Domestic Violence Homicide Doesn't Just Happen: Moving from Physician Bystander to Advocate

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The physician: Meghan

As the granddaughter of a mailman, I always have stamps in my wallet. When I attached a USPS® *Forever Stamp* to the envelope containing my patient's request for funds from a crime survivor's advocacy group, I thought I was helping her in a minuscule way. It never occurred to me that she would be dead before those funds arrived. **Intimate partner violence (IPV) is deadly and not something medical providers are sufficiently equipped to prevent, detect, triage, or treat.**

I became a primary care doctor in the year of the #MeToo Movement. As part of my formal medical education, I learned to routinely screen reproductive-age women for IPV

as part of a standard protocol. Even with that training, I was under prepared as a healthcare provider to care for women experiencing domestic violence. In hospital medicine, there is an intensive care unit for management of the most life-threatening conditions. But there is no intensive care unit or "treatment algorithm" for IPV. That's shocking given the morbidity and mortality associated with IPV. One in three women will experience violence from an intimate partner during her lifetime.[i] In 2015 alone, of the 3,500 US-based women who died due to homicide, almost half of those women – like my patient – were killed by a current or former intimate partner.[ii]

My patient had obtained a restraining order and our clinic's social worker was engaged with her to offer ongoing safety planning. As primary care provider lacking depth in IPV dynamics, I thought this plan was reasonable and that if her abusive partner violated the restraining order and hurt her again, she could call 911 and get safe. "The ED is always open," I told my patient. While I was taught – accurately – that leaving one's abuser is the most dangerous time in an abusive relationship with the highest risk of violence escalation, I struggled to operationalize this learning within familiar clinical frameworks. Unlike chest pain or respiratory distress, primary care providers cannot directly intervene with respect to an abuser's violent and unpredictable conduct. And I knew that my patient was conducting her own risk analysis: at our last visit, she said that her primary goal was to be free – free from abuse at the hands of her husband, free from fear of what he would do to her and free from worry about what he would say to her friends. I just didn't realize that that appointment would be her last with me.

The attorney: Jeannine

In the last decade, 55 people have been killed by intimate partners in Rhode Island, the state where I live and primarily work.[iii] Laws alone are insufficient to buffer survivors from the myriad health-related risks of domestic violence. As a public interest attorney embedded within care teams to support effective SDOH problem-solving, I have witnessed first-hand clinician unease about how best to support patients experiencing IPV, especially when the most valuable supports (e.g., representation in court proceedings, relocation assistance, behavioral health treatment and family counseling, etc.) often are driven by experts and resources external to the healthcare team. In my legal advising capacity, I often field questions about the legal rights and remedies available for IPV survivors. Healthcare team members should understand that:

- When a survivor attempts to navigate the legal system to secure a restraining order, divorce decree or child support order, they often experience fear, confusion, alienation, and re-traumatization. Every court hearing involves the prospect of direct, proximate contact with one's abuser – in the parking lot, on the sidewalk, in the courthouse elevator, in the courtroom. In restraining order proceedings, a survivor often attends the hearing alone, without an attorney. If she prevails, a judicial ruling is rendered, paperwork is distributed, and the

survivor is sent on her way, many times not understanding the scope and meaning of the protective order.

- The most important thing care teams can do when supporting an IPV survivor is communicate with them in a strengths-based, trauma-informed way that recognizes the survivor is the expert in their own life and safety. This skill and commitment will increase the odds of successful safe hand-off of the patient to expert safety planning and other resources, whether internal or external to the clinic. Consider the patient's network of social supports. Are they connected to a community-based or religious organization? Is their membership in a cultural or linguistic group a source of support or a challenge – or both? Will immigration status and income impact their ability to access concrete supports such as SNAP (food stamps) or TANF (cash assistance)?

My role as an integrated legal advisor to interdisciplinary pediatric, family medicine, and internal medicine care teams enables the team to spot and navigate interconnected SDOH. Think beyond a clinical practice guideline framework. Supporting patients to identify pathways to safety is not amenable to a rigid algorithm – it must be an honest, flexible, and holistic effort.

Meghan: I hope to honor my patient who lost her life by building my capacity – and that of my clinic colleagues – to engage in strengths-based, trauma-informed care for patients who have disclosed IPV. In the aftermath of my patient's homicide, I am reflecting on how healthcare teams can better serve IPV survivors, like going beyond the daily clinical work flow and engaging partners from other disciplines and sectors. Partnering with others such as lawyers, researchers, community-based organizations and activists can help other survivors. We need to work together to advocate for a future with less domestic violence.

If you are (or someone you know is) in need of support, contact the National Domestic Violence Hotline at 1-800-799-SAFE (7233).

[i], [ii] Petrosky, Emiko, Janet M. Blair, Carter J. Betz, Katherine A. Fowler, Shane P. D. Jack, and Bridget H. Lyons. 2017. "Racial and Ethnic Differences in Homicides of Adult Women and the Role of Intimate Partner Violence - United States, 2003-2014." *MMWR. Morbidity and Mortality Weekly Report* 66 (28): 741–46

[iii] RI Coalition Against Domestic Violence; http://www.ricadv.org/en/what-we-do/communications/news-releases/?open=1 (accessed 11/13/18)