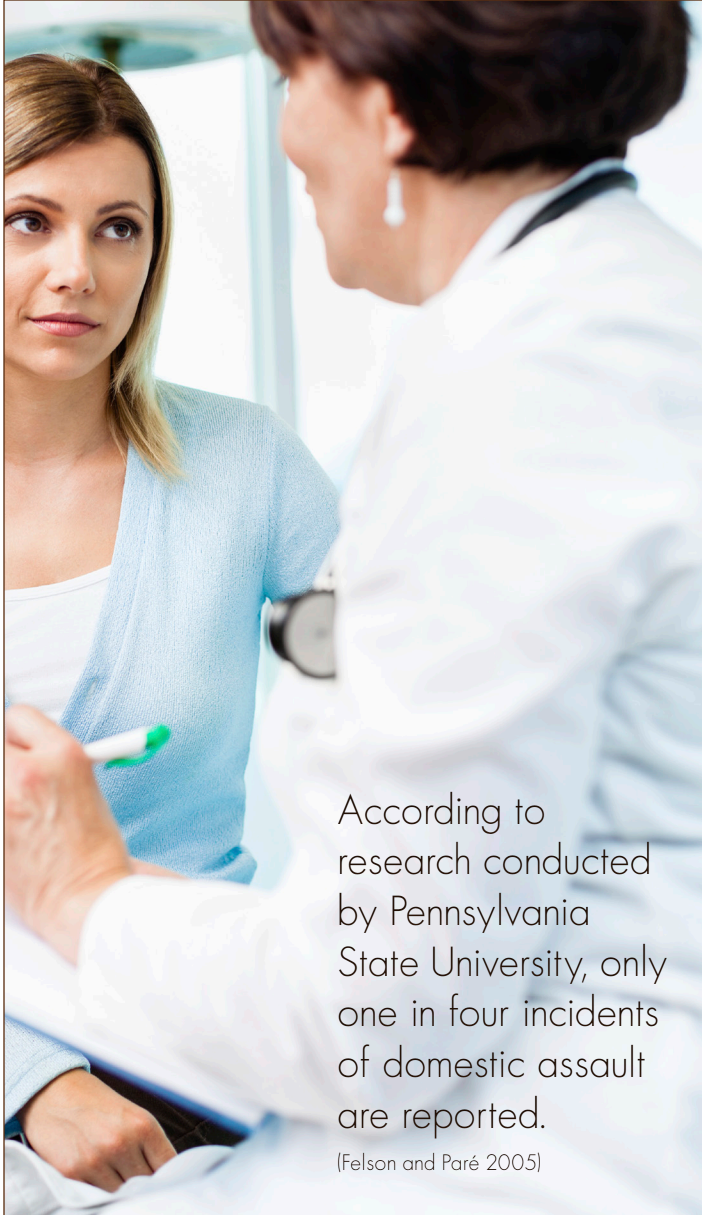


# Diagnosing Domestic Violence

By Nicole Li and Jonathon Wilson



According to research conducted by Pennsylvania State University, only one in four incidents of domestic assault are reported.

(Felson and Paré 2005)

## DOMESTIC VIOLENCE REPORTS IN WASHINGTON AND KING COUNTY BY YEAR

	2010	2011	2012	2013
<b>Domestic Violence Reports (WA)</b>	49,233	36,826	45,944	32,442
<b>Domestic Violence Reports (King Co, est.)</b>	13,579	10,157	12,672	8,948
<b>Annual % Change</b>	+2%	-25%	+25%	-29%

Sources: The Crime In Washington 2009–2013 Annual Report

Recent scandals have brought domestic violence once again to national headlines, although domestic violence seems a perennial problem in our society. Historically and generally, the issue is framed as male physical violence against a female partner or family member. Of course, we know the reality: Domestic violence includes not only physical violence, but also mental and emotional abuse, and there are male victims of domestic violence as well as female abusers. Intimate and family violence crosses gender, sex, and familial categories. This article addresses how conscientious communication can facilitate physician detection and response to patients living with domestic violence.

### Overview of Domestic Violence—Statistics & Laws

Over the course of their lifetimes, one in four women will be the victim of physical violence by an intimate partner; one in five will be raped. For men, the numbers are one in seven and one in 59, respectively (Center for Disease Control 2014). Each year, one in 20 men and women are the victims of non-rape sexual violence (Black, et al. 2011). Whether these sobering statistics accurately capture incidents and whether they reflect domestic violence in same-sex and other domestic relationships is not certain.

At the national level, measures addressing domestic violence include the 1994 Violence Against Women Act, which sought primarily to increase the punishments for abusers. It also provided funding for official training and for the Department of Justice's new Office on Violence Against Women. It would seem that this was a resounding success: Intimate partner violence dropped 64 percent from 1994 to 2010 (Pickert 2013), and in 2013 the Office on Violence Against Women gave out almost \$379 million in grants (Office of Violence Against Women). However, during that same period, the rate of violent crime in general decreased 43 percent (Federal Bureau of Investigation 2010). This calls into question how much of the decrease in domestic violence was a result of the Violence Against Women Act, and how much was the result of an overall decreasing trend in violent crime. Additionally, in 2013 the Department of Justice received \$27.1 billion, which was only 0.1 percent of the 2013 requested U.S. Budget (Office of Management and Budget); and of that, only \$412.5 million, or 1.5 percent, went to the Office on Violence Against Women. This also calls into question the financial commitment being made to end domestic violence.

Women in Washington state have a lifetime prevalence of rape, physical violence, and stalking by an intimate partner *more than 7 percent above the national rate* (Center for Disease Control 2014). In 2013, 32,442 instances of domestic violence occurred in Washington. King County, the largest county in the state

with 29 percent of the population (United States Census Bureau 2013), historically accounts for about 28 percent of statewide domestic violence cases—indicating approximately 9,000 cases in King County in 2013. And although this is a decrease from 2012, it is on par with the fluctuating recent historic trends (The Washington Association of Sheriffs and Police Chiefs). See table on page 32.

These figures must be understood in context. According to research conducted by Pennsylvania State University, only one in four incidents of domestic assault are reported (Felson and Paré 2005). This suggests that there are upward of 35,000 actual incidents of domestic violence in King County in 2013, adjusting the four-year high in 2012 up to 50,688 actual incidents. The actual numbers matter less than the recognition that this problem is difficult to quantify.

### Resources in King County

King County offers a number of resources to affected individuals. These are accessible at [www.kingcounty.gov/courts/Clerk/DomesticViolence/](http://www.kingcounty.gov/courts/Clerk/DomesticViolence/) and include tips on safety plans, confidential shelters, and hotlines. Many, if not all, of these resources are available to victims without charge; this is important in situations where the abuser controls the couple's money. In addition to state- and county-sponsored programs, it is important for victims to be aware of legal and health resources. Particularly when the victim may feel trapped and alone, such knowledge can be empowering.

Washington state law recognizes that domestic violence affects not only physical and mental health but also economic well-being and opportunity. Wash. Rev. Code § 49.76 prohibits employers from discriminating against employees who are victims of domestic violence and provides certain rights to victims to help them combat the violence in their own lives without endangering their careers (Wash. Rev. Code § 49.76.040 [2014]). An employee may take reasonable leave from work, with or without pay, for a number of reasons, including to seek legal or law enforcement assistance to ensure the employee's health and safety, or that of a family member of the employee, and to seek treatment for physical or mental injuries (Wash. Rev. Code § 49.76.030 [2014]).

In order to take this leave, the employee must notify the employer in accordance with employer policies regarding leave, or in an emergency situation no later than the end of the first day of leave taken. In requesting leave, an employee may be required to provide documentation. This requirement may be satisfied by a police report, court order, or documentation from an attorney, clergy member, domestic violence advocate, or medical professional from whom the employee has sought assistance. The employer must keep this documentation, along with the fact that the employee, or employee's family member, is a victim of domestic violence, confidential (Wash. Rev. Code § 49.76.040 [2014]).

In situations of emergency, however, these resources cannot act as quickly as the police. A call to 911 is necessary in order to

obtain swift intervention. The Washington state legislature has determined that official response to cases of domestic violence should stress the enforcement of the laws and the protection of the victim Wash. Rev. Code § 10.99.010 (2014). To this end, there are a couple of situations related to domestic violence in which Washington law requires the police to make an arrest and take the offending person into custody.

**Suspected Assault** First is the situation where the responding officer has probable cause to believe that a person 16 years old or older has assaulted a family or household member within the preceding four hours. This requires that the officer (1) believe that a felony assault has occurred; or (2) that an assault resulted in bodily injury to the victim, regardless of whether the injury is visible to the officer; or (3) that a physical action occurred which was intended to cause a person to reasonably fear imminent serious bodily injury or death. In this situation, the police are required to arrest the individual they believe to be the primary aggressor. This means that even if an abused individual has fought back in self-defense, he or she can still call 911; however, this does put the question of determining the primary aggressor to the responding officer's judgment. In making this determination, officers are to consider the comparative extent of injuries and fear of injury, and the history of domestic violence of each person involved (Wash. Rev. Code § 10.31.100[2] [2014]). This provision for mandatory arrest applies even if the offender asserts a claim of self-defense. The courts have held that the question of self-defense is not for the officer to decide, but rather is a question for a judge or jury (*McBride v. Walla Walla County*, 95 Wn. App. 33 [LEXIS 1999]). Another important point is that when the officer arrives, the offender must still be at the scene. The courts have limited the applicability of the mandatory arrest provision to just arrests, not mandatory investigations; officers are not required to perform an investigation beyond the immediate area. (*Donaldson v. Seattle*, 65 Wn. App. 611 [LEXIS 1992]). This makes it imperative that the police are called immediately following an incident of violence both so that the four-hour time window is not exceeded and the abuser may still be at the scene.

**Violation of a Restraining Order** The second situation in which an officer is required to make an arrest is when the officer has probable cause to believe that the person has violated a court order, of which the affected person is aware, which restrains them from: (1) acts or threats of violence; (2) knowingly entering or remaining on the grounds of a specified location; (3) knowingly coming within or remaining within a specified distance of a location; or (4) any other restriction or condition imposed by a temporary restraining order or preliminary injunction related to the physical or sexual abuse of a child (Wash. Rev. Code § 26.44.063 [2014]). (Wash. Rev. Code § 10.31.100[2][a] [2014]). This mandatory arrest applies not only to violation of orders from Washington state courts, but also the violation of orders related to domestic violence, harassment, sexual abuse, or stalking, issued by any state, tribal, or military court within the United States (Wash. Rev. Code



§ 10.31.100[2][b], § 26.52.010[3] [2014]). These provisions do not carry the four-hour time window that the physical violence provisions contain. However, as a practical matter to provide the police with probable cause, it is again important to call 911 immediately upon finding an abuser in violation of a court order.

These mandatory arrest provisions put a large amount of discretion into the officers' hands and may (or may not) result in the arrest of an abusive individual. Although Washington has a mandatory arrest statute on its books, the real question is the efficacy of enforcement. In 2013, 46,657 domestic violence offenses were reported in Washington, but only 24,460 incidents of domestic violence were cleared by arrest (The Washington Association of Sheriffs and Police Chiefs). This discrepancy could be for a number of reasons: Chief among them is that in the National Incident-Based Reporting System used, there can be multiple offenses per incident, and clearances are reported at the incident level and not at the offense level. This means that if one offense within an incident is cleared, then all offenses in the incident are cleared.

Additionally, there is the possibility that officers, once called to the scene of a reported domestic violence incident, simply don't have the necessary probable cause for arrest required by state law. Thus, the existence of mandatory arrest laws does not ensure that proper arrests are made. If probable cause appears lacking, then there is the possibility of *insufficient* arrests, a grace consequence given the research showing an approximately 94 percent increase in likelihood of prosecution and a 78 percent increase in conviction rate when an arrest is made (Nelson 2013). Conversely, if probable cause appears to exist but in fact does not, then there is the possibility of *too many* arrests.

Of all persons arrested nationwide for domestic violence, only 30.5 percent are convicted of the offense (this includes plea bargains). Whether this means that 69.5 percent of accused persons are in fact wrongfully detained—or whether the justice system failed to properly prosecute those arrested—is unknown. The fundamental efficacy of Washington's mandatory arrest law merits further research.

An individual arrested may eventually be released, whether through bail or a court order. Thus, although calling 911 may temporarily detain an abuser and initiate criminal legal proceedings against him or her, such action is unlikely to end the abuse. Obtaining a restraining order and/or seeking security in a domestic violence shelter may be necessary. To achieve real stability and safety, victims usually face many challenges.

Although calling 911 will not solve the problem, it is an important resource often underemployed. There are many reasons why an individual may not call 911 in response to domestic violence, including distrust or lack of confidence in the police and fear of subsequent reprisal by the abuser. Victims of long-term domestic

violence may have lost self-confidence, or feel a deep lack of self-worth, inhibiting their ability to initiate action.

Victims who do not speak English fluently face additional challenges. Victims who emigrated from countries where police are reasonably feared are not likely to seek police assistance in their new country; indeed, immigration status itself may cause some victims to avoid police even in an emergency. Gay, lesbian, or transgender victims may also hesitate before seeking police intervention in their personal relationships. Isolation—whether real or perceived—enables abuse to continue. As discussed below, rather than talking to the police, victims of domestic violence may turn in the first instance to someone already familiar and trusted, such as their physician.

### Domestic Violence—Physician Communication

Whether seeking medical help for injury consequent to abuse or simply as a part of routine care, victims of domestic violence come into contact with health care providers. Physician-patient communication is crucially important to virtually every aspect of patient health. Medical school teaches how to assess and act upon findings; the skills necessary to elicit information from patients and to understand signals conveyed by patients are deliberately honed in practice. Knowing what questions to ask and knowing how to achieve clear understanding from the information available are skills fundamental to diagnosing, providing appropriate treatment, and securing compliance, in short, to healing.

Since victims of domestic violence often interact with the health care system before turning to law enforcement, health care professionals are in the “unique position [of being able] to identify abuse and intervene early on.” However, this position brings with it significant responsibilities regarding confidentiality so as not to expose victims to further abuse (Goldman, et al. 2000). The questions become: (1) How can physicians communicate with patients to increase the likelihood that they will detect domestic abuse, and (2) how should physicians structure their communication so as to maintain patient confidentiality, and avoid exposing the victim to further violence or control from the abuser? These two questions are intertwined, and have the dual benefit of helping victims who seek medical treatment and reducing potential medical malpractice liability.

### Communication—The Fundamentals

First, it is important to acknowledge the factors that can inhibit, and the factors that might promote, open communication. Second, it is necessary to recognize that these factors may be the same, including: (1) The presence of a third party; (2) Clinical environment; (3) What you are doing and saying during the clinical encounter; and (4) Who you happen to be.

#### 1 The Presence of a Third Party

Many patients are accompanied by a partner or family member. Such person may be a true friend of the patient or may be an intimidating force in the patient's life. Having such a person in



the room can contribute to an environment tolerant of abuse, and the presence of the actual abuser allows that person to maintain control over the victim. It is important to screen patients privately, at least initially, so as to remove some of the fear of having an intimidating person hovering over them while they speak.


Methods that practitioners can take to help insure privacy include posting “patient-only” signs or explaining that it is standard procedure for patients to be assessed alone. If the third party refuses to leave, the practitioner could request that the suspected abuser fill out some administrative forms while the patient is screened, or another staff member could call the patient out and screen them while the physician stays with the third party; abusers are less likely to be suspicious if the physician remains with them (Levin & Weber, 2004).

Medical interpreters pose a different complexity, since their participation signals not only a linguistic barrier between the physician and patient but a cultural one as well. A good medical interpreter is sensitive not only to language and expression but also cultural sensibilities and their own role in the clinical encounter. Patients with limited English proficiency are entitled to free interpretive service under Title VI of the Civil Rights Act of 1964 from providers who receive federal assistance (Levin & Weber, 2004). Technology allows for affordable online interpretation. Unlike electronic medical records systems, online interpretation services very obviously and very easily improve medical practice. It is almost always inappropriate to have a patient’s family member interpret for the patient when recognized Internet services are available.

The Census Bureau identified zip code 98118 (which includes the Rainier Valley) as one of the most culturally and linguistically diverse in the nation. The immigration experience is often very stressful on individuals and families. Several community resources exist to facilitate new arrivals establish economic and social stability. API Chaya is a nonprofit that serves the Asian/Pacific Islander communities as well as human trafficking victims of all background. Codirector Sarah Rizvi states:

Doctors/medical professionals are really the front line in ensuring survivors of domestic violence are heard and referred to helpful resources. Many survivors will never go to the police or call a domestic violence organization they have no familiarity with, but if their doctor creates a safe environment and asks, they will tell. Survivors’ lives are full of fear, but they often trust their doctors and have relationships with them, so they will trust a referral from them. We have clients who have been able to call us from their doctor’s office, as that was the only place they could have privacy and safety to make the call.

*API Chaya runs a Healthcare Outreach Project, which provides on-site domestic violence screening training to health care providers. More information is available at [www.apichaya.org](http://www.apichaya.org).*



Victims of long-term domestic violence may have lost self-confidence, or feel a deep lack of self-worth, inhibiting their ability to initiate action.

The presence of medical assistants, nurses, and other providers may also influence patient communication. In practical terms, all third parties can be a distraction to both physician and patient, preventing direct and open communication. If you suspect that a patient has not been forthcoming about an injury or you instinctually feel concern for well-being without clear cause, it may be helpful to check your instincts with those of your staff; both medical and administrative staff observe patients and those who accompany them, sometimes incidental to their duties.

## ② Clinical Environment

Minimize things that distract from open communication when interacting with the patient: open doors, beeping phones or computers, excessive ambient noise.

Other areas of the clinic or hospital that the patient passes through on the way to see the physician can also influence the patient’s demeanor and communication. While some aspects of those environments may be out of a physician’s control, you can be aware of their possible influence. Remarking on existing noise or activity can show the patient that you are also present in the moment. Recognize openly that, in this brief circumstance, you are with the patient and want to understand what the patient needs.

## ③ What You Do and Say During the Clinical Encounter

**Don’t type when a patient is talking.** It is okay to jot down a note by hand. If you absolutely must type, angle the screen so that the patient can see what you’re doing.

**Eye contact matters.** No eye contact can feel dismissive and uncaring. Too much eye contact can feel unsettling. Sit facing toward the patient, clasping your hands or holding something innocuous. Make eye contact to indicate understanding or attention, and be aware if the patient seems to shy away.

**Be sensitive to the embarrassment and shame that often accompanies abuse.** Physicians are figures of unique authority. As such, patients both respect them and wish to be respected by them: It can feel humiliating to admit to being, staying, or feeling trapped in an abusive relationship. Being the victim of violence



and intimidation feels like being worthless. It isn't easy for patients to admit to physicians that someone who knows them well treats them badly.

**Ask opened-ended questions.** Explain at the outset that you ask these questions of all patients, as part of regular intake and assessment. For example, you might ask, "Do you smoke? Do you use alcohol, marijuana, or other drugs? Have you ever suffered a concussion, or hit your head really hard? Have you ever had sex against your will? Have you ever been a part of a family where hitting occurred? Has anyone hit or threatened to hit you in the last year?"

**Be responsive when a psychosocial issue is mentioned.** Follow up on suggestions or suspicions of abuse, even if you do not feel completely at ease. Domestic violence is a social problem that often yields medical problems. Your role is to provide patient-centered care, not to solve the social situation. By caring for the patient, you are a part of a network of resources.

**If the patient confirms abuse, ask whether current danger exists.** State the obvious: **Being abused is not the patient's fault.** Tell the patient that calling 911 is a real option, that counseling and legal resources are available, and keep relevant referral leaflets and information sheets discretely at hand.

#### 4 Who You Happen To Be

Unavoidably, you present your own language and culture and demeanor in the clinical encounter. How any of us appear is largely out of our control since our appearance depends on another's perception, understood through the lens of their experiences and assumptions. This includes how your patient perceives you. You can take meaningful steps to define yourself in others' eyes, through your words and conduct. Whether you are of an unfamiliar or different gender, culture, or appearance to your patient, however, is more difficult to mitigate. Be aware of that possibility, notice patient reaction as well as your perception of patient reaction, and **don't take it personally.** Ask directly if the patient would prefer to speak with the nurse, or another qualified provider, not dismissively but with the intent of facilitating effective communication.

"Recognizing cultural differences" is a familiar refrain. We hear it often because it matters enormously. We must also recognize the barriers that can arise from **sharing** a background. After all, it is a small bourgeois world that we live in, here in King County: A family's physicians can be both professional colleagues of the family and/or personal friends of the family. If it were not for Planned Parenthood, many children in this area would reach college before ever being treated by a health care provider who was not a family member or a family member's colleague.

If you are treating the family member of a colleague or friend, remember to whom you owe your first duty as a physician. The person before you is your patient: Advise, refer, and treat the patient without regard to other relationships. Be aware that

One in six people is so concerned about privacy issues that they engage in forms of privacy protection behavior, including withholding information from or lying to physicians, or not seeking medical treatment at all.

the embarrassment and humiliation noted above are particular concerns when the physician knows the patient in other contexts. Under HIPAA, a minor legally allowed to consent to particular treatment is legally allowed to prevent a parent from accessing the relevant medical record, in most situations (45 C.F.R. 502[g][3][i]). Physicians must understand that personal or professional familiarity with the patient's family can impact physician-patient communication; it also does not lessen or change the physician's obligations under state and federal privacy laws.

#### When Domestic Violence is Disclosed

Regardless of the disclosure of abuse, but especially if so, it is important to maintain the confidentiality of the patient. *One in six people is so concerned about privacy issues that they engage in forms of privacy protection behavior, including withholding information from or lying to physicians, or not seeking medical treatment at all.* For victims of domestic violence, these privacy fears translate directly into real safety concerns. Patient confidentiality is often inadvertently compromised through communications with family, employers, law enforcement, and insurers. To combat potentially damaging confidentiality breaches to family, it is important the physician only communicate directly with the patient whenever possible. Practicalities may hinder a physician's ability to maintain direct communication, including sending bills, or handling allegedly voluntarily signed spousal or family member disclosure forms (Goldman, et al. 2000).

Two more complicated communication areas are communications to and from law enforcement and insurers, as providers have a mandatory reporting requirement to the police for the abuse of children under 18 or vulnerable adults (King County 2010). For insurer communications, the confidentiality issues come from the need for billing communications and the possibility that the abuser, or an enabler of abuse, is the policy holder (Goldman, et al. 2000).

#### Reducing Physician Liability

Identifying and appropriately addressing domestic violence while maintaining patient confidentiality benefits victims directly and enables them to access other support. It also helps reduce physician liability in medical malpractice actions. In Washington, there are two relevant avenues for a patient to

establish a medical malpractice suit, and those are to show with a preponderance of the evidence that “(1) an injury resulted from the failure of a health care provider to follow the accepted standard of care; or (2) that a health care provider promised the patient or his or her representative that the injury suffered would not occur” (Wash. Rev. Code § 7.70.030 [2014]). In the application of this statute, an accepted standard of care is defined as the “degree of care, skill, and learning expected of a reasonably prudent health care provider at that time in the profession or class to which he or she belongs, in the state of Washington, acting in the same or similar circumstances; and that such failure was a proximate cause of the injury complained of” (Wash. Rev. Code § 7.70.040 [2014]).

While there do not appear to be any federal appellate cases or Washington state cases which involve medical malpractice in connection to domestic violence, it is nonetheless both ethical and prudent to foster and maintain honest communication with patients. For if the degree of care, skill, and learning comes to include effective and sensitive domestic violence communication techniques, then a provider who fails to adopt them could become vulnerable, particularly if he or she alerts an abuser of a patient seeking treatment, which thereby causes further abuse. Additionally, in the course of domestic violence conversations, it is important not to promise the patient safety. Not only does this provide a false sense of security to the patient, it also exposes the provider to liability through the second prong of Washington’s medical malpractice statute.

## Conclusion

The problem of domestic violence in our community must be addressed broadly, through government and education, with community and legal resources available to help those affected. Physicians play their part in this effort by fostering open communication with their patients, while keeping in mind their own liability and confidentiality obligations. ■

*Note: The authors recognize that domestic violence can be perpetrated against men as well as women and by both different-sex and same-sex partners, and that these are serious issues; however, this article was designed to focus primarily on the issue of different-sex violence against women.*

*Note: This article does not constitute a legal opinion nor is it a substitute for legal advice. Legal inquiries about topics covered in this article should be directed to your attorney.*

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