

Gender violence and mistreatment (I). Global aspects from the healthcare perspective

MIGUEL LORENTE ACOSTA

Institute of Legal Medicine of Granada. University of Granada, Spain.

CORRESPONDENCE:

Miguel Lorente Acosta
Paseo de España, 2, 6° D
23009 Jaén, Spain
E-mail:
miguellorente@supercable.es

RECEIVED:

18-12-2007

ACCEPTED:

10-1-2008

CONFLICT OF INTEREST:

None

The consequences of gender violence on health have frequently been disguised in the form of various clinical pictures and disorders, in the same way that violence is overlooked in society through justifications and rationalizations. Social transformation and critical thought regarding violence is favouring the rise of new cases, which have translated into a significant increase in domestic violence reports filed; reaching 43.5% in the last five years. These circumstances have resulted in a higher demand for emergency healthcare services. Nevertheless, in spite of this increase, the global prevalence of gender violence (30% of women as documented by the WHO) is inconsistent with the number of cases presented to emergency department, which is approximately 17%. Besides, female victims of violence require medical services 30% more often than women who do not suffer violence indicating that many of the cases show a symptomatology not related to the physical injuries resulting from violent aggressions. The objective of the present study was to point out the consequences of violence beyond the specific aggression and to assess the view of the medical professionals with respect to gender violence, specifically that of emergency physicians and highlight the limitations and difficulties they face. This will help to ensure that physician response is not influenced by the personal consequences derived from the violent aggression and limited to that specific aggression. Medical professionals must focus on the health of the woman who suffered the violence and should in no case, provide clinical assistance based on other types of factors (police report, beliefs and prejudices,...). Emergency physicians must be aware that "to do nothing is to do harm" because otherwise, women will continue to suffer violence and their health will further deteriorate. The data reported may help professionals maintain a code of conduct and respond to cases of gender violence following two very simple criteria: to act in the same way as they would in other health situations that have personal consequences, and to bear in mind that behind an aggression there is health problem caused by violence, which in many cases will characterize the clinical picture. [Emergencias 2008;20:191-197]

Key words: Violence. Emergency. Mandatory reporting. Public Health. Domestic violence. Aggression. Medical record.

Gender violence in Spain

Gender violence (GV) has historically been characterized by its invisibility, for remaining occult behind the walls of homes where it was produced so that invisible became inexistent, a circumstance which completely conditioned institutional actions and especially the healthcare administration where the action was also directed to the visible part of the aggression, leaving the health problems caused by living under GV within the inexistence of the invisibility.

The social changes of the last years and the

consequent critical positioning against GV has led to an increase in the reports of cases of GV. Indeed, from 2002 to October 2007, 326,247 reports were made with an increase of 43.5% (until the end of 2006) (Figure 1) and the subsequent demand for greater direct care to those inflicted, especially from the area of healthcare.

In these circumstances, the role of emergency physicians and the remaining healthcare professionals should be centred on assistance to the aggressions and the alterations caused by violence as well as the detection of occult cases. To achieve this objective it is necessary to know the character-

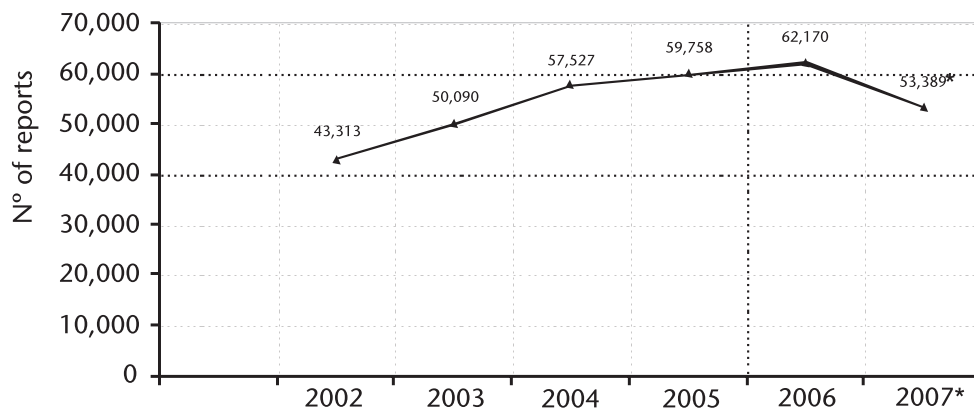


Figure 1. Reports of gender violence 2002-2007 (until October)*. Institute of the Woman.

istics of GV and know how it is manifest in practice. It is also necessary to be aware of the attitude taken by the professionals on presentation of a case and the obstacles presented in practice since it is only from this knowledge that what is done correctly may be potentiated and thereby improve what is not being adequately done.

Gender violence and health

Gender violence is not the aggressions which are only a very small part of the strategy of control which the aggressor develops. The consequences therefore go beyond the simple added effect of repeated attacks. According to the "Report on the World Population 2000" of the United Nations and the "World Institute on Violence and Health" of the WHO, one out of three women in the world has been or is being mistreated or abused¹. Fifteen to 30% of the female population in Spain is mistreated² and the Macro-survey of the Institute of the Woman of 2002 indicated a value of 11.1% for all the country. Mistreatment of women by their intimate partner is a global phenomenon found in all countries and affects women from all social, cultural and economic levels³.

Together with the violence in itself, the way it is done is an aggravating element of the consequences. The strategy followed by the aggressor first attacks the elements of past identity of the victim. Sources of external support continue thereafter (family, friends and work). The aggressor finishes by attacking the present elements of identity⁴ thereby facilitating isolation and reclusion in the violent relationship itself. Acute aggressions are characterised for reasons other than an objective conflict (unmotivated violence) and lead to a

conduct of hyper-vigilance and avoidance to elude any encounter with the aggressor and the possibility of a new attack. On the other hand, when the aggression occurs this usually takes place with great violence to achieve the objective of teaching the victim a lesson and terrorizing the woman⁵.

These characteristics of violence born within the framework of a relationship based on affection (emotional dependence) and the cultural component present at its roots (leading to a lack of critical references) make the violence justified and minimised and thus allow its prolongation over time⁵. In these circumstances, GV acts as a stressor due to both the continued exposure and the repetition of punctual aggressions, a situation which causes mechanisms of adaptation of the victims who undergo reinterpretation of reality from the circumstances lived, cognitive disassociation, and self-reproach which facilitate the prolongation of the violent relationship and cause all the chronic associated symptomatology at both a physical and psychological level⁶⁻⁸.

Feeling does not always coincide with perception and when the stimulus is very strong and the references for interpretation tend to filter some of its components, the significance of the target experience often does not coincide with reality. This happens with violence against women which, given the impact of its most frequent manifestations presented as aggression, make it difficult to see the underlying violence so that all the history which is invisible because of unawareness of control and submission remains hidden by the objectivity of the aggression. This tends to circumscribe the last blows and place their origin in a conflict for external factors which are solved in the end, although some of their consequences persist.

However, the impact on the health of the

women on whom GV is inflicted is not so much due to the punctual action of the aggression but rather what is denominated "exposure to violence": That is, the whole series of behaviour and attitudes aimed at questioning the position of the woman under the imposition and threat of aggressions and achieve her isolation from the main source of external support by both actions carried out by the aggressor as well as by the self-control the woman develops to avoid the conflicts which may lead to new aggressions. These dynamics lead the consequences of violence to go beyond punctual attacks and cause important damage in the physical and psychic planes. It should also be taken into account that on referring to the violent attitude of the aggressor in the context of the relationship or family, the consequences are felt by all the persons exposed to this situation and thus, the children cohabiting in this environment also feel the direct and indirect effects of violence.

The physical damage derived from the aggressions may include from slight injuries to severe organ and tissue involvement, with important implications in organism function and represent a high percentage of cases and even death. In its "World Report on Violence and Health" the WHO indicated the following lesions as the most frequent (Krug et al, 2002): abdominal/thoracic, haematomas and contusions, chronic pain syndromes, disability, fibromyalgia, fractures, gastrointestinal disorders, irritable colon, lacerations and abrasions, ocular damage and reduction in physical function. Sexual and reproductive consequences include: gynaecologic disorders, infertility, pelvic inflammation, pregnancy complications/miscarriage, sexually transmitted diseases (including AIDS), unsafe abortion and undesired pregnancy.

The psychological consequences (cognitive, affective-emotional, attitude, motivational, psychophysiological and behavioural) of mistreatment include stress and negative emotions (sadness, desperation, defenselessness, shame, rage, anxiety, fear, frustration) during the attack and after, threat or humiliation. The woman generally develops feelings of blame, shame, desperation, reduction in competence and resources (problem solving, decision making, social skills) and diminishment of autonomy and thus, perhaps, emotional dependence on the abuser^{2,9-11}. The most frequent symptoms experienced by the mistreated woman are anxiety, sadness, loss of self-esteem, emotional dependence, loss of sexual appetite, permanent fatigue and insomnia. In the most severe cases the woman may develop

chronic symptoms and disorders of greater or lesser clinical relevance and severity such as the post-traumatic stress syndrome, depression or anxiety^{8,12,13}.

In its "World Report of Violence and Health" (2002), the WHO also points out the following psychological consequences as the most frequent¹: smoking, alcohol and other drug abuse, depression, anxiety, alimentary and sleep disorders, feelings of shame and blame, phobias and panic disorders, physical inactivity, low self-esteem, post-traumatic stress disorder (PTSD), psychosomatic disorders, problems in sexual conduct and sexual dysfunction. Walker^{12,14} formulated the mistreated woman syndrome to determine all these symptoms and problems derived from violence and mistreatment and the responses of women to this situation. This syndrome is based on the theory of learnt defenselessness. Recent studies¹⁶ have described the appearance of chronic stress with repercussion in the suprarenal-hypothalamus-hypophysis in battered women, even without previous diagnosis of PTSD. The intensity and duration of PTSD has been related to alterations such as peri-traumatic disassociation in the acute time of the trauma¹⁷. In general it has been calculated that 60% of battered women has moderate or severe psychological problems⁵, although other authors cite values of around 85%¹³.

These circumstances lead the women to often recur to the consumption of medications and drugs as a formula of evasion, and although with a lower frequency, they may consider suicide (it has been estimated that 25% of mistreated women commit suicide) to end the situation^{2,13}.

Professional attitude of public healthcare towards gender violence

Is a differential diagnosis with GV really carried out in each of the alterations and pathologies mentioned above? And is the presence of these diseases investigated in each physical or psychological aggression attended in the emergency department to direct the therapeutic measures to this end?

The attitude of the professionals towards GV should not be different from any other problem except for searching for adaptation to the circumstances to achieve greater efficacy. This is no different from the approach to other clinical problems and only reinforces the individuality of each case. These circumstances surpass the biologicistic framework to place the problem within the social

context similar to what occurs with many other diseases which manifest with different nuances in each case. "There are not diseases but rather patients" stated Hippocrates and this is repeated in faculty classrooms. The same may be said of GV. There are individual elements of the personality of the aggressor and the woman, the characteristics of the relationship, the types and features of the violence rendered – frequency, intensity, type, use of elements to potentiate damage – which exist through their presentation in each of the persons to whom GV is inflicted and the characteristics of the circumstances.

- Studies carried out in the last years have reported a series of elements characterising the attitude of the healthcare professionals towards GV.

- Care is fundamentally initiated for the aggressions inflicted upon the woman and thus, the maintained situation of violence is reduced to the punctual actions of the aggressions.

- Considering the severity of the problem, response seems to be limited in form, largely motivated by the above perception and in content which is almost exclusively focused on the last episode and evaluated as an acute event not connected with a structural situation. These circumstances are translated into a partial implication centred on the idea of "sensitivity" towards the problem of GV.

- Cultural elements which construct an idea of GV around determined contexts and particular forms of presentation condition the response and direct it to a physical plane in search of acute episodes and certain women who coincide with the idea of the "victim profile". For example, this is reflected by not asking women of a higher socio-cultural level about the possibility of violence¹⁸.

- Some of the great obstacles for achieving the most adequate response include¹⁹: the lack of training, structural problems in department organisation (lack of time, absence of privacy, inadequate environment) and fear or insecurity related to legal consequences, particularly in understanding that this is a private problem which is aggravated by healthcare action.

Gender violence and healthcare emergencies

Gender violence may present to an emergency department in different ways. It may sometimes appear with objective manifestation of lesions, while on other occasions most cases arrive with a symptomatology which is difficult to relate to an

aggression, despite the manifestations being caused or influenced by exposure to violence. The clinical problem is not as much as how to approach these cases but rather in how to do so according to the attitude adopted by the woman towards the violence. Some women refer directly to the violence in response to the questions of the attending professional while in many other cases violence remains occult behind the same prejudices which hide the signs and symptoms.

"You can only see what you look at and you only see what is in your mind". With this phrase Alphonse Bertillon emphasised the importance of knowledge in the area of behaviour and since, in its absence, even the most objective could remain unnoticed. Urgent care and emergency department professionals should know GV to be able to identify its manifestations beyond the scope of the aggressions. Thus, they will be able to direct the interview, examinations and complementary studies to identify the origin of the problem leading to the need for assistance and thereby orient the action towards a solution of the punctual problem of acute manifestation and the approach to the causes leading thereto, and recommend continued action by other specialists. Otherwise, a lack of modification of the causes will lead to further problems and another request for assistance.

- According to different studies, the following are differential elements which may be presented in the care provided to cases of GV in the urgent care and emergency services:

- The incidence of all the cases attended by emergency services for lesions and non traumatic diseases is from 2% to 7.2%²⁰.

- Seventeen percent of the cases attend the emergency department, with this department presenting the highest incidence in comparison with the remaining hospital departments²¹.

- The general prevalence of GV is of 37% and the prevalence in the last 12 months has been of 14%.

- The prevalence of GV is higher in women who attend the emergency department for traumatism²².

- The incidences reported in the emergency care services and emergency departments do not correspond with the general prevalence in society which is of around 30% of the women over the age of 18 years (WHO, 2002) thereby indicating that a large part of these women do not seek healthcare as an acute problem and when they do so, the picture is influenced by the alterations caused by the violence. This fact indicates that most cases attend other services in search of a so-

lution for a health problem related to violence without referring to its existence. The situation is even more surprising in studies indicating that battered women request healthcare assistance 30% more frequently than women who are not²⁵, thereby demonstrating that they attend healthcare services without the violence being detected. This circumstance has been confirmed in other studies such as that by Bansal et al.²⁶ who reported that 38% of the women surveyed in shelters, who were therefore involved a serious situation of violence, had gone to healthcare services without the situation of GV having been detected.

- Perhaps behind these factors there is also the explanation for why men predominate among the subjects who attend hospital emergency departments in the different age groups, except for the group between 15 and 44 years of age in which women predominate in frequentation to these departments²⁷. This coincides with the period of age with a greater incidence of violence and aggression against women on behalf of their intimate partners and when the intensity of this violence is more severe. This circumstance not only translates into traumatic lesions but also into a series of pathologies and general alterations, particularly of the genito-urinary tract²⁵.

- The causes leading to deficient detection include the previously mentioned obstacles which should be taken into account to modify these obstacles and to improve healthcare response: professional formation (only 34% perform differential diagnosis in a situation of GV for physical aggressions)²⁸ and structural problems (time, privacy, conditions for carrying out the interview)¹⁹.

In view of this setting, it can be concluded that GV is presented in emergency care services and emergency departments more frequently than detected and, therefore, with a higher incidence than previously recognised. Moreover, on most occasions it lies behind a picture probably precipitated or aggravated by GV with elements which act against correct healthcare assistance towards the individual problem, the picture leading to the emergency department and the underlying disease and adequate action towards both a public health and social problem. On other occasions, the obstacles originate within the setting of the violence itself, with the women either hiding the cause of the injuries or with the symptoms presented or through direct interference of the aggressor (threat, vigilant attitude) or indirect obstacles such as those described in some studies. McCloskey et al.²⁹ concluded that in 17% of the cases the aggressor interferes with the healthcare

assistance to the battered woman either by impeding assistance or insisting that the manifestations are of an aetiology other than violence.

Treatment of gender violence in emergency departments

The specific circumstances characterising the presentation of cases of GV in the emergency departments should direct the professional action and the treatment to be applied as specified in the following points:

- Gender violence is an individual and public health problem independent of the social context in which it is produced (for example, influenza is not considered an environmental problem or parasitosis a veterinary problem or traffic accidents do not constitute a transportation problem, all of which are health problems independent of the aetiological factors which may influence their presentation).

- Professional action towards GV should be based on the same principles as for any other care and should, therefore, be centred on responsibility, not sensitivity, an element which will always be considered as a complement of the care provided, not a basis for the same (when someone asks for a surgeon to operate on a relative they do not seek a sensitive surgeon with a hiatus hernia but rather they seek a good professional with experience in this intervention).

- Professional action should not prejudice the circumstances to condition response, although the response should take these circumstances into account for adapting to them in form and time so as not to be inhibited. In the cases of GV "to do nothing is to do harm", since this allows women to continue in a situation in which violence progressively deteriorates their state of health.

- No scientific evidence has demonstrated that reports to the police by women or the reporting of lesions by the professionals increase the violence or the risk of the same. This argument is often wielded by professionals to inhibit themselves in these cases or those suspected of GV. This decision contributes to the persistence of the health problem due to the lack of action to the underlying disease and which is aggravated by facilitating the exposure of the woman to GV.

- Any action on GV or on suspicion of GV should be reported in the clinical history of the woman and should be made with a sense of continuity in which the healthcare professional manages the measures to be developed and arranges

for appointments with the woman to control the evolution of her state. A proactive attitude should be adopted to approach the problem of the woman from all the perspectives (social, workplace, familial) and with the reference being the health problem of the woman since, if this is not resolved, it will be difficult to solve the remaining problems. This does not mean that the healthcare professionals must manage all the problems, but those related to health should be managed with in depth care.

– Reporting of the lesions should never be an argument to condition the healthcare assistance provided and the continued treatment of the situation of GV which the woman has. Healthcare professionals are not police investigators or forensic physicians, but they should study the health problem of the patients attended due to violence and should be aware that as in the case of a disease which requires mandatory reporting nobody questions whether the case has been reported to the health authorities or asks for the consent of the patient, even if this leads to the quarantine of the patient. In the case of GV, when this has evidence of violence it must be reported to the judicial authorities since this action is not directed towards the individual-clinical problem but rather it is fundamentally made in view of a social-public problem.

The problem of healthcare action on GV has never been “what to do” but rather “why do”, that is, in which direction should the care provided be oriented, something which is done according to the conception of GV perceived, generally centred on the acute event causing physical injuries (aggressions) and understood more as a judicial than healthcare problem. The references cited throughout the present review provide some of the keys on the way to approach the different situations and circumstances which may characterise the presentation of the cases of GV in an emergency care service or emergency department. The recommendations on how to proceed before each of these have been described in different studies, including the “Good clinical practice guidelines for approaching situations of gender violence” by the Organización Médica Colegial (OMC)³⁰ and especially in the “Common protocol for healthcare action against gender violence” elaborated and published by the Spanish Ministry of Health and Consumption³¹, which should be used as a reference to direct professional response from the emergency departments for cases of GV, both as an acute presentation and a chronic manifestation. This protocol understands this to be an

individual problem of each of the women on whom it is inflicted and a public healthcare problem derived from the social circumstances which characterise both the origin and the result of gender violence.

References

- 1 Krug EG, Dahlberg LL, Mercy JA, Zwi AB, Lozano R (eds). World report on violence and health. Ginebra 2002. World Health Organization.
- 2 Echeburúa E, Corral P (1998). Manual de violencia familiar. Madrid. Siglo XXI (Eds).
- 3 Fischbach RL, Herbert B. Domestic violence and mental health: correlates and conundrums within and across cultures. *Soc Sci Med* 1198;45:1161-76.
- 4 Dutton DG, Golant SK (1997). El golpeador: Un perfil psicológico. Barcelona. Paidós.
- 5 Lorente M. Agresión a la mujer: realidades y mitos. Mi marido me pega lo normal. Barcelona, 2001. Ares y Mares.
- 6 Dobie KJ, Kivlahan DR, Maynard C, Bush KR, Davis TM, Bradley KA. *Archives of Internal Medicine* 2004;164:394-400.
- 7 Kubiak SP. Trauma and cumulative adversity in women of a disadvantaged social location. *Am J Orthopsychiatry* 2005;75:451-65.
- 8 Ruiz Perez I, Plazaola Castaño J. Intimate partner violence and mental health. Consequences in women attending family practice in Spain. *Psychosom Med* 2005;67:791-7.
- 9 Buchbinder E, Eisikovits Z. Battered women's entrapment in shame. A phenomenological study. *Am J Orthopsychiatry* 2003;73:355-66.
- 10 Dutton DG, Painters S. The battered woman syndrome: effects of severity and intermittency of abuse. *Am J Orthopsychiatry* 1993;63:614-22.
- 11 Matud MP. Impacto psicológico del maltrato a la mujer: un análisis empírico. 1999.
- 12 Walker (1991): Abused women, infants, and substance abuse: Psychological consequences of failure to protect. In PR McGrab & DM Doherty (eds.). Mothers, infants and substance abuse: Proceedings of the APA Division 12, Midwinter Meeting, Scottsdale, AZ, January 19-20.
- 13 Golding JM. Intimate partner violence as a risk factor for mental disorders: a meta-analysis. *Journal of Family Violence* 1999;14:99-132.
- 14 Walker: Terrifying love: Why battered women kill and how society responds. New York, 1989. Harper Collins.
- 15 Walker: Psychology and domestic violence. *Am Psychologist* 1989;44:695-702.
- 16 Griffin MG, Resick PA, Yehuda R. Enhanced cortisol suppression following dexamethasone administration in domestic violence survivors. *Am J Psychiatry* 2005;162:1192-9.
- 17 Briere J, Scott C, Weathers F. Peritraumatic and persistent dissociation in the presumed etiology of PTSD. *Am J Psychiatry* 2005;162:2995-301.
- 18 Kramer A, Lorenzon D, Mueller G. Prevalence of intimate partner violence and health implications for women using emergency departments and primary care clinics. *Womens Health Issues* 2004;14:19-29.
- 19 Furniss K, McCaffrey M, Parnell V, Rovi S. Nurses and barriers to screening for intimate partner violence. *MCN Am J Matern Child Nurs* 2007;32:238-43.
- 20 Ernst AA, Weiss SJ. Intimate partner violence from the

- emergency medicine perspective. *Women Health* 2002;35:77-81.
- 21 McCloskey LA, Lichter E, Ganz ML, Williams CL, Gerber MR, Sege R, et al. Intimate partner violence and patient screening across medical specialties. *Acad Emerg Med* 2005;12:712-22.
- 22 Weinsheimer RL, Schermer CR, Malcoe LH, Balduf LM, Bloomfield LA. Severe intimate partner violence and alcohol use among female trauma patients. *J Trauma* 2005;58:22-9.
- 23 Lipsky S, Caetano R. The role of race/ethnicity in the relationship between emergency department use and intimate partner violence: findings from the 2002 National Survey on Drug Use and Health. *Am J Public Health*. 2007;97:2246-52.
- 24 OMS. Informe Mundial de Violencia. 2002.
- 25 Campbell JC. Health consequences of intimate partner violence. *The Lancet* 2002;359:1331-6.
- 26 Bansal SK, Park E, Edwardsen EA. Medical inquiry for intimate partner violence as reported by women in a shelter. *J Emerg Med* 2008;34:341-5.
- 27 Roldán Ortega R, Machín Hamalainen J, Sánchez Espinosa J. Frecuentadores del Servicio de Urgencias de un hospital grupo I. *Emergencias* 1999;11:192-6.
- 28 Siendones Castillo R, Perea-Milla López E, Arjona Huertas JL, Agüera Urbano C, Rubio Gallo A, Molina Molina M. Violencia doméstica y profesionales sanitarios: conocimientos, opiniones y barreras para la infradetección. *Emergencias* 2002;14:224-32.
- 29 McCloskey LA, Williams CM, Lichter E, Gerber MR, Ganz ML, Sege R. Abused women disclose partner interference with health care: an unrecognized form of battering. *J Gen Intern Med* 2007;22:1067-72.
- 30 Lorente Acosta M, Toquero de la Torre F. Guía de Buena Práctica Clínica en Abordaje en situaciones de violencia de género. OMC. Madrid 2004.
- 31 Ministerio de Sanidad y Consumo. Protocolo común para la actuación sanitaria ante la violencia de género. 2007.

Violencia y maltrato de género (I). Aspectos generales desde la perspectiva sanitaria

Lorente Acosta M

Las consecuencias sobre la salud de la violencia de género (VG) con frecuencia se han agrupado en forma de diferentes cuadros y achaques, del mismo modo que la VG se ha invisibilizado en la sociedad alrededor de justificaciones y contextualizaciones. La transformación social y el posicionamiento crítico ante la violencia está produciendo un afloramiento de los casos, hecho que se ha traducido en un significativo aumento de las denuncias, que en los últimos cinco años ha sido del 43,5%. Estas circunstancias se han traducido en una mayor demanda de asistencia en los servicios de urgencias (SU). Sin embargo, a pesar de este incremento, la prevalencia general de la VG, establecida por la OMS alrededor del 30% de las mujeres, contrasta con la incidencia de estos casos en los SU, situada entorno al 17%, hecho que unido a que las mujeres víctimas de violencia acuden un 30% más a los servicios sanitarios que las mujeres que no sufren violencia, indica que muchos de los casos se presentarán con una sintomatología diferente a las lesiones físicas ocasionadas por las agresiones, y sin que sean relacionadas con la VG. En el presente trabajo se trata de destacar las consecuencias de la VG más allá de las agresiones puntuales y de analizar la actitud de los profesionales sanitarios ante la VG, de manera especial la de los *urgenciólogos*. Se pretende resaltar las limitaciones y obstáculos existentes con vista a mejorar la respuesta sin que ésta venga condicionada por las consecuencias sociales derivadas del hecho violento, ni limitadas a la acción puntual de la agresión. La actuación de los profesionales sanitarios debe centrarse en la salud de la mujer que ha sufrido la VG, y en ningún caso supeditar la asistencia clínica a otro tipo de factores (parte judicial, creencias y prejuicios,...). Los *urgenciólogos* deben tomar conciencia de que "no hacer es hacer mal", porque supone permitir que la mujer continúe bajo los efectos de la VG con el consecuente deterioro progresivo de su salud. Las referencias aportadas pueden facilitar el posicionamiento de los profesionales sobre el principio de responsabilidad, y llevar una actuación sobre la VG alrededor de dos criterios muy simples: actuar como se hace ante cualquier otro problema de salud con consecuencias sociales, y hacerlo teniendo en cuenta que detrás de una agresión hay un problema de salud ocasionado por la exposición a la violencia, que en muchos casos será el que caracterice el cuadro. [Emergencias 2008;20:191-197]

Palabras clave: Violencia de género. Urgencias. Parte judicial. Consecuencias sobre la salud. Tratamiento violencia. Agresor. Historia clínica.