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# Clinical Ethics and Domestic Violence: An Introduction

*Norman Quist*

**Norman Quist** is the Publisher of *The Journal of Clinical Ethics,* Hagerstown, Maryland, *Quist@clinicalethics.com.*


Investigations and commentaries on domestic violence and its sequelae have been featured in several recent medical journals. For discussion purposes, I will highlight aspects from three of them. According to Megan Bair-Merritt and her colleagues, in a recent issue of the *Journal of Pediatrics,* screening for domestic abuse in a pediatric practice can uncover cases that otherwise might not be identified.[1] Of the women who brought their children to a pediatric clinic at Johns Hopkins Children's Center, 23 percent disclosed that they had been victims of either emotional or physical abuse; 57 percent of the abused women indicated that at least one child had been exposed to this violent interaction.

"Abuse of one parent by their partner is not a private adult matter, but is very much a public health problem that affects children's health and well-being," Bair-Merritt writes. "Domestic violence happens often and children witness it, so it should be on every pediatrician's radar." Furthermore, the American Academy of Pediatrics has recommended that pediatricians attempt to recognize domestic violence in caregivers and intervene in a sensitive manner.[2]

Mary Ellsburg and colleagues, in a WHO study of 24,097 respondents in 10 countries, reported in the *Lancet* that violence against women may cause long-term mental and physical health problems, irrespective of the women's cultural background. Experiencing violence at the hands of a male intimate was associated with significantly higher odds that women would also report overall poor health, "irrespective of where a woman might live, her cultural or racial background, or the extent to which violence might be tolerated or accepted in her society or by herself."[3]

A study led by Robert Reid and reported in the *American Journal of Preventive Medicine* takes a different tack, studying domestic violence experienced by men. Reid and colleagues report that domestic violence experienced by men was far more common than expected and, as with women, results in significant negative health effects. Given these findings, the authors note that the failure of healthcare personnel to ask about and acknowledge men's experiences of intimate partner violence may be shortsighted: "violence appears to go in many directions, directed against children, against women, and, in some cases, men."[4]

Using the American Academy of Pediatrics recommendation as a rallying call, "that pediatricians attempt to recognize domestic violence in caregivers and intervene in a sensitive manner," yet expanding it to include all physicians, three questions come to the fore. First, assuming that pediatricians (and all physicians) do not report instances of domestic violence without some basis beyond a feeling of unease, it seems that some consent, participation, or compliance by the abused patient (or, for a child, that of the child and the non-abusing parent) is desirable, if not necessary, for "recognition." Second and most critically, how are we to understand and apply the recommendation to "intervene in a sensitive manner"? Having intervened, what

are the expected outcomes for the abused parent or child? Third, what mechanisms are in place, and how are they working, to guide a successful outcome following the intervention?

Any sensitive effort to identify, report, or intervene in suspected instances of domestic violence will require a discussion and some resolution of the entanglements of privacy, especially in the physician-patient relationship. Does our understanding and application of privacy in this context "reinforce a nonintervention norm, perpetuating a detrimental veil of privacy around what might otherwise be a well-recognized public health threat," as Felicia Cohn asks in this special issue of *JCE?*[5] If so, how did we get here and what ought we to do now? Or is it understood, borrowing Bair-Merritt's language above, and in what seems to be in keeping with the spirit of the recommendations from the American Academy of Pediatrics, that abuse is "not a private adult matter, but is very much a public health problem"?

Addressing one prong of the intervention challenge, it does not seem, in following the general theme of the three articles mentioned above, that domestic violence and its effects are veiled vis-à-vis a public health threat, although one can certainly hold that instances remain under-reported. Reasons for under-reporting have been variously attributed to patients' non-disclosure and physicians' reluctance or failure to inquire about or recognize abuse (which has been found to differ among specialties[6]). Nor do these articles suggest that instances, as reported, are minimized or toned down or that the situational encounter in the physician-patient relationship is uniquely challenged or stressed in arriving at a shared understanding of what to do and what can be done. Interestingly, studies elsewhere note that a significant proportion of the victims of domestic violence hope their clinician will ask, and would be prepared to talk about their experiences, if they were asked in a caring manner.[7] As central as privacy is here, it may be the latter consideration that presents the most significant practical challenge: What can be done?

Since reporting (recognition) always involves a risk, something is always hidden in domestic violence; what is recognized and what this means or requires seems to depend on how we see relationships — and how they are recognized at law: Who can do what to whom, with or without consent? Perhaps the pivotal issue is not so much how concerns for privacy have veiled domestic violence, but rather how often legal issues have veiled political and personal interests and power. It was not so long ago in our social and legal history that women and children were taken as property. It is not unreasonable to wonder how the residue of this history and behavior might continue to influence our attitudes and understanding of obligations in the social compact today. Instances of domestic violence bind or entangle the physician or healthcare provider to the patient or the child, and to a web of interpersonal, familial, and societal relationships, in unique ways. How are we to understand the obligations, limitations, and risks that follow, for both physicians and patients, when hints of domestic violence become full-blown acknowledgments?

A common refrain in each of our discussion articles, one echoed throughout the literature on domestic violence, is that physicians must do better at asking about domestic violence. Although "doing better" sometimes means that physicians should be asking all women about abuse, beyond suspected instances, it also means that physicians themselves must overcome personal barriers and hesitations that may keep them from asking. Physicians' reluctance has been attributed to many factors, including a sense of powerlessness and control, and insufficient time.[8] When physicians report embarrassment and hesitation in raising concerns of domestic violence, one might reasonably wonder if these attitudes and behavior might also be, as with patients, the consequence of shame. It may be that these physicians witnessed family violence in their own lives: 12 to 15 percent of physicians report that they either witnessed violence in their childhood or experienced physical abuse by an intimate partner.[9] It may be that some physicians empathize or identify, often unconsciously, with these women and men.[10]

There is another issue embedded in the public health position as advocated by the American Academy of Pediatrics and, in varying degrees, supported by the authors in the articles from the *Lancet,* the *Journal of Pediatrics*, and the *American Journal of Preventive Medicine,* the assumption that domestic violence is, *per se,* a medical issue, and is appropriately addressed, or defined, through a medical model. What might be said to those who see in this an increasing effort to "medicalize" what was formerly personal and private behavior, or alternatively, as an effort to broaden social/public intervention — a "social beneficence"? It has been

suggested that "the medical model of care and its discursive practices position women as individually accountable for domestic violence-related symptoms and injuries," that may enable practitioners "to distance themselves from interactions that may prove to be less comfortable and provide less than certain outcomes."[11] There is also significant discussion and criticism in the literature of increasing "medicalization" in society and in the personal realm: from what counts as mental illness, to managing folks who seem unable to resist artery-clogging diets, or parents and others who insist on medications for otherwise rambunctious children.[12] And how should we respond to parents who insist that sparing the rod will spoil the child? Where is the line between a concern for public health and public/social paternalism? (To be clear, nothing in my remarks should be taken to condone either physical or emotional abuse, even under the veil privacy; and any thorough discussion of these issues presupposes a parsing of family violence and domestic violence.) How might these boundaries be understood, and then defended?

Finally, at the end of the day, what may matter most in our efforts to address domestic violence, assuming that we see it, is that those who are abused can feel that they have a safe place, a safe relationship, wherein their experiences can be heard and validated. And since shame and resignation are powerful disincentives to action, an encouraging word, the openings available in a conversation of trust, might be just enough to justify the risk of disclosure — of speaking the words. How might we do this? It may not be in a clinical setting. A recent article in the *New York Times* describes an initiative sponsored by the city's Administration for Children's Services that trains beauticians to recognize signs of possible domestic violence among their clients.[13] The program seeks to take advantage of the long-talked-about "therapeutic relationship" between hairdressers and clients: "Only your hairdresser knows for sure." The program reaches women in their own neighborhoods, those who are most likely to go unnoticed, and it builds on an existing peer relationship in an environment where women feel at home. The stylists are trained to recognize the signs of domestic violence so they can identify victims and inform them of options, such as domestic violence shelters, safe houses, counseling, or reporting to the police. According to the *Times,* the materials and resource information these salons pass out disappears quickly. Is it working? As one stylist replied, "I will find out when she comes in to get her hair done."

My comments to this point have been by way of introduction, anticipating some of the issues that would likely arise in any consideration of domestic and intimate partner violence, and I have clearly raised many more questions than I have engaged. The articles collected in this issue of *JCE* on domestic violence are ambitious. They challenge readers to engage complex and sensitive — if not taboo — attitudes and behaviors that entwine with public health interests, personal and familial duties and obligations, political interests, and our social contract. Taken together, the articles challenge our history, our denial, and our complacency. They invite a renewed and revitalized public discourse and response.

## THE SPECIAL ISSUE OF *JCE*

In the lead article, guest-editor Felicia Cohn discusses family violence as a medical and a social concern.[14] What are the limits of concern and intervention into these intimate family matters? To understand "family violence," it is first necessary to understand the overarching issue of privacy in domestic life and its controlling influence on legal and social policy and practice. Cohn illustrates how our legal and social attitudes toward "privacy" have traditionally veiled violence against both women and children when it has occurred within the home, choosing to regard it as a private family matter.

Since many of the victims of domestic violence present at physicians' offices and emergency departments, healthcare providers are challenged, if not required, to respond. Yet Cohn reports that significant numbers of physicians indicate experiencing "professional discomfort within areas that are culturally defined as private"; they also fear offending the victim-patient. Cohn writes, "Despite the growing evidence of the impact on healthcare utilization and costs, the health professions have historically considered family violence primarily as a social or legal issue, rather than a medical issue." (The second article in this issue, "State Codes on Intimate Partner Violence: Victimization Reporting Requirements for Healthcare Provid-

ers," provides a cursory overview of mandatory reporting laws.[15]) A significant shift in focus occurred in 1991, when then-Surgeon General C. Everett Koop framed family violence as a health issue, convening the first workshop linking violence and public health. That year the American Nurses Association published guidelines for identifying and treating intimate partner violence and the American Medical Association did the same in 1992.

If significant numbers of physicians experience professional discomfort within areas that are culturally understood to be private (implicitly or explicitly), we can reasonably assume that their actions are constrained. In the third article in this issue, Gregory Luke Larkin argues that the failure of healthcare providers to act on behalf of their patient-victims runs contrary to the basic rights and concerns manifest in our common humanity: "While others have described dilemmas in reporting victims to the police, there have been few systematic attempts to describe an ethical framework from which cases can be broadly analyzed. 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."[16]

More than a decade after Koop's initiative, in the fourth article in this issue, Krugman and colleagues write, "the child protection system in the United States is struggling: 18 years after a federal advisory board called the situation 'a national emergency,' there are still problems in many parts of the U.S."[17] To address this failure, Krugman and colleagues propose a targeted study to implement a "hybrid" approach "combining the health-based approach previously used in Europe and our own child welfare-based approach." Such an approach would include the training of a multidisciplinary team (including pediatricians, social workers, psychologists, and/or psychiatrists) to assess and treat the behavioral dysfunctions of families who present for care.

Contra Krugman, Katz Rothman and Tiger argue that it is unclear that intra-family violence is best conceptualized within a medical framework, rather than a social framework.[18] They write, "By conceptualizing abuse and neglect in 'medical' terms and advocating medical responses — which the authors oppose to 'social' approaches — their proposed solution ignores entirely the structural conditions that often accompany abuse and neglect and that characterize many people's ambivalent, fraught, and antagonistic relationship with the medical care system — a social institution that exerts much power indeed. Nowhere do Krugman and colleagues discuss the role that poverty, stress, and the absence of resources play in abuse and neglect."

As the identification and management of domestic violence may increasingly rely on a clinician's response, what are the professional and institutional constraints? In "Ethical Dilemmas in Coding Domestic Violence," Rudman and colleagues focus on the unique challenges of documentation and coding of domestic violence in the clinical setting, and the challenges to meaningful intervention in a specific patient encounter.[19] They discuss emerging ethical issues across four domains: personal, relational, medical, and organizational. Are physicians prepared, and are they encouraged to take time and use resources, to look beyond a patient's immediate injury and disease to respond to hints of domestic violence?

Somewhat shifting the focus from that of the previous papers, Mark F. Carr addresses how attitudes of both healthcare providers and parents toward religious practices may sometimes blur the line between what counts as responsible and appropriate care and possible abuse.[20] Carr explains that some physicians may assign different religions different amounts of credibility, and acknowledges that some religious practices are more credible than others. To illustrate this point, he recounts a case in Utah of the "watermelon baby." Here, 21-month-old David Fink's parents, members of a Christian cult, thought him to be the Christ child. They had the idea that the Christ child could be kept pure by feeding him only watermelon and lettuce. In this instance, the state justifiably took the child under protective custody. While Carr notes that Christianity would place high on most people's credibility scale, this particular practice of Christianity has no credibility. Why, he asks? Although Carr goes on to suggest specific criteria as a way to assess the credibility of a religion, he also highlights aspects of the relationship between careproviders and parents that might help each to better understand the other: openness and an explicit effort to find points of common value.

In the final article, Wagman and colleagues discuss the ethical challenges faced by researchers and

practitioners who study, assess, and intervene in cases of intimate partner violence — in both higher and middle income countries — and they provide recommendations for research and practice.[21] After providing a brief overview of the global impact of intimate partner violence, they describe ethical guidelines relevant to research and the provision of healthcare services, discuss ethical challenges for both research and the provision of healthcare services, and offer recommendations for improving research and practice.

## NOTES

1. M.H. Bair-Merritt et al., "Screening for Domestic Violence and Childhood Exposure in Families Seeking Care at an Urban Pediatric Clinic," *Journal of Pediatrics* 152, no. 5 (May 2008): 734-6.

2. American Academy of Pediatrics Committee on Child Abuse and Neglect, "The Role of the Pediatrician in Recognizing and Intervening on Behalf of Abused Women," *Pediatrics* 101, no. 6 (June 1998): 1091-2.

3. M. Ellsburg et al., "Intimate Partner Violence and Women's Physical and Mental Health in the WHO Multi-country Study on Women's Health and Domestic Violence: An Observational Study," *Lancet* 371, no. 9619 (5 April 2008): 1165-72.

4. R.J. Reid et al., "Intimate partner violence among men: Prevalence, chronicity, and health effects," *American Journal of Preventive Medicine* 34, no. 6 (2008): 478-85.

5. F. Cohn, "The Veil of Silence around Family Violence: Is Protecting Patients' Privacy Bad for Health?" in this issue of *JCE.*

6. M.A. Rodriguez et al., "Screening and Intervention for Intimate Partner Abuse: Practices and Attitudes of Primary Care Physicians," *Journal of the American Medical Association* 282 (1999): 468-74; N.K. Sugg et al., "Domestic Violence and Primary Care: Attitudes, Practices, and Beliefs," *Archives of Family Med*icine 8 (1999): 301-6**.**

7. S.A. Eisenstat, "Domestic Violence," *New England Journal of Medicine* 341, no. 12 (1999): 886-92.

8. American Academy of Family Physicians, "Position Paper — Family Violence, 2000," *http://www.aafp.org/online/en/home/policy/policies/v/violencepositionpaper.html,* accessed 20 November 2008.

9. Ibid.

10. M. Lansky, "Hidden Shame," *Psychoanalytic Inquiry* 17 (1999): 347-61; and W. Kinston, "The Shame of Narcicism," in *The Many Faces of Shame,* ed. D.C. Nathanson (New York: Guilford Press, 1987).

11. V. Lavis et al., "Domestic Violence and Health Care: Opening Pandora's Box — Challenges and Dilemmas," *Feminism & Psycholog*y 15, no. 4 (2005): 441-60.

12. J. Kagan, "The Meaning of Psychological Abnormality," *Cerebrum,* published online by the Dana Foundation, 10 November 2008, *www.dana.org.*

13. L. Kaufman, "Enlisting the Aid of Hairstylists as Sentinels for Domestic Abuse," *New York Times,* 20 November 2008, A-33, *http://www.nytimes.com/2008/11/20/nyregion/20salons.html?partner= rss&emc=rss,* accessed 20 November 2008.

14. Cohn, see note 5 above.

15. Family Violence Prevention Fund, "State Codes on Intimate Partner Violence: Victimization Reporting Requirements for Healthcare Providers," in this issue of *JCE.*

16. G.L. Larkin, "Deadly Sins and Cardinal Virtues in the Clinical Management of Intimate Partner Violence," in this issue of *JCE.*

17. R.D. Krugman et al., "A Health-Based Child Protection System: Studying a Change in Paradigm," in this issue of *JCE.*

18. B. Katz Rothman and R. Tiger, "Social Problem or Medical Condition? A Response to Krugman's Proposal," in this issue of *JCE.*

19. W. Rudman et al., "Ethical Dilemmas in Coding Domestic Violence," in this issue of *JCE.*

20. M.F. Carr, "The Spectrum of Religion and Science in Clinical Encounters," in this issue of *JCE.*

21. J. Wagman et al., "Ethical Challenges of Research on and Care for Victims of Intimate Partner Violence," in this issue of *JCE.*