

Virtual Mentor

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CASE AND COMMENTARY

Asking Patients about Intimate Partner Abuse, Commentary 1

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Case

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

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.

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