

Domestic Violence and Clinical Medicine

Learning From Our Patients and From Our Fears

Domestic violence has been, until very recently, a secret pandemic.* Over the course of human history, virtually no other public health problem has been as prevalent or as challenging to the health and well-being of humanity as intentional injury. Eclipsed only by war, domestic violence has remained at the forefront of violence-related human morbidity and mortality. Evidence of the long-term, dramatic worldwide health impact of this pervasive problem is available from sources as diverse as historical archives, laws and legal opinions, modern radiologic analyses of several-thousand-year-old mummified remains, and survivor narratives. Although pandemic in scope, domestic violence until recently remained secret and undefined, in part because historically there was no common language to name the problem, describe its scope, garner the evidence, or take concerted action regarding intervention or prevention.

Much has changed over the last quarter century, initially because of grassroots self-help efforts of individual women and community-based advocacy groups. Many of these organizations arose from the women's rights and feminist movements of the 1960s, and are still active today. The medical community first began to recognize domestic violence as a substantial medical and public health problem in the mid-1970s, but it was not until the 1990s that attention to the diagnosis and treatment of domestic violence became recognized as legitimate in the discipline of medical practice.

We have come a long way in a relatively short time, but we still have a very long way to go. When this author went to medical school (in the mid-1970s), the term "domestic violence" was nowhere to be found in the medical lexicon, textbooks, published literature, or curriculum. The ongoing pandemic was addressed neither in the classroom nor at the bedside and as a consequence, remained largely unrecognized by and invisible to the medical community. Some mention was made of a condition, thought to be relatively rare, known as "child abuse and neglect," a diagnosis that had been introduced in the medical literature just 10 years previously.¹ Two articles in the current *Journal of General Internal Medicine* represent important and quite different steps in the right

direction toward diffusing knowledge and innovation about domestic violence further into the legitimate domain of contemporary medicine. Both articles offer important insights regarding how to approach the clinical care of patients at risk for domestic violence, yet each explores the problem from a distinctly different perspective.

Elliott et al., in this issue of the *Journal*, report the results of a written survey of physicians that queried screening rates for domestic violence, and identify factors associated with infrequent screening.² Their results, consistent with previously reported research, confirm that physician screening rates are generally quite low,³ despite clinical guidelines and recommendations regarding screening that have been promulgated by domestic violence resource centers, health care organizations, and professional associations.⁴⁻⁸ Elliott et al. break new ground in this study by determining that, in sharp contrast to the state of affairs only a decade ago, the vast majority of physicians have received some sort of training or education about domestic violence. Of concern, however, is that only a small minority felt comfortable with their skills in recognizing and treating patients at risk. Nearly half felt they had inadequate resources to address domestic violence if identified; and many feared offending patients by asking, or simply "forgot" to ask routinely. Despite potential methodological limitations of response rate, response bias, and social desirability bias, the findings reported are important in their own right and indicate the need for further study of the feasibility of comprehensive skill-based training, chart prompt reminders, and infrastructure improvements such as making patient education materials, advocacy services, and safety planning more widely available in the office setting. The important next step for research into physician behavior around screening and patient advocacy is, "If we build it (a comprehensive training and response infrastructure), will they screen?"

Nicolaidis uses the voices and commentary of domestic violence survivors to advance our knowledge and provide insights on how physicians can better care for at-risk patients.⁹ She writes about the process used to develop and produce a 30-minute educational documentary about violence, geared specifically to a physician audience. The video, *Voices of Survivors*, was produced from edited segments of audiotaped semistructured individual interviews with survivors (or in some cases, current victims) of abusive intimate relationships, with accompanying visuals of still photographs of survivors. The goal of the video project was to use the narratives and suggestions of survivors to improve physician awareness and empathy about domestic violence, provide tools that can increase detection, and reinforce helpful responses to

*The word pandemic is derived from the Greek pandemos - pan-, all + demos, people. The *Oxford English Dictionary* defines pandemic as "general, universal, especially of a disease. Prevalent, over the whole of a country or continent, or over the whole world." Pandemic is distinguished from epidemic, which generally connotes a condition that is prevalent yet limited to a smaller geographic area or population subset.

patients in the clinical setting. Four overarching themes were identified by the survivors whose stories were shared in the video: 1) domestic violence is both widespread and universal; 2) domestic violence encompasses much more than physical assault; 3) an understanding of the dynamics of power and control is essential in providing quality care; and 4) domestic violence affects the entire family, not just the direct victim.

As careful scientists, physicians seek the holy grail of “the evidence base” to guide their clinical decision making. Too often, the only evidence that is sought and valued is that which is derived from quantitative methods. Nicolaidis’ promising project teaches us from a different perspective, one that is qualitative, survivor-focused, and highly contextualized. Listening to the voices of survivors deepens our capacity to comprehend the pandemic of domestic violence by providing us with a rich understanding of the effects of abuse on people’s overall health and well-being, and conveys an important sense of respect and legitimacy to survivors and the stories they no longer wish to keep secret. Additionally, Nicolaidis’ *Voices of Survivors* is especially useful for physicians because it was produced by a physician with recognized expertise in domestic violence specifically for a physician audience. Thus, the video speaks to the culture of medical practice from an insider’s viewpoint, and has relevance that may be deeper than that which could be gained from a more generically produced educational product.

We learn best at the bedside, or in the ambulatory and community setting, at the “patient-side.” We are wise to listen carefully and respectfully to our patients as they tell us their stories and teach us what we need to know in order to be the trusted, compassionate healers that we all aspire to be. We owe our patients nothing less. Clearly, domestic violence is no longer a secret pandemic. We have

come a long way in just a quarter of a century. The new horizons that challenge us are in improving our capacity to respond in the daily routine of patient care, to become better and more patient listeners, and to focus our efforts increasingly toward prevention. After centuries of silence, we owe it to our patients to be wise and to learn as much as we can from our own investigation as well as from our patients’ experience.—**ELAINE J. ALPERT, MD, MPH**, *Boston University Schools of Public Health and Medicine, Boston, Mass.*

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