

A Qualitative Analysis of How Physicians with Expertise in Domestic Violence Approach the Identification of Victims

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Background: Physicians have been called upon to identify victims of domestic violence, but few studies provide insight into how physicians can navigate around the barriers to identification.

Objective: To describe how physicians who are committed to helping battered patients identify victims of domestic violence in health care encounters.

Design: Six focus groups were conducted.

Setting: Focus group research facilities.

Participants: 45 emergency department, obstetrician/gynecologist, and primary care physicians in the San Francisco Bay Area who identify and intervene with victims of domestic violence.

Measurements: Through constant comparison, a template of open codes was constructed to identify themes that emerged from the data. Data were analyzed according to the conventions of qualitative research.

Results: The data revealed five major themes: 1) how physicians framed screening questions to reduce patient discomfort; 2) patient signs that “switched on a light bulb” for physicians to suspect abuse; 3) direct and indirect approaches to identification, with an emphasis on facilitating patient trust and disclosure over time; 4) the rarity of direct patient disclosure; and 5) how physicians redefined successful outcomes of universal screening. Physicians also described two new barriers to screening: mandatory reporting and “burnout” due to lack of direct disclosure.

Conclusions: Identifying domestic abuse is difficult even for physicians committed to helping victims. Physician reports illustrate the need to frame questions and develop indirect approaches that foster patient trust. Given the many barriers to screening and the rarity of direct patient disclosure, it may be more productive to redefine the goals of universal screening so that compassionate asking in and of itself constitutes the first step in helping battered patients.

Advocates and other experts in domestic violence have recommended that as a first step in improving health care for victims, physicians should routinely screen for and identify patients whose partners are battering them (1–5). Although screening questions and guidelines have been developed to help physicians identify and intervene with victims, these guidelines do not address the complexity of physicians’ tasks, nor do they provide insight into how physicians should navigate around the myriad patient and physician barriers to identification.

The literature is replete with studies showing that victims of domestic violence are reluctant to disclose abuse to their health care professionals and that health care professionals are reluctant to ask their patients about domestic violence (6–11). Patients cite many reasons for not wanting to talk with physicians about abuse; the most common are fear of retaliation by their partner, shame, humiliation, denial about the seriousness of the abuse, and concern about confidentiality (11–14). The potential loss of confidentiality has repercussions far beyond issues of immediate personal safety—it threatens patients’ responsibilities to their families and raises economic concerns and fears about police interference (13). However valid the reasons, patients’ evasiveness and failure to disclose information, according to health care professionals, is a major barrier to the identification of domestic violence (15–17). In addition, physicians cite many reasons for not broaching the topic of abuse with patients; the most common are lack of time and support resources, lack of education or training, fear of offending the patient, and frustration with lack of change in the patient’s situation or the patient’s unresponsiveness to advice (9, 18–22).

Primary care physicians in Sugg and Inui’s qualitative study (22) characterized talking about domestic violence with patients as “opening Pandora’s box” and associated the act of even asking about abuse with unleashing their own fears and discomforts. These physicians described feelings of powerlessness about their inability to “fix it” and their sense of loss of control over patients’ decisions and

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outcomes. These data suggest that physicians' reluctance to intervene in this area is related in part to their beliefs about their role and what constitutes successful outcomes.

Although these barrier studies offer reasons for and in-depth accounts of what keeps physicians from "opening Pandora's box," little information is available about the physicians who do open it and take the first step in helping victims. We explored how physicians with experience in identifying and intervening with victims of domestic violence navigate around the barriers and try to help battered patients.

Methods

Participants

Qualitative research commonly uses purposive sampling, a method in which the participants who are best suited to provide a full description of the research topic are intentionally selected. We sought a sample of physicians in the San Francisco Bay Area who had experience in identifying and intervening with victims of domestic violence. The sample emerged by screening physicians recruited in "snowball" fashion. To identify important common patterns that cut across different settings (23, 24), physicians from three medical specialties were sought: emergency medicine, obstetrics/gynecology, and primary care (family practice and general internal medicine).

Recruitment procedures were conducted in consultation with a professional survey research organization. An initial list of 13 physicians known to have experience in domestic violence intervention and a list of physicians selected from the yellow pages were screened and asked to participate in a study exploring "the most effective ways for the health care system to meet the needs of domestic violence victims." Physicians were eligible if they 1) worked directly with patients 20 or more hours per week, 2) had identified and intervened with patients as victims of domestic violence, and 3) were "somewhat confident" or "very confident" about addressing domestic violence issues with patients.

Eligible participants were asked to identify other "colleagues who are concerned about and who treat victims of domestic violence." These physicians were likewise screened, asked to participate, and asked to identify others. When the goal of recruiting two groups of 6 to 11 physicians in each medical specialty who had the relevant domestic violence experience was reached (6 groups total), recruitment ceased.

Table 1. Core Focus Group Questions

1. Tell me how you go about identifying patients whom you suspect have experienced domestic violence.
2. What are the difficulties you encounter when identifying patients? What do you find to be useful?
3. What do you think is the most important thing to say or do in responding to patients whom you suspect might be victims of domestic violence?
4. Have there been cases in which you suspected that a person might be a victim of domestic violence, but you chose not to directly identify them as such?
 - Can you tell me about examples when that has happened?
 - Why did you choose not to directly identify the person?
 - Did you provide some kind of an intervention without directly identifying the patient as a victim of domestic violence?
 - What did you do or say to try to help?
5. What are the challenges in giving care to victims of domestic violence? What are the hardest parts for you?
6. What barriers do you think patients might have to seeking health care if they are in violent relationships?
7. Can you tell me about the rewards or gratification you get from working with patients who are victims of domestic violence?

Focus Group Method and Data Collection

Compared with survey or one-on-one interview formats, the focus group approach allows for more extensive exploration of the topic under discussion. Participants can collectively present different experiences and perspectives, generate ideas, and debate and compare their ideas with those of others in the group (25). Six focus groups, each containing 6 to 11 physicians, were convened during a 3-week period in January and February 1998. Each group consisted of physicians from the same specialty, and sessions were facilitated by two moderators who were members of the research team. The groups met for approximately 90 minutes in professional focus group settings with provision for hidden viewing. Several researchers viewed the groups from behind two-way mirrors and completed field notes, which were later compared with the moderators' observations. Before each focus group was convened, written informed consent was obtained from all participants and a written background survey was administered to gather demographic and practice information. Participants received a small stipend. The study procedures were approved by the University of California San Francisco Committee on Human Research.

The study used a semi-structured guide, which allowed the facilitators to follow certain topics and open new lines of inquiry when appropriate (26). Open-ended questions were formulated on the basis of previous interviews with survivors of domestic violence (27) and review of the literature. **Table 1** presents the core focus group questions. Audiotapes of the focus group sessions were transcribed; the principal investigator reviewed them for accuracy.

Coding and Analysis

For initial analysis, investigators conducted multiple readings of transcripts to identify prominent

Table 2. Characteristics of Study Participants (n = 45)

Characteristic	Data
Sex, % (n)	
Male	47 (21)
Female	53 (24)
Mean age, y	43
Ethnicity, % (n)	
White	76 (34)
Asian/Pacific Islander	11 (5)
African American	4 (2)
Hispanic	4 (2)
Other	4 (2)
Medical specialty, % (n)	
Primary care	47 (21)
Obstetrics/gynecology	27 (12)
Emergency medicine	27 (12)
Practice setting, % (n)	
Solo or two-physician	16 (7)
Group	51 (23)
City, county, or federal government	20 (9)
Nongovernment hospital	7 (3)
Other	7 (3)

themes. The investigators independently reviewed the transcripts and then met to review and discuss differences of opinion about interpretations and to further refine themes driven by the participants' own words and phrases. Through this process and through constant comparison of new data against these emerging themes, a template of open codes was constructed. The transcripts were coded and specific themes within the participants' narratives were identified in accordance with standard qualitative analytic convention (28). Coded data were organized by using QSR NUD*IST 4.0, a computer software program designed for qualitative data analysis (Qualitative Solutions and Research Pty. Ltd., Victoria, Australia). NUD*IST software helps ensure the consistency of the study findings and creates an audit trail (29). It is commonly used by qualitative researchers to document the development of codes, categories, and memos that recorded the research process and the formulation of theoretical ideas or interpretations of the data. The data were interpreted in the context of the original focus groups and the current literature. The final coding scheme and analysis of the findings were reviewed and disagreements were discussed as a team until consensus was reached.

To further enhance the credibility of the findings, a qualitative technique termed "member check" was used (30). Results were directed back to four research participants to confirm that their own experiences and those of other participants in their focus group were reflected in the findings.

Results

Of the 80 physicians who were screened, 53 were eligible for the study and 45 were able to attend the

focus groups. **Table 2** presents participant characteristics.

Participants reported that they identified an average of 28 patients per year as having been physically abused by an intimate partner and that they thought they had helped about 60% of identified patients. Physicians' descriptions of their processes of identification revealed five major themes that cut across all medical specialties: 1) how they framed screening questions to reduce patient discomfort and fear, 2) patient signs and symptoms that "switched on a light bulb" to suspect domestic violence, 3) direct and indirect approaches to identification, 4) the rarity of direct patient disclosure, and 5) how they redefined successful outcomes of universal screening.

Framing Screening Questions To Reduce Patient Discomfort and Fear

Many of the physicians in our study reported that they do not conduct universal screening for domestic violence. Those who do described incorporating screening questions into their routine health history, especially for new patients and pregnant patients and during annual examinations of returning patients. In general, physicians used standardized screening questions that were carefully framed to minimize patient discomfort and fear of being identified. Physicians "normalized" domestic violence in the health history by including it among other safety questions (for example, questions about seat belt use and gun safety) and by saying or implying that they routinely asked all of their patients about domestic violence. For example, one physician would say, "Domestic violence is a big problem in our society. Doctors have been asked to find out how many people have this as a problem, and we'd like to help people deal with it."

Participants also talked about individualizing their screening approach in order to be sensitive to patients' presenting problems as well as cultural or language barriers:

"Hello, I'm your new doctor, I need to ask you many questions." Unless they're horribly sick that day. "Do you have any allergies?" Eventually, "Who do you live with? How do you get along? I know when some people disagree, they throw things, they hit each other. They call each other names." Even if they said they got along great, I say, "Does that ever happen in your house?" I say that with the translator to my [Lao] patients. I say that in Spanish to my Spanish-speaking patients.

Some physicians, primarily those in emergency medicine, reported that the clinic nurse, social worker, or other ancillary staff routinely screened patients for domestic violence, mainly because the physicians did not have enough time.

Some physicians had stopped universal screening

or did not screen for domestic violence because of lack of time or resources that they perceived would be necessary to address the problem adequately. The most frequently discussed barrier in each group was mandatory reporting: Physicians repeatedly described their confusion about their role in mandatory reporting, including the requirements of the law and their concerns about the time and resources needed to fill out forms and get involved with police. They also discussed whether mandatory reporting promoted or jeopardized patient welfare and how to make the hard decision about when to follow the law: "... a lot of people are reluctant to open that Pandora's box by even daring to ask the question, even though there might be a strong suspicion."

Finally, physicians also discussed "burnout" and fatigue from trying to fit domestic violence screening into their busy schedules: "[Screening for domestic violence] is not productive, it's not satisfying."

Patient Signs and Symptoms That "Switched on a Light Bulb"

In general, physicians pursued the identification of domestic violence when patients presented with certain constellations of symptoms, injuries, or signs that "switched on a light bulb in our head." The most common were history of sexual, physical, or emotional abuse; depression; anxiety; chronic headaches; and pelvic pain or vague stomach pains that had not improved over time with treatment. In some cases, the provider suspected domestic violence if the patient's story about how the injury occurred did not fit the type of presenting injury. In other cases, physicians suspected domestic violence when patients presented with chronic injuries that fit a "pattern" ("the accident-prone patient"). They also described discovering injuries indicative of domestic violence (black eyes or bruises in "strange places") in the process of examining the patient for a different presenting problem.

Many physicians in our study, who were aware of and educated about domestic violence, reported that sometimes they forgot that domestic violence could be the underlying problem. They gave examples of cases in which failing to identify this problem led or could have led to expensive medical work-ups, hospitalizations, or unnecessary surgeries:

And [when you get these warning signs] sometimes it doesn't dawn on you, to be honest. "Why am I not getting anywhere with this patient? Why is she not seeming to do better over time?" [Then you realize] "I forgot about exploring this whole issue." It behooves you to [focus on those vague syndromes] because you can end up, in our case, taking people to surgery in the long run for a reason that may have something that's underlying.

Direct and Indirect Approaches to Identification

Once providers suspected domestic violence, their approach to identification varied. Physicians described how acute presenting injuries are "easy to go after" directly because they are obviously related to recent abuse. The more difficult cases were those in which the presenting problems were constellations of symptoms, subtle signs, or "patterns" that raised suspicions but were not accompanied by patient disclosure of the underlying cause. In the absence of clear trauma, providers tended to drop hints, probe over a series of visits, or otherwise communicate about the abuse indirectly over time. They couched their questions in a way that gave patients "a nice way out" or options about when they would disclose, with respect for the patient's situation and choices.

That's when I decide, "Okay, I'm going to use most of the time to get at the real reason that you're here." I don't say that, I say something like, "You know, I'm wondering what could be causing this. Have you got any ideas?" Or, "Anything happening at work or at home that you think might be aggravating this?" Or, "I know we're going to do some tests, but is there something on your mind?" Just really vague. And I try to get to that real early. So that I have time to listen. And I say, "You know, I've seen things like that before and for other people, sometimes that means that they're getting hit by their partners. Is it possible, is that going on for you?"

Some physicians who suspected abuse set the stage for identifying domestic violence by displaying body language that they thought would be conducive to disclosure: "The first thing I do is I stop moving... I stop writing, I sit up, and I look at the person. I think that [body language] alone tends to focus attention."

Physicians were careful to follow up on their suspicions and on vague patient responses regardless of whether the patient disclosed abuse; this sometimes created a tacit understanding with the patient about the abuse.

If we suspect it, we give a framing question. If people don't want to own up to it or if I'm wrong, I just tell people, "Well, this is a big problem in our society and I just want to let you know that. I'm here if you want to talk about it. There is a social worker here who wants to talk about it if you want to talk about it." And if I think of it, I give the person a card, whether they say they've run into the door or not.

In general, physicians reported that 1) the more time they had, the more indirectly they approached the topic; 2) identifying domestic violence required the development of a trusting relationship with patients over time to increase the chance of future disclosure and decrease patient dropout; and 3) it was more effective to approach the topic indirectly so as not to seem judgmental when patients' ethnic-

ity, class, sexual orientation, or cultural beliefs differed significantly from those of the physician.

Some physicians reported that making personal, compassionate statements about the patient (such as “you’re looking pretty tired” or “that sounds like it hurts”) without pressuring for disclosure led to the most disclosures in the long term. Physicians also pointed out the importance of developing one’s own style: “If I’m not comfortable with what I’m doing, I’m pretty much guaranteed it’s not going to work for me or for my patients.”

The Rarity of Direct Patient Disclosure

Physicians reported that patients responded to their direct and indirect attempts to identify domestic violence in various ways, ranging from angry denial to subtle acknowledgment to direct disclosure. The latter, however, rarely occurred unless the patient had an acute injury or the situation was emergent. Physicians generally reported that a screening question sometimes provided hints but rarely produced direct disclosure. With this lack of patient disclosure as the norm, physicians discussed being very careful to read patient cues, such as body language, tone, or hesitation.

Compassionate Asking Equals Success

Some physicians had come to believe that successful screening for or inquiry about domestic violence needs to be redefined so that compassionate asking in and of itself, rather than gaining direct disclosure, constitutes success. They reported that “success” did not depend on the physician knowing for sure that the cause of the presenting problem was abuse. In this process, they had also redefined their role in helping potential victims.

Physician 1: And I wonder what happens to [people] when they go home and they think that a physician asked [a domestic violence] question. And I wonder if we’re actually having some success that we don’t realize, because it didn’t happen right there.

Physician 2: I think it really depends on how you define “yield.” Because I think domestic violence might be the only thing in medicine I’ve let go of having to fix or cure or even know if it’s really happening. The minimum that I have to do is make sure I said that I know they don’t deserve it and that there’s resources available if they want them. But my knowing isn’t the success and isn’t the yield. It’s the framing. It’s the fact that they knew I was concerned about that. You know, like smoking and gun safety. They hear that I’m concerned.

Discussion

The themes described by this purposive sample of physicians offer new understanding into how physicians can navigate around barriers and try to help victims of domestic violence. Here, we discuss the

findings that we believe will be most helpful for physicians.

As has been recommended by domestic violence experts who have developed screening recommendations (31), the expert physicians in our study carefully framed screening questions. They did this in part by reassuring patients that asking about abuse in intimate relationships is part of a physician’s job and by educating patients about the prevalence of abuse. This approach aims to normalize the process of identification and disclosure, thereby minimizing such barriers as fear of offending patients, patient shame and denial, and patient fears of being identified. It also establishes a framework for physician–patient discussions of abuse and places domestic violence squarely in the domain of public health alongside counseling about smoking cessation and gun safety.

In general, the physicians in the study were aware of the common indicators, both acute and nonacute, of domestic violence (1, 32–34) and had developed direct and indirect approaches to pursue identification, which incorporated their individual style and fostered patient trust. In acute cases, physicians asked directly about abuse. In the more difficult nonacute cases, physician reports and data from survivors (11, 27) emphasize the need to broach the topic of abuse indirectly over time, use nonjudgmental language, display attentive body language, and make compassionate statements without pressuring for disclosure. The data highlight the need to focus identification efforts on building a respectful physician–patient relationship and creating openings for future disclosure rather than on “fixing the problem” or controlling the outcome. Reports from survivors describe the need for physicians to sometimes participate with victims in a complicated dance of disclosure and identification in order to help patients feel safe and overcome their fear and denial (27).

Although the goal of the study was not to uncover barriers, the participating physicians cited the well-noted barriers to screening of lack of time and resources (22). In addition, this study uncovered two new barriers to “opening Pandora’s box.” First, mandatory reporting laws for domestic violence worked as a disincentive for some experienced physicians to identify victims. Although the laws vary, most states require health care professionals to report to the police patients with injuries resulting from illegal acts, and some states (California, Kentucky, New Hampshire, New Mexico, and Rhode Island) specifically require that confirmed or suspected acts of partner violence be reported (35). (Physicians should contact state officials for information on state-specific mandatory reporting requirements.) Further education could clarify physi-

cians' confusion about the requirements of the law, but it may be difficult to override their concerns about patient confidentiality and welfare and their reluctance to involve the police. There is much debate about the risks and benefits of mandatory reporting (36, 37). We suggest that states with reporting laws currently in place ensure that physicians receive adequate education and support in using these laws to the benefit of the patient.

The second new barrier described by physicians who had stopped universal screening for domestic violence was "burnout" due to lack of patient disclosure. Although screening patients for other health problems (such as colon cancer screening or mammography) may produce a similarly low yield, investigating these risks may not require physicians to face the complex set of barriers associated with domestic violence. Physicians who overcome these barriers and attempt to screen for domestic violence may feel disappointed by what they perceive as a lack of "results."

The most interesting and potentially helpful insight this study offers may be a solution to this problem. Given the major barrier of lack of disclosure (15–17), some physicians actively redefined the goals of universal screening and reframed their role in helping potential victims. Rather than viewing identification as the first step in helping victims and the outcome which defines success, these physicians propose that the act of asking patients about abuse is the initial step in providing quality health care—that is, compassionate asking in and of itself constitutes success. We encourage physicians to let go of having to "fix" or "cure it"; instead, universal screening or any inquiry about domestic violence can be used to give all patients a preventive antiviolence message and potential victims the message that abuse is wrong, they do not deserve it, and their physician cares. Experts in domestic violence agree that asking the question itself is helpful (31, 38). In addition, our previous research with survivors of domestic violence revealed that, with or without direct disclosure and identification, compassionate asking from health care professionals provided validation and helped victims change their situation and move toward safety (27).

Our study has several strengths and limitations. Qualitative methods and purposive sampling allowed us to generate themes and to uncover in-depth information about the identification practices of physicians who try to open Pandora's box. Purposive sampling, however, offers limited generalizability. In addition, the study used a relatively small sample and relied on participants' recollections. Additional research may corroborate and expand on the findings in our study; for example, the types of questions that yield the most disclosure from pa-

tients, and whether physicians who define success beyond gaining disclosure play a more active role in helping victims of abuse, could be explored.

Our data highlight the fact that the development and implementation of a standardized screening protocol for domestic violence have not eased the difficulty of identifying victims in health care settings. On the basis of our findings, we suggest that the goals of universal screening and asking about domestic violence be redefined so that the act of compassionate asking in and of itself, rather than the outcome of disclosure, constitutes success. This emphasis could lessen the burden attached to identifying victims of domestic violence and increase physicians' sense of efficacy—outcomes that may make a big difference to many battered patients.

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We filled out all the necessary forms, with her doing most of the writing since I kept bleeding all over the paperwork. A nurse with a superprofessional air about her had a look at my finger and cleaned it up with Betadine and peroxide, which turned my entire hand a kind of leathery orange color. It reminded me of the stains I used to get from the first baseball glove of the season, a J. C. Higgins. With my good hand, I pulled out the severed tip of my little finger and unwrapped it from the Kleenex with my teeth. The serious nurse took the piece of my finger, dropped it into a clear plastic Ziploc bag, and put it on ice. She did this like a cop would handle an item of evidence at a crime scene.

Sam Shepard
 "More Urgent Emergencies"
Cruising Paradise: Tales
 New York: Alfred A. Knopf; 1996:63

Submitted by:
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