

Clinical Cases

Asking Patients about Intimate Partner Abuse

Physicians need to properly screen their patients for intimate partner abuse and provide referrals for support and counseling.

Commentary by Michael A. Rodriguez, MD, MPH, and Tracy Battaglia, MD, MPH

Learning Objective Recognize the prevalence of intimate partner abuse.
Recognize the impact on public health goals of patient nondisclosure.
Learn steps of a patient-centered approach to encouraging the disclosure of abuse.
Become familiar with resources for patients who have been abused.

This was the second time Dr. Mike Ricardo had seen Mrs. Ashley Wills for a possible broken bone. A few months ago Mrs. Wills came in saying she had slipped that morning when she went out to get the mail. She had bruising on her arms and neck, and her left wrist was broken. When Dr. Ricardo asked Mrs. Wills how she had gotten the bruises on her neck from falling in the driveway, Mrs. Wills had looked down at the floor and shaken her head without responding. Dr. Ricardo found it difficult to believe that Mrs. Wills' husband, a well-respected attorney in town, would be physically violent to his wife, but that is where the signs were pointing. Now Mrs. Wills was back complaining that her ribs hurt when she breathed. One of the nurses stopped Dr. Ricardo in the staff room as he headed over to the exam room where Mrs. Wills' was waiting,

"Hey Mike, I was just in 3 with Ashley Wills. She's saying her ribs hurt when she breathes, and it looks like one might be fractured. She's got mean bruises on her cheek and her arm. She said that she fell when she was out jogging, but I don't believe her for a second. Can't you get her to report it?"

Commentary 1

by Michael A. Rodriguez, MD, MPH

Intimate partner abuse (IPA) is a major social and health problem that impacts more than one-third of American women at some point in their lives [1]. Half of all female survivors of IPA report injuries, and 20 percent of them seek assistance from clinicians [2]. The immediate health consequences of IPA can be severe and sometimes fatal, and women with a history of abuse have greater chronic and behavioral health risks [3, 4]. On average, more than 3 women are murdered by their husbands or boyfriends in this country every day [2].

While clinicians routinely screen women for other potentially deadly but preventable conditions and behaviors such as high blood pressure and cigarette smoking, only 10 percent of primary care physicians ask their patients about abuse [5], which may be more likely to affect their health and endanger their lives.

Many survivors of abuse have realistic fears that disclosing the abuse will jeopardize their safety by potentially escalating violence, exposing them to embarrassment, and jeopardizing their family, as well as putting them or their loved ones at risk for other hardships [6]. Quite often survivors whose primary language is not English have difficulty relating their situation to hospital staff. Limited utilization of professional translator services causes reporting to rely on translation by family members, children, and partners, making some patients more reluctant to disclose information.

Clinicians may not screen patients for abuse because of their own discomfort and embarrassment, lack of time, fear of offending the patient, lack of training in knowing what to do when abuse is detected, or knowing what to do but believing it will not help [5].

Despite these barriers, clinicians and health care facilities can implement a policy that can save lives and dollars. This policy simply relies on clinicians taking the time to ask their patients one critical question: *Do you feel safe at home?* Alternative screening questions can be found in the resources listed at the end of this commentary.

With regard to the case study, Dr. Ricardo has been confronted with a second opportunity to address a serious case of probable intimate partner abuse. It is apparent that Dr. Ricardo was reluctant to confirm his suspicions about abuse when Mrs. Wills first presented with injuries. Dr. Ricardo should have put his preconceived judgments aside and asked Mrs. Wills about abuse in a direct and nonjudgmental way. A majority of women patients favor physician inquiry and report that they would reveal abuse histories if asked directly [7]. Dr. Ricardo may have been able to prevent Mrs. Wills' second visit to the hospital had he taken appropriate measures the first time. Some of the actions he can take include but are not limited to:

- Ensuring the safety of his patient and any children;
- Respecting her life choices;
- Holding the perpetrator responsible for the abuse;
- Providing phone numbers of hot lines, health care, legal and other resources;
- Scheduling follow-up appointments;
- Encouraging a safety plan for the future.

In addition to clinicians' individual actions, there are several other ways of creating a supportive environment such as: (1) hanging posters about preventing IPA in waiting areas and patient rooms, (2) placing victim safety cards in the bathroom and exam rooms for patients who need information but may not be ready to disclose, and (3) wearing "Is someone hurting you? You can talk to me about it" buttons.

As part of a strategy to have more clinicians respond to IPA, at least 6 states have passed mandatory reporting laws for injuries resulting from IPA. These laws have stirred much ethical debate in the medical literature. Concerns are that mandatory reporting may increase violence by the perpetrators, diminish patients' autonomy, and compromise patient-physician confidentiality. Supporters of the policy argue that it will facilitate the prosecution of batterers and encourage clinicians to identify intimate partner abuse. Because of the uncertain benefits of these mandatory reporting laws, the National Research Council has recommended a moratorium on such laws until more research is conducted on the advantages and disadvantages of mandatory reporting policies for partner abuse [8].

Whether or not clinicians report intimate partner abuse, they should confront the issue, so survivors can seek support and counseling as well as information about shelters and other resources. We have the opportunity to help the many hidden survivors of IPA in our community, but only if we properly screen patients, identify abuse, and provide referrals.

Some useful references for both health care professionals and IPA survivors are:

AMA Diagnostic and Treatment Guidelines

[Family Violence Prevention Fund](#)

[National Coalition Against Domestic Violence](#)

CDC guide to training materials and programs

National Domestic Violence Hotline

1-800-799-SAFE (1-800-799-7233) available 24 hours

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Commentary 2

by Tracy Battaglia, MD, MPH

Intimate partner violence (IPV) has become a widely recognized public health concern in the past few decades as a result of ongoing research that indicates a high prevalence of IPV with severe health consequences. Competence by health care professionals in screening for violence in intimate relationships has increasingly become a standard of care. The case of Dr. Mike Ricardo and Mrs. Ashley Wills highlights the fact that practicing clinicians continue to have difficulty integrating this standard into their everyday practice, and many IPV survivors do not readily disclose abuse, even when asked [1-2].

Violence against women is widespread in the United States. The National Violence Against Women Survey found that over 50 percent of women reported a lifetime history of physical assault, while for 25 percent of women that violence was perpetrated by an intimate partner [3]. IPV, also known as domestic violence, includes physical, sexual, and psychological assault. Psychological and emotional abuse are the most prevalent; as many as 75 percent of all women will be subjected to psychological aggression by an intimate partner in their lifetime. Studies have also found that women in abusive relationships have higher utilization of health care services and will often access the health care system multiple times prior to abuse detection. Consequently, health care professionals are in a unique position to regularly encounter women who are survivors of violence [4].

The first step in clinical practice is to identify the presence of violence. Ideally, this should occur during routine screening, prior to an acute injury. In fact, identifying violence through disclosure is therapeutic in itself, inasmuch as it validates the presence of an intensely private matter and is a requisite step in the healing process. Identification of IPV begins with direct physician inquiry. This case demonstrates that, despite standards setting, only about 10 percent of physicians screen patients routinely, while 80 percent inquire in the presence of suspicious injury. This is important since most women will not volunteer their histories and will avoid presenting with dramatic or suspicious injuries [4].

Physicians cite lack of knowledge, skill, resources, and time as well as their beliefs or misconceptions and personal experiences as reasons for not screening their patients for IPV [5-6]. Physicians fear that identification of IPV among their patients is like opening "Pandora's Box," which translates into time-consuming, complex care that requires expertise or resources they do not possess. Studies have shown, however, that survivors find it useful and empowering when health care professionals offer them education and referral to community resources. A statement such as "you don't deserve this" may go a long way for a woman who has never been told such abusive behavior is not acceptable. Even in the absence of on-site resources, physicians can easily provide statewide hotline numbers and program information.

Dr. Ricardo's disbelief that Mr. Wills, a well-respected attorney, could be a perpetrator of violence is a common misconception. Like Dr. Ricardo, many physicians falsely believe that violence only occurs among poor women of color. Although research has identified characteristics most often associated with a perpetrator of IPV, it is critical for physicians to be aware that any person regardless of gender, race, or socioeconomic status, can be a perpetrator of violence [4]. A high index of suspicion is necessary for all patients, since all women are at risk. Hence, the American Medical Association recommends direct questioning of all patients for IPV routinely [7]. Although we do not know the prior visit history in this case, it seems that Dr. Ricardo did not follow these guidelines.

Even in response to direct inquiry, patients may choose not to disclose. Physicians with expertise in IPV admit to difficulty identifying the presence of abuse in all cases [5]. Shame, guilt, and fear of perpetrator retaliation are some reasons women choose not to disclose when asked. Another barrier identified by both survivors and their physicians is lack of patient trust in the health care professional [5,8]. Some or all of these factors may play a role in why Dr. Ricardo was unsuccessful in obtaining disclosure from Mrs. Wills.

One recent study of trust in the patient-physician relationship identified certain physician behaviors that facilitate trust and, thus, make disclosure more likely [9]. Many of these behaviors represent the essentials of a patient-centered approach in which the doctor and patient share power and responsibility through a therapeutic alliance. Survivors describe trusted physicians as those who engage in open communication where medical decision making is shared and allow them to maintain some control after suffering under the power and control of their perpetrator. An explicit explanation of the confidentiality of the patient-physician relationship directly facilitates trust, especially when the use of information has potential consequences for the patient, such as retribution from the abuser or involvement of child protective services. Survivors of IPV are more likely to trust physicians who are familiar with them through repeated encounters and who show concern through nonjudgmental and empowering statements or gestures. Similarly, physician persistence in repeated questioning while respecting the decision not to disclose conveys a sense of caring. And a physician who shares personal information facilitates trust by eliminating the inherent imbalance of knowledge and power in the patient-physician relationship.

As Dr. Ricardo prepares to enter the exam room with his patient, Mrs. Wills, he has a unique and powerful opportunity for intervention. His ongoing relationship with Mrs. Wills through repeated encounters already lends him credibility. The fact that Mrs. Wills chose to seek care in his office as opposed to in an emergency department provides some evidence of trust in her relationship with his office. If Dr. Ricardo can overcome his prior misconceptions and follow a patient-centered approach of direct questioning and explicit confidentiality, he may increase Mrs. Wills' trust and get closer to a disclosure of abuse. Even in the absence of a direct disclosure, Dr. Ricardo can provide education and referrals that Mrs. Wills may use in the future, or at the very least empower her to return once again to his office for further care and repeated questioning.

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