Physician awareness of domestic violence: Does continuing medical education have an impact?

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One hundred currently practicing physicians were surveyed regarding screening and management of domestic violence to determine whether mandatory continuing medical education (CME) is likely to increase awareness of and response to domestic violence. The authors surveyed 25 family physicians and 25 obstetrician/gynecologists in each of two states, Florida and New Jersey. In addition, they polled 26 family practice residents in the University of Medicine and Dentistry of New Jersey–School of Osteopathic Medicine program.

Practices with a female physician were four times more likely to screen for domestic violence than practices with all male physicians. No difference existed in screening between family physicians and obstetrician/gynecologists; physicians in Florida and those in New Jersey; or attending physicians and family practice residents. Findings indicate that Florida's mandatory CME law does not appear to have made an impact on the management of domestic violence. Practices with a female physician were more likely to screen for domestic violence.

(Key words: domestic violence, partner abuse, continuing medical education, screening, obstetrician/gynecologists, family physicians)
and residents. Practices with a female physician were more than four times as likely to screen for domestic violence, a statistically significant difference ($P < .05$).

Table 2 shows the results for question 2 regarding subsequent screening. No significant difference existed between obstetrician/gynecologists and family physicians, physicians practicing in Florida and those in New Jersey, or male physicians and female physicians.

Table 3 shows the results for question 3 concerning the identification of a recent victim of domestic violence. Again, no difference existed between obstetrician/gynecologists and family physicians, physicians practicing in Florida and those practicing in New Jersey, or male physicians and female physicians.

Table 4 displays the results for question 4 regarding the impact of CME. No significant difference existed between physicians practicing in Florida and physicians practicing in New Jersey.

**Discussion**

Primary care physicians such as family physicians and obstetrician/gynecologists are frequently the first lines of defense for abused individuals. They are expected to treat the consequences of domestic violence, yet they have little or no exposure as to how best to handle the problem as it arises in their practices. Reid and Glasser$^4$ showed that 57% of physicians thought that their medical education did not prepare them adequately to deal with family violence. Currently, medical schools are expanding their curriculums to include the discussion of the role of domestic violence, but this early training frequently is not enough (a few hours at best), and it rarely is reinforced during residency and continuing education. The same study showed that 96% of those surveyed thought that physicians should receive more education. Ironically, a large multidisciplinary community-based study funded by the Robert Wood Johnson Foundation Health Care and Family Violence Field Project published in 1990 by Cohen and colleagues$^5$ showed that physicians who do attempt to treat fam-
ily violence were professionally and economically ostracized.

Perhaps more important than a lack of formal education are physicians’ attitudes (Figure 2). In one study, less than half of the physicians polled thought that domestic violence was a significant problem in their patient population.6 These physicians may be unaware of how pervasive and insidious AIPV is and have not realized that if they are treating women, they are inevitably treating some battered women.

Besides ignorance of the scope of domestic violence, the Robert Wood Johnson study demonstrates frank elitism, racial prejudice, and sexism of physicians. Physicians frequently believe that domestic violence is more common in nonwhite or poorer communities and does not occur in “nice,” “normal,” families or in “wealthier” communities.5 Physicians may perceive victims, particularly nonwhite, non-middle class victims, as “deserving” the abuse. Alternately, physicians themselves who are or who have been victims of domestic violence may choose not to deal with the issue in their practices because of their own unresolved conflicts.

Despite the efforts to increase awareness, we were disappointed to find that only 23% of family physicians and obstetrician/gynecologists screened for domestic violence. We were also disappointed that resident physicians performed no better than attending physicians. Although our study did show that practices with female physicians were more likely to screen for domestic violence, still it was less than half (47%) of such offices that did so.

It was hoped that the mandatory CME law passed by the Florida legislature would increase physician awareness of the human immunodeficiency virus and lead to increased screening and intervention. Unfortunately, this does not appear to be the case. Physicians in Florida are no more likely to screen than physicians in New Jersey. It would seem likely that if female physicians were more likely to screen in an initial visit, then they should also be more likely to identify recent victims of domestic violence. Our data show that indeed this identification was more likely; however, this variable did not reach statistical significance. Perhaps if we expanded our study to include more offices, we would have a greater power to see this difference.

It is disappointing that screening for domestic violence occurs so infrequently that residents who received information...
regarding domestic violence very early in their medical school careers were no more likely to screen than their role models. Mandatory CME does not make a difference.

References

Case report

Refractory torticollis after a fall

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Though multiple medical and psychiatric causes of torticollis have been described, cervical dystonias resulting from distant somatic dysfunctions have not. This article describes the treatment of a 62-year-old woman in whom refractory retro-torticollis of surmised pelvic etiology developed after a fall. Structurally, cervical dystonias have been addressed as problems that originate in the head and neck, but this limited view of the musculoskeletal component of torticollis may prevent physicians from directing osteopathic manipulative treatment to the underlying problem.

(Key words: torticollis, cervical dystonia, osteopathic manipulative treatment)

Spasmodic torticollis is a muscle dystonia characterized by a sustained movement of the head to one side. Variant dystonic states occur with the head flexed (anterocollis) or extended (retrocollis). Though spontaneous remission occasionally occurs, torticollis is usually chronic. Current treatment of torticollis frequently includes the use of botulinum toxin and, rarely, surgery. Torticollis is an indication for the use of osteopathic manipulative treatment (OMT) typically directed to cranial nerve XI (spinal accessory nerve), and a recent report of OMT in the emergency room described the focus of structural intervention for torticollis as being directed toward the cervicothoracic junction.

This article describes a patient in whom a combination retrocollis/torticollis developed after a fall. The clinical history and treatment regimen are described, and the manipulative assessment and treatment of cervical dystonia is discussed.

Report of case

A 62-year-old female presented to the clinic complaining of right-sided neck and shoulder pain with restricted motion of 3 weeks' duration. The pain began gradually over a few days after a fall that occurred when the patient stepped into a 3-inch-deep hole with her left foot. The patient described falling forward with her left knee bent, arms outstretched. The left arm and shoulder received the brunt of the impact. She reported mild to moderate soreness in the left upper arm and shoulder, which steadily improved over the time that the right-sided neck and shoulder pain developed, and mild swelling and bruising of the left tibial tuberosity. By 96 hours after the fall, the patient had a constant pain that she described as dull and achy, but worsening in intensity upon flexion, left sidebending, or right rotation of the head. The pain radiated from the left occipital base, laterally to the left acromion. There was also mild pain on palpation of the

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