OVERVIEW

This case involves a new patient who comes to a women’s health clinic for pregnancy care. During the examination, the physician discovers she is being physically abused when she does not want to undress for a physical exam. Multiple religious, ethical, and cultural issues underlie this scene, so the case is relevant for use in undergraduate and graduate medical education. The video highlights a situation involving a pregnant patient presenting with bruises but is presented to allow faculty the opportunity to discuss other issues not uncommon to the reproductive clinic. This video also allows future healthcare providers to address having difficult conversations, such as caring for intimate partner violence victims, that should not influence patient care. The physician’s handling of the situation is also portrayed to allow discussion of professionally managing patient encounters and not as a model to follow. Students need to be conscious of how to professionally handle these sensitive situations so we encourage faculty to view this facilitator guide as suggestive but not all encompassing.

Learning Objectives

At the end of the session, the student should be able to:

1. Explore strategies for identifying physically abused patients.
2. Discuss the religious and cultural beliefs pertaining to intimate partner violence (IPV).
3. Discuss the healthcare team’s role in caring for the needs of IPV patients.

Facts to Initiate Discussion

- Each year in the United States, approximately 5.3 million IPV victims, 18 years old or older, occur with 1,300 women losing their life as a result of IPV (Department of Health and Human Services, 2003).
- Male intimate partners or ex-partners are the most frequent offenders of violence against women (World Health Organization, 2012).
- The estimated IPV medical and mental health costs in the United States is $4.1 billion per year (Department of Health and Human Services, 2003).

Critical Points (Every Student Needs to Hear)

- IPV is a pattern of assaultive and coercive behavior by a person trying to establish control over a partner they desire to be intimate with (ACOG Committee Opinion Number 518, 2012). IPV behaviors may include physical injury, psychologic abuse, sexual assault, progressive isolation, stalking, deprivation, intimidation, and reproductive coercion towards an adult or minor partner (ACOG Committee Opinion Number 518, 2012).
- IPV occurs in every community and can be experienced by heterosexual or same-sex couples, both male and female irrespective of age, economic status, race, religion, ethnicity, sexual orientation, or educational background (ACOG Committee Opinion Number 518, 2012).
- Victims of IPV may suffer lifelong consequences, including emotional trauma, lasting physical impairment, chronic health problems, and even death (ACOG Committee Opinion Number 518, 2012).
- Healthcare professionals are often the first professionals to offer care to IPV victims (ACOG Committee Opinion Number 518, 2012).
- Laws on management of intimate partner violence differ by state. It is important for healthcare providers to keep current on what their state and county require. Many states have laws requiring reporting of fatalities, insurance discrimination against victims, reporting of IPV, protocols, training, and screening (Durborrow, Lizdas, O’Flaherty and Marjavi, 2010).
- Survey findings found white women are significantly less likely than non-white women to experience IPV (Tjaden and Thoernnes, 2000).
Questions to Ask

- How should the healthcare team proceed?
- What questions should the healthcare team/provider ask this patient?
- What priorities exist for this physician during this office visit?
- What members of the healthcare team would be essential to this case?

Concluding the Session

- Physicians need to practice screening all patients for IPV at various times since some women are hesitant to disclose abuse. Annual examinations and new patient visits are good intervals to do IPV screening. Signs to be aware of during include depression, substance abuse, mental health problems, requesting repeat pregnancy tests when the patient does not wish to be pregnant, new or recurrent STIs, asking to be tested for an STI, or expressing fear when negotiating condom use with a partner (ACOG Committee Opinion Number 518, 2012).
- Obstetricians should privately perform a IPV screening on a patient’s first prenatal visit, a minimum of once per trimester, and at the postpartum checkup (ACOG Committee Opinion Number 518, 2012).
- Creating a trusting, non-judgmental connection with a patient who is an IPV victim is important when asking the patient to reveal an abusive partner relationship.
- Providers need to acknowledge a patient’s trauma when IPV is detected and assess the patient and her children’s immediate safety (ACOG Committee Opinion Number 518, 2012). Healthcare teams can provide support for the development of a safety plan.
- Providers are required to report the abuse of children, yet, reporting IPV can jeopardize a minor’s safety so mandatory reporting is controversial (ACOG Committee Opinion Number 518, 2012).
- The examination of an IPV patient should be well documented so evidence is available for support of any future legal actions (ACOG Committee Opinion Number 518, 2012). Documentation should include a detailed description of the patient’s condition, including any pertinent photographs or body maps plus direct and specific quotes made by the patient during the exam.
Reading Resources