[Text on screen] The following program was recorded on August 11, 1993
Adapted from statements by battered women
[Female 1] I didn't tell my doctor about the hitting. He didn't ask me about the bruises. I guess he was kind of embarrassed.
[Female 2] My husband beat me for three years. Then one day I saw this flier that said if you suffer from violence, call this number, so I did.
[Female 3] I really hoped that, well, maybe a busy doctor could take the time to refer us to someone who could help.
[music]
[Text on screen] Medicine in the Nineties: Domestic Violence
[Dr. Wolfe] Battery is the single most significant cause of injury to women in this country according to C. Everett Koop. Today, Medicine in the Nineties examines domestic violence. Clinicians will understand its epidemiology, learn how to identify women who have been victims, and be able to implement timely, effective interventions that protect the patient, and are legally correct.
[Text on screen] Elliott Wolfe, MD Director, Staff Education Northern California Region
I'm Elliott Wolfe, Director of Regional Staff Education broadcasting live from Kaiser Permanente's Regional Offices in Oakland, California. Our own Gilroy Facility has now joined the network. Welcome. Dr. Charles Wibbelsman begins with an update.
[Dr. Wibbelsman] Thanks, Elliott, and welcome to this month's edition of "Update."
[Text on screen] Domestic Violence Domestic violence episodes are increasing at alarming rates in California and across the country. Estimates indicate that between two and four million women are battered each year. According to a recent
[Text on screen] 14 percent of American women are battered
national poll, 14 percent of American women admitted to having been violently abused by a husband or a partner. Statistics also show [Slide saying violence occurs in two thirds of all marriages]
that violence will occur at least once in two-thirds of all marriages.
With domestic violence on the rise, [slide saying State Bill #1652] California State Representative Jackie Speier has introduced Assembly Bill 1652 into the State Legislature aimed at establishing specific reporting requirements for domestic violence.
The purpose of this legislation will be to provide physicians with guidelines for good charting, clarify police reporting requirements, and establish immunity provisions for physicians.
Almost 35 percent of women that seek care in emergency departments are suffering from injuries or symptoms caused by ongoing abuse. Only one in 35 battered women is correctly diagnosed by medical personnel. And even if diagnosed, women may not receive information about or referral for protection from future battering.
[images of physicians working in a hospital]
Domestic violence confronts physicians with many medical and legal dilemmas; who to report, when to report, issues of confidentiality, and other complex situations. To help answer some of these legal concerns here's Dr. Louise Chiu, Director of our Regional Medical Legal Department.
[Text on screen] Louise Chiu, MD Director, Northern California Regional Medical Legal Department

[Dr. Chiu] If a woman does not want abuse reported, and let's assume that the patient has sustained injuries which require reporting, the physician really has no alternative but to report. He or she is under a legal obligation under the penal code to report this.
What I suggest to the physicians under these circumstances is to explain to the patient that the reporting is required by law, and that if he does not, he stands the risk of severe penalties. Also, at this time he really should explain to the patient the purpose of the law, and how the law will assist her in her best interest.

The patient probably should be advised also of the availability of domestic violence counseling that is available, and possibly referral for her protection.
Even if a physician is told in confidence by the woman that she does not want the abuse reported, the law really requires that the physician breach that confidence and report. The California Penal Code is mandatory as far as reporting these particular injuries as they are witnessed by the physician, and there is no other alternative to the reporting.

If the physician does not report as he's required and the woman subsequently returns to the violent environment and is injured again, or perhaps more severely, the physician may have two sources of liability. The first would be a criminal liability from the standpoint that he did not file the report, as required. This is a misdemeanor, and is punishable by a fine up to $500, and imprisonment -- possible imprisonment up to six months in the county jail.

The other liability is one of a civil liability. Assuming that the patient is injured again as a result of returning to the violent environment, she may subsequently file a civil suit against the physician for injuries sustained on the recurrent injury. The law is quite clear in this particular issue. It has been clarified in the child abuse reporting laws that where a child was not reported and subsequently was injured, the child brought a suit against the physician, and it was held that there was a cause of action for the child's injuries. So, this is an analogous situation, and the physician does run the risk of civil liability for subsequent injury to the domestic violence victim.
[Dr. Wibbelsman] And in a final note, the Joint Commission on Accreditation of Health Care Organizations is now requiring that emergency departments create written policies to help guide staff in the identification and referral of battered adults.
That's it for this edition of "Update." I'm Chuck Wibbelsman.
[three people sitting around a table]
[Dr. Wolfe] Thanks, Chuck. Joining me today are
[Text on screen] Debbie Lee, Associate Director Family Violence Prevention Fund
Ms. Debbie Lee, Associate Director of the Family Violence Prevention Fund in San Francisco, and
[Text on screen] Patricia Salber, MD Department of Emergency Medicine South San Francisco Medical Center
Dr. Patricia Salber, Department of Emergency Medicine at Kaiser Permanente Medical Center in South San Francisco, and Assistant Clinical Professor of Medicine at the University of California at San Francisco.
Viewers may call in questions at any time during the broadcast. The phone number is 8-427-2600 or 510-987-2600.
Pat, what are the clinical presentations of patients that you see in the emergency department who may be victims of domestic violence?
[Dr. Sabler] Well, Elliott, I think the most important thing is to stress that these patients can present in a variety of ways; that they may present with injuries, or they may present with other

medical complaints such as depression, suicide attempts, hyperventilation, anxiety, so there are a variety of clinical presentations.
[Text on screen] Patricia Salber, MD Department of Emergency Medicine South San Francisco Medical Center
To me, one of the most important clinical clues is the patient's demeanor; that is, a patient who comes in with a chief complaint for which she seems inappropriately unconcerned, or for which she seems overly emotional. For example, a woman who says she injured her ankle tripping down the stairs, and yet is crying and is inconsolable.
Another clue that I think is very important -- if the patient is accompanied by her companion, the companion's demeanor, as well, can be a very important clue to the presence of domestic violence. An example of this, which we see in the emergency department fairly frequently, is a woman who comes in with a minor injury, let's say a laceration to her face, and you say, "Mrs. Smith, what happened to you?" And the husband is at the foot of the bed and he says, "Oh, she fell." And you say, "Well, Mrs. Smith, were you knocked unconscious?" And he says, "No, she wasn't." And you really never can get her to communicate directly with you because he's answering for her. And that's another very important clue.
[Dr. Wolfe] Debbie, the patients who you have counseled, what do you think is the barrier that you see that they have between them and their physician and trying to communicate this issue of battering?
[Text on screen] Debbie Lee Associate Director Family Violence Prevention Fund
[Ms. Lee] Well, I think oftentimes women are going to be reluctant about talking about the problem of domestic violence because they're ashamed, because they're fearful of retribution because their husband has said if you tell anybody about this, you know, I'll kill you. So, I think the most difficult thing is just never having had ever talked about it. And the important thing here is --- I think one of the most key things that a physician or other medical personnel can know is to ask the question, because what they found in studies is that if people ask the question directly and non-judgmentally, that women do answer the question.
I think the medical professions play a very unique role, because I think whenever a physician approaches a patient, the patient believes there are medical reasons as to why the question is being asked. So, I think it also is a very opportune time, because I think a lot of women who have not turned to anywhere else are seeking medical help, so they -- medical professionals can play a very key role in early intervention, in bringing the subject up, and for oftentimes --- oftentimes it may be the first time the woman has ever talked about the situation.
[Dr. Wolfe] Pat, any other ideas for our physicians about clues to indicate the presence of domestic violence?
[Dr. Sabler] Sure. There are some specific clues from the history. One important clue is a patient who gives you a history, for example, about their injury that seems inconsistent.
I recently had a woman who came in and told me that she had fallen off a bar stool, and yet the only injury that I saw was a black eye looking very much like somebody punched her in the eye, so that is a clue.
Other clues that we see are a delay in presentation, so somebody will come in at 3:00 in the morning complaining of an injury and you look at the bruises and they look two or three days old. That's another thing that should prompt you to ask specifically if this was an injury due to battering.

[Ms. Lee] I think another thing to bring out is that domestic violence occurs in very high rates amongst pregnant women. In fact, they estimate that about 25 percent of women who are abused in fact are pregnant, so it's another indicator where --- in fact, I think it's very important, as Pat says, that there are many indicators, but in around --- in primary care situations, obstetrics/gynecology, it actually is a good idea for it --- the question of domestic violence to be part of taking history. Given the epidemic proportions, as Dr. Wibbelsman pointed out, of the problem we really should be asking these kinds of questions to all patients that come into the medical setting.
[Dr. Wolfe] So, Pat, let's go beyond the emergency department. Let's take urgent illness or primary care practice. How should physicians ask that question? I mean, how should it become part of the routine medical history?
[Dr. Sabler] That's a good question, Elliott, and it's a question as I speak to groups about domestic violence that I'm frequently asked. And I think there are analogies to what happened when the AIDS epidemic started and we initially had to ask questions that we felt a little bit awkward about, asking about somebody's sexual practices.
I believe that there's a number of ways that you can ask and gain confidence and express a sympathetic interested manner. One example that I've used when I see an injury is to say, "You know, many times when I see an injury like that it's because it's been caused by somebody hitting you. Is that what happened to you?" So, that's one way that you can ask the question.
And I think it takes practice. I think as you make a point of including this in your routine history, it will become easier and easier to ask it, and the less awkward and embarrassed we are when we ask the question, the more natural it will seem to the patient that the question should have been asked.
[Dr. Wolfe] So, of course, we need to teach medical students and residents about how to ask the question.
You know, this might be a good time to look at a physician in an urgent illness situation who is seeing a patient who is complaining of abdominal pain.
[Woman sitting on bed in clinic]
[Dr. Wolfe] Hello, Mrs. Turner. I'm Dr. Elliott Wolfe.
[Ms. Turner] Hi.
[Dr. Wolfe] Good to meet you today. My nurse tells me that you've been having abdominal pain. Why don't you tell me about it?
[Ms. Turner] Well, the pain --- my stomach has really been bothering me a lot, and the pain just seems to come and go, doesn't happen at any special time or anything like that. But I really feel uncomfortable with the pain.
[Dr. Wolfe] Now, I know you've had several visits here. You've seen several of my colleagues.
[Ms. Turner] Yeah. Yeah, I know. And the doctors can't seem to find out what's causing my pain; although they have done a lot of tests.
[Dr. Wolfe] Well, why don't I have you get undressed, put on the examination gown. Then I'll come back. You'll show me where the pain is, and I'll try to find out what might be causing it.
[Ms. Turner] Okay.
[Dr. Wolfe] Mrs. Turner, why don't you sit up now? My examination was totally normal, couldn't find anything wrong. You know the tests we did, they were also quite normal. But when I examined you, I did notice the bruises on your forearms. Can you tell me what happened?
[Ms. Turner] Oh, they're nothing. I do that to myself all the time. I just, I just hit my arm against the dresser. Doctor, what's causing my abdominal pain?

[Dr. Wolfe] Mrs. Turner, when I see these bruises, I'm concerned about defensive injuries. I'm concerned that someone may have been hitting you. Can you tell me if that has ever happened to you?
[Ms. Turner] Yes. He only hits me when he's been drinking. Last night he had a couple of beers and he was tired, and I pushed him, bugged him to help me with the kids. I shouldn't have done that. You know, he really is a good man, and a good father.
[Dr. Wolfe] But Mrs. Turner, many women believe they've done something to cause the beating. In fact, there is no reason ever for a beating, ever.
Tell me about the children; how old are they?
[Ms. Turner] I have a little boy, he's six, and my girl is three.
[Dr. Wolfe] Does your husband ever hit the children?
[Ms. Turner] Oh, no, never. He would never do that.
[Dr. Wolfe] Do you feel safe going home?
[Mrs. Turner nods yes]
Do you have a friend you could turn to --
[Mrs. Turner shakes no]
-- or a family member --
[Mrs. Turner shakes no]
-- or a place where you could go to feel safe?
[Ms. Turner] He's okay now. He just blows up and then he hits me, and then he cools off. He's really sorry now. I feel safe about going home today. And I can't talk to my mother or my friends about this. I'd be too embarrassed. They wouldn't understand.
[Dr. Wolfe] Mrs. Turner, I want you to know that you are not alone. There are many women in the same situation that you find yourself in. In order to help you, I'm going to give you a list of agencies, people who you could call who know about family violence. At any time, they can give you help. Also, I'm going to give you a list of shelters, places where you could take the children at any hour of the day or night and feel safe.
[Ms. Turner] Thank you, doctor. It makes me feel better to know that I can talk to somebody about this.
[three people sitting around a table]
[Text on screen] Comments & Questions 8-427-3600]
[Dr. Wolfe] Debbie, please give me your views of this encounter.
[Ms. Lee] Well, Dr. Wolfe, I think you did a wonderful job, actually, in really assuring her and bringing her out. I noticed that at first she was very ambivalent --
[Text on screen] Comments & Questions (510) 987-2600]
but it really is her reluctance to talk about it because, again, about embarrassment, because other friends and family members may get --- know about it.
I noticed also she blamed herself, and you sort of assured her that no matter what she did, it wasn't her fault
[Text on screen] Debbie Lee Associate Director Family Violence Prevention Fund
And I think that those are very simple messages, but very important ones, again, particularly coming from a physician, because I think so many times the messages to women subtly by friends and family members is like "oh, I can't believe he's that bad." Because a lot of these men are --- I mean, they're just the guy next door. It's --- generally, they're not people who have serious mental health problems, et cetera. They have a problem with violence, and believe in our

society that somehow it's okay to beat your wife. So anyway, all of that encouragement is really key, I think.
I think, also, what you did there was while she said no, I didn't --- don't want to seek any help at this time, you still went forward and said, "Well, I'm very concerned about you, and I'd like you --- I'd like to give you some more resources." And I think that that's very helpful.
In counseling women in a hospital for many years, what I found is that oftentimes women said no, I don't want to do anything right now. And I think it's very important at that point to just say well, in the future if at some time you want to pursue some kind of alternatives, here's some information which you can call in the future; again, not blaming her for not taking action now, but sort of setting her sights to the future at some point when she wants to make those changes.
[Dr. Wolfe] Of course, that was the purpose of our handout for today. We'll come back to this but, of course, these are referral sites at every one of our counties and places where we have office buildings and medical centers.
What have the studies shown about the psychological profile of women who are battered? Is there --- are there any unique features, or anything about their psychology?
[Ms. Lee] No -- there have been some studies which have looked at whether women who are battered come from battering --- come from families where either their parents --- there had been battering amongst their parents, or between the parents, or they themselves as children have been battered. And pretty much the studies indicate that women come from both sides where there has been no violence in their family previously.
As far as a real personality profile, there really isn't. Women come from all classes, all races. I think even at times you'll see women who come from certain communities, either African American, or Latino who will say well, it's part of my culture. But when you really look at the numbers of women who are battered, it's part of everybody's culture. So that's another thing to really dispel.
And even when women talk about that, I think it's important to say well, it shouldn't be --- it's not acceptable. It shouldn't be acceptable no matter what culture you come from.
[Dr. Wolfe] We are beginning to get phone calls. Why don't we stop here for a moment, take our first phone call from Santa Clara. Go ahead.
[Text on screen] Live by Phone: Santa Clara
[Caller] Hi. There was no mention in the presentation regarding the reporting issues in the presentation that was given earlier.
[Dr. Wolfe] We will be coming to reporting issues later in the broadcast, if that's all right. I think we should hold that off for a moment.
Are there any further questions from Santa Clara?
[Caller] No, thanks.
[Dr. Wolfe] Yeah, we will come to that.
Pat, I want to now talk about the physical examination of the patient. This particular physician found clues. What are other clues, and how could the physician document these findings?
[Dr. Sabler] Right. What we commonly describe --- the most common injuries that women who are battered experienced are injuries which are in a central pattern. And what I mean by that is, it's about the head, about the chest, and about the abdomen. The problem is that that's not very specific.
You pointed out very clearly in the clinical scenario that any injury that looks like a defensive injury is another tipoff that could be due to battering.

We also believe, as Debbie mentioned earlier, because battering is so common in pregnancy, any injury that occurs during pregnancy should prompt a physician to ask directly whether there's been any violence in the home.
[Text on screen] Patricia Salber, MD Department of Emergency Medicine South San Francisco Medical Center
I think it's also very important -- in our busy clinical practices sometimes we see patients who are completely dressed, maybe sitting with sunglasses on, or some other way of concealing old injuries. I think it is important for us to try and get as much of a complete physical exam as possible, even in the constraints of a busy clinic, or urgent care, or emergency department.
[Ms. Lee] I'd like just to add to that. The District Attorney in San Francisco, I once asked her what would be most helpful when she gets reports from physicians. And the one thing that she really said was to write clearly, because I think a lot of physicians may be fearful as these cases increasingly are noticed in their own practices that they're going to be called to court.
And the thing with a lot of prosecutors offices now is that they have physicians employed by their offices, so when it comes to a medical interpretation of what is actually written content-wise in the report, they will call in their own. But the times when they do need to call in a physician is to --- when they can't read the report. So, that's one of the most important things. And additionally, of course, is to write very, very explicitly about those injuries. If the hospital has a body map, that's going to be extremely useful. And also, coloration of injuries is real key. I once had a women who came in who had injuries that were purple which indicated, of course, that she had been battered recently. But, also, the physician had noted that she also had injuries of other colors throughout her body, and that was very helpful in the corroboration of her story that she was beaten several weeks prior, and she was able to get a restraining order. And also eventually get custody of her child because of that evidence that was so clearly written in the record.
[Dr. Wolfe] Is there a role for photography?
[Dr. Sabler] Absolutely there is a role. In Kaiser South San Francisco we keep a Polaroid in the department. You do need to get permission from the patient to take photographs, but it's been my experience that most of these patients are very interested in having their injuries documented, so I do try and take Polaroid. But you do, as Debbie says, also need the body map, because it's not infrequent that the injuries will be in an area where they don't show up very well. It's common to have women who are kicked, or punched, or beaten about the scalp where you really won't have anything to show, so you can draw. And you don't actually need a preprinted body map, you can just draw a little sketch right on the chart and say these are the areas that are tender that correlate with her story.
I also want to add something that Debbie was saying about the chart. When you get a patient who won't necessarily tell you everything that happened, but you still suspect that battery was at the root of this woman's injuries. As was the case for me in the woman that fell off the bar stool, what I put in the chart was that this woman told me she had fallen off the bar stool, but that her injuries were more consistent with a direct blow to the eye.
Should she down the line decide that she would like to pursue a restraining order or some other legal action, that kind of documentation, even though she didn't tell you that she was battered, can support her case.
[Ms. Lee] You know, I think that oftentimes for physicians, ones that I've spoken to, that oftentimes they feel very frustrated because there is clearly an interest in not seeing this woman come back again, seeing her get out of the situation. And in these cases, it is different, that the

goal here really is to try and give that woman support and information so that she will make the moves, and make the changes, and seek the alternatives that she does need to do to get out of the situation, which is different than child abuse, and in elder abuse where clearly the role of the physician is legislated and it's required that, you know, we intervene in certain different ways. But in this situation, I think it's just this whole area of encouraging the woman, understanding that it takes several times before a woman finally leaves. Because, of course, what we're asking her to do, and what we're hoping that she will do, is to at least leave for part of the time. And that means changing her whole life. And in this day and age, to change her whole life when she has kids, financially, that's a very difficult thing to be doing.
[Dr. Wolfe] Yeah. I want to explore a little bit for our colleagues, since we have physicians of many specialties watching the broadcast, that this goes beyond primary care, you know.
[Text on screen] Elliott Wolfe, MD Director, Staff Education Northern California Region
You've mentioned pregnancy, so obstetricians and gynecologists are obviously very, very sensitive. There's a problem of sexual abuse, as well, so I'm sure that that particular specialty is sensitive.
What clues can you give to our colleagues about other specialties?
[Ms. Lee] Well, maybe you want to speak about surgical?
[Dr. Sabler] Sure. This is actually an area of interest for both Debbie and I through the research that we're doing with the Family Violence Prevention Fund, and we have been
[Text on screen] Patricia Salber, MD Department of Emergency Medicine South San Francisco Medical Center]
working on developing protocols specifically oriented to the emergency physician. But the next step in this project will be to address other specialties to help them heighten their awareness. For example, a woman may present to ophthalmology clinic with a retinal detachment, and unless asked directly, the ophthalmologist may not ascertain that the reason why she has a retinal detachment is because she was hit in the head.
Ear, nose and throat may see women with facial fractures or broken noses. Orthopedic clinic may see fractures, so what we're hoping to do eventually working in collaboration with the specialty organizations are to develop lists of clues oriented specifically to the surgical sub-specialties, to pediatrics, adolescent medicine in particular, and as well as OB/GYN and the primary care specialties.
We believe that women are presenting to many different physicians with injuries and illnesses that are related to or due to battering, and that we're missing them because we don't have a heightened index of suspicion.
[Ms. Lee] Sometimes I think for physicians in some of these sub-specialties the fear may be greater about opening the flood gates of oh, my goodness, I don't want to bring this issue up. These women are just going to take all my time, and I don't have that kind of time.
And what Pat and I have really talked about is that it's very --- it can be done in a fairly short period of time. And you can bring it up, and also set limits with her. For example, to ask the question as directly as possible if she's been battered, or if she's been hit by somebody that causes these injuries. And then just to find out shortly from her what's been going on. But then fairly quickly to move on, I just want to let you know that I'm very concerned about this because we do see so many women. And then move into encouraging words and giving some referrals and information, either within the Kaiser hospitals, or outside to agencies.
But it can be done fairly quickly, because another thing is that we have worked with another physician who's been doing some interviews with patients who have been battered, who have

come to the emergency department, or the hospital system. And it's very interesting because he's really revealed that many patients really do understand that the reasons why --- one of the quotes was the reason why she felt that her physician didn't ask was that he was embarrassed. But they also --- one of the direct quotes was about the fact that, "I know they don't have much time, but even if they had brought the issue up shortly, it would have encouraged me to pursue assistance earlier."
So, I think physician --- I mean, patients are quite aware of the limited time, and physicians will just need to set those limitations.
[Dr. Wolfe] So ---
[Dr. Sabler] Right. I would like to just pursue that a little bit, because in speaking at a number of the Kaiser facilities, it becomes clear to me that people have trouble with what the goal is. We talked about this already, but I want to come back to it because, to me, it's the --- it's a major problem, it's a major barrier that we need to overcome in order to deliver the kind of care that we want to deliver, and to do the kind of preventative medicine that we certainly want to do in this problem.
So, I want to reiterate that the goal isn't "I got her to go to the shelter today." I hear that over and over. "She wouldn't go to the shelter so I must have failed. I spent 20 minutes, so I don't want to do it again." The goal is to deliver the message that we care about this problem, that you're not alone, and that there is help available. And the mere act of giving the information, of giving the phone numbers, we've learned from the focus groups, is an incredibly effective therapeutic intervention.
And what we're talking about is a potentially fatal illness. Somewhere between two to four thousand women die each year as a result of injuries due to battering. So, it is extremely important that we recognize that the goal is to give information, and to provide support, and to give referral.
[Dr. Wolfe] So, even with the short time that some of our primary care physicians have with visits, it's actually a doable process.
[Dr. Sabler] Absolutely.
[Dr. Wolfe] Yeah.
[Dr. Sabler] Debbie and I have plans in the future to write what we call "The One-Minute Intervention," and when we get that together we'd like to come back and talk to you about it.
[Dr. Wolfe] Very nice. Now, what about the argument that I --- that we've heard and talked about that this is a social problem. It isn't a problem for physicians. How do you respond to that?
[Ms. Lee] Well, the reality is, is that it's a problem for physicians, it's a problem for medical care centers because ---
[Text on screen] Debbie Lee Associate Director Family Violence Prevention Fund
facilities, because women with injuries who are battered come into the medical setting.
I think the parallel I make, and --- is really about the fact -- for example, I have high cholesterol, and my eating habits and what happens outside in my life affects how I'm going to resolve my cholesterol. And in this situation, while these injuries are caused by something of a social problem, we need to address that fact. Otherwise, she's going to return again, and that's what we know, is that battering is usually of a cyclical nature. It becomes more severe and more frequent over time unless there is intervention, so that you will see her again in your clinics unless there's some kind of action that she is encouraged to take.

[Dr. Sabler] Elliott, I think we also need to talk --- we focused really on women presenting with injuries, but I just wanted to spend a minute and talk about some of the other presentations that women can make that I know in my own practice in the past I look back and wished that I had asked direct questions; one of which is suicide gestures, or suicide attempts.
Now, if these are suicide gestures and attempts that end up in hospitalization, oftentimes the psychologist or psychiatrist will get that history, but there are some minor suicide gestures that on occasion get sent home. And these are the kinds of presentations that we see. "I took two Tetracycline and three Valium, and I did it because I had a fight with my husband."
Oftentimes what I find is that people don't go beyond that. And what I would encourage people to do is can you tell me what kind of fight did you have? Was this a physical fight? And I suspect that you would find more often than not that there was physical abuse in some of these suicide gestures that we see.
Another is repetitive psychosomatic complaints. So, women who come in with chronic pelvic pain, chronic abdominal pain, chronic headaches; and I'd like to give an example of a patient that I saw recently who had chronic headaches. And when I got her chart, because the nurses all said, "Oh, well, she's a regular. We see her all the time," the very first thing that I saw was, "Patient has decided to leave her husband who's been abusing her for many years." So, I went from the back of the chart to the front.
She was 42 years old. She had a chart that was three inches thick. The first two inches were repeated visits to the emergency department, fell -- broke toe, fell -- broke arm, fell -- broke nose, fell -- hurt neck. And then there were notes in the chart when she'd present to clinic, chronic neck pain. There was actually a note that said, "Patient adamantly refuses to believe that her complaints are psychosomatic." Well, in fact, they were not psychosomatic, they were her attempting to seek help for a chronic condition, and the chronic condition was battering.
[Dr. Wolfe] We have another phone call from the region this time. Go ahead, please.
[text saying Live by Phone: Regional Office]
[Dr. Wibbelsman] Hi, Elliott. It's Chuck Wibbelsman. I have a question for Pat. I want to know how you would deal with a situation where a woman would come in, her chief complaint was an injury that she self-inflicted. On further evaluation you find out that she has been battered by her husband, and the husband is sitting out in the waiting room. How are you going to deal with that husband, as far as a physician, and legally?
[Dr. Sabler] Okay, that's a very good question. And with the presentation of a wound that was self-inflicted, obviously,
[Text on screen] Patricia Salber, MD Department of Emergency Medicine South San Francisco Medical Center
you'd first have to determine whether there was a suicide risk, and whether she needed to be hospitalized for that. But let's say she comes in with another minor complaint, minor battery, and he's out there. And the question is what to do for her?
The first thing that you need to do is to find out what she wants. You need to find out whether she believes that it's safe to go home, whether she believes that her children are safe, whether she, in fact, wants to as an adult make the decision to go home with him.
If she decides that she doesn't want to go home with him, there's a number of ways to deal with the suspected or potential batterer who's in the waiting room; one of which is to merely tell him she's going to be there for a while for evaluation. That works very well in the emergency department. We could say come back tomorrow when we get done with the evaluation, or you could actually tell him that she has a problem that needs work-up in the hospital setting. So, you

really can tell a number of stories to encourage him to leave, and allow you to freely arrange a safe setting for her.
Now, there are some complexities to this. We had a woman who came into one of the emergency departments where I work who had a gun held to her head, and the husband had pulled the trigger and it didn't go off. And when I saw her, she had been pummeled from head to toe with his fist because he was so frustrated he wasn't able to shoot her. And he was currently holed up in the home with the children. And what we did in that situation, she wanted to go home to her parents, and when we evaluated her we felt that that would actually be extremely dangerous because we felt that would be the first place that he would go if he was some way able to elude the police who were at the house where he was holed up. And we arranged to have her housed out of the county for her safety.
But I think as physicians we're used to being resourceful, and we're used to being creative, and that there are ways to have the potential batterer believe that it's okay for him to leave, that she's in safe hands.
[Ms. Lee] I think many times what I hear physicians say is that in --- when there's battering, oftentimes the man will join the woman, or push his way in the examination room, et cetera. And I think it's very important at that point is to do everything possible to try and separate because, obviously, she is not going to talk about the battering with him there. And, in fact, it can endanger her because if you talk about it in front of him, he may --- when they go home, he's going to even beat her up further given the fact that she's divulged the information to somebody else. And that's oftentimes a big fear for batterers, that other people know.
[Text on screen] Comments & Questions 8-427-2600 [Dr. Wolfe] Yeah. Are physicians ever caught in the middle of any of these, I mean, in terms of physician injury and concerns in the emergency department?
[Dr. Sabler] Oh, absolutely. That can happen. Most of the time my personal experience and my experience in talking to other people who have identified batterers who are there with the women that they've battered is that you are in a non-violent way able to separate them. You can send her to x-ray and get the history there. You can tell him it's department or clinic rules that only one person is in the room at a time. But we have had occasions where we've had extremely hostile and threatening batterers, and in that case I recommend calling security, up to and including having him forcefully removed. But that's really the exception.
[Ms. Lee] I think another precaution is ---
[Dr. Wolfe] Yes, go ahead.
[Ms. Lee] --- also if a woman is hospitalized, it should be pursued whether she wants to get her name off the computer system so that when somebody calls into the hospital to try and find her, her name will not be there, and then she will, you know, inform those people that she wants to have contact with where she is. But I think it is an important thing. And that all medical staff shouldn't be shy about calling security at any time.
Again, I think, as you said, it's the exception to the rule, because usually violence occurs in the privacy of the home. People don't want to expose that.
[Dr. Wolfe] Chuck, any follow-up?
[Dr. Wibbelsman] The other part of the question I wanted to know is once you've established that
[Text on screen] Live by Phone: Regional Office
the woman has been assaulted by her husband, and the husband is out there in the waiting room, the emergency room, don't you have to call the police?

[Dr. Sabler] Whether the husband is there or not, you do need to call the police. In the State of California, as Louise Chiu said, the penal code is such that all injuries due to criminal assault must be reported. That doesn't apply just to emergency departments, that applies to patients who present in any clinical situation. The report must be both by telephone and in writing. And when you telephone, my experience is in the two counties that I've worked in, that the police will be interested in coming and arresting the patient. But that's variable. It really depends on what county you're in, and in some cases the police are more interested if the injuries are more severe than less severe, but it is something that may happen.
Now, whether you have a legal obligation to assure that he stays there until the police arrive is a different issue, and we don't actually have that obligation.
AB 1652 which you talked about at the beginning of the program actually has more specific requirements for physicians to talk about who is the suspected batterer, and where are their suspected whereabouts? And if that passes in that form, we may have to be much more involved in sort of the criminal justice side as it occurs in our clinic setting.
[Dr. Wolfe] Pat, I think you said "arrest the patient." I think you meant arrest the batterer.
[Dr. Sabler] Oh, absolutely.
[Dr. Wolfe] Yes. Yeah, yeah.
[Dr. Sabler] Sorry.
[Dr. Wolfe] Yeah.
[Ms. Lee] I'd just like to underscore one thing, and that is that I think it's very important, particularly in light of the obligation, the strengthened obligation that medical personnel may have now in reporting. I think it's very important that these other aspects of giving support to the woman and telling her what her options are go hand and hand with that reporting, because I think our greatest fear is that a reporting law like this will also have a chilling effect upon women, whereby the next time they won't come to the emergency department. They won't seek out the assistance of their physician because there is still some ambivalence as of yet in having their situation reported to the police. So, I think it really is very important just to make sure that the physician talks to the patient about, you know, in some encouraging ways.
[Dr. Wolfe] Okay, we have several more phone calls.
Chuck, is that it for you?
[Dr. Wibbelsman] Very much.
[Dr. Wolfe] Yeah, thanks very much. Our next call is from Vallejo. Go ahead, please.
[Text on screen] Live by Phone: Vallejo
[Caller] Yes. If the patient has either mental or physical handicaps, does the physician have different reporting requirements, such as more so much of those for children or the impaired elderly?
[Dr. Wolfe] Thank you.
[Dr. Sabler] At the current time, it's my understanding that they don't, that there aren't more specific. Debbie, do you have something to add on that?
[Ms. Lee] Well, I am not completely familiar with it, but in the elder abuse reporting law, it also applies to dependent adults, so it depends to what degree that adult is dependent on a care taker. So, you may want to just look into it. I believe that your social services departments would probably know that given their responsibilities around elder abuse reporting, et cetera.
[Dr. Wolfe] Thank you. Our next call is from Hayward. Go ahead.
[text saying Comments & Questions 8-427-2600]
[Caller] Yes. I'd like to applaud the organization in its efforts to

[Text on screen] Live by Phone: Hayward]
educate our medical physicians and other health care providers on domestic violence.
As I look around in the audience at the Hayward facility, I'm finding that we have a female-dominated audience. Has this been true in other presentations that you have given to health care providers?
[Dr. Wolfe] Thank you. Maybe both of you can answer that.
[Dr. Sabler] Well, maybe I'll start.
[Dr. Wolfe] Yeah.
[Ms. Lee] Go ahead.
[Dr. Sabler] Since I've had the extreme pleasure of going to a number of the medical centers and speaking on domestic violence, and I haven't noted a female predominance; although, I must say that people who come up and talk to me after and want to become more involved in doing things further to educate their own medical centers do tend to be women.
[Ms. Lee] I think ---
[Dr. Wolfe] Yeah, go ahead.
[Ms. Lee] --- it's interesting to note that actually it was the American Association of Gynecologists and Obstetricians that were one of the first medical associations to bring this issue forward to their membership, so that doesn't --- it doesn't cut across, necessarily, female-male lines. But I do think that when I've gone out in doing training particularly to interns and residents, there is a comfort level by female providers in asking the question a little bit more. And I think this is just a key thing. I think that we just --- for every physician, nurse, or whatever, that you really sort of need to practice to figure out how you're going to feel comfortable about asking the question, and integrate it into the exam, as Pat said, just like how we --- how physicians talk about sexual practices, et cetera.
[Dr. Wolfe] Okay. Our next call is from Santa Clara. Go ahead, please.
[Text on screen] Live by Phone: Santa Clara
[Caller] This is Roger Kennedy from Santa Clara. I have a question about two other aspects of domestic violence. One is the same sex domestic violence, which I think is easily hidden. And, in particular, also women against men, which is a very, very hidden part of the epidemic. Could you comment on that, please?
[Dr. Wolfe] Okay. Thanks, Roger. Debbie?
[Ms. Lee] Surely. I'm glad you brought that up. Yes, there is quite a bit of domestic violence in same sex relationships, as well. And it's something that oftentimes, particularly within the
[Text on screen] Debbie Lee Associate Director Family Violence Prevention Fund]
criminal justice system we've seen that people seem to dismiss it. The police seem to dismiss it because they believe it's part of sort of the culture.
But oftentimes in those situations -- and also there's a sense that perhaps it's just a mutual battery case, and then people throw up their hands and say well, what am I supposed to do? They're both fighting. But in the majority of the cases the studies are coming out that usually there is a primary aggressor and someone who remains the victim. I mean if you think logically about it, if it's mutual battery, there's not an advantage to beating each other up. There's more advantage if there's one person who wins more often than the other.
In the situation of females battering men, yes, it does occur. FBI statistics indicate at about three to five percent of incidences, but as you can tell, the incidence is much higher by men to women.
[Dr. Sabler] Actually, I'd like to add something to that.
[Dr. Wolfe] Yes.

[Dr. Sabler] Although the FBI statistics say it's about five percent, there are some areas of the country where domestic violence hotlines are reporting up to 20 percent of the men who --- of the victims who are calling who are men.
[Text on screen] Patricia Salber, MD Department of Emergency Medicine South San Francisco Medical Center]
And I recently have taken care of at least two men who were victims of domestic violence with their female partners being the aggressor.
[Dr. Wolfe] Roger, any follow-up?
[Caller] No, that's fine. Thank you.
[Dr. Wolfe] Okay, thanks very much. We are getting close to the end of the broadcast, and I wanted to be sure that we covered everything that we wanted to.
Is there anything more we should say about the method of referral? Anything?
[Ms. Lee] Well, maybe I can just say briefly that there are ---
[Dr. Wolfe] Yeah.
[Ms. Lee] --- shelters throughout the state, throughout the United States, I believe in every county in California except for one, there is a shelter. Usually, these shelters have hotlines, 24-hour hotlines, and what I often recommend, if you do have a woman in your --- under your care that is having trouble making a decision, wants to talk more about it, that, in fact, you can sit her down next to a phone and have her call up the shelter and speak right away. I think it's oftentimes very effective sort of way because sometimes women go home and they might not make the call.
Shelters generally take women anywhere from a month to six weeks, usually with --- oftentimes with children. They usually have a small fee, but oftentimes that is waived. And what they really allow a woman to do, and I think this is a good thing to talk about to women, is that a woman is oftentimes totally overwhelmed with the possibility of changing her life. What about her job? What about her house? What about her finances? And when you think of that, sure, it would be discouraging to leave.
But the thing about a shelter is -- what I say is, it's a place for a woman to go to start putting things together, and she needs to take things one step at a time. And it gives her the safe place to be able to take those steps inch by inch.
Also, of course, she may be concerned about her husband, and wanting to get him into counseling. There are a number of men's programs, and I noticed on the resource guide that you developed that there are a number of counseling programs for men.
Oftentimes, most of those counseling programs get their referrals by way of the criminal justice system. If the guy has been arrested and he has no prior charges, then he can get in --- he will be diverted to a counseling program. Otherwise, it's oftentimes very difficult for men to volunteer to go that kind of counseling program.
[Dr. Wolfe] Well, we really are at the end of the broadcast. We just have just a short time for any final comments that each of you would like to make. And I know both of you can stay for a few minutes, so anyone who does want to call in can go ahead and do that, and we'll answer your questions.
[Dr. Sabler] I have a comment that I would like to make which broadens the issue for physicians beyond domestic violence. I believe that the time where we can say that violence in general is only a criminal justice problem is gone. I believe that we all need to, as physicians, acknowledge that violence is a serious not just public health issue, which kind of makes us think that that's what the Department of Health service is doing, and not what the individual physician is doing,

but that violence is a health issue that affects all of our patients at some level, whether they're victims, whether they've changed their lifestyle, old folks who can't go out at night because they're afraid of the streets.
And I believe that there are a lot of things that physicians can do to help decrease the epidemic of violence that's occurring in our society. And because of that, as you know Elliott and Debbie, we have established a nonprofit organization called "Physicians for a Violence-Free Society," and I would like to invite all Kaiser physicians, and nurses, and other health care personnel to join us in our efforts as physicians to decrease the violence that is affecting all of us in so many different ways. And if people are interested they can contact me at Kaiser South San Francisco through the interoffice mail.
[Dr. Wolfe] Thank you, Pat.
[Ms. Lee] Well, I'd just like to end with the Family Violence Prevention Fund in joint with Pat Salber and others has done a study of the emergency departments in California, and that will be available. It's coming out in the press next week.
We are also in the process of developing model training curriculum and model policies and procedures for emergency departments, and that should be published in another six months or so.
[Dr. Wolfe] Well, thank you both for being on the broadcast. And I know we can keep talking, and really thanks very, very much for helping us prepare for the program.
I know that both of you are listed and thriving in a busy practices
[Dr. Wolfe holding up binder]
Directory of Speakers on Physician-Patient Communication, and you can reach either Debbie or Pat by looking at this directory.
There were many excellent comments and suggestions after last month's broadcast on giving bad news. A clinician wrote that,
[slide showing clinician's comment]
"The timing of giving news in the office usually depends on what available slots are open. End of day is unrealistic."
[slide showing clinician's comment]
Another physician stated, "The approaches suggested are not new to any of us, but we seem not to use them in all too many cases. I wonder how we can begin to set aside our old ways and our cynicism in favor caring in the best way possible, applying proven communication techniques, and delivering both good and bad news in the most effective and respectful manner possible."
[slide showing date and information]
On September 9th, Medicine in the '90s presents our annual review, "The Primary Care, the Patient with HIV Infection."
Thanks for being with us today, and see you on September 9th.
[music]
[Text on screen]This program has been a production of Regional Staff Education and the Audio Visual Center