COMMENTARY

Clinicians, intimate partner violence, and opportunities

The long-term and trusting relationship between patients and primary care providers permits repeated opportunities for detection and intervention of intimate partner violence (IPV). Clinicians, however, do not seek this information regularly, even in settings where partner violence is common. We need to develop knowledge, skills, and behaviors for identifying abuse, assessing safety, displaying cultural competency, and acknowledging associated legal and ethical responsibilities.

Many factors are associated with the perpetration of IPV. Although no evidence exists that alcohol use *causes* abuse, criminal justice studies suggest that alcohol is a factor in two thirds of cases of IPV.[1] Alcohol use, often combined with other drug misuse, is a significant predictor of physical, sexual, and psychological violence.[2,3] Providing quality health care to victims of violence involves asking all patients about alcohol and other drug misuse. Through collaboration among clinicians and social workers, we can provide access to resources and more effectively help patients address the abuse in their lives.

It is possible to affect levels of IPV through changes in social policy. Studies examining policies designed to reduce the availability of alcohol through price mechanisms, such as regulations that increase state-level beer taxes, suggest that these policies may help to reduce rates of intimate partner abuse[4] and domestic violence against children.[5] Because several factors contribute to the occurrence of IPV, including alcohol use, health care advocates interested in reducing violence should collaborate with policymakers as part of a comprehensive approach to addressing drinking problems as well as violence.

While IPV affects people from all sectors of society, studies have found higher prevalence rates among welfare recipients than in women in the general population.[6] Thus, clinicians need to understand the unique IPV issues these women face. The 1996 Personal Responsibility and Work Opportunity Act ("Welfare To Work"), with its emphasis on joining the labor force, restricts the time during which participants can obtain welfare benefits. Welfare-to-work programs may create greater opportunities for economic independence, but they may escalate the violence within relationships as the perpetrator attempts to maintain control. Efforts by victims of domestic violence to move from welfare to work can be sabotaged by batterers in many ways, including threats to the safety of partners and their children. The Family Violence Option encompassed within welfare reform allows states to waive work requirements and time limits and to increase services to victims of IPV without financial penalty. Some employers, such as Blue Shield of California, have modified workplace policies to include flexible schedules, training employers and employees on abuse, and providing time

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for victims of domestic violence to attend medical appointments. Likewise, welfare workers have collaborated with the community to modify their protocols for case management to better assist women affected by IPV.

Clinicians and policymakers can improve efforts to address IPV on several levels. Increased knowledge of the complexities associated with partner violence can improve the sensitivity and effectiveness of health care interventions. This knowledge also permits policymakers to consider benefits and disadvantages of social policies such as those aimed at reducing alcohol misuse and welfare rolls. Collaboration between clinicians, social workers, and policymakers is integral to the design of interventions and policies that lead to greater independence, improved health, and increased safety for patients who are survivors of IPV and their children.

References

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The inventory

Twenty men in white, all dead,
Stand in a photo behind his desk.
Dark mahogany, it is littered
With prescription pads, unopened journals.
He was the last survivor of his class.

Antiseptic smells emanate from the examining room
Stocked with instruments of potential cruelty,
Nasal speculae, steel irrigating syringes.
A table with stirrups hides across the hall
Behind wooden partitions.

He wore a white tunic over gray trousers.
The leather headband across his brow
Bore the large mirrored monocle
Through which he, Cyclops, gazed
Into people's orifices by reflected light.

Had this stranger been my father?
In pride he guided an immaculate Fleetwood
Through neighborhoods now deceased,
East Bronx, West Bronx, South Bronx,
Carrying his big black bag into patients' homes.

Discovered in the trunk of his car,
It contained a stethoscope, otoscope,
A red rubber catheter, a case of hypodermics
He boiled in frying pans on kitchen stoves,
To administer morphine or penicillin.

Up at dawn, home at bedtime,
Seven days a week,
Often away in the middle of the night,
To him and his patients
There could be no other.

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