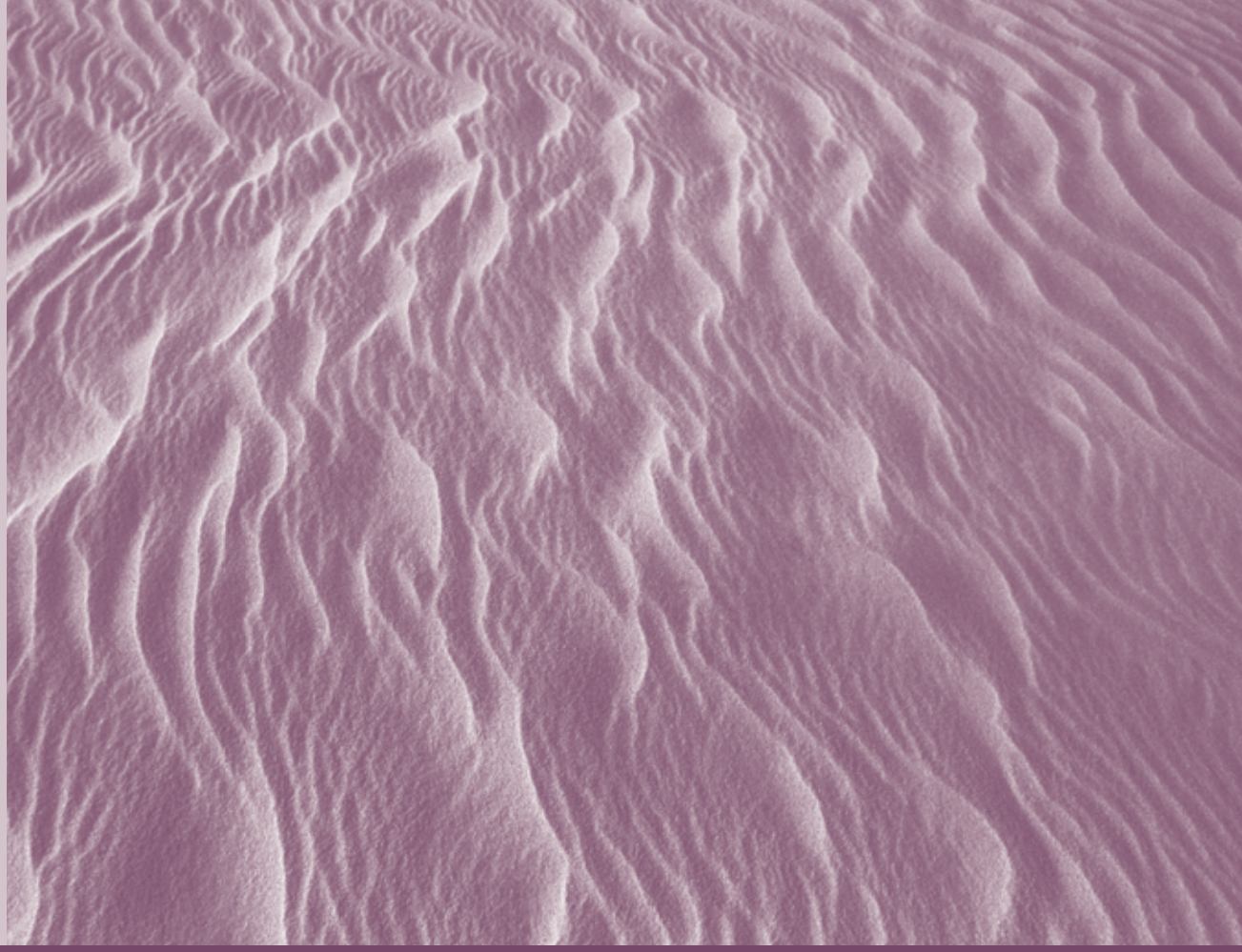
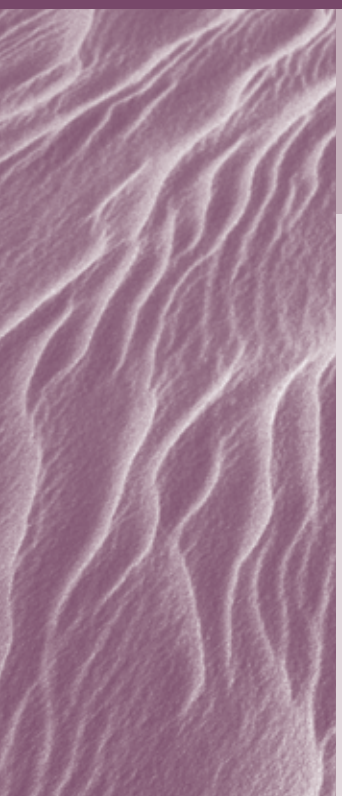


Building Academic Capacity and Expertise

in the Health Effects of Violence and Abuse

A BLUEPRINT FOR ADVANCING PROFESSIONAL HEALTH EDUCATION



AVA
ACADEMY ON
VIOLENCE & ABUSE

MISSION

The mission of the Academy on Violence and Abuse (AVA) is to advance health education and research on the prevention, recognition, treatment, and health effects of violence and abuse.

VISION

By expanding health education and research, AVA will integrate knowledge about violence and abuse into the training of health professionals, promote the health of all people, protect the most vulnerable, and advance health policy that promotes safe families, workplaces, and communities.

AVA LEADERSHIP

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Building Academic Capacity and Expertise

in the Health Effects of Violence and Abuse

A BLUEPRINT FOR ADVANCING
PROFESSIONAL HEALTH EDUCATION

Phase I:

Proceedings from a Pre-Conference Symposium
at the Family Violence Prevention Fund
2007 National Conference on Health and Domestic Violence
March 15, 2007
Marriott Hotel, San Francisco, California

From the Academy on Violence and Abuse

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In 2002, the Institute of Medicine (IOM) published a report entitled, *Confronting Chronic Neglect: The Education and Training of Health Professionals on Family Violence*, which details the IOM's findings regarding health professionals' education on family violence. Although some progress has been made since the report's release (e.g., increased awareness among health professionals and more education materials, conferences, and publications), health problems related to violence and abuse remain marginalized within the curricula of most schools of medicine, public health, and dentistry. Only nursing schools have made noticeable progress in regard to family violence education.

One major recommendation of the IOM report was that health professional organizations develop and provide guidance to their members, constituents, institutions, and stakeholders regarding violence and abuse education. Specifically, the recommendation emphasized the need for organizations to provide guidance in (1) competencies to be addressed in health professional curricula, (2) effective teaching strategies, and (3) approaches to achieving sustained behavior changes among health professionals. The IOM further recommended that health professional organizations identify and disseminate information on approaches for overcoming barriers to training on family violence.

The Academy on Violence and Abuse (AVA) was founded in 2005 to address these concerns and to support implementation of the IOM recommendations. The mission of the AVA is to advance health education and research regarding all forms of violence and abuse. In March of 2007, the AVA organized a one-day symposium as part of the pre-conferences at the Family Violence Prevention Fund's national health conference. AVA invited key informants and representative stakeholders to explore the needs of professional health education on violence and abuse at all levels of training. The purpose of this document is to disseminate the findings and recommendations of that symposium.

The key findings and recommendations from the symposium are as follows:

- The health impact of violence and abuse are both acute and chronic in nature. While the consequences of acute physical trauma are usually addressed in the health care setting, the underlying causes can be missed. Being victimized by abuse is often stigmatizing to patients and therefore can be hidden from practitioners. The long-term effects of abuse and the comorbid associations with many chronic diseases are underappreciated. Improving the understanding of these connections represents a major challenge for researchers, educators, and health policy makers.
- Understanding these complex interactions and applying that understanding to clinical practice requires a multidisciplinary approach. Patients who suffer from violence and abuse present to all health specialties and disciplines. Creating core competencies common to all health professionals and reducing the fragmentation of responsibility is a priority.
- Violence and abuse should not be seen as a new topic competing for a separate domain in the health care curriculum but rather a topic that crosses multiple disciplines and provides an opportunity to teach more sophisticated interviewing and diagnostic skills. Progress toward this end will require a collaborative approach as well as a clear focus on public health prevention.
- Training health care and public health professionals is a serious responsibility that is overseen by many organizations and must meet the regulatory demands of several agencies. The AVA should seek to understand each sector and their methods of operation and decision-making and map a course for change in order to integrate violence and abuse education within the current structure.
- Many groups and organizations have an interest in advancing health education on violence and abuse. By creating alliances, fostering mutual regard, and identifying common commitments, the leaders of these organizations can positively effect legislative or policy change at the national, state, or agency levels.
- The American Academy of Pediatrics and the American Board of Pediatrics are to be commended for adding the subspecialty of Child Abuse Pediatrics in recognition of the expanding science and clinical experience of child-abuse–focused clinicians. However, while there may be subgroups with more advanced skills, all practitioners should have basic competency in the recognition and initial care of victims of violence and abuse.

Specific recommendations for integrating education about violence and abuse into health professional curricula appear in Section VI of this document.

The Academy on Violence and Abuse (AVA) acknowledges that many organizations have already provided leadership in efforts to advance health professional education on the health effects of violence and abuse. The continued participation and contribution of many organizations is vital to our progress. These include the American Association of Colleges of Nursing, the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, the American College of Nurse Midwives, the International Nursing Network on Violence Against Women, the Family Violence Prevention Fund, the National Association of Social Workers, and the Council on Social Work Education.

In addition, the AVA acknowledges the importance of the continued commitment of the Association of American Medical Colleges, the Accreditation Council for Graduate Medical Education, the American Medical Association, the American College of Physicians, the American Association of Colleges of Nursing, and the American Dental Association. The AVA intends to call upon the experience and expertise of these organizations and others to help in formulating and implementing the strategies of the Blueprint.

The AVA also wishes to acknowledge Tasneem Ismailji, MD, MPH, chair of the AVA Scientific, Education, and Research Committee, who organized the presentation of key informants and the discussion of field experts that make up this document. The members of the committee include Debra Houry, MD, MPH; Ellen Taliaferro, MD; David Schneider, MD, MSPH; Connie Mitchell, MD, MPH; Debbie Lee; and Jacquelyn Hauser, MBA.

The AVA is very grateful for the continuing guidance and support of the Family Violence Prevention Fund and for all of their assistance in the organization and planning of the AVA Pre-Conference held at their 2007 National Health Care and Domestic Violence Conference. In particular, we recognize Debbie Lee and Lisa James, MA, who share their knowledge, leadership, and resources in their efforts to consistently encourage the evolution of this important issue.

At the end of this document is a list of conference participants. Their thoughtful questions and engaging discussions following each panel expanded on the presentations and contributed to the outcome of this document. We are most appreciative of their expertise, time, and wisdom.

Thanks to the efforts of David McCollum, MD, the entire conference proceedings were video recorded and are available online at the Academy on Violence and Abuse website. You can hear and see the speakers and their PowerPoint presentations and listen to the discussion that occurred after each panel at *www.avahealth.org*. In addition, two board members, Philip Scribano, DO, MSCE, and David Schneider, MD, MSPH, provided extensive review, which contributed to the final wording of the document. We appreciate their time and effort.

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According to the Centers for Disease Control and Prevention,[1] in 2005, 18,124 people died as a result of homicide and 32,637 took their own life. Each year, women experience about 4.8 million intimate partner-related physical assaults and rapes, and men are the victims of about 2.9 million intimate partner-related physical assaults. In 2006, social service agencies reported that 905,000 children were identified as being maltreated. In the United States, 1 in 6 women and 1 in 33 men report experiencing an attempted or completed rape at some time in their lives. Youth violence is widespread in this country and is the second leading cause of death for young people aged 10 to 24. More than 720,000 violence-related injuries in young people were treated in US emergency rooms in 2006. Violence and abuse cost billions of dollars in health care and lost productivity.

Beyond visible injuries, violence and abuse contribute to less apparent but equally serious physical and emotional health problems that can have a lifelong effect on one's ability to achieve and maintain health and quality of life. Recent research shows that child abuse and childhood exposure to domestic violence are major etiologic factors for adult premature morbidity and mortality.[2] Early childhood exposures to trauma and violence lead to changes in brain anatomy that, if untreated, may have permanent pathologic consequences.[3, 4] Children witnessing family violence are more likely to experience depression, anxiety, substance abuse, allergies, asthma, and gastrointestinal problems and are more likely to engage in high-risk behavior later in life.[5, 6]

Adult victims of violence and abuse also suffer long-term health consequences. Intimate partner physical and psychological abuse is linked to a number of health problems, including arthritis, chronic neck and back pain, migraines, chronic pelvic pain, vision problems, and stomach ulcers.[7] As the problem of elder abuse becomes more clearly understood, we are learning that the consequences of abuse are particularly grave for the elderly because of frailty and comorbid illnesses. In fact, community-dwelling elders with a reported history of abuse experience a threefold increased risk of death.[8]

The World Health Organization and many other health organizations believe that violence can be prevented and its impact reduced through health care and public health efforts.[9] Victims of violence have identified their health provider as their preferred source of help. This means that the identification, intervention, and prevention of violence should be an essential component of all phases of training in nursing, medical, dental, and public health educational systems.[10, 11] Unfortunately, most curricula are woefully deficient in the area of violence education.[9] To address the needs of patients exposed to violence and abuse and to effectively participate in public health prevention efforts, health professionals must be better trained and prepared.

Without formal training, health care professionals may lack knowledge and understanding about the issues surrounding violence and abuse and may be inexperienced in recognizing related physical and emotional health symptoms. Skilled clinicians and experienced researchers in the health effects of violence and abuse are needed to inform the academic process, to serve as mentors to students and faculty, to provide consultation to those providing care, to define the research agenda, and to develop the corps of educators needed to establish this new field of expertise.

The AVA has as a primary goal the support of scholarship—discovery, integration, application, and education—regarding the health effects of family violence. The AVA facilitated a pre-conference symposium at the 2007 Family Violence Prevention Fund National Conference on Health and Domestic Violence in San Francisco, California. Three panels of expert key informants were convened to provide information and insights from the field. Each panel was followed by an hour of in-depth discussion with audience members who themselves were experts, key stakeholders, advocates, and experienced

Continued

practitioners in the field. The purpose of the discussion was (1) to reach initial consensus on the issues and (2) to formulate general recommendations and initial steps for implementing health professional education in the health effects of violence at all levels of training. This report includes key summaries of the symposium's discussions. It captures a range of ideas from the field, but those ideas do not necessarily represent final policy of the AVA.

This document contains the proceedings and recommendations that are now considered Phase I for building academic capacity and expertise in the health effects of family violence. Phase II will follow as the specific strategies for change are implemented. We anticipate publishing and presenting a report of Phase II activities in 2009.

While the term "family violence" is often used by panelists and discussants in this document, the AVA recognizes that all forms of violence or abuse—from any individual at any point in one's lifespan—can have a lasting effect on the physical and mental well-being of the individual.

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II ■ CONFRONTING CHRONIC NEGLECT:

A SUMMARY OF THE REPORT ISSUED BY THE INSTITUTE OF MEDICINE

Presented by Jacquelyn C. Campbell, PhD, RN, FAAN, Anna D. Wolf Endowed Professor
and Associate Dean for PhD Programs and Research, Johns Hopkins University School of Nursing

In 2002, the Institute of Medicine released *Confronting Chronic Neglect: The Education and Training of Health Professionals on Family Violence*. This report was congressionally mandated to examine the training needs of health professionals and the existing curricula and efforts to foster knowledge and skills of health professionals in this area. The committee surveyed the accreditation requirements for health professionals, collected policy statements of health professional organizations regarding family violence, and collated and described existing curricula on family violence from around the country.

The conclusions of this multidisciplinary committee were as follows:

1. **The full effects of family violence on society and health have not been adequately documented or studied.**
2. **Variation in definitions, surveillance strategies, and databases has resulted in inconsistent and unclear evidence about the magnitude and severity of family violence.**
3. **There are no consistent federal sources of support for education research on family violence.**
4. **Curricula are available but are very limited in terms of scope, integration in the program, instructional time, and resources provided.**
5. **Evaluation of education and training efforts has received insufficient attention.**
6. **Core competencies can be developed and will vary by role, functions, and interests.**
7. **Educational theories about behavior change suggest useful teaching strategies that should be incorporated into curriculum and training programs.**
8. **Challenges to implementing comprehensive training efforts include the nature of accreditation, licensure, and certification as well as the roles of health professional organizations, attitudes of individual professionals, and views of stakeholder groups.**

Four key recommendations made in the report include:

- The US Department of Health and Human Services should establish new multidisciplinary education and research centers to advance scholarship and practice in family violence.
- Health professional organizations should develop and provide guidance to their members, constituents, and institutions to address competency areas, effective teaching strategies, and approaches to promoting and sustaining behavior change in health professionals.
- Health educators in academic health centers and health clinics should test and evaluate any innovative training models or programs.
- Federal agencies and other funding agencies of educational programs should support curriculum evaluation on family violence in order to determine the impact on health practice and outcomes on patients.

III ■ PANEL A: NURSING, MEDICAL, AND DENTAL EDUCATION ON VIOLENCE AND ABUSE

Moderator: Ellen Taliaferro, MD

EXPERIENCE AND WISDOM FROM THE FIELD OF NURSING

Presented by Janice Humphreys, PhD, RN, NP, FAAN, Associate Professor, School of Nursing, University of California San Francisco

Family violence and abuse education within nursing education currently surpasses that found in physician education, with 90% of Bachelor of Science and nursing programs including content on intimate partner violence and child abuse and neglect. The Nursing Network on Violence Against Women International, a nursing organization formed in 1985, encourages the development of a nursing practice that focuses on health issues relating to the effects of violence on women's lives. The American Association of Colleges of Nursing considers violence and abuse training as a core competency for entry-level nurses. The American College of Nurse Midwives has requirements and exemplary education in abuse and violence for certified nurse midwives.

The nursing core competencies encompass three levels of practice: basic undergraduate, advanced practice, and leadership. Core competencies include (1) identification, assessment, and documentation of abuse; (2) intervention to secure safety and reduce vulnerability; (3) recognition of cultural and value factors influencing family violence; (4) recognition of legal and ethical issues in treating or reporting family violence; and (5) engagement in activities to prevent family violence. Each competency is defined by a set of performance indicators. In addition, the nursing competencies recommend that students receive tools for successful screening, risk factor identification, patterns of injury, documentation, assessment for immediate danger, safety plan development, and the use of validated assessment instruments. The teaching approach stresses skill-building and guided clinical experience rather than a straight didactic approach, which has been shown to be inadequate. Instruction is based on established theories to guide behavior change. Curricula exist at the undergraduate, masters, and doctorate levels.

Within nursing education are numerous examples of curricula that can be used as models. Model curricula vary greatly but ideally are multidisciplinary, incorporate guest speakers, and include service-learning projects. Courses exist for entering college freshman (in the form of freshman seminars on relationship violence) that emphasize critical thinking, personal values, and self-reflection. Family violence is a key element in another course on health promotion and disease prevention and provides an opportunity to discuss screening and case finding, physiologic consequences, and long-term impact of violence and abuse. One institution now offers clinical nurse specialist training to prepare nurses for acute care and for forensic care and participation in public surveillance and fatality reviews. For any of these educational offerings, an informed faculty is crucial to fostering behavior implementation and change, modeling and reinforcing behaviors, and providing a supportive environment for both students and faculty.

Family violence education should both be integrated within the overall curriculum and through independent courses. Family violence cases provide appropriate examples when teaching about communication and assessment skills and how to avoid stigmatizing illness.

HOW TO INFLUENCE THE PROCESS, POINTS OF LEVERAGE, POSSIBLE PARTNERS, AND ALLIES IN THE MEDICAL SCHOOLS

Presented by Robert W. Block, MD, FAAP, Professor and Daniel C. Plunket Chair, Pediatrics,
University of Oklahoma College of Medicine (with content contributed by Richard Krugman, MD, FAAP)

Should domestic violence, child abuse and neglect, and elder abuse be considered part of the same problem, or are they separate? The answer may depend on whether we are discussing patient care, research, education of students and residents, or policy development. Domestic abuse, child abuse and neglect, and elder abuse are introduced at many levels in the medical school curriculum. Instruction must move beyond awareness to behavioral skills in identification and intervention. At present, there is no specific body of knowledge about violence and abuse that all physicians receive during their training and no standard way to assess what the physician has learned. Organized medicine has, for the most part, ignored the recommendations from the National Advisory Committee on Child Abuse and Neglect and from the Institute of Medicine. These recommendations should be revisited and implemented, with emphasis not only on prevention of abuse but on management and prevention of the ensuing health problems that arise from abuse.

Barriers to a unified approach include the vastly different needs of research versus education and practice versus policy development. Other barriers are the inconsistencies in the definitions of abuse as well as the differences in reporting laws from state to state. The challenge is one of implementation, as there are, in fact, many well-developed curricula already in place in some of our medical and nursing programs. Unfortunately, their use and success seem to rely on the presence of committed faculty who champion the importance of this curriculum.

Change will require ongoing education of physicians already in practice, most of whom are naïve to the chronic health effects of violence and abuse. They often feel unskilled in their approach to patient interviewing, unqualified to interpret the information the patient may divulge, and helpless to respond effectively. Evidence-based medicine will require research support from federal medical organizations such as the National Institutes of Health, Centers for Disease Control and Prevention, or the Violence Against Women Act (VAWA) Health Cares Initiative—not just from the Department of Justice.

Examples of curricula exist but need to be studied, validated, and then perhaps replicated. The University of Oklahoma College of Medicine, Tulsa Campus is an example of a medical school that has a model for training physicians on violence and abuse. Medical students may elect a one-month course in domestic violence, child abuse, and sexual assault. They spend time with sexual assault nurse examiners, visit crime labs, ride in police cruisers during domestic violence calls, and learn about the role of law enforcement in domestic violence cases. They are required to write a paper on the topic of abuse as well as a case report.

Health professional schools, especially highly leveraged schools of medicine, gravitate toward the better-funded health issues. As long as violence is treated simply as a social or criminal problem, the health implications will be underemphasized, and funding needed to address the health aspects will suffer. Violence and abuse occur at any age with both short-term and long-term health consequences. There are often common etiologies for the occurrence of violence and abuse and many comorbid conditions such as substance abuse, mental health problems, and socioeconomic issues. The problem presents itself across all specialties.

MAKING CURRICULAR CHANGES TO INCLUDE THE PROBLEM OF VIOLENCE AND ABUSE

Presented by Michael Wilkes, MD, PhD, Vice Dean for Curricular Affairs, University of California, Davis, School of Medicine

Violence and abuse in the current curricula are "orphan topics." They do not belong to one department, one discipline, or one particular specialty. Therefore, such topics can be overlooked, neglected, or fragmented.

In order to try to change medical school curricula, one must understand that curricula are governed by overlapping spheres of influence, including (1) imposed external characteristics and health policies such as ethical mandates and reporting laws; (2) organizational mission, both spoken and unspoken, regarding what is rewarded or not rewarded; (3) patient characteristics, demographics, knowledge, beliefs, and attitudes; (4) physician characteristics, beliefs, specialties, experience, and focus areas; and (5) culture, both individual and the collective culture of medicine. Through this mixing process of overlapping spheres, students become homogenized and adopt the culture of medicine.

In general, there is need for a sea change in medicine. This involves recognizing the value of emotional intelligence, teamwork, trust, openness, and caring. Education should prime the pump for future learning and should motivate students to the value of lifelong learning by recognizing that we can't possibly teach all that is needed to be mastered in four years of medical school. The curriculum must be more integrated and less territorial. Faculty need to support the concept, with every member demonstrating competency in family violence. Faculty members who teach the importance of the behavior change will, themselves, need to change their own behavior and commit to being lifelong learners. Medical education should not be about fact-learning and performance on multiple-choice exams.

At the University of California Davis, (UC Davis), domestic violence was placed at the center of a curriculum that emphasizes physician behavior—not what the physician learns but how he or she applies it. The UC Davis program relies heavily on videos, interviews, and reenactments of standardized patient scenarios. The focus is on behavior change and teaching for behavior change, not lecturing and memorization of facts. According to theories of cognitive dissonance, you can't teach what you don't believe. Faculty development is a critical component; before each of the 12 to 14 problem-based and case-based learning sessions, the small-group preceptors participate in one hour of faculty development. The teaching methodology at UC Davis has been in place for several years and is well regarded by both students and faculty.

Again, it is about behavior change and not knowledge alone. The problem is not about getting more about family violence into the medical curriculum. The real problem is how can we change medical education overall. The key is to focus less on content, more on process and the behaviors involved in being a competent physician, such as openly addressing barriers to health or socially stigmatized topics such as exposure to violence and abuse. We must teach students how to be lifelong learners so that as new insights into health care arise, experienced doctors adopt new behaviors into their practices.

DO DENTAL PROFESSIONALS FACE THE SAME CHALLENGES AND BARRIERS TO ADDRESSING VIOLENCE AND ABUSE IN THEIR TRAINING PROGRAMS?

Submitted by Leslie Halpern, MD, DDS, PhD, MPH, Assistant Professor, Harvard School of Dental Medicine
(Due to circumstances beyond her control, Dr Halpern was unable to participate and therefore has submitted this written summary.)

At least 50% of adults visit the dentist once a year, and the majority of patients have positive attitudes toward their dental practitioner. Therefore, dentists are in a unique position to help victims of violence. Victims of violence and abuse will most often present with injuries to the head, face, and/or neck regions. Reports from emergency department visits indicate that greater than 75% of the time, women who presented with facial injuries had been assaulted by their intimate partner. In addition, most of these injuries are seen within the oral cavity, especially in children and young adults. The physical signs of abuse such as facial bruising, fracture of bones in various stages of healing, finger marks, burns, orofacial injuries such as torn frenums, lip lacerations, loose teeth, and multiple fractures of teeth and dental neglect are all findings in physical abuse. Oral manifestations of sexually transmitted diseases, fearfulness of the dental exam, difficulty sitting or walking, and fear of the reclined position of the chair all should send "bells and whistles" to the practitioner as signs and symptoms of sexual abuse. The ability to question in a nonjudgmental and supportive manner can aid a victim in feeling more at ease because victims tell us they do want to be asked.

Education about violence and abuse in the training of dentists has been insufficient even when the signs of abuse are present. Reasons for lack of identification may be divided into two types: (1) inadequate education on the approach to identify victims and (2) barriers to questioning that include cultural norms, personal embarrassment by the doctor, and patients accompanied by their partners or family members.

In 1993, the American Dental Association (ADA) amended its code of ethics by stating: "Dentists shall be obliged to become familiar with the signs of abuse and neglect and to report to the authorities…." In 1996, the ADA further developed an educational policy that advised looking for symptoms such as conflicting histories of injury, behavioral changes, multiple injuries at various stages of healing, and recoil behavior during the oral exam. In 2006, the ADA news ran a commentary summarizing the importance of increasing the dental community's education, understanding, and obligation to recognize the signs and symptoms of family violence. The American Association of Oral and Maxillofacial Surgeons (AAOMS) states, in accordance with the ADA and American College of Surgeons, that "Surgeons are encouraged to take a leadership role in communities, hospitals and medical schools in preventing and treating IPV [intimate partner violence]."

Educators of oral health have taken a variety of steps to provide the knowledge base for dentists regarding the above stumbling blocks. The Prevent Abuse and Neglect through Dental Awareness (PANDA) coalition began in Missouri in 1992, with Lynn Mouden, DDS, as one of its cofounders. The PANDA coalition is comprised of the Missouri Dental Association, Delta Dental Plan of Missouri, the Missouri Division of Family Services, and the Missouri Bureau of Dental Health. As of January 2004, Missouri's program has been replicated by 46 states as well as by international coalitions in Romania, Guam, Peru, Canada, Finland, Israel, Belgium, Iceland, Nigeria, South Africa, the Federated States of Micronesia, and Papua New Guinea.

Continued

PANDA educational programs include information on the history of family violence in our society, clinical examples of confirmed child abuse and neglect, and discussions of legal and liability issues involved in reporting child maltreatment. While originally intended for dental audiences, the PANDA education programs are also presented for physicians, nurses, teachers, daycare workers, and anyone who has an interest in preventing family violence.

More recent approaches to educate the dental community have involved tutorials and diagnostic protocols to identify more victims and to refer them for intervention. A recent article written by Hsieh and colleagues and published in the Journal of the American Dental Association describes an interactive multimedia tutorial for dental practitioners that involves attitudes, knowledge, and practice behaviors regarding domestic violence/abuse. The use of a diagnostic protocol using injury location and a verbal questionnaire has significantly increased the identification of victims by oral and maxillofacial surgeons in the emergency department. This protocol crosses both geographic and socioeconomic barriers and is being tested in other clinical settings.

Both the general dentist and oral maxillofacial surgeons are in a unique position to recognize the impact that violence and abuse may play in their patient population. As stated by JP Kenney, "Dental practitioners have four R's of responsibility—recognize, record, report, and refer—to protect our patients and their families from the cycle of violence." As such, the dentist or the oral and maxillofacial surgeon is often the first to see and evaluate victims of violence and abuse in the emergency department or the private practice environment. Practitioners need to follow these steps to incorporate formal training in every dental school and residency program in the country.

PANEL A: SUMMARY OF KEY DISCUSSION POINTS

1. **Teaching students to address violence and abuse requires current educational approaches to creating behavior change.**
   - Medical schools appear to still be organized around concepts and constructs of disease as opposed to how to interact and talk with patients about perceptions of their health, barriers to their health, and goals for their personal well-being. Issues of violence and abuse often arise through these personal discussions.
   - When focusing on passing certification examinations, students work to attain just the right amount of facts they need to pass exams and focus less on acquiring the necessary skills. How do we persuade certification boards to include content on violence and abuse?
   - Medical schools need to spend more time teaching techniques on how to recognize and diagnose issues that are not readily apparent, that require time and trust, and that are complex in etiology and in intervention. Family violence prevention programs provide an excellent model for this.
   - The expense of providing high-quality education geared toward behavior change instead of fact memorization must be appreciated, especially now, when we are challenging why the most expensive health care system in the world doesn't result in the best possible outcomes on measures of health.
   - Given that, in health care, there is significant focus on what constitutes ethical practice, it becomes our ethical responsibility to explore all the avenues that help people improve their health. Not to explore issues of violence is unethical. The cost of ignoring the effects of violence and abuse is too great; it merits our work.

2. **The short-term and long-term effect of trauma is a fairly new field with new approaches.**

   - Thinking about family violence as an "orphan" issue means that it can be cordoned off as a certain topic that we choose to address or not, rather than perceiving violence and abuse as greatly hindering one's capacity for well-being. Understanding the health impact of trauma experiences is integral to the training of every health practitioner.
   - A component of any curriculum must include a process for students to self-reflect and learn from their own experiences with violence and abuse. Students are trained to "not bleed in the water full of sharks," and they suppress personal issues as a way to cope and survive in the training process. Educators shouldn't be expected to be therapists, but medical schools must provide the environment, support, and mentoring for students, residents, and faculty to explore these issues in the safety of the training institution so that they don't later subvert the clinical interaction. Panelists discussed the value of parallel charting, in which students enter chart notes for the patient and separate chart notes about their own feelings and actions. Any training should address the impact of violence and abuse beyond the identified victim and address vicarious and secondary trauma and its potential impact on the health professional.
   - The focus of education needs to be on diagnosis of violence and abuse. We are looking for accurate diagnosis of a shame-based disease. This is difficult to do and difficult to teach.
   - When colleagues ask, "Why should I spend time on this when there is no evidence on how to intervene or whether intervention is effective?" we must be intellectually honest that our research on both educational outcomes and clinical interventions for victims of family violence is still very limited.

3. **The influence of culture on both definitions and interpretations of family violence must be addressed in the educational experience.**

   - People from different cultural or international backgrounds may challenge that the American paradigm regarding family relationships roles and rights clashes with their own and may not be functional for them.
   - A component of education about family relationships is facilitation of a process of introspection about one's family of origin. This process may require time, privacy, and safety for people to explore the issue and question their own cultural beliefs or myths.
   - It is also helpful to focus less on cultural differences and more on cultural universalities, such as the need for each person to have a sense of safety and security in their life.
   - Unfortunately, every culture has elements of violence and every culture has resisted addressing the causes of violence.

4. **There are barriers.**

   - Education must also be extremely sensitive to the constraints of health care practice. We must test models for intervention that can be implemented without an undue burden to the clinician.
   - Incorporating the electronic medical record, while it affords some advantages in documentation, may actually become another barrier to effective patient-practitioner interaction.

5. **There is hope.**

   - There are many resources available for training and assistance. Advocates, nurses, and social workers should be seen as allies, and faculty should encourage students and residents to view them as additional teachers. Also, medical and nursing school faculty could do much more collaborative work as researchers, clinicians, and educators.
   - We can't all do everything. It is important to find what we can do best and make our contribution. Not all people have the skills to address the problem of violence and abuse. However, students who have the potential to be excellent trauma/victim care specialists will not have the opportunity to share their talents if we do not interject curricular content about violence and abuse and include the topic on the board certification examinations.

Moderator: David Schneider, MD

INTEGRATING GENDER-BASED HEALTH ISSUES INTO GRADUATE MEDICAL EDUCATION: THE EXPERIENCE OF ONE HEALTH ORGANIZATION

Presented by Peter J. Sawires, MA, Director of the Residency Education Initiative at Physicians for Reproductive Choice and Health and Founder of the National Conference on Health and Domestic Violence

Making changes within resident and postgraduate education takes time and persistence, but it can be done. Resident education is often "prescriptive" and is dictated by the various accrediting organizations. The organization Physicians for Reproductive Choice and Health (PRCH) wanted to integrate evidence-based sexual and reproductive health education into resident and postgraduate education. PRCH also wanted to ensure that residents receive education in sexual and reproductive health that is relevant to the scope of practice, patient populations, and clinical standards unique to each specialty. The organization's goal is to foster ownership of some of the most relevant issues as suggested by accrediting bodies and the constellation of stakeholders that inform and influence these bodies. To address these intentions and goals, PRCH organized a multiyear project called the "Residency Education Initiative," during which it identified 32 core issues. PRCH surveyed existing requirements in various specialties and then convened a committee for each specialty consisting of content/issue experts, physician advocates, specialty opinion leaders, accreditation officials, specialty board members, association representatives, residency directors, and other leaders who offered specific expertise, influence, and contextual insights. A critical step was to "map" each specialty in order to identify the decision-making bodies, the leverage points, and the critical steps for change.

The leverage points are diverse and varied among specialties. They include the following:

- Accreditation Council for Graduate Medical Education requirements themselves
- Funding streams
- Practice models and definition for scope of practice
- State and federal laws
- Core competencies and performance measures
- Quality-of-care measures
- Specialty-wide initiatives/movements and major trends in clinical and educational innovation
- Systemwide issues and movements, including health disparities, preventable errors, prevention, and health collaboratives
- Pre-eminent research models in each specialty and in recent seminal studies

The project was successful for several reasons. First, PRCH worked from within, developing a system of relationships, identifying known supporters, and providing regular feedback. Second, PRCH offered opinion makers a visible role in the process, framing the work to provide solutions and models that added value to the areas of greatest focus and concern in the field. Finally, the organization gave credit for the advances made to the committee members and partners. The AVA and other interested organizations should start with a consensus approach to generating core competencies and performance measures for physicians—just as nursing organizations have done for nurses.

BASED ON THE AMERICAN ACADEMY OF FAMILY PHYSICIANS' EXPERIENCE, HOW CAN ALL DOCTORS BE TRAINED IN MINIMAL COMPETENCIES REGARDING VIOLENCE AND ABUSE?

Perry Pugno, MD, MPH, CPE, Director, Division of Medical Education, American Academy of Family Physicians

Currently, the Residency Review Committee requirements for Family Medicine state that curricula should include the assessment of risks for abuse, neglect, and family and community violence. The operative word is "should." In order to receive the kind of priority level for implementation that would be required, the word "should" needs to be replaced by the word "must" because programs are accredited based on how they meet the "musts."

The Accreditation Council for Graduate Medical Education (ACGME) provides a list of institutional requirements, common program requirements, and specific program requirements. Violence and abuse should be a part of the "common program requirements" applicable to all residency programs. Violence and abuse is a broad, interdisciplinary topic that is too easily fragmented into specialty silos, so the commonalities of risk assessment, identification, documentation, and intervention are not reinforced. "Siloizing" also leads to the misperception that dealing with violence and abuse is "too difficult" for most doctors. Breaking down the silos will politically strengthen the field.

A national organization should take the lead and engage with medical education regulatory bodies (e.g., Association of American Medical Colleges, Accreditation Council for Graduate Medical Education, Liaison Committee on Graduate Medical Education, Accreditation Council for Continuing Medical Education, American Board of Medical Specialties, Residency Review Committees, American Medical Association) and collaborate with public and advocacy organizations (e.g., Family Violence Prevention Fund, American Association of Retired Persons, American Board Association, US Department of Justice). Also, excellent models for curriculum and continuing medical education currently exist. One example is the curricular materials developed in California for health professionals (The California Medical Training Center) to better address domestic violence and elder abuse and to provide forensic exams in child abuse and sexual assault.

There will be resistance to this effort because the current curriculum requirements seem to fill all available training time. Many individuals present themselves to the education regulatory bodies with "an ax to grind," and there is resistance in general to unfunded mandates. Making progress will require patience, organized persistence, and the voice and support of many.

ADDING FAMILY VIOLENCE TO THE MASTERS IN PUBLIC HEALTH: CURRENT STATUS AND FUTURE DIRECTIONS

Elaine Alpert, MD, MPH, Associate Professor of Public Health, Boston University

The public health approach to addressing violence and abuse is ideal because it is prevention-focused, science-based, advocacy-oriented, and involves assessment, planning, and evaluation. The public health approach to addressing violence and abuse is valuable and appropriate because of the following:

- Public health personnel are respected in the community.
- There is inherent value in multidisciplinary teams.
- Public health programs can be change agents through community education or policy innovation.
- Public health training includes methods for innovation in prevention.
- Public health training includes the development of expertise in planning and evaluation.

A public health model goes beyond the biomedical "disease-oriented" approach. It is contextual, multidisciplinary, and ecological in focus, which works well for addressing violence and abuse. Public health also recognizes the value of true primary prevention rather than just "cleaning up the debris."

Education on family violence and sexual assault is relevant to students' lives. It is a frequent topic of discussion in mass media and in entertainment, and many students are personally affected. The Association of Schools of Public Health has determined that a number of schools of public health have "some material" on injury but did not specifically survey for curricula regarding violence and abuse. There are no core competencies for public health officials regarding violence and abuse because it is not currently perceived as a priority.

Teachers of violence and abuse issues are not always valued as integral to the teaching mission of an academic department and may become marginalized and perhaps less productive. There is value in creating a community of professionals with expertise in issues of violence and abuse within an institution to support one another and to continue to advance the field on many fronts. Now that a great deal of funding has been diverted to preventing bioterrorism and mass disaster planning, violence issues have taken a back seat as faculty step laterally to follow funding sources.

Effective teaching means using adult education strategies with case-based, real-world application, as well as formal and informal venues for learning. Effective teaching should incorporate field experience, surveillance strategies, and program evaluation. Effective teaching respects the "heart" and not just the art of health care and public health. Students have high praise for education on violence and abuse within their public health curriculum, and their direct quotes should be noted:

"The [School of Public Health] should create a 'specialty' on victim services. It could encompass [intimate partner violence, sexual violence], child abuse, hate crimes, gang violence."

"This course has definitely influenced my career goals. I entered with a firm conviction to pursue a career in HIV and STD prevention and now I am seriously considering either combining violence prevention with sexual health issues or just focusing on children who witness [domestic violence]."

Public health educators owe this—training in issues of violence and abuse—to their students and the public they serve.

PANEL B: SUMMARY OF KEY DISCUSSION POINTS

1. **A national organization is needed to organize for change in physician training on family violence assessment and prevention. It should do the following:**
   - Address violence and abuse within the institutional framework. Current interest is demonstrated by funding and research in health behavior, health outcomes, and physiologic precursors. Clinical translation services awards, roadmap research, and projects to reduce health disparities are all possible areas where violence and abuse research could fit.
   - Become politically active and partner academia with advocacy.
   - Raise awareness through messages to the public and to academic communities about the impact of trauma and violence on individual health and the health economy.
2. **Crafting core clinical competencies is a good place to start.**
   - Begin with the IOM core competencies (see Appendix A) and add new information about assessments across the lifespan (e.g., assessing for adverse childhood events).
   - There are overlapping core competencies for family violence. These should be developed through a team approach where each domain is respected; physicians should not "call all the shots." All parties must accept that different terms and language will be used (e.g., "patient" vs. "survivor" or "victim").
   - Influence program directors in the various specialties and help them to see the opportunity for incorporating education about the effects of violence and abuse in the curriculum.
   - There is a need for measurable performance outcomes and descriptions of how these are best measured and best taught.
   - The World Health Organization has a model for education and prevention that can serve as an example.
   - The American Medical Association National Advisory Council on Violence and Abuse has submitted suggested core competencies in caring for victims of violence to the Council on Medical Education because the Council can then influence other accrediting bodies.
3. **Data surveillance is important.**
   - Multiple data sources currently exist, but local surveillance tools are needed. The public health sector is a perfect entity to develop these tools.
   - Local community domestic violence service providers are rich with information and valuable qualitative research. This local data can be very powerful in motivating change by legislators and county boards of supervisors and school boards.
   - Greater precision is needed regarding the lexicon of terms regarding family violence (e.g., screening vs. reporting vs. assessment vs. diagnosis vs. case finding). The CDC needs to define these terms. Having a common lexicon will also be essential in creating core competencies across all groups.
4. **Regulatory issues affect victim care.**
   - How is the Center for Medicare and Medicaid Services involved in education initiatives? Perhaps "pay-for-performance" can give "credit" for including interview questions and attention given to violence and abuse-related health issues. If the medical complexity code is what drives the amount of payment, one goal may be to have the rules reflect that if any form of violence exposure is a component of the problem, then the coding warrants the highest level of complexity.
   - All billing systems are organized around diseases. Doctors and nurses talk about diagnosing domestic violence or adult maltreatment, and much concern remains about "medicalizing" violence and abuse and actually creating pathology for an already burdened victim. However, if we want to play by the rules of medicine, we need to diagnose. Can we do that and know that our ultimate goal is the healthy functioning of families and individuals?
   - The Agency for Healthcare Research and Quality looks at specific indicators for quality, and these indications should also be defined for family violence.

V ■ PANEL C: FELLOWSHIP AND SUBSPECIALIZATION IN VIOLENCE AND ABUSE

Moderator: Dave Corwin, MD

LESSONS LEARNED BY THE AMERICAN ACADEMY OF PEDIATRICS AND THE AMERICAN BOARD OF PEDIATRICS IN CREATING A SUBSPECIALTY IN CHILD ABUSE AND WHAT THIS MAY MEAN FOR THE FUTURE

Robert Block, MD, American Academy of Pediatrics, American Board of Pediatrics

The implications of developing highly trained clinicians in family violence and the effects such a development may have on the various parent disciplines require thoughtful consideration before moving toward subspecialty certification. Some critical considerations before considering subspecialization are as follows:

- Certification of additional qualifications to current competencies rather than subspecialization
- Subspecialist versus generalist—creates competition and potential for friction
- The ramifications of adding more requirements for extra training

Pediatrics is the specialty that is furthest along toward subspecialty training in violence. It has led the way in ensuring protection of victims of child abuse and violence. Development of a subspecialty is a response to a national emergency and timed to coincide with several efforts:

1. **The American Board of Pediatrics approval of subspecialty certification**
2. **The Health CARES (Child Abuse Research, Education and Services) Initiative proposed to the US Congress but lacking spending authorization**
3. **The National Association of Children's Hospitals and Related Institutions' (NACHRI) recommendations that screening for child abuse be a measure of hospital quality in children's hospitals**
4. **The Ray Helfer Society, which is a well-established professional organization dedicated to advancing physician leadership in the field**
5. **The American Academy of Pediatrics' education programs on violence prevention, funded through the Doris Duke Foundation**

Some might argue that a cursory knowledge of violence and abuse in children is all that is necessary to handle the issue within the general patient population. However, despite having laws mandating reporting in all 50 states, 37.5% of children suspected of being highly likely to be a victim of child abuse were not reported to Child Protective Services by pediatricians responding to a recent survey. Twenty-three percent of health providers reported that their training in child abuse was inadequate. Evidence is mounting that exposure to childhood violence and abuse has more far-reaching consequences than previously understood. Data from the Adverse Childhood Experiences study shows persistence of the health effects of child abuse well into adulthood. It also showed that over half of the adults studied had at least one adverse childhood experience.

For child abuse, as opposed to other forms of abuse, the present body of knowledge is strong and more complete. There have been 26 texts focused on child abuse as of 2003, and 662 articles indexed in medical journals as of 1996. Recent PubMed searches have shown 16,176 citations for the search term child abuse and 15,523 for child neglect.

Despite the growth of scholarly publications, funded research on child abuse has been slow. There have been 22 funded studies, with awards ranging from $26,000 to $6.5 million. This growing body of literature, coupled with an improved understanding of the cause and effects of and effective interventions for child abuse, has allowed the academic discipline of pediatrics to begin the process of subspecialty certification in child abuse pediatrics.

One model for becoming a subspecialty is the Certificate of Special Qualification for pediatrics. Perhaps a Certificate of Added Qualifications might be better for cross-disciplinary certification and development. However, two things can happen when a new subspecialty is developed: (1) the subspecialty can become elitist and foster a certain amount of exclusivity in the discipline or (2) subspecialists can create training, develop clinical skills and a common language about the field, and work collaboratively across disciplines and with the primary specialties.

So far, pediatrics is one specialty that has acknowledged that certification is important for an individual to be recognized by their peers for their expertise in violence and abuse. Certainly the development of new certification or subspecialty training helps to create a generation of child abuse subspecialists. The new subspecialists will be the new violence experts and will develop the research and evidence base for the emerging field of violence and abuse that will, in turn, be vital to training the next generation of primary care physicians as well as subspecialists and experts in violence assessment, treatment, and prevention. Even with a cadre of highly trained experts in violence and abuse to serve as the academics in the field, the overall goal should remain to have as many clinicians from a variety of disciplines trained in the detection and management of violence and abuse.

Pediatrics anticipates that the certification process will have numerous effects, including:

1. **Creation of the next generation of child abuse pediatricians and faculty**
2. **Development of a cadre of pediatricians to serve as child abuse pediatric subspecialists in children's hospitals and related institutions and to provide care in all clinical settings**
3. **Expansion of the scientific understanding of child abuse through new research that underlies clinical decision making**
4. **Development of clinical practice models to meet fiscal and economic challenges**
5. **Pooling of clinical experience, leading to excellence in care**

IS FORENSIC MEDICINE OR FORENSIC NURSING THE SUBSPECIALTY WE ARE SEEKING, OR IS IT SOMETHING DIFFERENT?

William Smock, MD, Professor, Department of Emergency Medicine, University of Kentucky

An area of expertise gaining increased interest is forensic medicine. The word "forensic" means "pertaining to the law." Forensic medicine was not a major issue for medical education prior to the 1990s. Currently, it is taught at the fellowship level or in continuing education forums. Forensic nursing has a longer history and is an established area of specialization for nurses that can include higher pay and privileges. A nurse, particularly an emergency department nurse, may be the first member of the health care team that recognizes the occurrence of abuse and the need for injury evaluation and evidence collection. Forensic nursing has led the field in the creation of abuse response teams such as the Sexual Assault Response Teams (SARTs) with highly trained Sexual Assault Nurse Examiners (SANEs).

Forensic medicine is playing an increasingly important role in the health care needs of violence victims. Victims of violence present to the emergency department on a constant basis. Failure to recognize the signs and symptoms of abuse leads to misdiagnosis, medical errors, poorer quality of care, and compromised patient safety within the health care system.

Forensic education in violence and abuse should be directed toward determining the etiology of the injury and developing the chain of evidence. This begins with the health history and physical examination. The story about the injury must be consistent with the physical exam findings and must explain the pathophysiology and pattern of the injury. Training in the pathophysiology of injury is essential for accurate injury assessment. Examples of physical exam-etiological connections that should be taught include: 1) scratches or bruises to the neck—indicating strangulation, 2) linear, parallel lines on face—indicating a slap injury, and 3) a linear blanched area surrounded by parallel hyperemia/hemorrhage—indicating an injury caused by a stick, pipe, or bat.

Education on injury assessment allows the clinician to understand and interpret the mechanism or mode of injury. Additional training in legal review and courtroom testimony fosters clinician credibility as an expert during an investigation or trial. Through the recognition and interpretation of injury, coupled with the forensic documentation and quality evidence collection, clinicians can provide excellent care and collaborate well with the efforts of the legal system to address violence and abuse.

FAMILY MEDICINE AND THE "CERTIFICATION OF ADDED QUALIFICATIONS" IN FAMILY VIOLENCE

Perry Pugno, MD, MPH, CPE, Director, Division of Medical Education, American Academy of Family Physicians

Family medicine has recognized the benefits of having a Certification of Added Qualifications (CAQ) and the academic recognition that comes with certification. Family medicine has recognized that certification evokes respect from one's peers, helps in academic promotion and tenure, provides evidence of qualification as an expert in legal proceedings, leads to opportunities for increased income, defines the leadership role in raising social awareness, and improves patient care. Family medicine might consider a CAQ in Family Violence. Currently, precedents exist for subspecialties with a multidisciplinary approach. Family medicine is considering two new CAQs in sleep medicine, which has multiple sponsors, and in child abuse, with pediatrics taking the lead.

One key element in the development of a multidisciplinary approach to a CAQ in family violence is determining which organization will take the lead role. This lead role could be performed by either the American Board of Medical Specialties or one of a number of medical specialties that are contributing to the development of the new subspecialty in violence and abuse. The potential risk of having one of the medical specialties take the lead in developing a CAQ in violence and abuse is the risk of competition between organizations for a leadership role.

Family medicine recommends the following steps for the development of a subspecialty in violence and abuse:

1. **The subspecialty needs to define the scope and content of its discipline. Doing so will require collaborating within and among the various specialty areas; deciding who will participate; setting the definitions, scope, and content; and identifying the major components of knowledge, skill, and attitudes that define the discipline.**
2. **The evidence-based content in family violence will need to be identified and developed. Areas where evidence is lacking will need to generate the knowledge base necessary to support the new subspecialty.**
3. **The subspecialty needs to define a set of core competencies that are measurable.**
4. **The subspecialty needs to establish a core curriculum, vetting the available curricular models and applying the latest educational approaches to the adult learner.**

In moving toward subspecialty certification, a few key strategies may be helpful. Champion educators and researchers of the new subspecialty will need to be identified and promoted within the discipline. This process will allow a coalition supporting the subspecialty to coalesce around the champions. Funding sources will need to be identified in order to provide "seed" money and start-up funds for training programs and research in the new subspecialty. Tailoring family violence to the question of safety may interest the Agency on Healthcare Research and Quality. The Health Resources and Services Administration may have an interest in violence prevention as a preventive health program.

In addition to the strategic component, certain philosophic questions will need to be answered in developing the new subspecialty. The questions include:

- What is the motivation to create a new subspecialty?
- Are there any unintended consequences to developing the subspecialty?
- Is the intention to increase the competency of all health professionals or just a few?
- Will the subspecialty help or hinder the AVA mission?
- What is the value of an inclusive, multidisciplinary approach versus the current trend toward an exclusive approach?

PANEL C: SUMMARY OF KEY DISCUSSION POINTS

1. **Will subspecializing further contribute to "silo-ization" that may detract from creating a common foundation of knowledge and skills for all health practitioners?**
   - In developing the training for the new subspecialty in violence and abuse, stakeholders should pay particular attention to building interdisciplinary roles and providing cross-disciplinary training, fostering collaboration with other disciplines, and providing help for training. Domestic violence community advocates can also provide support and training in order to improve competitiveness for Health Resources and Services Administration Title VII and private foundation funding and to obtain high-profile funding.
   - Consider common training that can be done through distance-learning education. Course materials that are content-specific can be provided in self-study programs.
   - Because of the way the American Board of Pediatrics structured the Certificate in Child Abuse Pediatrics, the certificate could be offered through other boards, such as family medicine or emergency medicine, after candidates complete certification requirements equal to those required for pediatrics.
   - An additional concern is that victims may be reluctant to seek help for violence-related conditions or injuries from a health professional identified as a specialist in family violence. Lack of public understanding of the role of a family violence subspecialist and confusion about the relationship of this clinical subspecialty to the criminal justice system may harm the relationship between patients and their clinicians. Preserving the trust between a patient and her/his health care provider requires thoughtful consideration.
   - As the new subspecialty in family violence emerges, stakeholders must take care to avoid marginalizing the professionals and community leaders who have been working in the area of violence and abuse but have no specialized training. Determining the role of "grandfathering" versus alternative means of documenting expertise and experience may be necessary to be inclusive yet retain the rigor surrounding the new subspecialty. This process must maintain the value of certification representing a high level of expertise in family violence.
   - A helpful model to consider may be the nursing model for competencies at the basic practice level, the advanced practice level, and the leadership level.
   - If any effort for subspecialization goes forward, anyone with interest and basic competency as a clinician should be able to obtain this advanced training.
2. **In developing common core competencies for training, subspecialists should avoid "medicalizing" family violence and applying a pathology label to violence victims.**
   - The new subspecialty should consider other approaches beyond the medical model. For example, a "training to the team" approach that fosters mutual respect and good communication should be one of the defining competencies in this new expertise. Suggestions are to develop collaborative training and curricula and to provide general board examinations.
   - Poor quality of care and lack of patient safety can lead to misallocation of resources or worse, misdiagnosis and medical error. We cannot have it both ways; we can't ask physicians to avoid diagnosing "adult maltreatment" because we don't want to medicalize it and then fault physicians for not identifying it.
3. **There are concerns that some practitioners who care for victims of violence may be too aligned with the criminal justice system and that "forensic care" may have too much focus on injury and not enough on all the other health ramifications of violence and abuse.**
   - Injury assessment training is vital for accurate diagnosis. In designing a curriculum on the care of victims of violence and abuse, attention should be given to the proper recognition and documentation of injuries. Failure to recognize evidence of physical abuse and document these findings is a disservice to patients. It may mean that there will continue to be a need for a higher level of training to accurately diagnose acute injuries.

- While forensic pathology training may be a necessary part of subspecialty training, the new subspecialty must be careful not to align training too closely to the criminal justice system, where the focus of family violence narrows to injury assessment.
- Forensic specialists who are willing and skilled in courtroom testimony can unburden general practitioners.
- Injury assessment that identifies suspicious injuries that then triggers an automatic response by law enforcement is believed by many to have a potential for harm. While there is no published evidence of harm, neither is there data that the involvement of law enforcement has been helpful.
- Is the driving force behind forensic medicine an economic one? Forensic medical exams and medical expert review and testimony are often reimbursed through police departments or victims-of-crime funding while the clinical care of victims of violence struggles for adequate compensation for services. The need for adequate reimbursement to care for this population may further challenge how we view violence and abuse.
- A trained forensic examiner has the well-being of the patient in mind and actually can contribute to the beginning of healing of the trauma victim. These psychosocial interactive skills are very important.

4. **Will subspecializing marginalize "non-certified" health professionals?**
   - The expansion of medical/health/nursing knowledge is the major force in creating niche practices, and that goes for violence and abuse as well. As with any new subspecialty, caution must be taken to ensure that the role of the "generalist" in the detection and management of family violence is respected. Certification should signify a higher level of expertise, but the vast majority of clinical care for victims of family violence will be provided by the generalist clinician, and the generalist should be able to care for most cases.
   - Providing care to victims of violence can be complex, multidisciplinary, and long-term, and it might be too time consuming for most practitioners to do effectively. Thus, consultation and referral services might be very welcome.
   - While we hope that all clinicians have basic knowledge and skills in caring for victims of violence, the courts may have a bias toward the specialist and possibly devalue the nonspecialist.
   - Well-defined roles for family violence subspecialists will need to be clarified as the subspecialty evolves. Since family violence is predominately a "cognitive" subspecialty, the clear delineations characteristic of the "procedural" subspecialties are not as evident. Careful definition of the role of a family violence subspecialist will be needed to assure a continued place for the subspecialty while protecting the role of the generalist in family violence detection and management. If the subspecialty is able to develop in this manner, it will allow for mutual support around the area of family violence.
   - Health professionals should practice to the limits of their knowledge and then refer. If referral becomes an automatic "turf," is patient care further fragmented on an issue that compounds almost every health problem?
   - An essential question regarding the development of a subspecialty in family violence is whether it will be viewed as an academic or clinical subspecialty. Academic specialties focus on development of experts in the medical schools for research and teaching, as opposed to clinical specialists who care for patients in the field. This distinction also dictates how the subspecialty will be viewed by other professionals and the general public. Patients and/or violence victims may have a certain set of expectations that may not match how the subspecialty sees itself within the broader context of health care.
   - Can subspecializing help promote a research agenda and help gain a foothold in the academic institution without carving out an exclusionary clinical specialty? This is a question that many have asked.
   - Because of the stigma associated with violence and abuse, what do we call persons with expertise in health issues related to violence and abuse?

Nursing, Medical, and Dental Education Recommendations

- Urge the Association of American Medical Colleges to establish core competencies for physicians just as the American College of Nursing has done for nurses. Core competencies should define the performance measures at the basic, advanced practice, and leadership level for all health professionals. Sequential learning concepts should be considered as students become residents and then practitioners. Faculty development on family violence is essential so that educators/mentors will demonstrate the core competencies and teach these to the next generation.
- Advocate for funding sources to support those training programs that give violence and abuse priority placement. Given the economic cost of this issue, it warrants more resources, and this information must be provided to legislators and the general public. Professional health organizations and health insurers should advocate for legislation that supports efforts to address family violence such as the Health Cares Act within the Violence Against Women Act. This legislation, if funded, would have provided resources for education and research centers on family violence.
- Provide curricula that include focused coursework as well as problem-based and case-based learning that addresses violence and abuse. Curricula should be multidisciplinary and interactive and include guided and supervised field experience. Sound theoretical concepts for behavior change and adult learning theory should be incorporated. Models and standardized patient cases that include scenarios for various types of violence exposure should be created for use and made available to the larger academic community and training institutions.
- Seek funding to evaluate some of the innovative educational approaches being utilized in some centers throughout the United States—specifically, innovative educational strategies that (1) demonstrate behavior change in the approach to providing health care by students and (2) provide models, resources, and templates for broader implementation.
- Ensure that curricula include a reflective learning process for students to explore their own experiences, beliefs, and biases regarding violence and abuse so that they can become more effective clinicians.
- Include measures for identification, documentation, and intervention in family violence as measures of quality improvement within health practices and institutions.
- Encourage deans to create a supportive institutional environment for the issue of violence and abuse by sponsoring seminars, supporting grantsmanship strategies, and offering intramural awards for exceptional work in the field of violence and abuse.
- Professional health organizations should provide quality continuing education for professionals who are not aware of the health impact of violence across the course of a lifetime.

Graduate, Public Health, and Postgraduate Residency Training Recommendations

- Describe an organizational map of each accrediting body—what it does, how it operates and makes decisions, critical steps in the decision process, and possible points of leverage. Garner support from leaders within these organizations to further this effort.
- Define violence and abuse core common competencies for use by any health professional and have them enacted as "common program requirements" with the Accreditation Council for Graduate Medical Education. Encourage adaptation by specialty to add any additional skills or scope of practice within that specialty group.
- Align these efforts with current programs addressing patient safety, chronic care, or quality of care. Accurate diagnosis is a quality-of-care measure, and creating a care plan for victims of violence is a patient safety issue.

- Use "must do" wording rather than "should do."
- Identify the formal and informal venues for teaching, and define the benefits of each.
- Consider how to teach about family violence while meeting the residency service requirements and educational requirements.
- Seek funding at the national nongovernmental organization level and from the private sector to bring this issue to the public's attention.
- Focus on partnerships, coordinated responses, and team approaches but also foster alliances among trauma surgeons, orthopedic surgeons, hospital administrators, public health officials and advocates, social workers, community leaders, and others.

Fellowship and Subspecialty Training Recommendations

- While subspecialization now exists within pediatrics (child abuse pediatrics) and nursing (forensic nursing), the consensus opinion from the forum was to make no recommendation to seek further subspecialization at this time. Some believe that subspecialization could improve the quality of care, develop and disseminate new scientific knowledge, help raise awareness, provide recognition and resources for professionals doing the work, and relieve the generalist from complex and time-consuming care. However, there is considerable concern that subspecialization may be regarded as exclusive because of the additional years of training and certifying examination and may actually limit access to care rather than expand it. Others advocate that a multidisciplinary approach inclusive of the generalist is preferred in order to address the basic care needs of patients experiencing violence and abuse. Other questions to address: Do we further alienate our patients by subspecializing? Will subspecialization limit the generalist's credibility in court proceedings or will it encumber or enhance the court process? Will subspecialization serve as an excuse by some generalists to further avoid the issue?
- Being able to assess injuries and evaluate their etiology is a component of good care and accurate diagnosis. While a subspecialty in forensic medicine might refine the understanding of injury pathophysiology, it might prioritize the needs of the criminal justice system over the health and safety needs of patients.
- The child abuse pediatrics subspecialty within the American Board of Pediatrics could be a good model for learning about the subspecialty process, and other fields may follow by developing a subspecialty in their respective boards. However, entry to the child abuse pediatrics subspecialty should be open to other boards such as family medicine, general surgery, emergency medicine, and psychiatry.
- Support and foster a change in the vernacular from "intentional injury" to "violent injury." The term "intentional injury" may detract from the serious implications of this major health problem.
- Proceed cautiously with careful evaluation of specialty care centers for violence and abuse. Are more patients identified when there is a referral center? Are fewer physicians and nurses assessing for histories of violence when referral centers are not available? Is there a difference in the quality of care in a violence and abuse center that justifies the need for specialization?

APPENDIX A: BASIC LEVEL OF CORE COMPETENCIES NEEDED FOR ADDRESSING FAMILY VIOLENCE BY HEALTH CARE PROFESSIONALS

(As defined by the Institute of Medicine)

Competency	Performance Indicators
Identify, assess, and document abuse.	1. Recognize risk factors for victimization and perpetration of violence. 2. Recognize physical and behavioral signs of abuse and neglect, including patterns of injury (including unusual forms of abuse such as Munchausen syndrome by proxy and poisoning), across the life span. 3. Screen for family violence experiences using valid and reliable instruments that are developmentally appropriate. 4. Assess clients via interview and appropriate health examination processes. 5. Document injuries and health effects, using forensic guidelines in obtaining and recording evidence (such as recording specific, concise, and objective information utilizing body maps and photographs). 6. Identify and address problems of emotional, physical, and sexual abuse and neglect.
Intervene to secure safety and reduce vulnerability.	1. Assess for immediate danger. 2. Develop a safety plan with victims and families. 3. Consult with and refer to specialists and community resources for safety, education, caretaking, and support services (such as protective services, social work, shelter, child abuse hotlines, legal, mental health, substance abuse, and criminal justice) as appropriate. 4. Maintain appropriate clinical follow-up.
Recognize that cultural and value factors influence family violence.	1. Communicate nonjudgmentally and compassionately. 2. Recognize the cultural factors important in influencing the occurrence and patterns of responses to family violence. 3. Provide culturally competent assessment and intervention to victims and perpetrators of family violence. 4. Explain culturally normative behaviors and relationship patterns that could be misconstrued as dysfunctional and/or violent. Recognize potential dilemmas in providing care and accessing resources that may arise from cultural differences.

Competency	Performance Indicators
Recognize legal and ethical issues in treating and reporting family violence.	1. Know state reporting laws and mandates, local and state reporting agencies, and their procedures and regulations, including potential liability for failure to report. 2. Know ethical principles that apply to patient confidentiality for victims as well as the limits of that confidentiality. 3. Understand the need to balance respect for individual autonomy with concerns for safety of vulnerable persons when making reporting decisions. 4. Understand the health professional's role in court testimony (as either a regular or an expert witness).
Engage in activities to prevent family violence.	1. Promote activities to increase public awareness of family violence. 2. Promote activities to address populations at risk. 3. Participate in health policy activities to address family violence. 4. Promote community action to establish and enhance programs to support victims and family members and for perpetrator interventions, especially at early stages. 5. Understand the impact of services (such as home visitation nurses) on the prevention of physical abuse and neglect. 6. Understand the principles of prevention of family violence (including sexual abuse of children).

Used with permission from *Confronting Chronic Neglect: The Education and Training of Health Professionals on Family Violence,* IOM series. Washington, DC: National Academy Press, 2002.

APPENDIX B: PRE-CONFERENCE ATTENDEES

Our thanks to the many experts and stakeholders who contributed to the discussion while attending the pre-conference. Since not all introduced themselves as they spoke, we were not able to specifically credit their ideas and comments, but we wanted to acknowledge all of them here.

Kathy Bell
Laura Benjamins
Robert Block
Candace Burton
Maria Irma Bustamante-Gavinq
Marti Carlin
Marie Christensen
Nan Cicha
David Corwin
Carrie Cunningham
Bruce Ettinger
Aleesha Grier
Merik Gross
Susan Hagedorn
Hide Helleberud
Tasneem Ismailji
Susan Kelley
Linda Lewis
Graciela Laguna
David McCollum
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Charles Mouton
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Heather Rozzi
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David Schneider
Philip Scribano
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