

A Physician Assistant Response To Domestic Violence

This material was adapted from the publication entitled, “Improving the Health Care System’s Response to Domestic Violence: A Resource Manual for Health Care Providers,” produced by the Family Violence Prevention Fund in collaboration with the Pennsylvania Coalition Against Domestic Violence.

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We as PAs have the opportunity to impact on an enormous health care problem in America today. You may be surprised at the prevalence of domestic violence and from where it may be lurking in your practice. We are called to reduce injury and violence as outlined in Healthy People 2010. In fact, domestic violence, sometimes referred to as intimate partner violence, is linked to eight out of the ten national indicators, including mental health, tobacco abuse, substance abuse, responsible sexual behavior, overweight and obesity, and even immunizations (children of battered women are less likely to get immunized). And yet providers fail to recognize the problem because they don’t routinely inquire about or document an abuse as the cause of their patients’ symptoms.

Prevalence

The U.S. Department of Justice reports that nearly one third of American women report being physically or sexually abused by a boyfriend or husband at some point in their lives. In 2001, 85% of victimizations by intimate partners were against women and 15% of victimizations were against men. Domestic violence occurs in both adult and adolescent intimate relationships. The victim and perpetrator may be dating, cohabitating, married, divorced, or separated. They are heterosexual, gay or lesbian. Those with disabilities and language or cultural barriers are at greater risk.

Understanding Domestic Violence

The intimate context of the violence is important in understanding the nature of the problem and in developing effective interventions. The abuse, a purposeful and instrumental behavior repeated over time, is directed at achieving compliance from and control over the victim. Perpetrators isolate victims by controlling their access to their resources: time, transportation, food, clothing, shelter, insurance, and money. Victims use many different strategies to cope with and resist the abuse in order to temporarily bring safety to themselves or their children. To successfully intervene means to understand the victim’s behaviors as a normal response rather than condemning them as passive, masochistic or inappropriate.

Presentation of Victims.

Clinical presentation of abuse can include acute injuries, complications of conditions, or chronic illness.

Almost any type of injury can be a manifestation of abuse. The most common sites of injuries are the head, face, neck and areas that are usually covered by clothing. Other manifestations include

injuries which do not fit the provided explanation; injuries in various stages of healing, suggesting infliction over time; injuries with delayed presentation to the provider; and complaints of injury without physical evidence of trauma.

Example: A 34-year-old woman had been seen by several different physicians for jaw pain. Finally, a primary care physician diagnosed temporomandibular joint syndrome and referred to a specialist. This specialist, knowledgeable about domestic violence, determined the TMJ syndrome had been caused by repeated episodes of battering during which the woman's husband had grabbed her by the jaw and forcefully yanked it from side to side.

While acute injuries may be the most obvious, it is often the long term medical and psychological consequences that are the most debilitating. Pain is a common presenting symptom. In one pain center 66% of women with headaches had been physically or sexually abused as adults. Another study in a GI clinic found 36% of their women patients had abusive histories. Between 67% and 83% of HIV positive women in one clinic had been in an abusive relationship with men who refused to use barrier protection.

Example: A 37-year-old woman was seen by a cardiologist after presenting to the ED with chest pain, dyspnea, palpitations, diaphoresis, and dizziness. Her EKG revealed sinus tachycardia with no acute changes. Further questioning elucidated a history of panic attacks which had begun after her husband threatened to kill her if she ever tried to leave.

Clinicians need to feel comfortable asking screening questions and direct questions about violence. You might routinely say, "Because violence is common in women's lives, I now ask every woman in my practice if their partner has ever hurt them."

Initial Assessment

Anyone who has been battered should be assessed for serious injury or homicide before being discharged from the health care setting. The following are considered risk factors: Violence outside the home, violence against the children (or when pregnant), threats to kill the victim, the children, or threats of suicide, escalation of threats, serious injury in the past, batterer abuses drugs, especially those known to increase violence (amphetamines, PCP, crack cocaine), readily accessible weapons, batterer is obsessed with the victim, and the victim attempting to leave or divorce in the near future. (Abusive men are most likely to kill their female partners when the woman tries to leave or seek outside help). Ask the victim if she feels she is in danger of being seriously hurt or killed. If she says yes, take this very seriously. If she says no, but you believe she is at risk, discuss this with her frankly.

It is also critical that the provider regard the victim's choice in how help proceeds. For some battered women, calling the police invokes retribution by their batterers, a consequence only the victim will know. The following is a true scenario in western Pennsylvania:

"Jane" has been beaten by her husband for the last 5 years. Jane's husband said that he will kill her if she calls the police. Instead, Jane consulted a civil attorney who will help her to file a Protection from Abuse Order. Jane's attorney advised her that she get her injuries documented by

a medical professional. When she arrived at the physician's office, the doctor told her that he is a mandatory reporter and is required to file a report with law enforcement. Jane repeatedly asked the doctor if he could just treat and document the injuries so that she could proceed with a civil remedy. The doctor said that he is legally required to report her injuries. Jane got up and left the physician's office. She was so disconcerted that she decided not to file for a PFA Order. Jane has not gone back to receive medical treatment for subsequent injuries caused by the violence.

Under Pennsylvania statutes, mandatory reporting of injuries by firearm or criminal act is exempt in the case of domestic violence. A report cannot be made without the victim's consent. The following is a second true scenario in eastern Pennsylvania:

Mary received treatment from a physician for her domestic violence related injuries. Without informing Mary, the doctor reported the incident to the local police. After leaving the doctor's office, Mary went to a family member's home for support. While she was there, the police arrived at her home and spoke to Mary's abuser. The medical report did not provide specific information about the time, date, or nature of the incident that caused Mary's injuries. The police did not receive any corroboration from Mary or from any additional witnesses. Thus, the police left Mary's home without arresting her abuser. Mary's abuser became enraged. When Mary arrived home she did not know what had transpired. She received the brunt of the abuser's anger...

History of Present Illness

Ask specifically about what happened, when this abusive episode started, who inflicted the injuries, and whether there have been prior incidents. Include the time, date, and location of episodes, using the victim's words whenever possible. Elicit the relationship between physical and/or psychological symptoms and the abuse.

Physical Examination

Your patient should be informed of each step you are about to take so that the exam itself does not become another traumatic experience. Perform a thorough and careful exam of the entire body, using a body chart, if available, and include a mental status and neurologic exam. Sexual assault procedures go according to your facility using standard evidence collection. If possible, take color photographs (Polaroid preferred) to attach to the patient record. Take photos from different angles and include a full body, close up, and the patient's face and evidence of the medical facility where taken.

The victim should be assessed for potential suicide or homicide on her part. If there is significant risk, an emergent psychiatric evaluation/hospitalization should be obtained. This may also provide immediate safety in some situations.

Provide Information About Domestic Violence

The most important message to be conveyed is that most violence continues over time and that the isolation, fear, entrapment, and the risk of lethality tend to increase. The perpetrator alone is responsible for his violence and only he can stop the abuse.

Refer

It is essential to have an updated list of domestic violence service agencies and other community agencies to give to battered patients. For a county listing of domestic abuse programs and shelters, please visit the Pennsylvania Coalition Against Domestic Violence at pcadv.org or call 1-800-932-4632.

Providing quality health care involves integrating routine inquiry about domestic violence into clinical practice. Some women return to violent partners several times before they feel safe enough to leave, feel they can survive on their own, or can accept that the person they love will not change. Asking questions can build bridges, decrease isolation, and create hope.