Responding to our abused patients

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Résumé

LES MÉDECINS PEUVENT GRANDEMENT AIDER LEURS PATIENTS qui ont subi des épisodes de violence ou des mauvais traitements. Il arrive souvent que les médecins ne réussissent pas à découvrir ce genre de problèmes malgré le nombre croissant d'études et les efforts des associations médicales et de médecins individuels. On peut augmenter les chances de découvrir ces difficultés en posant des questions directes sur le problème présenté et en procédant à une sélection régulière de tous les patients, ou encore en recourant à des outils types de sélection. Un outil conçu par un groupe communautaire peut aussi inciter un patient à parler des mauvais traitements subis dans une relation antérieure ou dans sa relation actuelle.

Editorial

Éditorial

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This week marks the eighth anniversary of the Montreal Massacre in which 14 young students, all women, were murdered by a young man, a stranger. It appeared he was outraged by their feminism, which he attributed to them because they had chosen to study engineering. As horrifying as that event was, the well-being and safety of thousands of Canadian women and children is threatened not by strangers but by the violence perpetrated by the men with whom they have close personal relationships.

When the Ontario Medical Association established its Special Committee on Wife Assault in 1984 under the visionary leadership of Dr. Joan Bain, little information on the significance of violence and abuse as a health issue was available in medical journals or texts. Since then physicians, researchers and several medical associations have written extensively about doctors' unique role in helping patients deal with the health consequences of violent and abusive experiences. The tasks we face in helping these patients fit well with our patient-management skills: we can recognize and identify a problem, evaluate its duration and severity, offer suitable treatments, refer to appropriate community agencies, educate patients about the problem and the risks of not taking action, and document relevant positive and negative findings.

The increased morbidity and mortality associated with a history of abuse have been well documented in studies undertaken in a wide range of settings. One study found that 64% of women undergoing laparoscopy for pelvic pain had histories of childhood sexual abuse, as compared with 23% of those undergoing laparoscopy for tubal ligation or infertility.[1] Another study at a hospital-based chronic-pain centre revealed that one-third of the subjects had a history of physical and/or sexual abuse, and for 78% of them the abuse started after they married.[2] Among patients seen at a university-based gastroenterology clinic, 44% reported a history of sexual or physical victimization either as children or adults.[3] One Canadian study of obstetric patients showed that 6.6% of them had been abused while pregnant and 95% of these women had experienced the abuse during the first trimester.[4] For those abused early in pregnancy, 95% also experienced abuse in the first 3 months after giving birth.[5] The breadth of these studies demonstrates that, regardless of the particular focus of their clinical care, physicians need to address the ways abuse can affect the physical and mental health of women and their children.

In 1992 this fact was reinforced when the US surgeon general, Dr. Antonia Novello, encouraged health care providers to "take an active, vigorous role in identifying this serous recurrent public health problem."[6] At the same time the Council on Scientific Affairs of the American Medical Association drew attention

to "the widespread prevalence of violence against women" and to the needs of victims of violence.[7] That same year, the Joint Commission on Accreditation of Healthcare Organizations required emergency departments seeking accreditation to establish policies, procedures and education programs concerning the treatment of battered adults.[8]

Elsewhere in this issue (page 1555-6), we are reminded how difficult it is for some women to recognize and publicly acknowledge the abuse they face within personal relationships. The article describes how a community organization in Eastern Ontario uses a lengthy list of potentially abusive behaviours (page 1557-8) to help women achieve comfortable, open disclosure.

The list started from discussions among a group of male abusers and grew with the input of women who had been abused and the community workers helping them. Because some women tend to minimize the significance of their partners' unacceptable controlling behaviours, the list can help them label their experiences for what they are: abusive.

This type of list can also help women who have acknowledged their experiences to describe their relationships in more detail. Such disclosure of abuse by a patient the physician knows well can be critical in pushing a doctor to consider how the abuse may have affected the patient's physical and mental health.

Unfortunately, the rate of identification of abuse in medical encounters remains low, despite the increased attention the issue has been receiving. Some physicians still fail to see the connection between patients' health problems and their history of abuse; others feel uncomfortable about asking the relevant questions.

However, asking questions is a crucial aspect of providing care to people who have been abused. Physicians can question patients about abuse in past or current relationships, particularly when there are symptoms or patterns of injury that cause concern. Doctors should emphasize that similar problems often arise within the context of abuse and ask if this is true of this particular patient.

Routine screening has been advocated for all patients seen in family medicine settings, emergency departments and prenatal clinics. Radomsky has shown it is useful to ask all new patients about the possibility of abuse and to revisit the issue whenever symptoms or injuries are apparent.[9]

Grunfeld and colleagues demonstrated the benefits of routinely asking all female patients seen in emergency departments about possible abuse. Physicians can begin with a very general statement — "many patients with similar injuries have been hit by someone" — and then ask the patient if this is the case with her.[10]

Some family physicians prefer to use a standardized screening tool to help ask women about abuse. This led to development of the Woman Abuse Screening Tool (WAST), which has been evaluated and shown to have good reliability and validity.[11] The first 2 questions ask women to rate the degree of tension in their relationships and the difficulties they and their partners have in working out arguments. The last 5 questions are asked if there are affirmative responses to the first 2; they will elicit more details about the woman's experience. WAST is currently being field-tested with urban and rural physicians in southwestern Ontario, and validated with a French-speaking population.

Incorporating this kind of information into a clinical practice can pose a challenge for many established physicians. Newer graduates may be more comfortable doing this because the objectives and examination questions of some undergraduate curricula and residency programs, such as family medicine, recognize violence and abuse as important health problems.

However, we will not see a reduction in the social and health problems associated with violence and abuse without the ongoing efforts of community groups like the one highlighted in this issue of *CMAJ*. If everyone works together, our patients, colleagues and family members will benefit.

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