Gregory Luke Larkin, "Deadly Sins and Cardinal Virtues in the Clinical Management of Intimate Partner Violence," *The Journal of Clinical Ethics* 19, no. 4 (Winter 2008): 334-45.

Deadly Sins and Cardinal Virtues in the Clinical Management of Intimate Partner Violence

Gregory Luke Larkin

Gregory Luke Larkin, MD, MS, MSPH, FACEP, is a Professor of Surgery and Associate Director of Emergency Medicine in the Department of Surgery, Section of Emergency Medicine, Yale University School of Medicine, in New Haven, Connecticut, *gluke.larkin@yale.edu.*

INTRODUCTION

The burden of harm caused by domestic violence is significant in both human and economic terms. Study samples from healthcare settings consistently report that physical violence from IPV affects approximately one-third to one-half of all women during their lifetime, and from 6 percent to 15 percent of all women annually.[1] Partner violence causes the loss of more healthy years of productive life (YPLL) for women 15 to 44 years of age than breast cancer, cervical cancer, obstructed labor, war, or motor vehicle crashes combined.[2] Other studies have corroborated that violence by intimate partners results in more ill health and premature death among women of reproductive age than any other risk factor, including high blood pressure, obesity, and smoking.[3] Women bear the brunt of the global IPV burden. However, men, too, are part of the carnage, as studies suggest more than 800,000 men are physically or sexually assaulted by intimate partners each year in the U.S. alone.[4] Transgendered individuals and those within same-sex relationships are also at risk. Indeed, partner violence cuts across all age, racial, ethnic, socioeconomic, sexual, and gender lines. Nonetheless, the perspective employed in this article reflects the most prevalent form of partner abuse: violence perpetrated by men against women.

Regardless of patient phenotype, partner violence is costly to healthcare systems as well as to individuals. The mean direct annual healthcare costs are $1,064 (92 percent) higher for female victims of domestic violence than for a general random sample of female patients in the U.S.[5] IPV-exposed individuals also sustain significant indirect costs due to lost productivity secondary to both injury and mental health issues. According to the U.S. Centers for Disease Control and Prevention, the total value of days lost from employment and house chores is $858.6 million annually. The estimated total cost of intimate partner rape, physical assault, and stalking in the U.S. exceeds $5.8 billion each year, of which almost $4.1 billion is for direct medical and mental healthcare services.[6]

Given the magnitude and scope of the IPV problem, it is concerning that many healthcare providers continue to minimize, ignore, and under-diagnose abuse across the lifecycle. It is perhaps unsurprising that recent torts highlight the attendant risks of serious morbidity and mortality alongside risks of significant malpractice for mismanaged cases of IPV.[7] Even sincere attempts to respect forensic, reporting, safety, privacy, and autonomy concerns can leave physicians feeling conflicted. Avoiding unnecessary risk in negotiating the moral, medical, and social challenges surrounding cases of IPV demands an understanding of the

overarching ethical obligations of physicians to vulnerable victims. Professional and ethical obligations include duties to recognize, treat, respect, and protect victims in the clinical setting. Beyond acute detection and protection, more-extended legal duties to report, document, testify, and ensure victims' safety beyond the clinical setting are less clearly established. While others have described dilemmas in reporting victims to the police,[8] there have been few systematic attempts to describe an ethical framework from which cases can be broadly analyzed.[9] Such a framework should integrate philosophies informing moral human behavior, such as social contract theory and virtue ethics, that empower healthcare providers to protect, on behalf of their patient-victims, *the basic rights manifest in our common humanity.* Herein are described some of the essential virtues that inform the practical, medico-legal, and ethical framework that must be considered when treating patients and families in the throes of violence and neglect.

THEORIES OF ETHICS

An ethical framework for understanding the moral and medical obligations to patient-victims may be constructed from a variety of viewpoints, including theories emphasizing ethical principles, social contract obligations, virtues, and human rights, among others. Principlism, for example, may be used to guard the primacy of patients' autonomy over paternalistic notions of protecting the safety of patient-victims. Although principlism clearly supports beneficence, nonmaleficence, and justice as well,[10] its guidance can also create confusion in how to weigh or order competing principles in the heat of a dynamic IPV event, in which emotion and psychosocial stress create serious challenges to both the autonomy and safety of the patient.

Social contract theory has served as a useful construct for understanding professional obligations to patients who need medical services, but cannot afford to compensate for them, as part of social reciprocity or as a *quid pro quo* for practicing and living within the same society that affords professional respect, autonomy, status, and income to physicians.

However laudable, the handing down of bioethical principles and philosophically derived duties may be resisted by certain adult learners who see them as either lofty platitudes or generic solutions that do not cohere with their own experience working with victims of violent crime. At worst, a "do your duty" approach can be counterproductive; a subtle disincentive or "anti-carrot" to clinical doctors in the trenches, smacking of legalism, preaching, and coercion. At best, this duty-driven approach may create feelings of obligation that, in turn, suggest technical functions or tasks to be executed. This latter approach may breed short-term improvements in practice, but divorced of motivation or inspiration, such gains are unlikely to be sustained.[11] A more basic, flexible, and eclectic moral framework is needed that allows for a wide array of clinical presentations and harm-reduction strategies without demanding a fixed response or obeisance to abstract principles that require interpretation in a busy clinical setting.

An alternative starting approach that emphasizes dispositional traits or virtues may be more likely to positively enjoin physicians into a paradigm of practice that is based on inspired behavior and a sense of self-efficacy and professionalism. While many pre-medical students are chosen for character gifts, a lack of post-graduate practice leads to atrophy and a disconnect between motivation and action, and many new physicians who have been weaned from ideals view doctoring merely as a means to an end, rather than as a calling, *telos,* or end in itself. A rediscovery of virtue, in the MacIntyre sense,[12] might reverse this trend in many who are similarly dispossessed of their professional idealism.[13] The aspirational "carrot" of being a "good doctor," an Albert Schweitzer, a real-life incarnation of a Camus's, Dr. Rieux[14] or some similar paragon of virtue, may be a more palatable and sustainable model of professionalism than one steeped in rules, guidelines, and legal dicta. Additionally, virtues are readily understandable to practicing clinicians who may make cognitive links to familiar mentors and role models in fiction and history.[15] Virtue ethics is also more widely applicable across the broad spectrum of domestic violence, giving specific dispositional guidance that focuses more on the HOW to attend to victims rather than on the WHAT-to-do of practice guidelines. Well-practiced virtue can become the habit of a lifetime, while even carefully validated guidelines rarely last more than three years.[16]

As a moral foundation, virtue ethics does not dispense with social contract theory, principles, or other layers of clinical and ethical guidance; instead, it is an additive and complementary way to showcase clinicians' character as a keystone or source from which duties, principles, laws, and right actions flow. While duties and principles may describe the letter of the law, virtue connotes the spirit. Hence, the perspective of virtue ethics will be used herein as it is the oldest and most fundamental theory of ethics setting out to describe essential qualities that providers must consider if they are to confer consistently careful, ethical, and professional identification, assessment, treatment, and referral upon victims of violence in the clinical setting.

VIRTUES AND VICES

Complementary to the social contract, the miter of virtue may empower providers in their role as representing the interests of patient-victims and the greater community of which they are a part. In fact, the virtues may be seen as cross-pollinating with ethically laden clinical duties that have been derived from the social contract. While there are many such duties in cases of domestic or partner violence, they may be remembered using the mnemonic S.A.D.D.E.S.T: Screening, Assessment, Discussing DV, Documentation, Ensuring emergency referrals and treatment, Sending or Suspending reports, and Testifying to the trauma. These social, professional, and ethical duties are informed most strongly by the following seven candidate virtues:

1. Trustworthiness
2. Vigilance
3. Non-judgment
4. Charity
5. Prudence
6. Courage
7. Justice

These virtues are an essential antidote to what I offer as the seven deadly sins of domestic violence management, respectively:

1. Unreliability
2. Indifference
3. Prejudice
4. Disdain
5. Carelessness
6. Cowardice
7. Injustice

Although they are not as specifically articulated as vices, these problematic attitudes have been well described in multiple ways as barriers to screening, identification, and intervention in a variety of studies and settings.[17] Most research suggests a widespread perception by clinicians that there is insufficient time, desire, or ability to handle cases of IPV without opening up a veritable "Pandora's box" of psychosocial problems and clinical woes.[18]

Virtues are the natural counterpoint to these shortcomings or "vices," although this solution has not been articulated previously. The manifold ways in which these seven candidate virtues intersect with clinical duties in cases of domestic violence are detailed below as a 7x7 matrix (see table 1). While this lattice of clinical qualities is not all-inclusive, certain virtues, such as compassion and patience, are aligned so closely with others, such as charity, they are not mentioned separately. As Plato and Aristotle observed, there is considerable overlap among many of the virtues, reflecting both their compatibility and their interdependence.[19] It would be difficult to have only one virtue and not possess at least some of the others. In addition, many of the virtues apply to more than one clinical duty or activity and bleed into one another. This multiva-

lent appeal to the ancient, character-based theory of virtue ethics suggests that a morally excellent provider will apply, in the Aristotelian sense, the "right stuff" to a patient in the right way, in the right amount, at the right time.[20] Mixing and matching virtues is important, as each clinical situation and patient narrative dictates a tailored response comprising a proportionate contribution of each virtue represented. While I must resist the temptation to describe what makes helpers good people or good citizens, I shall not resist the temptation to describe what makes them good clinicians in the context of IPV. In this analysis, we recognize the timelessness of the classic virtues of Western thought, and we examine three of these first: prudence, courage, and justice.

Prudence

Prudence had its etymological birth in the ancient Greek term *phronesis*, or practical wisdom. This virtue connotes discernment, perspicacity, judiciousness, proper discrimination, and a strong nose for common sense. Phronesis was considered by Aristotle to be the prerequisite basis of all ethics, since it was needed to properly weigh between justice, courage, temperance, and all the other virtues and vices.[21] Today, prudence, or sound judgment, remains indispensable to the proper application of technical and moral facts in a particular case of family violence.

In the context of domestic violence, prudence is central to all phases of evaluating, treating, documenting, referring, and sometimes reporting victims. An area in which prudence is particularly important is in the evaluation of both internal and external threats to the safety of a victim. Internal threats to safety may be a victim's impaired judgment or plans to self-harm or attempt suicide. External threats to safety include the danger of homicide, and such factors related to perpetration of same, such as the escalation of violence, threats of homicide, access to firearms, a history of attempted strangulation, stalking, intense jealousy, and, importantly, the victim's plans to leave the relationship or a recent separation. All of these factors elevate risk of recidivism.[22] Prudence demands detailed assessment of these lethality factors and a possible *parens patriae* role for the healthcare team, depending upon the patient's mental state, decision-making capacity,

Table 1. The Seven Cardinal Virtues in the Clinical Management of Intimate Partner Violence

	Prudence	Courage	Justice	Vigilance	Trustworthiness	Non-Judgment	Charity
Screen/Identify	√	√		√√√√	√√	√√	√
Access risk	√√√√			√√	√	√	
Discuss DV	√				√√	√√	√√√
Document objectively	√		√√		√√	√√√	
Ensure emergency referrals	√	√	√	√	√√√	√	√√
Send/suspend reports	√	√√√√	√√√		√	√	
Testify to the trauma		√√	√√√√		√√	√√	√

√ Denotes the relative strength of the association of the candidate virtues with the clinical duties in the SADDEST IPV management paradigm.

suicide risk, the stage of readiness for change, and opportunities for safe disposition that minimize threats and harms.[23]

Beyond the safety of the victim, prudence is also needed when cases involve dilemmas in child protection, informed consent for research, mandatory reporting in the context of patient's refusal, attempted homicide, suicidal tendencies, *Tarasoff*-type warnings to threatened perpetrators, co-morbid substance abuse, acrimonious patients, prisoner abuse, abuse of emancipated minors, forensic documentation, testifying in court, duties to protect despite a patient's refusal, decision-making capacity under duress, and abusive legal surrogates for incapacitated patients, just to name a few. Hence, the multitude of possible professional, legal, and moral dilemmas in the context of family abuse is bewildering. Yet in spite of this bewilderment we might embrace prudence as a means to our desired end: the prevention of violence. The prudent provider will carefully attend to the particular needs of a particular patient and tailor his or her approach accordingly in order to optimize the safety of the patient.

There are no quick formulae for the determination of right action and right emotion, since each patient and each situation is unique. As medical artists entrusted with the care of victims, prudent clinicians must strive to keep abreast of their shifting legal, professional, and social obligations, striking a balance between a tendency to overlook IPV and a parentalistic or police-like zeal to over-report it. Balancing burdens and benefits, deciding when to triage, choosing when to refer, and knowing when to honor a treatment refusal and when to override it are all manifestations of prudence. The practical wisdom required to take care of a patient who is also a victim with an individual set of values, resources, family dynamic, and life narrative cannot be found in textbooks. All clinical judgment involves prudence. This is particularly critical in the high-stakes world of IPV, in which many victim-patients dance with death on a daily basis.

Courage

Virtue is bold, and goodness never fearful.
— Measure for Measure

Moral courage is a type of *fortitude* that clinicians need to remain steadfast advocates for patients who have suffered IPV, against utilization-review nurses, managed-care gatekeepers, insurers, employers, police, trainees, consultants, incompetents, assailants, families, the media, et cetera. Courage is manifest in other ways too, such as acting decisively to keep a patient safe by transferring her to another city or center so she does not have to go home to be exposed to more abuse. It takes fortitude to get a patient admitted when they do not have insurance and the admission is largely socially inspired — for safety. Courage can be seen as an Aristotelian mean between cowardice and foolhardiness.[24] While refusing to treat a perpetrator of violent crime is cowardice, directly and openly confronting a perpetrator in the Emergency Department (ED) because you disapprove of his actions is foolhardy. Courage is something else. Courage is the moral resolve to refuse; to refuse to dump IPV patients who are disruptive, to refuse to discharge before it is safe, to refuse to put fiscal concerns over patients' welfare.

Courage is also needed to abide by reporting statutes while helping victims and perpetrators of crime, rape, and child abuse, as well as IPV. The decision to send or suspend reports of IPV requires the courage to stand up for patients' interests and safety first. All 50 states and the District of Columbia require reporting of children to protective services for the very suspicion of abuse, granting immunity from civil and criminal liability to persons who report. Similarly, 43 states have mandatory reporting laws for elder abuse, although enforcement of such laws is rare.[25] However, in IPV cases, the situation is more complex. If there is any history of an assault with a deadly weapon including firearms, knives, or other sharp objects, it must be reported in 43 states and the District of Columbia. In 19 states reporting by healthcare workers is mandatory if caring for a patient with an injury that resulted from a crime. While IPV is a crime in all 19 of those states, it is not explicitly mentioned in the reporting statutes.[26] Only seven states specifically require reporting IPV directly to the police (California, Colorado, Kentucky, New Hampshire, North Dakota, Oklahoma, and Rhode

Island). Excepting California, most states include provisions to protect the victim's identity and require patient consent before reporting. California law requires physicians to report the victim's name, assailant's name, and details of injuries within 48 hours or risk fines up to $1,000 and six months in jail. Compliant physicians are immune from any civil liability that may result from a breach of confidentiality or from acting without a patient's consent. IPV reporting laws are an area in which ethics are less clear than for cases of child abuse, as the victims of IPV are almost always competent adults. While studies report that 56 percent of abused women and 71 percent of non-abused ED patients support mandatory reporting,[27] most professional organizations such as the American Medical Association and the American College of Emergency Physicians oppose mandatory reporting in favor of professional trust and patient-victim autonomy.[28] Proponents of reporting laws suggest their benefits outweigh their risks, as at least one study indicates that many victims do not wish to be responsible for reporting abuse and prefer that others do so for them.[29] Given that the source of many victims' injuries are not recognized in acute-care settings, supporters of mandatory reporting argue that laws are needed to raise awareness, increase identification, send a societal message that IPV is a crime, and offer one of the only opportunities for accessing professional help outside the medical setting.[30]

Despite these assertions, however, there is a paucity of good data suggesting that reporting is always useful or that one reporting approach is suitable for everyone.[31] The potential deleterious effects on both the doctor-patient relationship and healthcare-seeking behavior, especially for new immigrants, is significant.[32] Whether police will respond to a report in a desired way is also an unanswered question. For non-citizens, such reporting is fraught with fears and problems. There is also a concern that reporting will lead to retaliation by the perpetrator, and decreased safety for the victim in the short term.[33] At least one California study reports that the passage of mandatory reporting laws did little to increase the rates of identification and reporting to police.[34] It would seem somewhat more courageous to resist a reporting law when the potential fine to the physician is less material than the violation of professional trust incurred by reporting against a competent patient's wishes. Provided that the courage is inspired by the goal of doing what is best for the patient, using the particular patient-centered risks and benefits of each situation as a guidepost would seem both courageous and prudent.

Tarasoff warnings to either police or to a potential victim are also an area of some controversy and concern, however rare.[35] If a victim clearly identifies the perpetrator or another person whom she intends to kill, an emergency admission should be arranged for the homicidal patient-victim as it would be if she were suicidal. Whether or not the perpetrator should be warned should await a referral to a licensed psychiatrist.

Finally, at the macro level, a measure of bravery is also required to enjoin colleagues and administrators to assign adequate resources and time to properly care for victims of violence. Ultimately, we must have the courage and integrity to speak out and take responsibility for the failings of our profession and bravely right the wrongs of our own moral failings, as well as those of our colleagues. We must monitor and discipline ourselves and resist the temptation to blame others when opportunities to save victims are missed.

Justice

Another quality that helps providers care for victims of IPV is a strong sense of fairness or justice. Justice was the central theme of Plato's *Republic* and it remains one of the four key principles of medical ethics today.[36] The ethical and virtuous physician will act as a professional and as an advocate for victims of IPV, to ensure that services are accessible and available to all who need them. Fairness is central to IPV-related activities of documentation, ensuring referrals, sending or suspending reports, and, especially, testifying to the trauma. Justice may require the physician to attend and testify at a court proceeding or else participate by a deposition that provides clinical testimony on behalf of a patient. This inconvenient and uncompensated activity is an important obligation that is driven by patients' needs, particularly since victims are often so affected by post-traumatic stress that they may not be able to advocate adequately for themselves. In addition, promoters of justice will work for fair treatment at the meso level within hospitals and within professional organizations to improve the education of providers regarding domestic violence. Lastly,

at the macro level, physicians and other clinicians who bear witness to the trauma of IPV have a responsibility to promote the fair treatment of women and other vulnerable persons at the societal level. By working with the media and policy makers, physicians can be especially effective at promoting policy that fairly allocates resources for victims of violence and in implementing prevention strategies that are both evidence-based and cost-effective.

FOUR MODERN VIRTUES FOR IPV

Having discussed the cardinal virtues of antiquity and their role in the management of cases of domestic violence, I would now like to explore additional virtues that help express some of the community of values that are unique to cases of IPV, of which Aristotle could not have foreseen: non-judgment, charity, trustworthiness, and vigilance. This tetrad, drawn from the experience of clinicians working with IPV patient-victims, provides an important perspective on many of the ethical and clinical challenges that befall victims of violence and those who care for them.

Non-Judgment

Non-judgment is an Eastern virtue first described in ancient Hindu literature.[37] Cases of IPV include a spectrum of severity, actors, perpetrators, and victims that crosses all ages, races, ethnicities, sexual preferences, disabilities, and economic and social strata.[38] Victims of violence are frequently female, poor, members of ethnic minority groups, recent immigrants, mentally ill, and drug and alcohol dependent; patients who are already at considerable risk of marginalization in the prevailing healthcare system. However, it is important to screen those patients who do not fit these stereotypes as well, as seemingly "wholesome-appearing" patients may fly under the radar of most clinicians and yet still be at significant risk. Hence, suspending prejudice and judgment is especially relevant as it underscores the need for screening, identification, treatment, and referral to be freely given, without bias against any of the vulnerable upon whom violence has been visited. Non-judgment combines elements of understanding, with the Rogerian concept of unconditional positive regard (UPR) toward others.[39] Although emergency providers may feel a certain moral repugnance toward hateful couples or spouses who call each other names in the ED, cynical remarks and feelings of contempt must be resisted. Reframing intoxicated or addicted IPV patients as victims of disease engendered by both genetic and environmental interactions may help providers see the humanity behind the sights, smells, and sounds of mental illness. Non-judgment may also invoke faith-based notions of accommodation or "turning the other cheek" when, for example, an angry patient-victim hurls insults and threats.

Non-judgment does not mean neglecting reporting statutes or giving a drug addict unlimited refills on Percocet. It does mean, however, that the virtuous practitioner will give a patient the benefit of the doubt in an *unbiased* and *unprejudiced* way. This is most important in emergency settings, where many of the poor or intoxicated patients have poor hygiene, limited education, and a value system that may sometimes be at odds with that of the emergency physician. In our pluralistic and culturally diverse society, we must respect and honor the uniqueness of each patient. We must respect autonomy and weigh the benefits and burdens of treatment for each particular patient with impartiality, treating the perpetrators of violent crime with the same regard as the victims. Being tolerant of different races, creeds, customs, habits, and lifestyle preferences is vital if we are to maintain the public trust. The temptation to use disparaging remarks and gallows humor to ridicule psychotic victims must be resisted. Non-judgment is especially important in the task of documentation on the medical record, as cases of IPV are best represented by using the language of the patient to describe the assault. Injuries should be objectively recorded with a body map or photographs. One should refrain from stating "patient claims" or "alleges" an assault in the record, as this may disparage a legitimate claim of dangerous IPV. Similarly, providers' prejudice and bias should not dictate the type of treatment or referral that is given to victims, even though many victims are seen as "frequent fliers" or over-utilizers of services in the years before their death by IPV-related suicide or homicide.[40]

Charity

Effacement of self-interest, *altruism*, and *charity* are perhaps the highest levels of virtue. In cases of IPV, charity is demonstrated when screening is done with patience, compassion, and sensitivity. It is most evident in how patients are spoken to about their exposure to violence. Charity is embodied by carefully counseling victims and thoughtfully delivering reassuring messages such as the following:

1. Partner violence is very common but it is very wrong.
2. Partner violence is always a crime.
3. It is not your fault.
4. No one deserves to be hit by her partner, including you.

Charity goes well beyond the mandates of nonmaleficence and mere beneficence. Charity denotes the cheerful giver, such as one who volunteers to stay late to help a family through their referrals to social services. An altruist is neither clock-watching nor self-seeking, but is willing to attend to a patient's needs beyond the merely medical. Giving a patient bus fare or volunteering to testify on her behalf in court are examples of walking the extra mile with a patient when it is neither asked for nor required; this is true charity. Even in this age of diminishing professional autonomy and entrepreneurial invasion, charity remains the pinnacle of all virtue because, at its core, it is about genuine caring and selfless giving. "For one human being to love another human being: that is perhaps the most difficult task that has been entrusted to us, the ultimate task, the final test and proof, the work for which all other work is merely preparation."[41]

Trustworthiness

Trustworthiness and *integrity* are moral prerequisites; they are essential to all human relationships, professional or otherwise. Integrity allows the bearer to combine all of the other virtues and adhere to bioethical principles. Trustworthiness is vertically integrated across all phases of medical IPV management: screening, assessment, discussions of domestic violence, documentation, ensuring emergency referrals, sending or suspending reports, and testifying on a patient-victim's behalf. All require trust. It is only through the virtue of trust that the promotion of patients' autonomy is possible; sick and vulnerable victim-patients are forced to trust that physicians will look out for their best interests. Patient-victims trust in, and rely on, emergency physicians to protect their interests through competence, informed consent, truthfulness, and the maintenance of privacy and confidentiality.[42] Without fidelity to trust, no amount of autonomy would ever be enough to guarantee protection of patients' interests and allow for IPV screening and disclosure.

In defense of parentalism, sometimes physicians have to act to restore autonomy when it is not truly present. The *parens patriae* role is sometimes required when victim-patients are intoxicated or immobilized by fear. Even as adults, some victims cannot act in their own best interests and so rely on professionals to help them be safe. The inherent asymmetries of the doctor-patient relationship are amplified in caring for victims of abuse and neglect. In these encounters, the physician appears both more knowledgeable and more powerful than usual, while the victim-patient often feels frightened and vulnerable. This power gradient can actually be a good thing, for it is, in fact, a rare chance for clinicians to share the power of protection, putting Aesculapian authority to proper use. It is challenging, however, to sometimes protect and narrow a patient's options without threatening her family dynamic, economic stability, or autonomous choice. It is very difficult to earn the trust of a new patient who is frightened, skeptical, injured, and worried from the outset. Beyond the rapport established in the first 10 seconds of an encounter with a patient, emergency physicians must rely heavily on status trust. An untrustworthy, suspicious doctor can hope for little more than an adversarial, legalistic interaction that will result in neither disclosure of abuse nor a willingness to receive help. This legitimate concern regarding trust is further validated by research reporting that men are less adept than women at unmasking IPV and that it takes numerous screening attempts before many victims will admit to IPV exposure.[43]

Scientific integrity and trustworthiness are also important, particularly among academic researchers who seek to help the cause of IPV through research. Here, it is essential that colleagues, as well as victim-

subjects, can trust that they will not be exploited for power, profit, or prestige. Intellectual honesty, like informed consent, is critical to promote the welfare of patients and the honor of the profession. Intellectual honesty also implies knowing one's limits, and having the humility and integrity to obtain consultation, assistance, or referral when it is in the patient's best interest to do so. It serves no good end to imagine oneself as all-wise and all-knowing. Competence, even power, comes from the humility of knowing our limits and knowing when to access additional information, or others with different technical abilities, especially mental health professionals in cases of IPV. Being trustworthy in all aspects of professional life gives frightened, anonymous, and vulnerable IPV patient-victims reassurance and confidence when they need it most.

Vigilance

While some physician organizations readily acknowledge the significant societal incidence and prevalence of IPV in the population, individual physicians are often indifferent, frequently arguing that domestic violence is not an important medical problem that should be addressed in the everyday clinical setting. It is indeed true that IPV is not so much a medical disease as it is a risk factor for disease, similar to hypodermic needle use being a risk factor for HIV. Furthermore, there is a paucity of data documenting the benefits of screening and intervention for IPV outweigh the risks.[44] The general lack of an IPV evidence-base and reactions against IPV medicalization have led to its wholesale dismissal in the minds of many clinicians. This assertion of insignificance is made despite the following reality: approximately half of the survivors of IPV suffer acute, long-term, or even permanent physical injuries, including fractured skulls, broken bones, traumatic brain injury, spinal cord injury, paralysis, pre-term labor, premature rupture of membranes, ruptured uteri, low-birth-weight babies, and fetal demise.[45] Exposure to abuse also leads to impaired immune function, rendering victims more susceptible to infection. Moreover, women who are subjected to IPV are at increased risk of contracting HIV and other sexually transmitted infections, and they are known to have higher rates of both sterility and unplanned pregnancies. In addition to affecting safer sex and contraceptive use, fear of violence within a relationship may cause women to avoid HIV testing, and may decrease partner notification, decrease ante-natal HIV testing (thereby increasing the risk of maternal-child transmission), and decrease compliance with antiretroviral therapy for HIV-positive women, due to fear of discovery.[46]

An even more common outcome of partner violence than physical injury are disorders such as irritable bowel syndrome, fibromyalgia, anxiety disorders, depression, and various chronic pain syndromes.[47] In the U.S., it is estimated that 10 percent of all gynecologic office visits and 25 percent of all hysterectomies for chronic pelvic pain actually reflect somatization due to IPV.[48] The deleterious mental and emotional effects of abuse are profound, and many last years after a woman is out of an abusive relationship. Multiple studies report that, compared to unexposed patients, women who have experienced IPV are more likely to suffer from depression, post-traumatic stress disorder, alcoholism, substance abuse, and suicidal ideation, and make more suicide attempts.[49] Undeniably, IPV is more of a risk to health than tetanus, hypercholesterol, and allergies to medication combined.

Therefore, rather than dismissing IPV as a non-medical problem, enlightened clinicians should consider that since more than half of all assault victims and approximately 44 percent of female domestic homicide victims seek ED care within two years of their death, a strategy of vigilant surveillance is another legitimate way to save a life.[50] Studies report that victims will deny abuse an average of two to five times before actually acknowledging the problem to anyone,[51] hence more routine screening approaches can unmask IPV before it becomes clinically apparent.[52] Routine screening enhances the rates of identification and referral by more than 500 percent.[53] Computerized identification protocols promote more general or universal screening and can identify women who are at increased risk of IPV, possibly reducing their use of the revolving ER door over time, as they link with more useful mental health and women's services.[54] Not screening at least high risk patients endangers those who are in unsafe situations who go entirely undetected, while we wait for an adequate evidence base or a large enough study to prove an obvious point.

Emergency medicine is a particular specialty where vigilance is required, as physicians are called upon to be ready, willing, and able to assist patients, paramedics, and colleagues immediately, 24 hours a day. This

around-the-clock guardianship does not weaken during weekends, holidays, or nights, times when many victims flee their homes for the shelter of the ED. Providers' alertness and preparedness are critical on the night shift, despite the circadian disharmony that threatens personal wellness. To be vigilant in times of interpersonal trauma, domestic disaster, or life-threatening abuse impacts the proper disposition and long-term outcome of medical and mental health patients. Eveready, responsive, and argus-eyed, emergency physicians and other acute care providers stand sentinel as medical guardians who can unmask, diagnose, and properly and holistically treat the spectrum of abuse across the life cycle. By letting our guard down, cases are missed, lives are lost, and lawsuits are settled.

On a daily basis, cases of family violence present to the ED or clinic from all walks of life, and from all phases of the life cycle: child, partner, and elder abuse are rampant, but sub-clinical cases are more often missed than detected. Some, like the comatose shaken baby, are overt, but many are subtle, such as a child in status asthmaticus who lives in a house full of smokers, or the elderly parent in rapid atrial fibrillation who hasn't received her Warfarin in weeks. Calling protective services when guardians refuse to have their progeny vaccinated, or when adult children drop off demented elders in the ED before leaving town for vacation, would seem to cohere with state laws that mandate the protection of those at the extremes of life.

ETHICAL MANAGEMENT OF PARTNER ABUSE

The ethical duty to recognize, protect, and treat victims of partner abuse and neglect is difficult to fulfill, as available evidence suggests. Most studies reveal that physicians are often derelict in their duty to identify and report mistreated or abused persons. When abuse is confirmed, the first priority is the safety of the patients. Safety must be secured while respecting autonomous choice, however, and it must also be prudently determined through either a mini-mental status or related exam whether or not the patient is competent. If competent, it is essential to determine whether or not the patient voluntarily refuses or accepts intervention. If the patient is in immediate danger, she must be separated from the alleged abuser, and, if necessary, she may be emergently admitted. This type of social admission may be condemned by payers in the current managed-care milieu, but protecting the medical industrial complex from marginal economic burdens is clearly less important than courageously protecting patients.

CONCLUSION

Cases of IPV are associated with significant risk for both patients and providers alike. Recent litigation against emergency physicians highlights the ethical and legal complexity inherent in cases of intimate partner violence. Treating patients and families who may be scarred by suspected abuse and neglect is at once frustrating, disturbing, and painful; yet this is one of the rare clinical opportunities in modern medicine to rescue the underdog, to protect the weak, to lock up villains, and maybe even save a life. A peripatetic pathway towards risk reduction and clinical excellence is the espousal of morally excellent character, or virtue. Beyond virtues of antiquity, such as courage, prudence, and justice, modern virtues of vigilance, trustworthiness, non-judgment, and charity form a foundation upon which more optimal patient-victim and provider interactions may take place. For providers who care for vulnerable patients who are exposed to family violence, the virtues of justice, vigilance, courage, trustworthiness, prudence, non-judgment, and charity are an important counterpoint to the vices of injustice, indifference, cowardice, unreliability, carelessness, and contempt. Virtue-inspired practice allows for a genuine opportunity to make a true difference in the lives of couples, children, parents, grandparents, and the larger human family from which we all hail.

NOTES

1. J. Abbott et al., "Domestic Violence Against Women: Incidence and Prevalence in an Emergency Department Population," *Journal of the American Medical Association* 273, no. 22 (1995): 1763-7; S.R.

Dearwater et al., "Prevalence of Intimate Partner Abuse in Women Treated at Community Hospital Emergency Departments," *Journal of American Medical Association* 280, no. 5 (1998): 433-8; N.E. Gin et al., "Prevalence of Domestic Violence among Patients in Three Ambulatory Care Internal Medicine Clinics," *Journal of General Internal Medicine* 6, no. 4 (1991): 317-22; L.K. Hamberger, D.G. Saunders, and M. Hovey, "Prevalence of Domestic Violence in Community Practice and Rate of Physician Inquiry," *Family Medicine* 24, no. 4 (1992): 283-7; J. McCauley et al., "The 'Battering Syndrome': Prevalence and Clinical Characteristics of Domestic Violence in Primary Care Internal Medicine Practices," *Annals of Internal Medicine* 123, no. 10 (1995): 737-46.

2. World Bank, *Investing in Health: World Development Indicators* (New York: Oxford University Press, 1993), *files.dcp2.org/pdf/World Development Report1993.pdf,* accessed 4 November 2008.

3. C. Garcia-Moreno et al., "Public Health. Violence Against Women," *Science* 310, no. 5752 (2005): 1282-3.

4. S. Lipsky et al., "Violence-Related Injury and Intimate Partner Violence in an Urban Emergency Department," *Journal of Trauma* 57, no. 2 (2004): 352-9; C.C. Mechem et al., "History of Domestic Violence among Male Patients Presenting to an Urban Emergency Department," *Academy of Emergency Medicine* 6, no. 8 (1999): 786-91.

5. A.L. Coker et al., "Physical Partner Violence and Medicaid Utilization and Expenditures," *Public Health Report* 119, no. 6 (2004): 557-67.

6. National Center for Injury Prevention and Control, *Costs of Intimate Partner Violence against Women in the United States* (Atlanta, Ga.: Centers for Disease Control and Prevention, 2003), *http://www.cdc.gov/ncipc/pub-res/ipv_cost/ipv.htm,* accessed 4 November 2008.

7. *Kringen v. Boslough and St. Vincent Hospital,* No. 96-622. In. No. 96-622 ed: D. Mont. filed July 25; 1996.

8. M. Rodriguez et al., "Mandatory Reporting of Domestic Violence Injuries to the Police," *Journal of American Medical Association* 286, no. 5 (2001): 580-3.

9. Council on Ethical and Judicial Affairs, American Medical Association, "Physicians and Domestic Violence. Ethical Considerations," *Journal of American Medical Association* 267, no. 23 (1992): 3190-3; F. Cohn, M. Salmon, and J. Stobo, ed., *Confronting Chronic Neglect: The Education and Training of Health Professionals on Family Violence* (Washington, D.C.: National Academy Press for the Institute of Medicine, 2002).

10. T.L. Beauchamp and J.F. Childress, *Principles of Biomedical Ethics*, 4th ed. (New York: Oxford University Press, 1994).

11. G.L. Larkin et al., "Effect of an Administrative Intervention on Rates of Screening for Domestic Violence in an Urban Emergency Department," *American Journal of Public Health* 90, no. 9 (2000): 1444-8.

12. A. MacIntyre, *After Virtue,* 2nd ed. (Notre Dame, Ind.: University of Notre Dame Press, 1984).

13. Ibid.; E.D. Pellegrino and D.C. Thomasma, *The Virtues in Medical Practice* (New York: Oxford University Press, 1993).

14. A. Camus, *The Plague* (London: Allen Lane, 2001).

15. G.L. Larkin, "Mapping, Modeling, and Mentoring: Charting a Course for Professionalism in Graduate Medical Education," *Cambridge Quarterly of Healthcare Ethics* 12, no. 2 (2003): 167-77; R. Hindiyeh and G.L. Larkin, "Mentorship in Emergency Medicine," in *Emergency Medicine: AAEM's Rules of the Road for Medical Students. The Guide for a Career in Emergency Medicine* ed. A. Kazzi and J. Schofer (Milwaukee, Wisc.: American Academy of Emergency Medicine, 2003), 371-6.

16. P.G. Shekelle et al., "Validity of the Agency for Healthcare Research and Quality Clinical Practice Guidelines: How Quickly Do Guidelines Become Outdated?" *Journal of American Medical Association* 286, no. 12 (2001): 1461-7.

17. D. Miller and C. Jaye, "GPs' Perception of their Role in the Identification and Management of Family Violence," *Family Practice* 24, no. 2 (2007): 95-101; M.A. Woodtli, "Nurses' Attitudes Toward

Survivors and Perpetrators of Domestic Violence," *Journal of Holistic Nursing* 19, no. 4 (2001): 340-59.

18. N.K. Sugg and T. Inui, "Primary Care Physicians' Response to Domestic Violence: Opening Pandora's Box," *Journal of American Medical Association* 267, no. 23 (1992): 3157-60.

19. Aristotle, *Nicomachean Ethics* (Cambridge: Cambridge University Press, 2000); Plato, *The Republic,* 2nd rev. ed. (Harmondsworth: Penguin, 1974).

20. Ibid.

21. Ibid.

22. J.C. Campbell et al., "Intimate Partner Homicide: Review and Implications of Research and Policy," *Trauma Violence Abuse* 8, no. 3 (2007): 246-6.

23. K.H. Burkitt and G.L. Larkin, "The Trans-Theoretical Model in Intimate Partner Violence: Stage Change Over Time," *Violence and Victims* 23, no. 4 (2008): 411-21.

24. Aristotle, *Nichomachean Ethics,* see note 19 above.

25. S. Moskowitz, "Saving Granny from the Wolf: Elder Abuse and Neglect: the Legal Framework," *Connecticut Law Review* 31 (1998): 77-204.

26. Family Violence Prevention Fund, "State Codes on Intimate Partner Violence: Victimization Reporting Requirements for Healthcare Providers," initially prepared by Josephine Yeh, JD, in 2002 and revised by Mary Malefyt Seighman, JD, in 2007, in this issue of *JCE.*

27. Ibid.

28. American College of Emergency Physicians, "Mandatory Reporting of Domestic Violence to Law Enforcement and Criminal Justice Agencies," *Annals of Emergency Medicine* 30, no. 4 (1997): 561.

29. L.G. Iavicoli, "Mandatory Reporting of Domestic Violence: the Law, Friend or Foe?" *Mt Sinai Journal of Medicine* 72, no. 4 (2005): 228-31.

30. C.J. Sachs et al., "Failure of the Mandatory Domestic Violence Reporting Law to Increase Medical Facility Referral to Police," *Annals of Emergency Medicine* 31, no. 4 (1998): 488-94.

31. C. Wathen and H. Macmillan, "Interventions for Violence Against Women: Scientific Review," *Journal of American Medical Association* 289 (2003): 589-600.

32. M.R. Hill, "Mandatory Reporting of Domestic Violence: Why It Would be a Mistake," *Current Surgery* 58, no. 4 (2001): 397-8.

33. A.C. Gielen et al., "Women's Opinions About Domestic Violence Screening and Mandatory Reporting," *American Journal of Preventive Medicine* 19, no. 4 (2000): 279-85.

34. Sachs et al., "Failure of the Mandatory Domestic Violence Reporting Law to Increase Medical Facility Referral to Police," see note 30 above.

35. *Tarasoff v. Regents of University of California*, 131 Cal.Rptr. 14, 551 P.2d 334. In: Supreme Court of California; 1976; S.A. Anfang and P.S. Appelbaum, "Twenty Years After Tarasoff: Reviewing the Duty to Protect," *Harvard Review of Psychiatry* 4, no. 2 (1996): 67-76.

36. Plato, *The Republic,* see note 19 above.

37. P.S. Vidyalankar, *The Holy Vedas* (Delhi: Hind Pocket Books, 1998).

38. P. Tjaden and N. Thoennes, "Coworker Violence and Gender: Findings from the National Violence Against Women Survey," *American Journal Preventive Medicine* 20, no. 2 (2001): 85-9.

39. C.R. Rogers, *Client-Centered Therapy, its Current Practice, Implications, and Theory* (Boston: Houghton Mifflin, 1951).

40. Federal Bureau of Investigation, *Uniform Crime Reports* (Washington, D.C.: Federal Bureau of Investigation, 1992); C.A. Claassen and G.L. Larkin, "Occult Suicidality in an Emergency Department Population," *British Journal of Psychiatry* 186 (2005): 352-3.

41. R.M. Rilke, *Letters to a Young Poet* (New York: W.W. Norton, 1934).

42. G.L. Larkin et al., "The Emergency Physician and Patient Confidentiality: a Review," *Annals of Emergency Medicine* 24, no. 6 (1994): 1161-7.

43. Larkin et al., "Effect of an Administrative Intervention on Rates of Screening for Domestic Violence in an Urban Emergency Department," see note 11 above.

44. C. Garcia-Moreno, "Dilemmas and Opportunities for an Appropriate Health-Service Response to Violence Against Women," *Lancet* 359, no. 9316 (2002): 1509-14; J. Ramsay et al., "Should Health Professionals Screen Women for Domestic Violence? Systematic Review," *British Medical Journal* 325, no. 7359 (2002): 314.

45. C. García-Moreno et al., *WHO Multi-country Study on Women's Health and Domestic Violence against Women: Summary Report of Initial Results on Prevalence, Health Outcomes and Women's Responses* (Geneva: World Health Organization, 2005).

46. Garcia-Moreno et al., "Public Health. Violence Against Women," see note 3 above.

47. B. Gerbert et al., "Physicians' Response to Victims of Domestic Violence: Toward a Model of Care," *Women Health* 35, no. 2-3 (2002): 1-22.

48. García-Moreno et al., *WHO Multi-country Study on Women's Health and Domestic Violence against Women,* see note 45 above.

49. Garcia-Moreno et al., "Public Health. Violence Against Women," see note 3 above.

50. M. Wadman and R. Muelleman, "Domestic Violence-Related Homicide: Emergency Department Use Before Victimization," *Annals of Emergency Medicine* 27 (1996): 119.

51. G.L. Larkin et al., "Universal Screening for Intimate Partner Violence in the Emergency Department: Importance of Patient and Provider Factors," *Annals of Emergency Medicine* 33, no. 6 (1999): 669-75.

52. Larkin et al., "Effect of an Administrative Intervention on Rates of Screening for Domestic Violence in an Urban Emergency Department," see note 11 above.

53. Larkin et al., "Universal Screening for Intimate Partner Violence in the Emergency Department: Importance of Patient and Provider Factors," see note 51 above.

54. K.V. Rhodes et al., "Better Health While You Wait: a Controlled Trial of a Computer-Based Intervention for Screening and Health Promotion in the Emergency Department," *Annals of Emergency Medicine* 37, no. 3 (2001): 284-91; K.V. Rhodes and W. Levinson, "Interventions for Intimate Partner Violence against Women: Clinical Applications," *Journal of American Medical Association* 289, no. 5 (2003): 601-5.