AMERICAN MEDICAL ASSOCIATION WOMEN PHYSICIANS SECTION

Resolution: (Assigned by HOD)
(A-25)

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Subject: Expansion of Standardized Screening for Intimate Partner Violence in Acute Care Settings

Referred to: Reference Committee (Assigned by HOD)

Whereas, intimate partner violence (IPV) is defined by physical violence, sexual violence, stalking, and psychological aggression including coercive methods of a current or former intimate partner[1]; and

Whereas, IPV is associated with increased risks of cardiovascular, neurological, gastrointestinal, immunological, endocrinological, and reproductive health complications, as well as significant mental health conditions, including post-traumatic stress disorder (PTSD) (61%), depression (50%), and suicidality (20.3%)[2,3]; and

Whereas, two in five women and one in four men reported IPV and a related physical or psychological health impact in their lifetime, and transgender and non-binary individuals are affected at a rate 2.2 times greater than that of cisgender individuals[4,5,6]; and

Whereas, current USPSTF guidelines for IPV screening only recommends that women age 14 to 46 be screened due to lack of adequate research in other demographics[7]; and

Whereas, the USPSTF released a recommendation statement in 2024 stating that studies are needed to assess screening tools in men, same-sex couples, transgender persons, and the elderly to better detect IPV in these populations[7]; and

Whereas, commonly utilized screening tools such as Harm, Insult, Threaten, Scream (HITS) and Partner Violence Screen (PVS) only detected IPV in 30% of men currently experiencing IPV, indicating the need for improved screening tools in male-identifying patient populations[8]; and

Whereas, although 80% of women experiencing IPV seek emergency department services for IPV-related injuries, up to 72% of these women report never being screened for IPV by a healthcare provider[9]; and

Whereas, despite the increasing prevalence of IPV in elderly populations, which can increase an individual's 3-year mortality risk by 3.3 times, over 60% of physicians report never having screened an adult aged 65 or older for IPV[10,11]; and

Whereas, only a minority of people exposed to IPV are recognized in healthcare settings, suggesting that current screening guidelines are inadequate at detecting IPV[12]; and

Whereas, the Veterans Health Administration, American Academy of Pediatricians, and New York Department of Health have all updated their IPV screening recommendations to be more gender- and age-inclusive due to the benefits of expanded screening[13,14,15]; and

Whereas, current USPSTF recommended screening tools focus primarily on physical and sexual threats and injury, and fail to assess for psychological, financial, or reproductive abuse[7,16,17,18]; and

Whereas, psychological abuse, defined as any nonphysical behaviors designed to control, subdue, punish, or isolate another person through the use of humiliation or fear, is the most prevalent form of IPV, with over 100 million Americans reporting having been a victim of psychological abuse at one point in their life, yet remains under-recognized in current screening tools[18,19]; and

Whereas, financial abuse, defined as an individual's deliberate control of their partner's ability to acquire, use, and maintain economic resources, is a leading cause of homelessness in women yet remains under-recognized in current screening tools[20,21]; and

Whereas, reproductive abuse, defined as threatening or forcing a partner to get pregnant by damaging or withholding birth control and using sexual violence or coercion, is a risk factor for contraction of sexually transmitted infections, including HIV, yet remains under-recognized in current screening tools[22,23]; and

Whereas, verbal, psychological, financial, and reproductive abuse may occur in isolation of physical or sexual abuse, meaning that a large proportion of patients experiencing IPV may not be identified with existing screening tools[18]; and

Whereas, the most common forms of IPV experienced by LGBTQ+ individuals are threats of being "outed", and invalidation of gender identity, both of which are not represented on any major IPV screening tools used in acute care settings, leading to insufficient detection of abuse unique to this patient population[24]; and

Whereas, existing AMA policy addresses promoting resources, advocating for funding, and encouraging research specific to the LGBTQ+ population, but does not explicitly focus on expanding universal IPV screening guidelines to include all underserved populations, nor does it emphasize the urgent need to develop and adopt alternative screening tools that address multiple forms of abuse across diverse demographic groups[25]; and

Whereas, expanding IPV screening can improve detection, reduce long-term health burdens, and mitigate economic costs of IPV-related medical expenses, which amount to $4.1 billion annually in the United States[17,26,27]; therefore be it

RESOLVED, that our AMA advocate for expansion of current national guidelines to include IPV screening for all individuals, regardless of gender identity or age, upon first patient contact in acute care settings; and be it further

RESOLVED, that our AMA advocate for federal funding of research to validate screening tools that assess emotional, psychological, financial and reproductive abuse alongside physical and sexual violence in all patient populations regardless of gender identity, sexual identity, or age.

Fiscal Note: (Assigned by HOD)

Date Received: XX/XX/2025

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RELEVANT AMA POLICY

Family and Intimate Partner Violence H-515.965

(1) Our AMA believes that all forms of family and intimate partner violence (IPV) are major public health issues and urges the profession, both individually and collectively, to work with other interested parties to prevent such violence and to address the needs of survivors. (2) Our AMA believes that all physicians should be trained in issues of family and intimate partner violence through undergraduate and graduate medical education as well as continuing professional development. (3) Our AMA encourages physicians to (a) routinely inquire about the family violence histories of their patients as this knowledge is essential for effective diagnosis and care

[CSA Rep. 7, I-00 Reaffirmed: CSAPH Rep. 2, I-09 Modified: CSAPH Rep. 01, A-19 Modified: Speakers Rep. 01, I-24]

Improving Screening and Treatment Guidelines for Intimate Partner Violence (IPV) Against Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Other Individuals (LGBTQ) D-515.980
Our AMA will: (1) promote crisis resources for LGBTQ patients that cater to the specific needs of LGBTQ survivors of IPV; (2) encourage physicians to familiarize themselves with resources available in their communities for LGBTQ survivors of IPV; (3) advocate for federal funding to support programs and services for survivors of IPV that do not discriminate against underserved communities, including on the basis of sexual orientation and gender identity; (4) encourage research on intimate partner violence in the LGBTQ community to include studies on the prevalence, the accuracy of screening tools, effectiveness of early detection and interventions, as well as the benefits and harms of screening; and (5) encourage the dissemination of research to educate physicians and the community regarding the prevalence of IPV in the LGBTQ population, the accuracy of screening tools, effectiveness of early detection and interventions, as well as the benefits and harms of screening.
[Res. 903, I-17 Modified: CSAPH Rep. 01, I -18]

Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991
1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.
2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.
3. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender,

queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors. 4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.
[CSA Rep. C, I-81 Reaffirmed: CLRPD Rep. F, I-91 CSA Rep. 8, I-94 Appended: Res. 506, A-00 Modified and Reaffirmed: Res. 501, A-07 Modified: CSAPH Rep. 9, A-08 Reaffirmation A-12 Modified: Res. 08, A-16 Modified: Res.903, I-17 Modified: Res. 904, I-17 Res. 16, A-18 Reaffirmed: CSAPH rep. 01, I-18 Reaffirmed: CSAPH Rep. 08, A-24]

Improving the Identification of Intimate Partner Violence (IPV) in People with Disabilities D-515.974

(1) Our AMA advocates for increased research on the prevalence of intimate partner violence (IPV) in people with disabilities and the unique IPV-related issues faced by people with disabilities. (2) Our AMA advocates for increased research on the efficacy of population-specific intimate partner violence (IPV) screening tools that address the specific manifestations of abuse faced by people with disabilities.
[Res. 903, I-24]