

## CHAPTER 7

# The Health Care Community

In 1985, former Surgeon General C. Everett Koop declared violence in America to be a public health emergency and convened a historic conference on violence and public health, involving physicians, nurses, public health workers, researchers, policymakers, and advocates. Yesterday's emergency has become today's epidemic, with some inner cities looking more like war zones than urban communities. The costs to the U.S. health care system are astounding:

- Three percent of U.S. medical spending—and 14 percent of injury-related medical spending—is caused by interpersonal violence.<sup>2</sup>
- During 1994, U.S. hospital emergency department personnel treated an estimated 1.4 million people for injuries from confirmed or suspected interpersonal violence.<sup>3</sup>
- One insurer, Blue Cross/Blue Shield of Pennsylvania, estimated that more than \$32 million a year is spent in that state alone to treat domestic violence injuries.<sup>4</sup>
- Gunshot violence in the United States costs \$4.5 billion a year in medical expenses alone.<sup>5</sup>
- Alcohol-related crashes cost \$45 billion per year, with the average cost per victim at \$16,000.<sup>6</sup>

Whether looking at the cost of the expensive emergency surgery needed by more than half of all gunshot victims, the permanent brain or spinal cord damage suffered by a high percentage of the survivors, or the psychological trauma and long-term health consequences endured by victims of relationship violence and sexual assault, violence in America is both a major health risk for individuals and an enormous drain on the nation's health resources.<sup>7</sup>

Dr. Koop's urgent message challenged health care providers and the public to seek out the root causes of violence and develop the best treatments. This new focus for health professionals has been demonstrated at an institutional level, from the U.S. Surgeon General and the American Medical Association to local chapters of organizations like the American Academy of Pediatrics, the American College of Physicians, and the American College of Emergency Physicians.

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*Identifying violence as a public health issue is a relatively new idea. Traditionally, when confronted by the circumstances of violence, the health professions have deferred to the criminal justice system. . . . [Today] the professions of medicine, nursing, and the health-related social services must come forward and recognize violence as their issue.<sup>1</sup>*

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Former Surgeon General  
C. Everett Koop

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*The AMA can bring its organizational resources to bear on a national agenda [of violence prevention through publications and advocacy]. . . However, the true success of our commitment will come when we as physicians, treating patients one at a time, make a difference by breaking the cycle of violence that engulfs people's lives.*

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Dr. Robert E. McAfee,  
former President  
American Medical Association

Organizations such as the American Medical Association, the American Nurses Association, the American Association of Emergency Nurses, and the American Academy of Pediatrics, have taken a strong and visible role in efforts to reduce violence and create a safer, healthier society. Many professional organizations actively supported legislation such as the Brady Law, the Assault Weapon Ban, the Violence Against Women Act, the Child Safety Act, and laws to reduce drug distribution and handgun possession by juveniles. Medical and public health research organizations, often funded by the Centers for Disease Control and other Federal agencies, have examined the risks of violence from many perspectives, greatly increasing the knowledge base of criminal victimization. Physicians have established coalitions with law enforcement personnel, social service workers, clergy, teachers, parents, and government leaders to actively fight the epidemic of violence. Their energy and commitment comes from seeing firsthand the consequences of violence, from the gunshot wound in the trauma unit to the abused child in the community clinic.

What happens in the clinical setting is paramount from the victim's point of view. Physicians must diagnose, treat, and mend victims of crime, while also consoling and caring for them and their families. Treating patients with sensitivity to their physical conditions, as well as to the psychological impact of victimization, can help the overall physical and mental healing process.

The President's Task Force on Victims of Crime recognized that the medical community is often the first to come into contact with crime victims who have experienced some form of injury. Because victims are understandably fearful and insecure when they arrive at medical centers, the 1982 Task Force recommendations focused on the clinical setting and the need for hospital personnel—from the emergency room to the billing department—to be sensitized to the emotional trauma of victimization and to treat the whole patient, not just the physical manifestations of the criminal violence.<sup>8</sup> The *Final Report* also recommended that hospitals should:

- develop and implement training programs for hospital personnel to sensitize them to the needs of victims of violent crimes, especially the elderly and those who have been sexually assaulted;
- provide emergency medical assistance to victims of violent crime without regard to their ability to pay and collect payments from state victim compensation programs;
- provide emergency room crisis counseling to victims of crime and their families;

- encourage and develop direct liaisons with all victim assistance and social service agencies; and
- develop, in consultation with prosecuting agencies, a standardized rape kit for proper collection of physical evidence.

In the 15 years since the Task Force released its recommendations, changes in professional norms, institutional resources, and clinical practice have made it easier for the health care community to respond effectively to crime victims. One of the most visible indicators of change in hospital response is the adoption of standardized protocols for victim care, as well as statutory requirements for victim services in many states. In addition, the Joint Commission on Accreditation of Hospitals, the organization that accredits these facilities, has added standards for victim response to its review requirements.

Great strides have been made to sensitize health professionals to the signs and symptoms of domestic violence and child abuse and educate them in appropriate treatments. Hospital-based Sexual Assault Nurse Examiner (SANE) programs are springing up around the country to assist rape victims in supportive settings, and some hospitals have developed comprehensive social services for crime victims, including individual and group counseling.

The medical community has responded slowly and inconsistently, however, to the recommendations of the Task Force concerning training of all hospital personnel, counseling in the emergency room, and referrals to victim assistance organizations. The health care community is just beginning to institute pilot projects to address the special needs of crime victims such as adolescent gun violence victims, one of the fastest growing populations of crime victims in the nation,<sup>9</sup> and the hidden victims of family violence. In the words of Donna E. Shalala, Secretary of Health and Human Services:

[W]e simply must do better. Because a battered woman may never call the police... she may never contact a lawyer... she may never enter a shelter, but, eventually — even if it's only for a routine check-up — she will probably visit a doctor, nurse, or community health worker. And we must be ready when she does... [W]e want to better reach out to health care professionals... strengthening our ability to screen, treat, and prevent violence against women.<sup>10</sup>

## **Established Programs**

Since the President's Task Force *Final Report* was released in 1982, significant advances have been made in identifying and treating victims of family abuse, providing supportive services for sexual assault victims, and reimbursing crime victims for medical expenses.

## **Family Violence**

The health care community has responded to family violence, which encompasses abuse across the entire life cycle—children, adults, and the elderly. Coalitions of national health organizations have been established to address family violence and develop protocols on recognizing and treating family violence. The American College of Obstetricians and Gynecologists (ACOG) became the first national medical organization to address domestic violence in response to the high incidence of physical abuse among pregnant women. ACOG collaborated with the National Coalition Against Domestic Violence to publish bulletins and brochures about domestic abuse for its members and their patients.

Another major health organization, the American Medical Association (AMA), also has pushed the medical community to respond more forcefully to family violence. In 1991, the AMA launched its Campaign Against Family Violence to heighten physicians' awareness of domestic violence, child abuse, and elder abuse as public health problems. The campaign sought to improve physicians' ability to recognize the risk factors and symptoms of abuse and refer patients for shelter and services when needed. The AMA has published a set of diagnostic and treatment guidelines for physicians in the areas of child physical abuse and neglect, child sexual abuse, domestic violence, and elder abuse and neglect. Both the AMA and the American Nurses Association have developed protocols for appropriate intervention and treatment of family violence. The Joint Commission on Accreditation of Healthcare Organizations now requires hospitals to develop protocols for the identification and treatment of battered women.<sup>11</sup> A couple of the more successful hospitalwide protocols for assessing and intervening on behalf of domestic violence victims are the Advocacy for Women and Kids in Emergencies (AWAKE) program at Children's Hospital in Boston, Massachusetts, and WomanKind, a 24-hour case management, advocacy, crisis intervention, hospital-wide training, support group, and outpatient assistance program serving three Minnesota hospitals.

## **Sexual Assault**

Beside providing immediate treatment for victims, medical staff are required to collect relevant evidence to document an assault and to report their findings. Appropriate documentation provides useful information for prosecutors and victims when taking criminal and other legal action against perpetrators. As the 1982 President's Task Force Report recommended, a primary consideration is the use of appropriate evidence collection kits to gather information in sexual assault and sexual abuse cases for later evidentiary use at trial. This must be done sensitively, but competently, so that the trauma of the rape examination is minimized and evidence is collected accurately.

Many hospitals have established protocol for the comprehensive treatment of sexual assault victims, including the use of specialized kits for forensic exams. However, one study found that such an exam occurred in only 17 percent of all rape cases.<sup>12</sup>

Since 1990, the number of Sexual Assault Nurse Examiner (SANE) programs across the country has doubled to 86.<sup>13</sup> SANE programs offer an innovative approach to handling the medical/evidentiary aspects of sexual assault and child abuse cases through the use of technology, nurse examiners, and specialized settings. Instead of having doctors handle these cases in busy emergency rooms, SANE programs create a special environment for victims and use trained nurse examiners to conduct the evidentiary medical examination and present the forensic evidence at trial. According to the Tulsa Police Department, the nationally recognized Tulsa SANE program has substantially improved the quality of forensic evidence in sexual assault cases. The Sexual Assault Resource Service of Minneapolis is developing a guidebook for starting SANE programs for use by communities.

### Compensation for Emergency Medical Care

Victim compensation programs in all 50 states, the District of Columbia, and the Virgin Islands reimburse private and public hospitals for the cost of emergency medical assistance to crime victims when that cost is not covered by private insurance or other public medical benefits. In most states, emergency medical assistance is reimbursed to the hospital in the full amount of the cost billed. In others, state law or rule authorize providing victim compensation programs to pay a percentage of the billed amount, similar to the practice followed by private insurance carriers or public medical programs such as Medicaid. For example, Delaware pays 80 percent of billed charges; Arkansas, California, and Maine pay 75 percent; Florida covers 66 percent; and Louisiana pays 65 percent. A number of states also ensure, by law, that victims are not held responsible for the remaining amount of the bill.<sup>14</sup>

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*I hugged an emergency room doctor when he told me my son was going to die. I clung to a stranger because no one else was there.*

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A survivor of a drunk driving crash

### Promising Practices

Pilot programs linking victim services with health care settings are increasingly being initiated across the country. These promising practices bring together professionals from many disciplines to create victim services that aid recovery without revictimizing patients or their families.

### Professional Education and Training

Education and training for physicians and other health care providers are essential to ensure a sensitive and forensically sound response to criminal injuries. Until a family violence curriculum becomes standard in all professional schools for medical personnel and

in postgraduate continuing education programs, health care personnel are likely to overlook this form of abuse, missing an important opportunity for early intervention and support. Fortunately, excellent training protocols for responding to victims have been developed, and they are being used by some hospitals around the country.

- With funding from the U.S. Department of Health and Human Services and several major foundations, the National Health Initiative on Domestic Violence, a project of the Family Violence Prevention Fund (FVVF), has developed, evaluated, and disseminated multidisciplinary training programs to strengthen the medical community's response to battering in a variety of settings. The programs were tested in 12 California and Pennsylvania hospitals in 1994 and 1995. In only 9 months, all 12 hospitals successfully designed and implemented a comprehensive interdisciplinary emergency department response to domestic violence, which includes physicians, nurses, social workers, administrators, and community advocates. The model is now being used in more than 130 hospitals and health care settings. FVVF recently published a manual with step-by-step instructions to develop this field-tested, low-cost model program, as well as a blueprint to create a citywide health care response to domestic violence.<sup>15</sup> In 1997, the Initiative began its second phase, expanding into ten states to work with a coalition of interested organizations to develop and implement a statewide plan for a comprehensive hospital-based response to domestic violence. A national conference, *Domestic Violence and Health Care: Initiatives for the New Millennium*, was held in Washington, D.C., in November 1997 to flesh out the steps necessary to expand and improve the U.S. health care response to domestic violence.
- Individual hospitals are pioneering specialized victim services training for physicians and mental health professionals. The Harborview Center for Sexual Assault and Traumatic Stress at Harborview Hospital in Seattle, Washington, one of the oldest victim service programs in the nation, has been a national leader in developing comprehensive mental health services for sexually abused children and adults. A medical training program at Harborview, supported by state funds, provides training to physicians and other health care providers who examine sexual assault victims. The program also provides emergency department training in acute response, a mentorship program for doctors, colposcopy<sup>16</sup> slide review for quality assurance, and protocols for administering tests for sexually transmitted diseases to adolescent and adult patients reporting rape.
- At Children's Hospital in San Diego, California, the Center for Child Protection (CCP) was established in 1976 to address the prevention, diagnosis, and treatment of child abuse and family violence. Its services include intensive home visiting, assessment, and case

management; support for pregnant and parenting teens; assistance to women in identifying and accessing resources to break the cycle of family violence; and individual, group, and family therapy to victims of child abuse and their caretakers. The success of these programs led to numerous requests for training and technical assistance from other health care providers. In response, CCP started a clinical training program that offers accredited continuing education to physicians in conducting the medical evaluation of child sexual abuse and to interview specialists in conducting forensically defensible videotaped interviews of children. CCP's San Diego Conference on Responding to Child Maltreatment and Summer Seminars by the Sea provides state-of-the-art multidisciplinary education to 2000 professionals from around the world each year.

- An interactive teleconference was used statewide in Alabama to train public health department employees in domestic violence identification and treatment. Developed through a partnership between the Alabama Coalition Against Domestic Violence and the Alabama Department of Public Health, this innovative training program used a talk-show format: an Alabama newscaster was host, and a physician, shelter director, attorney, and three survivors played the roles of talk show guests.<sup>17</sup>
- In its continuing effort to educate the medical profession about domestic violence, the American College of Obstetricians and Gynecologists has produced a slide lecture about the health care needs of domestic violence victims. Target audiences include OB-GYN residents, third-year OB-GYN medical students, first- and second-year medical students in courses such as Introduction to Clinical Medicine, and other health care providers including emergency department personnel, dentists, nurse midwives, nurse practitioners, and mental health providers.
- In 1997, the Program Against Sexual Violence and the School of Dentistry at the University of Minnesota received funding from the Office for Victims of Crime to develop a comprehensive education model for dentists and dental auxiliaries regarding family violence. The project will produce a training videotape on the clinical and medical signs of family violence in the dental setting; develop a curriculum for a six-hour seminar designed to train dental professionals to recognize family violence and to implement appropriate intervention; and design a comprehensive training packet which will enable the dental team to easily apply the intervention model to their own office setting.
- Victim Services in New York City has launched a 3-year pilot project with HIP, the city's largest managed care health provider, to respond to victims of domestic violence. The pilot has four components: physician and staff training; universal screening of all female

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*The chief medical examiner told me that this (the bombing) tore down every (protective) wall he had built up.*

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Diane Leonard  
survivor of homicide of  
the bombing of the  
Alfred P. Murrah  
Federal Building,  
Oklahoma City, OK

patients; care management of identified domestic violence victims; and public education and outreach to HIP members. Other goals of the pilot include developing models of coordinated care between the mental health and primary care physicians, developing outcome measures to track benefits of the intervention, and developing actuarial data on the prevalence and cost of domestic violence to HIP. Over 185,000 HIP members will be served by the project. The project is funded by HIP, the Robert Wood Johnson Foundation, Chase Bank, and the New York State Department of Health.

### **Multidisciplinary Approaches in Health Care Settings**

Health care, mental health, religious, and social service agencies must work closely with police officers and detectives, prosecutors, judges, court personnel, correction professionals, and victim assistance providers when assisting victims of crime. In the past, these professionals have not necessarily shared the same goals, nor were they amenable to working together. These allied professionals are beginning to recognize that they must cooperate and understand each other's functions when responding to criminal victimization.

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*Education is the most powerful tool we have in our quest to break the cycle of violence because it addresses the problem where it begins — at the grassroots.*

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Dr. Percy Wooton,  
President, American  
Medical Association

- The Violence Prevention Task Force of San Francisco General Hospital (SFGH) was established in 1994 to build bridges between the many hospital departments that interface with victims of violence, and between the hospital and the community. Comprised of representatives from the hospital's trauma, surgery, emergency services, psychiatry, nursing, pediatrics, family medicine, social work, and administration departments, the task force is facilitating institutional change in the way crime victims are treated. They also seek to foster a culture of violence prevention at SFGH. Members of the task force conduct staff training sessions to raise consciousness about violence and sponsor annual educational fairs for community victim service agencies to share resources and dialogue with health care workers.
- The Center for the Vulnerable Child at the Los Angeles County-University of Southern California Medical Center was founded in 1984 as one of the first hospital-based family violence advocacy centers in the nation. The state-of-the-art medical treatment and forensic documentation provided by the center is complemented by a multidisciplinary approach, including legal, social, and mental health services, to guarantee that all patients are treated with dignity. The center uses new interactive computer technology called telemedicine to consult with health providers in rural areas on conducting examinations of abused children. In addition, the center is using Office for Victims of Crime funding to develop a hospital-based emergency shelter for victims of spousal abuse and their



children to serve as a laboratory and training site. The shelter will assist victims of spousal assault by assessing the potential for repeated violence to parents and children in a safe environment.

- The Children's Advocacy Center in Niagara, New York, a service of Niagara Falls Memorial Medical Center, is another example of a multidisciplinary program in a hospital setting that offers a single child-friendly facility for children who have been physically or sexually abused. Prosecutors, police officers, social services workers, therapists, victim advocates, and medical professionals work together to investigate allegations and to reduce the trauma for these children. The center also provides training for team members several times a year.
- The National Crime Victims Research and Treatment Center at the Medical University of South Carolina provides specialized mental health services while working closely with police agencies, the prosecutor's office, the local rape crisis center and battered women's shelter, the state crime victim assistance network, and the crime victims compensation agency. Physically injured crime victims hospitalized in the medical center are provided with information about the justice system, crisis counseling, and referrals for outpatient treatment.
- In the rural community of La Crosse, Wisconsin, the Gundersen Lutheran Crime Victim Services and Victim Resource Center, a program of the Gundersen Lutheran Medical Center, is testing a five-county crisis response protocol for victims of traumatic crime. Supported by a Victims of Crime Act subgrant, the program works to improve the accessibility of clinical service resources to victims of serious crimes; increase victims' access to staff; enhance the skills of physicians, nursing staff, and clinicians for crisis management response; and improve communication among law enforcement, district attorney's offices, and clinical support services.
- The American Academy of Facial Plastic and Reconstructive Surgery (AAFPRS), in partnership with the National Coalition Against Domestic Violence, the umbrella group for the majority of domestic violence shelters across the nation, provides free medical services to victims of domestic abuse. Shelter counselors refer domestic violence victims who have received injuries to the face, head, or neck to AAFPRS for consultation with a surgeon, and suitable candidates are given reconstructive surgery at no cost. Since July 1994, 614 victims have been referred to plastic surgeons.

## **Programs Assisting Adolescent Gunshot Victims and Victims of Gang Violence**

While multidisciplinary protocols are becoming routine for treating victims of child abuse, sexual assault, and family violence, guidelines to address the unique needs of violently injured adolescents did not exist until recently. In November 1996, a Task Force on Adolescent Assault Victim Needs convened by the American Academy of Pediatrics published a model protocol for appropriate care of these victims from their arrival in the emergency department to their discharge from the hospital. The work of the task force was guided by the premise that comprehensive care of violently injured adolescents must address their psychosocial needs as well as their physical injuries. The protocol is designed to promote full recovery and to reduce the risks of reinjury and reactive perpetration.<sup>18</sup>

The OVC Special Report, *Victims of Gang Violence: A New Frontier in Victim Services*, released in October 1996, recommended that hospital-based counseling and prevention programs be established in medical facilities that provide services to gang violence victims. Several hospitals are already testing pilot programs for children and adolescents that involve a range of disciplines over time and across hospital, clinic, and community settings. A few are highlighted below.

- The Teens on Target program at the Summit Medical Center in Oakland, California, and at the Rancho Los Amigos Medical Center in Los Angeles has been hailed nationwide as a model for hospital-based gang violence intervention. It provides immediate and long-term assistance to teenage victims, intervention with gang members who accompany victims to emergency rooms, and gang prevention strategies for schools. The program uses trained peer counselors, many of whom are in wheelchairs because they were victims of gang violence, to give bedside support to injured teens and help them find alternatives to violence.
- Project Ujima is a unique multidisciplinary collaboration of the Children's Hospital of Wisconsin, the Social Development Commission/Milwaukee Youth Opportunities Collaborative, the Medical College of Wisconsin, the Wisconsin Department of Health Education, and Family Services of Milwaukee. The project was created to prevent violence and improve the health of violently injured youth in the Milwaukee community. To accomplish this, the project's partners established a network of medical, psychological, and social support systems to provide emergency service for young victims and their families. In the Children's Hospital emergency department, peer counselors, community-based staff, and a social worker provide support and a sense of safety and trust. Following discharge, youth and families are visited at home by service

providers who provide them with continued medical care and a complete health assessment as well as integrated violence prevention services. Training sessions for hospital staff focus on effective communication and sensitivity toward violently injured youth of different races and ethnic backgrounds.

- KidStART is a Violent Injury Prevention Center for physical and psychological healing of violent injuries that started in 1995 as a pilot at the Children's Memorial Medical Center in Chicago, Illinois. KidStART counselors meet each week with an average of 21 young victims of violent injury in the hospital's special art studio, where they paint, draw, make masks, and sculpt in clay. Parents, siblings, and other hospital patients may also participate. The program has had a visible impact on these patients by allowing them to express and validate their feelings of fear, frustration, and pain utilizing creative arts as their primary media.
- The Violence Prevention Club, established in 1991 by the Boston Violence Prevention Program and now replicated at the Boston Medical Center, is designed to provide guidance and support to young people with spinal cord and other injuries caused by violence. Young gunshot victims in the hospital have immediate contact with a member of the violence prevention staff and are matched with peer counselors who also have sustained gunshot injuries. The recovery period in the hospital and rehabilitation center offers a window of opportunity for survivors to be exposed to supportive resources and peer role models in the community. Once discharged, they are encouraged to become advocates for prevention. Youth and adult staff of the Violence Prevention Club have trained and assisted other spinal cord injury units and city health departments across the nation in developing their own violence and victimization intervention initiatives.

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*Time, it seems, is the only thing I have right now. For the past five weeks I have been sitting in a hospital room beside my husband's bed, for something that was so senseless and so wrong to happen to him. Five weeks ago my husband was shot three times in the head in a gang related incident. Violence and crime has to be changed to love and hope.*

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The wife of a shooting victim

## Recommendations from the Field for the Health Care Community

### HEALTH CARE COMMUNITY RECOMMENDATION FROM THE FIELD #1

**All professional schools that educate future health care professionals, including schools of medicine, nursing, social work, rehabilitation, hospital administration, and public health, should incorporate victim issues into their curricula.**

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*Doctors—and other health care professionals—need to know the signs of abuse, what questions to ask, and how to screen women from all cultures and ethnic groups who may have suffered domestic abuse. They need to know that if they suspect child abuse, they also need to screen the parents . . . In a managed care environment, a woman doesn't generally have one doctor—a Marcus Welby or Ben Casey taking care of her throughout her life. So it's particularly important that every doctor, nurse, physician's assistant, and midwife is learning about domestic abuse right along with anatomy and physiology.<sup>20</sup>*

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Health and Human  
Services Secretary  
Donna Shalala, 1997

It is critical that the health care community learn about the psychological, as well as the physical trauma caused by crime. At a minimum, courses on the trauma of victimization, child sexual and physical abuse, elder abuse and neglect, domestic violence, and sexual assault should be a standard part of curricula for health care providers. The objectives of a violence curriculum should be: to educate about risk factors, indicators, prevalence, and consequences of violence; to increase awareness of the prevalence of family violence; to emphasize the need to screen all patients for alcohol and other drug abuse; to enhance provider-patient communication skills, including how to take a violence history; to foster a multicultural understanding and sensitivity; and to expand knowledge of victims' rights and available services to enhance capability for quality and timely referrals.<sup>19</sup> These topics should be included in professional licensing examinations, and continuing education programs throughout their careers.

**HEALTH CARE COMMUNITY RECOMMENDATION FROM THE FIELD #2**

**All patients should be routinely assessed for indications of domestic abuse or other history of violence, and any signs or symptoms of abuse should be documented in their medical records.**

State legislatures should consider following the lead of California, the first state to mandate that all hospitals and licensed clinics routinely screen patients for indicators of abuse,<sup>21</sup> document such indicators in their medical records, and refer patients to domestic violence assistance resources.<sup>22</sup> The law also requires all health care providers to complete domestic violence course work or training as part of the licensure and recertification process. Other states, such as Florida and New York, require similar training for physicians licensed by the state. Whether required by state law or not, health care responders should be instructed and trained to gather evidence to document domestic violence injuries for use later in criminal, juvenile, child protective, and civil proceedings. Medical personnel should document the patient's injuries and report in as much detail as possible, using sketches or photographs and the exact words the patient uses to describe the incident.<sup>23</sup> Support systems for the protection of health care professionals who report child abuse, neglect, and child witnessing of violence should be strengthened.

**HEALTH CARE COMMUNITY RECOMMENDATION FROM THE FIELD #3****Hospitals should establish training programs and protocols for all hospital personnel about the rights and needs of victims of crime.**

Annual mandatory training programs for hospital staff on victims' needs should include presentations by individual victims or victim panels on the trauma of victimization and victims' rights laws. The training should be multidisciplinary and devote special attention to victims of sexual assault, child abuse, domestic violence, elderly victimization, hate and bias crimes, and catastrophically injured patients, including those injured in drunk driving crashes. Protocol similar to those developed by the AMA and American Nurses Association should be developed to ensure appropriate procedures for collecting, preserving, and transmitting evidence and to eliminate repeated interviews of victims by doctors, nurses, and social workers.

**HEALTH CARE COMMUNITY RECOMMENDATION FROM THE FIELD #4****Medical facilities including hospitals and rehabilitation and trauma centers should serve as gateways to assist victims of crime. Response staff should be available in these settings to provide onsite crisis counseling, follow up with patients, and serve as links to in-house and community resources.**

The health care, social service, criminal and juvenile justice, and other professional communities must integrate their response to violence if victims are to be provided a safety net that functions effectively. Medical settings should develop linkages with a variety of area resources including victim service agencies. Special consideration of the needs of victims, such as food, clothing, transportation, and the development of safety plans should be taken into account in emergency rooms and trauma centers. Programs should involve the family in aftercare and should educate them about victims' needs and rights before they leave the hospital. In all cases, victims must be informed about options and be at the center of decisions related to their aftercare.

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*Actually, a nurse who had been a survivor of drunk driving herself told me about crime victims compensation.*

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A survivor of a drunk driving crash

**HEALTH CARE COMMUNITY RECOMMENDATION FROM THE FIELD #5**

**Victims of sexual assault should be given emergency medical care, forensic examinations, and testing for HIV and sexually transmitted diseases at no out-of-pocket cost and in a supportive setting. More hospitals should consider establishing Sexual Assault Nurse Examiner programs to respond sensitively to the needs of sexual assault victims.**

Specialized medical examinations for child and adult victims of sexual assault have forensic, health, and psychological purposes. In these times of dramatic changes in the health care delivery system and a shift to managed care, it is especially important to ensure that victims receive the full range of treatment they need including diagnosis and treatment of injuries, and testing, counseling, and treatment for sexually transmitted diseases. Financing these critical services could be accomplished through government support of forensic practitioners, criminal or juvenile justice system reimbursement for examination costs, or coverage by VOCA-funded crime victim compensation programs. In federal sexual offense cases, the Attorney General should provide for the payment of the cost of two anonymous and confidential tests of the victim for the HIV virus and sexually transmitted diseases, including gonorrhea, herpes, chlamydia, and syphilis.<sup>24</sup>

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*At the hospital, I was denied a shower. I drove home in the same clothes and condition as at the time of the rape.*

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A rape victim

HIV testing should be conducted at an anonymous testing site that provides pre- and post-test counseling. Anonymous testing allows the victim to keep his/her results private and avoids the potential for the results to be discovered by defense attorneys or insurance companies when the test is performed in a hospital setting. Any costs associated with the testing should be covered by the medical community or by crime victim compensation.

**HEALTH CARE COMMUNITY RECOMMENDATION FROM THE FIELD #6**

**Cultural competency guidelines should be developed to help health care providers improve screening and intervention services for victims from diverse backgrounds.**

Detection, treatment, and prevention services for victims of domestic assault, elder abuse, child abuse, and sexual assault are often nonexistent, inadequate, or culturally inappropriate in rural,

inner-city, lower income, minority, and immigrant communities. Where these services do exist, victims may be inhibited from seeking help because of cultural barriers. Health care providers often compound these problems by their lack of knowledge about options available to patients, by not discussing the topic out of their own discomfort, and by insensitivity to the cultural context of abuse. Imaginative approaches are needed to foster multicultural understanding on the part of students in professional schools. For example, where standardized patients are used as a teaching method, they should represent the community's racial, cultural, and linguistic groups.<sup>25</sup>

**HEALTH CARE COMMUNITY RECOMMENDATION FROM THE FIELD #7**

**Medical personnel should be knowledgeable about and have policies in place to ensure that statutory privacy protections are applied to medical records, abuse reporting forms, and medical legal evidence. They should respect the confidentiality and privacy needs of all victims of crime and assist them in dealing with unwanted media attention, especially in cases of sexual assault and assaults on children.**

Although horrendous crimes may be of interest to the public, crime victims do not have to share the details or their feelings with the public. Hospitals and clinics should develop protocols for protecting the rights of victim-patients in their care who do not want to be interviewed or photographed. Victims of domestic violence, sexual assault, and gang violence may need to be admitted under an alias to protect them from further acts of violence. Security guards should be alerted when violence or unwanted media attention is a possibility.

**HEALTH CARE COMMUNITY RECOMMENDATION FROM THE FIELD #8**

**Counseling and prevention programs and/or a referral system to such programs, should be established in medical facilities that treat violence-related injury, including gunshot victims, to address the broad spectrum of needs of these victims.**

The importance of counseling and prevention programs for victims of gang violence was emphasized in the 1996 OVC Special Report, *Victims of Gang Violence: A New Frontier in Victim Services*. Rehabilitation-based intervention strategies to reduce adolescent acquaintance violence are being used in major trauma centers across the country and should be replicated, wherever possible.<sup>26</sup>

**HEALTH CARE COMMUNITY RECOMMENDATION FROM THE FIELD #9**

**Protocols for appropriate security and safety procedures should be developed to assist hospital personnel in responding to incidents of gang, family, and other violence that might result in staff victimization.**

Patient assaults on personnel in emergency rooms and other health care facilities threaten the welfare not only of the assaultive patient, but of staff and visitors. Victims report intense emotional reactions as well as physical injury. While risk management is widely recognized as an important element of the management response, crisis intervention procedures and peer counseling also should be established for emergency service personnel and health care providers affected by assaultive incidents.<sup>27</sup>

**HEALTH CARE COMMUNITY RECOMMENDATION FROM THE FIELD #10**

**Pediatricians, family practitioners, internists, and other health care professionals treating young children should be educated about the effects on children of witnessing domestic violence and violence in the community.**

Several studies have documented that children are victims of and witnesses to a significant amount of violence, including homicides and serious assaults.<sup>28</sup> It has also been estimated that at least 3.3 million children witness physical and verbal spousal abuse each year, from insults and hitting to fatal assaults with guns and knives.<sup>29</sup> Pediatricians, pediatric nurses, social workers, and others working in clinical settings need to be able to recognize and treat both short-term and long-term consequences of violence to children, including post-traumatic stress disorder, or ensure appropriate referrals for counseling.



**HEALTH CARE COMMUNITY RECOMMENDATION FROM THE FIELD #11**

**Technology should be utilized to improve medical services for crime victims, especially in underserved and rural areas.**

Many crime victims who live in underserved, rural, or remote areas do not have access to physicians to conduct forensic and other needed medical examinations. To help provide these crucial services, rural communities should consider using new technology to link nurse practitioners to trained physicians who can help them to conduct examinations and review procedures. Web sites should be established to provide information and links to local resources for families seeking help on victimization issues.

**HEALTH CARE COMMUNITY RECOMMENDATION FROM THE FIELD #12**

**Statutes and policy should be adopted to prevent insurance companies from discriminating against victims of crime by denying and/or canceling coverage or by charging higher premiums for such coverage.**

Some victims and their advocates report that it has become a practice among some insurance carriers to deny claims made by individuals that resulted from their criminal victimization. In addition, some insurers have either refused to cover such victims or have attempted to charge victims exorbitant premiums to obtain such coverage. As a matter of public policy, insurers granted the privilege of doing business in the various states should be required to provide victims with basic coverage much the same way companies are required to insure high risk drivers.<sup>30</sup>

**HEALTH CARE COMMUNITY RECOMMENDATION FROM THE FIELD #13**

**All health care professionals should be educated about sensitive death notification techniques.**

Death notification is rarely, if ever, addressed in medical schools, although nursing journals, pastoral care journals, and some medical social worker literature addresses it. OVC has funded the development of four death notification seminars, one geared specifically toward

health care providers. The protocol presented are based, in part, on interviews with hundreds of family members who had been notified of the deaths of their loved ones.

**HEALTH CARE COMMUNITY RECOMMENDATION FROM THE FIELD #14**

**Catastrophic physical injury victims, including assault and drunk driving crash survivors with serious injuries, should receive specialized neuro-psychological evaluation in health care facilities.**

Emergency room professionals place primary importance on treatment of injuries that are obvious or are detected by x-ray, CT scan, or MRI. Victims who have been seriously injured should also be referred to neuro-psychologists for evaluation of closed head injury and post-traumatic stress disorder. Five to 45% of motor vehicle crash survivors who seek medical attention will develop PTSD within the year following the crash and an additional 15% to 30% will develop symptoms but not enough for the full diagnosis.<sup>31</sup>

The recommendations in this chapter were based upon input from participants at public hearings and reaction and working groups, as well as papers submitted by experts in the field, identified in Appendix A. The recommendations do not necessarily reflect all of the views of the contributors, nor do they necessarily represent the official views of the Department of Justice.

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## Endnotes

- 1 Koop, C.E., "Foreword," in *Violence in America: A Public Health Approach*, ed. M.L. Rosenberg and M.L. Fenley, New York: Oxford University Press, 1991.
- 2 Miller, T.R., M.A. Cohen, and B. Wiersema, *Victim Costs and Consequences: A New Look*, National Institute of Justice, February 1996, NCJ 155282.
- 3 Rand, M.R., *Violence-Related Injuries Treated in Hospital Emergency Departments*, Special Report, Washington, D.C.: U.S. Department of Justice, Bureau of Justice Statistics, August 1997, NCJ 156921.
- 4 Flitcraft, A., "Physicians and Domestic Violence: Challenges for Prevention," *Health Affairs*, Vol. 12, Number 4, 1993:159.
- 5 Headden, S., "Guns, Money & Medicine," *U.S. News & World Report*, July 1, 1996:34.
- 6 Miller, T.R., and L.J. Blincoe, "Incidence and Cost of Alcohol-involved Crashes," in *Accident Analysis & Prevention*, Vol. 26, Number 5, 1994:583-591.
- 7 There is increasing evidence that the impact of crime-related trauma takes its toll on the long-term physical health of its victims. Dr. Dean Kilpatrick, a national expert on victimization, notes that crime victims have higher rates of health care utilization than nonvictims of crime. Moreover, female crime victims have been found to have higher rates of several prevalent health problems. Compared to nonvictims, crime victims have higher rates of several behaviors that contribute to health morbidity and mortality such as heavy alcohol and drug use, drunk driving, smoking, bulimia, and obesity.
- 8 President's Task Force on Victims of Crime, *Final Report*, Washington, D.C.: U.S. Government Printing Office, December 1982:89-94.
- 9 According to the Federal Bureau of Investigations 1995 Uniform Crime Reports, juvenile gang killings increased 38% over the last five years. Federal Bureau of Investigations, *1995 Uniform Crime Reports*, Washington, D.C.: 1995:17.
- 10 Shalala, Donna, Remarks to the Family Violence Prevention Fund National Conference, *Domestic Violence and Health Care: Initiatives for the New Millennium*, Washington, D.C., November 3, 1997.
- 11 Information on pioneering research and program development by physicians and nurses is contained in "Best Practices: Innovative Domestic Violence Programs in Health Care Settings," San Francisco, CA: Family Violence Prevention Fund, February 1997.
- 12 Kilpatrick, D., Edmunds, C., and A. Seymour, *Rape in America: A Report to the Nation*, Arlington, VA: National Victim Center and the Medical University of South Carolina, National Crime Victims Research and Treatment Center, 1992.
- 13 Data obtained from SANE program survey conducted by the Sexual Assault Resource Service of Minneapolis under OVC Grant # 96-VF-GX-K012.
- 14 Florida law, for example, provides that "the deductible or copayment provision of any insurance policy shall not be applicable to a person determined eligible pursuant to the Florida Crimes Compensation Act. . . ." FLA. STAT. ANN. §624.128.
- 15 "Best Practices: Innovative Domestic Violence Programs in Health Care Settings," published by the Family Violence Prevention Fund, 1997.
- 16 Colposcopy is the microscopic examination of the cervix.
- 17 This program is described along with a sampling of other innovative health care domestic violence programs in "Best Practices: Innovative Domestic Violence Programs in Health Care Settings."

- 18 American Academy of Pediatrics, "Adolescent Assault Victim Needs: A Review of Issues and a Model Protocol," *Pediatrics*, Vol.98, No.5, 1996:991- 1001.
- 19 Alpert, E.J. and S. Cohen, eds., "Educating the Nation's Physicians about Family Violence and Abuse," *Academic Medicine*, Supp.72, January 1997:1; Thurston, W.E. and L. McLeod, "Teaching Second-Year Medical Students About Wife Battering," *Women's Health Issues*, Vol.7, No.2, 1997:92-98.
- 20 Shalala, D., *Domestic Violence and Health Care: Initiatives for the New Millennium*, Remarks to the Family Violence Prevention Fund National Conference, Washington, D.C., November 3, 1997.
- 21 According to Dr. A. Heger, Medical Director of the Violence Intervention Program at L.A. County—USC Medical Center, 28% of emergency room visits are related to family violence.
- 22 West's Ann. CAL. HEALTH AND SAFETY CODE §1233.5 (West). Patient screening to detect spousal or partner abuse.
- 23 McAfee, R.E., M.D., "Medical Records," in *The Impact of Domestic Violence on Your Legal Practice*, American Bar Association Commission on Domestic Violence, 1996.
- 24 Violence Against Women Act of 1994, tit. IV of the Violent Crime Control and Law Enforcement Act of 1994, Pub. L. No. 103-322 (September 13, 1994) codified at 42 U.S.C. 13701, at § 40503.
- 25 Pinn, M.T., V.W. Chunko, "The Diverse Faces of Violence: Minority Women and Domestic Abuse," *Academic Medicine*, Supp., January 1997:72.1.
- 26 See, e.g., De Vos, E., D. Stone, "Evaluation of a Hospital-based Youth Violence Intervention," *American Journal of Preventive Medicine*, Supp. Vol.12, No.5 1996:101-108.
- 27 Lanza, M.L., "Nurses as Patient Assault Victims: An Update, Synthesis, and Recommendations," *Archives of Psychiatric Nursing*, VI:3, 1992:163-171.
- 28 See "Silent Victims, Children Who Witness Violence," Commentary, *Journal of the American Medical Association*, Vol.269 No.2, 1993:262- 264.
- 29 Osofsky, J.D., "Children Who Witness Domestic Violence: The Invisible Victims," *Social Policy Report*, Vol.IX No.3, 1995:2-3.
- 30 Under current federal law (Kennedy-Kassenbaum legislation) it is illegal for insurance companies to discriminate based on a pre-existing condition when a person transfers from one insurance plan to another. Abuse cannot be considered a pre-existing condition. In addition, Senator Paul Wellstone (D-MN) and Representative Bernard Sanders (I-VT) have introduced legislation that would effectively prevent discrimination of insurance carriers against victims of crime. Called the Victims of Abuse Insurance Protection Act, it would prohibit insurers and health carriers from making coverage determinations on the basis that the applicant or insured is or has been the victim of domestic abuse. It would also prohibit insurers from using or disclosing information about the person's abuse history, with limited exceptions. S. 467, H.R. 1117.
- 31 Hickling, E.J., and E.B. Blanchard, "Post Traumatic Stress Disorder and Motor Vehicle Accidents," *Journal of Anxiety Disorders*, Vol. 6, 1992:283-304; Green, M.M., McFarlane, A.C., C.E. Hunter, & W.M. Griggs, "Undiagnosed Post Traumatic Stress Disorder Following Motor Vehicle Accidents," *The Medical Journal of Australia*, Vol.159, 1993: 529-534.