REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 6-I-07

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

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

INTRODUCTION

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

PHYSICIANS' DUTY TO DETECT AND PREVENT ABUSE

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

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

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the manifestation of co-morbid conditions, so that patients may receive appropriate care.[7] Finally, physicians have a duty to protect the welfare of all members of society by working to reduce the prevalence of violence and abuse among the general population (see *Principle VII*).

The prevention of violence requires a multi-faceted intervention strategy. Traditional means of violence prevention fall within the domain of the judicial and law enforcement systems. However, the public health approach to violence prevention is also effective and therefore creates the opportunity for the medical community to address this pressing social issue. The foundation of the public health approach to violence prevention incorporates four major steps: the framing of the problem as a scientifically testable hypothesis; the identification of applicable risk and preventive factors; the development and testing of prevention strategies; and the promotion and dissemination of those strategies that have proven effective.[8]

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

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

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

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

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

CONFIDENTIALITY AND THE REPORTING OF VIOLENCE AND ABUSE

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

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

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

Physicians' duties to protect a patient's confidentiality and autonomy are not absolute, however, and the disclosure of medical information may be warranted for the protection of patients or the community.[14] Physicians are legally required to report suspected abuse in most states[15] and such reporting is considered to be protected disclosure by HIPAA.[16] If reporting is mandatory, physicians should notify the patient and then proceed to disclose only the minimal amount of information necessary for the patient's protection (see E-5.05). Physicians should continue to research issues pertaining to mandatory reporting practices and seek changes in legislation if evidence indicates that mandatory reporting requirements contravene patients' best interests (see E-9.025, "Advocacy for Change in Law and Policy").

CONCLUSION

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

RECOMMENDATION

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

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

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

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

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

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

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

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

A. Physicians must treat the immediate symptoms and sequelae of violence and abuse, while also providing ongoing care for patients so as to address any long-term health consequences that may arise as the result of exposure.

B. Physicians should be familiar with current information about cultural variations in response to abuse, public health measures that are effective in preventing violence and abuse, and how to work cooperatively with relevant community services. Physicians should help in developing educational resources for identifying and caring for victims. Comprehensive training in matters pertaining to violence and abuse should be required in medical school curricula and in post graduate training programs.

C. Physicians should also provide leadership in raising awareness regarding the need to assess and identify signs of abuse. By establishing guidelines and institutional policies it may be possible to reduce the volume of abuse cases that go unidentified, and consequently, help to ensure that all patients receive the benefit of appropriate assessment regardless of their age, gender, ethnicity, or social circumstances. The establishment of appropriate mechanisms should also direct physicians to external community or private resources that might be available to aid patients.

D. Physicians should support research in the prevention of violence and abuse and seek collaboration with relevant public health authorities and community organizations.

3. Physicians should comply with the following guidelines when reporting evidence of violence or abuse:

A. Physicians should familiarize themselves with any relevant reporting requirements within the jurisdiction in which they practice.

B. When a jurisdiction mandates reporting suspicion of violence and abuse, physicians should comply. However, physicians should only disclose minimal information in order to safeguard patients' privacy. Moreover, if available evidence suggests that mandatory reporting requirements are not in the best interests of patients, physicians should advocate for changes in such laws.

C. In jurisdictions where reporting suspected violence and abuse is not legally mandated, physicians should discuss the issue sensitively with the patient by first suggesting the possibility of abuse, followed by describing available safety mechanisms. Reporting when not required by law requires the informed consent of the patient. However, exceptions can be made if a physician reasonably believes that a patient's refusal to authorize reporting is coerced and therefore does not constitute a valid informed treatment decision. (I, III)

(New HOD/CEJA Policy)

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

ACKNOWLEDGMENTS

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