence training for physicians, as the last two decades have illustrated, is the single best next step toward remedying the silent pain of victims. Only with this training will the American healthcare system be truly equipped to confront the horrific, persistent menace of domestic violence.

203. Laurie S. Kohn, *The Justice System and Domestic Violence: Engaging the Case but Divorcing the Victim*, 32 N.Y.U. REV. L. & SOC. CHANGE 191, 244-45 (2008) (though this article argues for victim inclusion in decisions made by the justice system, the argument remains valid for the medical system).