[Doctor] Looks like you've got some bruises.
[Patient] Oh, well, I got these black and blue marks when I slipped on the ice and fell.
[Doctor] Uh-huh.
But, those bruises don't look like she fell. It looks like someone hit her. Her husband? She doesn't look like the type to have this happen. Should I say something after the examination? Maybe I'm wrong. Will I offend her? Do I have the time? What could I say? What - what could I do anyway?
[text on screen reads] Clinical Aspects of Domestic Violence for the Obstetrician/Gynecologist
[Dr. Jones] Domestic violence, or battering is a health problem that affects many patients in our practice. As physicians, we are charged with the responsibility of not only treating the symptoms, but also diagnosing the underlying cause of the problem. For most women in their reproductive years the ob/gyn is their only health care provider.
Until a few years ago I didn't realize how widespread domestic violence was. In the past I saw a few cases a year where I suspected domestic violence or battering, but I used to believe that battering mostly took place among lower socioeconomic groups. That's just not the case. And I found that out when I changed the questions I asked and started asking my patients more directly about it. I was stunned by the answers. Now I was confronting these cases two or three times a week.
Now, I had viewed myself as a reasonably perceptive caring physician, and I had missed all this. And if I've missed all this, surely others have as well.
Consider these facts:
A woman is battered every 15 seconds in this country. Twenty-five to forty-five percent of all women who are battered are battered during pregnancy. Domestic violence occurs among all races and all socioeconomic groups. Battering may be the single most common cause of serious injury to women, more than rapes, automobile accidents and muggings combined.
Given the prevalence of domestic violence, you can be sure you are seeing in your practice women with signs and symptoms of battering. Domestic violence is more than battering and physical injury. It can be emotional and psychological abuse, sexual assault, intimidation or any coercive behavior. The abuser is usually someone who has or used to have an intimate relationship with the woman.
Why get involved? Patients who are injured by domestic violence exhibit certain signs and symptoms. After completing this CME program, you will be able to better confirm the presence of domestic violence and refer the patient appropriately.
We'll also demonstrate techniques for routine screening, intervening and making referrals, and assessing risk. And we'll look at some of the legal issues surrounding domestic violence.
[text on screen reads] Why get Involved?
[Presenter] Both the American College of Obstetricians and Gynecologists technical bulletin and the AMA's Diagnostic and Treatment Guidelines on Domestic Violence recommend routine screening of patients for abuse. The presence of domestic violence has an enormous impact on your patient's overall health and well-being and your patient may be in more danger if she's pregnant.
Recent studies have shown that domestic violence often begins or escalates during pregnancy, and pregnancy is often the only time healthy women see a doctor on a regular basis. By using routine screening and other intervention techniques to go beyond just treating the symptoms and injuries, you may be able to diagnose the underlying cause and refer the patient for treatment.
Here's what past victims of domestic violence had to say about talking to their doctors.

[Ms. Vedders] I very reluctantly told my ob/gyn exactly what had happened, which was the first time I had admitted to anyone other than some very close friends what had happened to me. I was very embarrassed because I was sure that this was my fault.
[Ms. Conrad] I was pretty ashamed of it, too. I mean, it's pretty embarrassing to say, yes, I'm a pretty intelligent person, but I got involved in this kind of a relationship and now I don't know if I want to get out or not, or if I can get out.
[Presenter] It takes only a minute to screen a patient, but that minute can save that patient a lot of pain, time and money when later injuries must be treated.
[Ms. Conrad] I think that if a doctor or a nurse had asked me enough questions that weren't questions that would make me defensive, I probably would have opened up. I probably would have spilled the entire story and said, yes, this is what's happening. Please help me.
[Presenter] Studies have shown that victims of domestic violence want their doctors to ask about abuse. Patients with no history of abuse don't mind these questions and are in favor of routine inquiries.
Understanding the dynamics of an abusive relationship is crucial to successful intervention with your patients. Often it's difficult for abused women to recognize what's happening to them. A woman may stay in an abusive relationship because she may still love her partner and not want to leave, or she may feel afraid or ashamed. She is often conditioned by her partner to think she deserves the abuse, or she may be dependent on the partner for financial support.
A woman doesn't consent to getting beaten, but over time she may resign herself to it.
She has an increasing sense of isolation and despairs of finding help.
[text on screen reads]Signs and Symptoms
[Presenter] There are signs and symptoms that can alert you to the possibility of domestic violence. None are pathognomonic, but they do arouse suspicion. These warning signs fall into three areas: physical injuries, physical symptoms and behavioral signs. We'll examine each one separately.
First, we'll demonstrate one technique for probing patients about suspicious physical signs.
[Doctor] During the examination, I noticed some bruises on your breasts and on your abdomen. Can you tell me how these injuries happened?
[Presenter] Patients may also present with chronic pain, evidence of substance abuse or physical symptoms related to stress or depression. When these symptoms are demonstrated, it is appropriate to probe the situation further.
[Doctor] You've lost some weight.
[Patient] I know I should be eating more especially now with the baby, but I'm just not very hungry.
[Doctor] Are you getting enough rest?
[Patient] I haven't been sleeping well and I have been getting a lot of headaches.
[Doctor] What do you think is the cause of this?
[Patient] My husband's not excited about the baby. He's worried about money and when he's worried, he gets mad at me.
[Doctor] What does he do when he gets mad?
[Presenter] Probing is also appropriate when the warning signs are behavioral in nature. The patient's partner can be very watchful or protective. He answers questions directed to her.
[Nurse] Is there anything you'd like to talk to the doctor about?
[Male] I don't think so.

[Presenter] You may notice that she doesn't want to speak up or disagree in front of her partner. Her partner seems to be reluctant to leave her side. In order to talk with the patient privately, some physicians ask the partner to wait outside explaining that he can rejoin the patient after the examination.
[text on screen reads] Routine Screening
[Presenter] Domestic assaults become more frequent and severe over time. Routine screening can interrupt the escalating violence. Your intervention may help the woman take control of her life to stop the abuse before the injuries get worse. Screening for domestic violence may be as simple as adding one question to the patient's medical history form, such as, are you presently in a relationship in which you are threatened or being physically abused? But you may get at the problem better by asking verbally how are things at home, or how do you and your partner resolve conflict at home? And start out with an opening statement that lets the woman know she is not being singled out and that it is not a unique situation.
[Doctor] Because abuse has become so common in women's lives, I've begin to ask about it routinely.
[Presenter] This statement validates the reality of domestic violence and shows the patient you're concerned. It also gives the patient permission to discuss this as another health issue that affects her overall well-being just as she would talk about allergies or hereditary diseases in her family. Keep in mind that if your patient is being abused, she may not choose to respond right now. She may be afraid of your reaction or of what might happen to her once she tells. After your opening statement you might ask:
[Doctor] Are you in a relationship where your partner has physically hurt you or threatened you?
[Presenter] Here's another approach based on what the patient tells you.
[Doctor] You mentioned that your husband is under a lot of stress. Has he physically hurt you or threatened you?
[Patient] He hits me sometimes.
[Doctor] Where does he hit you?
[Patient] In the stomach.
[Doctor] And how often does this happen?
[Presenter] Notice that the questions are asked in the same style and tone as the other medical background questions. Patients should have the feeling that these questions are just as clinical as background questions about the history of heart disease or diabetes.
These screening questions may also be asked by your nurse or other members of your staff. Some patients may feel more comfortable talking to them rather than to a doctor. Other examples of routine screening questions can be found in the accompanying monograph.
[text on screen reads] Intervening and Making Referrals
[Presenter] Once you've diagnosed that your patient is a victim of domestic violence, what do you do next? Let's look at one example of how a physician might intervene.
[Doctor] You've said that your husband hits you. Would you like to talk about what's happening to you?
[Patient] When he gets angry, he loses control.
[Doctor] And how do you feel about it?
[Patient] I don't know. I thought it would stop. He keeps promising he won't do it again.
[Doctor] Would you like to do something about it?
[Patient] Sometimes I want to leave him, but I'm afraid of what he might do to me.
[Doctor] Are there children in the house?

[Patient] Yes, I have a son.
[Doctor] Is your husband hurting him?
[Patient] No. Not yet, anyway.
[Doctor] Okay. If you'd like, I have some information from some local agencies that could give you some help, give you some information and find a shelter for you and your son, if you need it. Is it safe for you to take some information home? Is it safe for you to go home?
[Presenter] Here the physician encourages the patient to talk about how she felt and what she wanted to do about the situation. The questions were direct and non-judgmental. She found out whether any children were at risk. She also offered to give the woman information if it was safe for her to take it.
If it's not safe for your patient to take literature home, suggest that she read the material while she's in your office. After she's read it, you can discuss what she wants to do next.
Make sure you know about the local resources for domestic violence in your area and keep their brochures and other materials on hand. There are local organizations in most areas that can give women shelter, information about legal rights, welfare applications and counseling. Many offer these services free of charge. However, because of precarious funding these organizations are often in flux, so it's important to keep current on what's available in your area.
Often, individual therapy or counseling is indicated, but family counseling or family intervention therapy is not. This is not a fight between two equals. There's a problem of balance, coercion and the exercise of power. Therefore, family counseling in these situations can not be done with candor and openness and without the fear of recrimination. This kind of counseling can actually increase the woman's danger because her partner may punish her for speaking about their situation.
However, some patients do develop serious psychiatric problems related to the battering. If your patient shows signs of post-traumatic stress syndrome, refer her for psychiatric evaluation.
[text on screen reads] Assessing Risk
[Presenter] The next step in intervention is to assess the patient's level of risk. She could be in danger of being killed if she leaves her partner, or if she makes it clear to him that she's ending the relationship. If there are children at risk, the woman needs to make arrangements for them, too. This will not only protect the children, but it will also help prevent the impression that the woman abandoned them when she sought shelter. This can be important if there are subsequent custody hearings. If your patient decides to return home, help her to assess the level of risk for her and the children.
[Doctor] Do you want to make any arrangement for you and your son, contact a shelter?
[Patient] No, I'm going back home.
[Doctor] Okay. Since I'm concerned about your overall health, I need to ask you some questions in order to help you assess your risk. Has your husband threatened to kill you?
[Patient] Yes.
[Doctor] Does he threaten your son?
[Patient] No.
[Doctor] Is there a gun or a weapon in the house?
[Patient] My husband has a hunting rifle.
[Doctor] Do you think he's capable of killing you?
[Patient] I don't know. I don't think so.
[Doctor] Is he violent outside of the house?
[Patient] No.

[Doctor] Do you have some place you and your son could go if you think you need help? Stay with family or friends?
[Presenter] Help your patient to consider her risk objectively, but remember it's her decision. Your role is to help her take control of the situation, but only at the level she's prepared to deal with emotionally and physically. If she wants immediate medical or psychiatric intervention, help her to arrange that. If she decides to go to a shelter and it's full, consider admitting her to a hospital until other plans can be made. Keep in mind that she will also need to make arrangements for the children. If she decides to stay with her partner, help her to focus on ways to recognize when violence is coming and how she can protect herself and her children.
[Doctor] Your aim is to get out of the house before he gets violent. Have you noticed whether or not your husband habitually does anything or says anything before he starts hitting you? Is there any pattern to his behavior?
[Patient] Well, yeah, he gets real quiet at first and he doesn't talk at all.
[Presenter] Encourage your patient to develop a safety plan for when she needs to leave the house quickly. More information about developing a safety plan and assessing the patient's risk can be found in the monograph and in ACOG's technical bulletin On the Battered Woman.
You may have patients who deny there's a problem, who choose to do nothing right now. Your willingness to raise the issue
and offer your help is important to these patients even if they choose not to act.
The patient must be allowed to maintain her autonomy and you as the physician must learn to walk away without showing verbal or non-verbal value judgments.
[text on screen reads] Legal Issues
[Presenter] There are some legal issues surrounding domestic violence that may affect your practice.
A few states do have reporting requirements for physicians, but most states don't. However, in those that don't the victim may fall under other reporting requirements for child abuse, elder abuse or abuse of the disabled.
If you're legally required to report injuries inflicted by weapons, discuss your legal obligations with the patient. Explain the reporting and investigation procedures that will follow. Help her to assess her needs for safety once the assault is reported.
Now, let's talk for a moment about documentation. It's critical in cases of domestic violence because your notes and her medical records may be subpoenaed if the patient presses charges against her partner. Your records may be able to support the woman's statements that she has been abused and injured over time. You may be called to testify about the contents of the medical record or the statements you've made.
Include a thorough description of the complaint using the patient's own words whenever possible. Give a detailed description of any injuries and include the results of lab tests or diagnostic procedures.
Draw the injuries on a body map or, with the patient's permission, photograph them.
The AMA's diagnostic and treatment guideline on domestic violence have more information about how to document these cases.
[Dr. Jones] Remember, domestic violence can cause enormous harm to your patient's overall health and well-being. Your role is to know the signs and symptoms, routinely screen your patient for domestic violence, intervene and make referrals and assess the patient's level of risk. Your intervention may have the added benefit of encouraging your patient to help herself to take

control of her own life. Your concern and intervention are crucial in this process. You must make a difference.
[Ms. Vedders] I think if a woman hears from a doctor how dangerous abuse is physically and emotionally, I think she's more apt to take his - his or her advice than she is from perhaps her sister or her - her friend.
[Ms. Conrad] You know, she believes I am no good. Nobody cares about me. And if a doctor takes the time to ask those questions, then she starts to feel that somebody does care. And if somebody does care, then there must be some kind of hope out there for her and somewhere to go.
[text on screen reads] The American College of Obstetricians and Gynecologists
Brought to you through an educational grant from Searle
The American College of Obstetricians and Gynecologists and GD Searle would like to acknowledge and thank the following people for the time they devoted to reviewing these materials.
Ronald A. Chez, MD Professor of Obstetrics and Gynecology Professor of Community and Family Health Department of Obstetrics and Gynecology University of South Florida
Morton A. Stenchever, MD Professor and Chairman Department of Obstetrics and Gynecology University of Washington