May 20, 2008

Screening for Abuse May Be Key to Ending It

By ERIN N. MARCUS, M.D.

The silver-haired woman greeted me at the clinic door, one arm suspended in a bright blue sling.

This wasn't her first visit. In the preceding few months, she had come to the clinic twice with assorted aches and inexplicable pains. Now her husband had broken her arm, and the reason for those visits had become glaringly obvious: he had been hitting her.

And the domestic violence screening question I'd asked months before — nestled between queries about smoking and seat belts — seemed to have been spectacularly ineffective, since she'd answered "no."

When I had asked about violence at home, I had been following guidelines set by the surgeon general and many professional groups, including the American Medical Association. Those who support routine questioning say domestic violence is as or more common in women than many diseases for which doctors regularly check, including breast and colon cancer, and its health risks are well documented.

Despite these recommendations, screening for domestic abuse in seemingly healthy women is nowhere near as widespread among doctors as testing for breast cancer or high cholesterol.

Some physicians see domestic violence primarily as a criminal justice issue, and take umbrage at being expected to delve into a difficult, messy topic when they already have to screen for many other conditions and diagnose complicated diseases in the span of an ever-shorter visit.

In a recent nationwide study of nearly 5,000 women, only 7 percent said a health professional had ever asked them about domestic or family violence. When surveyed, doctors often respond that they don't

ask such questions because of a lack of time, training and easy access to services that help these patients.

Some have reported that they worry about offending patients and believe asking won’t make any difference.

“Just like anybody else, doctors avoid things they may have discomfort doing,” said Dr. Michael Rodriguez, a researcher and family practitioner at the University of California, Los Angeles. “There’s also an expectation on the part of some folks that once we identify abuse she should just walk away, and frustration when she doesn’t.”

Dr. Rodriguez and other experts say that urging an abused patient simply to leave may not be realistic or safe, for several reasons: The risk of being murdered is highest at the time one leaves, the woman may depend on her partner for food and shelter, and patients may not respond well to a doctor who dictates what to do.

They also say the best way to ask about such abuse is in a private place, with no family members present, as part of the routine patient history. If the patient says she has been battered or threatened at home, experts recommend that the doctor offer empathy, tell her what’s happening is wrong, document her story in the medical record and provide her with information on places to go or refer her to someone who may be able to help, like a social worker.

Barbara Gerbert, director of the Center for Health Improvement and Prevention Studies at the University of California, San Francisco, said that while some women might deny domestic violence at first, the question itself could have a profound effect: many women remember that their doctor asked and eventually, even years later, reveal their secret.

“Just by asking, you may be planting a seed for change,” she said.

Numerous studies indicate that doctors ask about domestic violence poorly, however, and don't handle it well when they do get a yes answer.

Felicia M. Frezell, 34, an office manager in Omaha, told me recently that she visited her doctor's office many times with her five children during the 15 years she lived with her ex-husband, who was convicted in 2005 of raping her. She said that even though she often had bruises, no one ever asked her why — until she asked her doctor to look at her swollen black eye and told him her husband had hit her.

"He just said, 'You'd better get out of that situation' and left it at that," Ms. Frezell said, and added: "Looking back, I didn't know the resources that were out there. The doctor's office is a good place to go because it's neutral and it's confidential. It's not like telling your husband you're going to the police department."

According to the Bureau of Justice Statistics, from 2001 to 2005 (the last year for which statistics are available) there was an annual average of nearly 511,000 violent assaults against women — and 105,000 against men — by a spouse or intimate partner, about half resulting in physical injury.

Despite such numbers, the United States Preventive Services Task Force concluded in 2004 that although clinicians should "be alert" for signs of violence, there was insufficient evidence to recommend for or against screening asymptomatic patients for domestic abuse — mainly because of a dearth of large-scale scientific studies looking at this question.

While many researchers say more money is needed to pay for such studies, some say the analogy to routine screening misses the point.

"Trying to equate it to a Pap smear is the wrong paradigm, and it's just irrelevant," said Dr. Christina Nicolaidis, a general internist and researcher at Oregon Health and Science University. "It's not a test you can just check off."

“The reasons to ask,” she continued, “are to educate a patient and to open the door so that the patient knows she can come to you. It’s part of developing a real relationship with your patient. Over time, you might be able to uncover the abuse and improve her safety, but you also might better understand why she’s having her symptoms and how to better approach her self-management of her illness.”

Abused women are at increased risk of chronic pain, depression, anxiety and alcohol and substance abuse, and they can have problems taking their medication correctly and getting to appointments. In one recent study, women who said they had been abused within the past year were more likely to have partners who interfered with their medical care.

Seven years ago, the Institute of Medicine, which advises the federal government, issued a major report on the training of health workers on family violence. The report concluded that such violence “was not a consistent priority” in health workers’ education and recommended that the Department of Health and Human Services establish education and research centers in family violence.

By unhappy coincidence, the report was unveiled at a news conference on Sept. 11, 2001, and has since “collected dust,” said one of the authors, Felicia Cohn, who now directs medical ethics at the University of California, Irvine.

“Certainly other issues took precedence at the time,” Dr. Cohn added, “but the continuing inattention is both inexcusable and embarrassing. This is a public health pandemic with immense health care implications.”

For my silver-haired patient — and other women I see at the clinic where I work — there have been no simple answers. I keep the telephone numbers for a local women’s shelter and the police department’s domestic violence unit in my lab coat pocket. And I keep asking the question, so my patients know there’s a place they can turn.

Erin N. Marcus is a general internist and associate medical director of the Institute for Women's Health at the University of Miami Miller School of Medicine.