Domestic Violence and Health Care Transcript

[00:00:02.13]

[DOMESTIC VIOLENCE
AND HEALTHCARE]

[BEST PRACTICES IN ACTION]

JACQUELYN CAMPBELL: It used to be when we first talked about domestic violence, we talked about battered women having a whole range of psychosomatic complaints. We used to talk about it in those kinds of terms. As if it was, you know, all in their heads.

COLLEEN MOORE: Traditionally we think that domestic violence is a social concern. It's a family problem. It's something that happens behind closed doors. And that it can best be solved by law enforcement or the courts. But I think if we look at it, we certainly understand that there are health effects.

DEBRA HOLBROOK: It used to be, somebody would come in b -- obviously injured by a partner. It was, it was apparent. They had -- um -- punch marks. They had patiki eye from strangulation in their eyes. They had -- um -- wounds from being whipped with a cord. It was obvious. Medical practitioners would turn a blind eye. Because we had no -- what were we

gonna do with that information?

[00:01:01.04]

Basically. We had nowhere to go to help you.

[BALTIMORE, MD]

COLLEEN MOORE: I'm Colleen Moore. And I work here at Mercy Medical Center in the Family Violence Response Program. And I saw working in this area as a way to be a practical feminist.

[COLLEEN MOORE
MERCY FAMILY VIOLENCE PROGRAM]

It was -- uh -- not so heady that it was so pie in the sky or ivory towerish. Um -- but it had real impact.

The hospital-based program is able to link patients who are coming in for injury or with symptoms to services they would need out in the community. As well, it's able to get them treated for their medical needs.

[00:02:01.01]

FEMALE VOICE: Hi, you're gonna come back here with me.

COLLEEN MOORE: It's a wonderful opportunity, since they're coming to the doctor, to -- to put them in touch with the services that are out in the community. Secondly, it is certainly to treat and to document w -- the injuries that they may have sustained. Or other symptoms that they have. So that we have a paper trail that shows that there's been a history.

JACQUELYN CAMPBELL: Before 1985 in this country --

[JACQUELYN CAMPBELL
JOHNS HOPKINS]

-- uh -- domestic violence was not recognized as a health problem. And in 1985 former Surgeon General Koop had a conference and brought together experts and actually documented some of the health care -- uh -- consequences of all forms of -- of violence. There's a whole range of health care problems that battered women incur. Abused women have more chronic pain. What we have found is that much of that pain is related to old injury. So, for instance, one of the things that women oftentimes say is, "I get slammed against the kitchen cabinets."

[00:03:03.00]

And they'll say, "You know, it's not that bad, it's some pushing and shoving and sometimes he'll

slam me against the kitchen cabinets." Well, if you think about, if you get slammed against the kitchen cabinets over and over again, eventually you're gonna develop chronic back pain. And it -- it's gonna be injury. It's gonna be constant injury. Unless that physician or that nurse practioner is smart enough to really do a trauma history and find out that they've been abused and that this is multiple, you know, injuries that have never actually been treated. Or haven't been treated in a cumulative way. They don't see the true picture.

[EMERGENCY DEPARTMENT]

FEMALE VOICE: He's gonna go to the tenth floor.

MALE VOICE: [INAUDIBLE]. But he says he'll stay. If the walk-in process okay, he's gonna be dangerous. Okay.

FEMALE VOICE: Okay.

COLLEEN MOORE: Here at Mercy we ask three questions related to personal safety. We ask a question that relates to -- uh -- just sort of generally -- physical or emotional abuse.

[00:04:03.19]

Recognizing that emotional abuse can have just as many harmful effects on your health, as physical abuse.

MELISSA ANTON: Do you have any -- uh -- any relationship where you feel threatened or afraid.

FEMALE VOICE: No.

MELISSA ANTON: Or are you having any physical -- any -- anybody hurting you physically? He's hitting you, slapping you, punching you?

FEMALE VOICE: No.

MELISSA ANTON: Yelling at you? Saying mean things? Okay.

COLLEEN MOORE: Every patient is screened the same way. It's a required field in our medical charts. The best practice is to be asking universally. Not to make assumptions based on gender, based on age, based on race. It's a good practice to ask about specific behaviors. "Have you -- have you ever been hit? Have you ever been slapped? Have you ever been kicked? Strangled?" Specific things. Because victims often will define things differently.

DR. STEPHEN SCHENKEL: One of the challenges of screening --

[DR. STEPHEN SCHENKEL
ER CHAIR]

-- is there's -- there's the first question, "Are you screening?" And, yes, we are screening. So now you've screened, what do you do with the answer?

[00:04:59.25]

If someone says, "No," you've no problem. The question is, "What do you do if someone says yes?" And if you don't have something in place to handle that, then screening is not worthwhile. Don't screen and do nothing. Screen and do something.

MELISSA ANTON: If they respond yes to any of our three questions, then if it's during the day --

[MELISSA ANTON
NURSE]

-- and Colleen Moore's here, we will Colleen and Colleen will come in and talk to her and do further screening to continue, you know, giving 'em resources. And, you know, places -- if they need a place to stay, you know, make sure that they're safe. I mean, if -- if we -- just figure out where they are in the process.

COLLEEN MOORE: Screening need always be in private. There can never be the assumption that the caring partner or even the, you know, mother who's accompanying the patient -- uh --

wouldn't in some way play into compromising a patient's safety if they were asked to disclose.

JACQUELYN CAMPBELL: One of our challenges is not only the -- to have policies in place that say that nurses and physicians need to routinely assess for domestic violence.

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But how they do it. You know, if they've got a check list and they go, "You're not abused, are you?" "Okay." Or, you know, or ask it in a way that's not engaging. That's, you know, clearly uncomfortable. One of the things that sometimes we underestimate is -- is women are gonna choose who and when to disclose to. I mean, we can ask all day. If we ask badly, she's never gonna tell us.

DEBRA HOLBROOK: Nurses -- I'll toot our horn --

[DEBRA HOLBROOK
COORDINATOR, FORENSIC NURSING
MERCY MEDICAL CENTER]

-- have been voted the most trusted profession of all jobs. And we are number one in the United States every year when this country does its polls. People tend to tell us stuff that they wouldn't tell the police, they wouldn't tell their doctors. They -- they spill their guts, so to speak, to us.

COLLEEN MOORE: Or there was a nurse who had dis -- who had an interest in past trauma and how that affects later life -- uh -- health outcomes. And that one person, who was a pre-op nurse --

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-- uh -- in screening before surgeries, often that nothing to do with any kind of domestic violence or other abuse, was generating like a third of the referrals that we had at one time.

JULIE BATISTA: I think the secret to -- uh --

[JULIE BATISTA
NURSE]

-- getting the information from a patient, first of all you have to have a rapport with the patient. There's always something you can find in common with the patient, whether it's you lived a similar place, you have grandchildren. You have to make the patient feel comfortable.

DEBRA HOLBROOK: I ask all the questions and then at the end I say, "Now because we care about you as a patient, may have no -- no relationship with why you're here today, but I wanna ask you this because we care, "Are you safe in your home? Does anybody hit you? Do the injuries that you have today have to do with anybody hurting you?" Now, you're not reading them, you're just talking to somebody.

FEMALE VOICE 1: Do you feel threatened or afraid at home?

FEMALE VOICE 2: No, not at all.

FEMALE VOICE 1: Okay. Um -- we just do this screening with everybody.

FEMALE VOICE 2: Okay.

[00:08:02.16]

FEMALE VOICE 1: [INAUDIBLE] women. Just to make sure. 'Cause we have great resources here at Mercy that can help.

DEBRA HOLBROOK: Now a lot of these patients may not answer positively on a screening. I mean, you -- you figure -- you -- you've got a perfect stranger screening you when you come into an emergency room. Or anywhere in the hospital -- for surgery, you're on the floor, wherever. That person asks you very personal questions, that for whatever reason you're not telling anybody about. Because you've been involved in violence in your home. Maybe it'll cross the line. Maybe the next time it'll be their child who's assaulted. Or they'll say something. Or they'll threaten them in such a way. Or whatever crosses their line, they will remember that somebody at Mercy Medical Center cared to ask and provide safety. And so they'll tell us maybe the second time.

COLLEEN MOORE: I think the biggest lapse in terms of opening that door to get people to talk about their situation is victims not being assured of confidentiality.

[00:09:01.17]

So it is impor -- important for doctors to know what the reporting requirements are in whatever state they happen to be.

DEBRA HOLBROOK: If it doesn't cross a certain line, we can't report it. We can't do that by state law. And I'm in favor of that. And I'll tell you a personal story. When I was in X-ray school, I had a friend who was in a intimate personal violence situation -- her husband was abusing her. She was -- her -- he broke her wrist. She went into the hospital emergency room. She was x-rayed. They didn't believe her story. They called the police. He was arrested. Her husband was arrested. He was out of jail before she got out of the hospital. He took her hostage, tied her up, made her watch while he slit her parents' throats and killed them. She knew that he would do that. He'd always threatened to do that. So people know what their boundaries are when they're safe to report.

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They've gotta get their game face on. They've gotta get all their ducks in a row before they leave. She wasn't ready. And so I am not gonna take that role of the -- the person, the medical personnel

on the white horse that calls police. Because I'm not there to help her afterwards.

[OBSTETRICS AND
GYNECOLOGY]

COLLEEN MOORE: Labor and delivery is an area where there's -- there's much focus on this. And second to the Emergency Room, that's where most of my referrals are coming. Because people are at risk during their child-bearing years. Because people -- because pregnancy itself is a risk factor.

DR. ROBERT ATLAS: Well approximately one in eight women --

[DR. ROBERT ATLAS
OB/GYN CHAIR]

-- and have significant abuse during pregnancy.

[00:11:01.27]

The -- the misnomer is that women believe that when they get pregnant, their risk is less for domestic violence. And, in fact, it's the opposite. There's an increased risk that they themselves have for domestic violence.

JACQUELYN CAMPBELL: It has been subsequently substantiated that one of the pre-cursors of low birth weight is domestic violence abuse during pregnancy. Both related to -- uh -- the stress of being abused during pregnancy, Which is one of the things that can compromise birth weight for women. Also probably related to them not gaining sufficient weight during pregnancy. Again, because of the stress.

COLLEEN MOORE: It's not unusual for people to come in, even in advanced states of pregnancy, who've been assaulted. And it's -- it's disturbing that, you know, sometimes those assaults seem targeted at -- at the pregnancy.

DR. ROBER ATLAS: Most -- uh -- pre-natal clinics will offer and will be asking specific questions -- uh -- in their screening with their nursing staff.

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So there is a practice where they're -- either where there's a questionnaire for a patient, or with the -- the nursing staff, that they bring these issues up. It's very interesting because having a patient tell a doctor that they are the product of abuse is -- is -- does not occur very often. There is -- unless you have a very good relationship with the -- with the patient.

FEMALE VOICE: I'm not right now.

DR. ROBERT ATLAS: I mean, the best exc -- example I can give is I -- uh -- earlier in my

career, where I did not do -- uh -- routine screening. And the only way I knew that this woman was the product of abuse is when they found her stabbed 75 times. And that was a month after delivery. So, that was my wake-up call in regards to -- to these events. It can be dangerous and devastating for -- for the mother.

[SEXUAL ASSAULT
FORENSICS UNIT]

[00:13:01.22]

[MERCY NEW EMPLOYEE TRAINING]

COLLEEN MOORE: We need to be able to understand what different types of abuses there are. What our limits are, in terms to -- in terms of how we can help. What are the best ways to help? And, really, what are our roles in -- in any part of the hospital in terms of responding appropriately? Mercy's unique. We're one of only four hospitals in the state that has a dedicated program that's responding to victims of abuse. Now, in your minds, what do you think a hospital could -- ?

A number of years ago -- uh -- the situation was that any sexual assault victim who needed a forensic exam could get that kit from the police and take it to a hospital and then any random doc, who may not have had any experience with it, would try to collect the evidence. So what was created here is -- is the situation in many places across the country -- is that there's an actual

center where the safe nurses -- the sexual assault forensic examiners -- have one home.

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Where police will bring victims directly here.

DEBRA HOLBROOK: When a patient presents, that needs a forensic -- eh -- medical examination, we're called in. We're deployed. We're available on call 24/7 around the clock. If they have some type of injury, we take pictures. We collect the evidence. And if it -- a licensed personnel -- medical personnel -- get that information, then it is admissible in court. One of the biggest ground-breaking things we've done is with strangulation. We have an alternative light source, which is the only one to my knowledge in the state that's used on live patients, that can see injuries underneath the skin. So we have folks who are strangled. And maybe they're dark-skinned. Or maybe it's been too soon for their injuries to appear. We can see the marks. And they literally light up like a Christmas tree on their neck. Or, you know, wherever the injury is on their body, with being able to see bruising underneath the skin. That takes their case to court now.

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COLLEEN MOORE: Even a hospital that doesn't have access to a forensic program, certainly keep a Polaroid. Um -- that -- that kind of documentation is so powerful. And so important that a victim have that as immediate access.

[COMMUNITY OUTREACH]

COLLEEN MOORE: The Family Violence Program is very interested in being able to insert itself in different councils that exist --

[BALTIMORE DOMESTIC VIOLENCE
FATALITY REVIEW BOARD]

-- to insure that coordinated community response includes the health care community. It's important that the medical community be involved in the coordinated community response to domestic violence. Because it has so much extra to offer -- uh -- law enforcement and prosecution.

FEMALE VOICE: We were made aware of the forensic nurse and the -- the tool that -- that you can test --

[00:16:01.19]

FEMALE VOICE: [INAUDIBLE]

FEMALE VOICE: Yes.

FEMALE VOICE: Looks for bruising below skin.

COLLEEN MOORE: In the community we want to make ourselves visible to make sure that the role of the health care provider is recognized in the coordinated response to domestic violence.

DEBRA HOLBROOK: If people don't know you're here and what you do, they're not going to come to you. So that's so important that -- that the hospitals do that when they start a program. Is start out in the communities, at community fairs, at schools, at scout camps, in science classes at college. We get into where the doctors are trained at University of Maryland -- talk to the -- to be able to talk to the residents. We get into nursing schools, to be able to talk to nursing students. To let them know now that we're here.

[TAKING ACTION]

FEMALE VOICE: I am seeing if she was having any chest pain, any --

JACQUELYN CAMPBELL: One of the issues for the -- uh -- HMOs, for the different health care systems, is they're trying to say, "Okay, can -- can we save money right away?"

[00:17:04.14]

You know, if we hire domestic violence -- um -- specialist for the health care system, if we train all of our nurses and physicians to find out about domestic violence, to intervene more

effectively, will I see a -- a cost savings the first year? Well, probably not. You know, when you look at the costs, not only the health care costs, but also the employment costs, the -- uh -- sick days that battered women oftentimes have more of, the court costs, the, you know, criminal justice system costs -- you know, when you add up all those different costs, it's -- it's quite staggering. And that's one of the things that -- that we like to -- uh -- present to the health care system, to try and put some interventions in place in the health care system.

COLLEEN MOORE: A doctor might feel very frustrated if there's nothing accessible within the hospital.

[00:18:03.10]

Or within the -- their clinic. No social work that would be able to help out if they come across a victim of domestic violence. But there certainly are things that an individual doctor could do that would greatly benefit a victim. Documentation is the biggest thing. If a victim comes in with a bruise and it's not properly documented, once that fades it never happened.

One step that can be taken is to be sure that in the hospital women's room, in your office, that you have materials available. To have a brochure that you could pass to somebody. To have a discreet, what we call a shoe card, which could easily be concealed -- that has the hotline numbers, that has a very small safety plan -- uh -- that somebody could -- could walk out with. Um -- that -- that is -- that in and of itself is a big step.

[00:19:02.24]

COLLEEN MOORE: I would suggest that, for anybody who's interested in expanding the services offered in their facility, that they try to partner with a service provider. A service provider understands that the hospital's where the high risk victims are coming. And they're very, very interested in having a foot in the door and access to -- to that stream where -- where victims are coming in.

DEBRA HOLBROOK: I just want doctors and nurses to know that I've been there. I've been a critical care nurse for many years. The last thing we wanna deal with is extra baggage with these people. We wanna do the surgeries, we wanna get the bullets, we wanna fix their blood pressures, we wanna just take care of the person. But it's the whole person that needs to be taken care of. And maybe the reason they're in with you for a GI bleed is because they've been harboring the stress of being threatened to be killed every day for the last three years.

[00:20:00.28]

And now it's worn a hole in their gut. Maybe the reason they're having migraines is because of the stress of being beat up all weekend long 'cause a football team somebody wanted didn't win. You know, before you throw somebody on medicine, take the time to ask questions about, "What else is going on in your life? How can -- how can we help you with that?" And if you don't have the ability to help in your office or in your small community, then by goodness get that list of people who do have those services to bring to your patient. 'Cause you'll change their lives.

Maybe even save their lives.

[END CREDITS]

END OF TRANSCRIPT # #