VMS RESOLUTION
DOMESTIC VIOLENCE AS A HEALTH CARE CONCERN

As Passed by VMS Council, October 18th, 2003

WHEREAS, nearly one-third of American women (31%) report being physically or sexually abused by a husband or boyfriend as some point in their lives; [1] and

WHEREAS, the level of injury resulting from domestic violence is severe: of 218 women presenting at a metropolitan emergency department with injuries due to domestic violence, 28% required hospital admission, and 13% required major medical treatment; forty percent has previously required medical care for abuse; [2] and

WHERAS, domestic and sexual violence have major consequences in Vermont: in 1999, according to the Vermont Department of Public Safety, there were 16 homicides and of those fatalities, 7 met the Domestic Violence Fatality Review Commission's definition of domestic violence related fatalities; in the same year1,276 domestic assault offenses were reported; [3] and

WHEREAS, in addition to injuries sustained during violent episodes, physical and psychological abuse are linked to a number of adverse physical and mental health effects including arthritis, chronic neck or back pain, migraine and frequent headaches, sexually transmitted diseases, chronic pelvic pain, stomach ulcers, pregnancy complications, substance abuse, depression, anxiety and post-traumatic stress disorder; [4, 5, 6, 7, 8, 9] and

WHEREAS, ninety-two percent of women who where physically abused by their partners did not discuss these incidents with their physicians and 57% did not discuss the incidents with anyone; [10] and

WHEREAS, in four different studies of survivors of abuse, 70-81% of the patients reported that they would like their healthcare providers to ask them privately about intimate partner violence; [11, 12,13,14] and

WHEREAS, physicians are uniquely positioned to help victims by routinely screening for domestic and sexual violence and offering appropriate referrals and interventions; and

WHEREAS, physicians may not be aware of current screening tools for domestic and sexual violence and local options for referral and intervention; therefore be it

RESOLVED, that the Vermont Medical Society (VMS) reaffirms its 1983 policy urging the Governor and the Vermont State Legislature to give high priority to social programs addressing domestic and sexual violence against members of all vulnerable segments of our society – its prevention, and interventions for victims and perpetrators; be it further

RESOLVED, that the VMS work with the Health Care and Domestic Violence Leadership Team, a state-wide coalition led by the Vermont Department of Health and the Vermont Network Against Domestic Violence and Sexual Assault, to make an action plan to improve the healthcare response to domestic violence in Vermont, including educational and policy initiatives; be it further

RESOLVED that the VMS collaborate with the Leadership Team to create and disseminate a domestic violence curriculum and toolkit for physicians; and be it further

RESOLVED, that the Vermont Medical Society create a task force of physicians who will review the curriculum, help plan how to implement the curriculum, and discuss longer-range responses to domestic and sexual violence.

[1] The Commonwealth Fund, *Health Concerns Across a Women's Lifespan: The Commonwealth Fund 1998 Survey of Women's Health*, May 1999.

[2] Berios, D.C. and Grady, D., Domestic Violence: Risk Factors and Outcomes. *The Western Journal of Medicine*, 155 (2), August 1991.

[3] Vermont Domestic Violence Fatality Review Commission, First Biennial Report, January 2003, p. 3.

[4] Coker, A., Smith, P., Bethea, L., King, M., McKeowen, R., Physical Health Consequences of Physical and Psychological Intimate Partner Violence. *Archives of Family Medicine*, 9, 2002.

[5] Housecamp, B.M., Foy, D., The Assessment of Posttraumatic Stress Disorder in Battered Women. *Journal of Interpersonal Violence*, 6 (3), 1991.

[6] Gelles, R.J., Harrop, J.W., Violence, Battering and Psychological Distress among Women. *Journal of Interpersonal Violence*, 4 (1), 1989.

[7] Housekamp and Foy, 1991.

[8] Parker, B., McFarlane, J., Soeken, K. Abuse During Pregnancy: Effects on Maternal Complications and Infant Birthweight in Adults and Teen Women. *Obstetrics & Gynecology*, 841: 323-328, 1994.

[9] Parker, B., McFarlane, J., Soeken, K. Physical Abuse, Smoking and Substance Abuse During Pregnancy: Prevalence, Interrelationships and Effects on Birthweight. *Journal of Obstetrical Gynecological and Neonatal Nursing*, 25: 313-320, 1996.

[10] The Commonwealth Fund, First Comprehensive National Survey of American Women Finds them at Significant Risk (News Release), July 14, 1993.

[11] Caralis, P., Musialowski, R. Women's Experiences with Domestic Violence and Their Attitudes and Expectations regarding Medical Care of Abuse Victims. *South Medical Journal*, 90: 1075-1080, 1997.

[12] McCauley, J., Yurk, R., Jenckes, M., Ford, D. Inside 'Pandora's Box': Abused Women's Experiences with Clinicians and Health Services. *Archives of Internal Medicine*, 13:549-555, 1998.

[13] Friedman, L., Samet, J., Roberts, M., Hudlin, M., Hans, P. Inquiry About Victimization Experiences: A Survey of Patient Preferences and Physician Practices. *Archives of Internal Medicine*, 152:1186-1190, 1992.

[14] Rodriquez, M., Quiroga, S.S., Bauer, H. Breaking the Silence: Battered Women's Perspectives on Medical Care. *Archives of Family Medicine*, 5:153-158, 1996.