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ETHICS CASE
Interviewing a Patient about Intimate Partner Violence
Commentary by Charles Moser, PhD, MD

Melinda is visiting with Dr. Sherman, her internist, for a well-woman check-up. After the exam, Dr. Sherman asks Melinda whether she has any concerns about her health or well-being that she wants to discuss. Melinda nervously and hesitatingly says that her husband of many years has begun "demanding more and more of me," as she puts it.

"How do you mean?" Dr. Sherman asks.

"He is a good father," Melinda says first. Then she says, "But he is more and more aggressive in bed. He didn't used to be like this. If I say I'm scared or that I don't want to have sex, he doesn't stop. He just keeps going. I don't want to make him mad. I don't want to ruin things between us."

Dr. Sherman says, "I'm concerned for you, Melinda. No one should be frightened into having sex when she doesn't want to. Do you feel unsafe? Do you think your husband might get abusive if you refused?"

Melinda withdraws at these questions and says dismissively, "Guess it's just how men are. I'll figure it out."

Commentary
It seems obvious that this was not the best way to handle the situation. Dr. Sherman was not able to get answers to her questions and Melinda did not feel that she could confide in Dr. Sherman. Melinda left without resolution, follow-up, referral, or plan; she also left with the impression that Dr. Sherman did not understand her.

When reading this case, domestic violence (DV) or intimate partner violence (IPV) immediately comes to mind, and it should. All health care workers need to consider DV in the differential diagnosis, even when there are no obvious physical injuries. DV is related to numerous undesirable health outcomes [1], but some interventions by health care workers have been shown problematic [2]. We are just beginning to ask women what interventions are helpful [3].

Dr. Sherman seems to have made the determination that DV is the issue, but I think that may be a bit premature, and her approach obviously was not helpful. Let me suggest another approach.

If Melinda came in and said, "I am having knee pain," almost reflexively we would start taking a history. Is it one knee or both? Is the pain sharp, dull, or burning? Is the pain constant or episodic? How frequent are the episodes? How long do the episodes last? When did it start? Was there a precipitating event? Does anything make it better or worse? To make a diagnosis or prescribe treatment without this type of history is just poor medical practice.

Likewise, in Melinda's case, the first step is to take a history in a nonjudgmental manner and using a style that will build trust with Melinda. Ideally the history should take place before the physical exam and before the patient disrobes: the history may unveil concerns that require attention during an exam, and we want to be sensitive to vulnerability the patient might experience. Discussions about sexual concerns that take place between an unclothed patient and a clothed health care practitioner are fraught with problems, both practical and ethical.

There are two separate but related aspects to the sexual history: how do you talk about sex with a patient in a professional manner and what information do you need? The exact wording and order of the questions will depend on the patient and the jargon and slang with which the patient and physician are most comfortable.

Questions for History

- When did your husband start disregarding your feelings? (Melinda indicated that this was a new behavior.)
- Was there an event that precipitated his becoming more aggressive with you? (For example getting fired, or the death of a family member. Note that Melinda described the behavior as aggressive. It can be helpful to use the patient's own words.)
- How often (or what percent of the time) is he aggressive with you in bed?
- Is the behavior increasing in *frequency*?
- Is the behavior increasing in *intensity*?
- Can you predict when it is going to happen? If so, what do you notice?
- Does anything make it better or worse?
- Is he aggressive with you outside of the sex? (Again, using her language.)
- Is the sex painful?
- Prior to his becoming more aggressive, how would you describe your sex life?
- If he was not so aggressive, would you want to have sex with him more frequently?
- Do you agree to sex to avoid making him mad? How frequently?
- How often do the two of you have sex now?
- How often did the two of you have sex before he became so demanding?
- Do you ever initiate sex *now*?
- Did you initiate sex *in the past*?
- Has he asked for new or different sex acts?
- What do you think has led him to change the way he treats you?

We want to be careful not to blame the victim, but Melinda's own medical concerns may play a role in the couple's problems. The assumption is that something has changed with her husband, but it is possible that Melinda has changed as well. These questions may lead to exploring Melinda's medical concerns, which may need to be addressed as well.

- Is she perimenopausal or menopausal? (This might signal a change in her sexual response pattern.)
- Does she have vaginismus?
- Does she have vulvodynia?
- Has she noticed decreased lubrication, difficulty having orgasm, decreased desire, or pain with sex?

Answers here may lead to questions about her husband and what brought about the changes in him.

- Has he been drinking alcohol to excess or using drugs?
- Has he been having trouble controlling his temper in general?
- Is he having problems at work?
- Are there money problems?
- Does he have any new medical or psychiatric problems?
- Do you think he is having sex with anyone besides you?

These questions allow Melinda to feel heard. They are not judging her or her husband; they are obtaining the history and setting the stage to solve problems. At some point, Dr. Sherman may ask, "How can I help? What are you hoping I will do?" By asking Melinda about her own goals, the physician is actively engaging her in the process and empowering her to be part of the solution. The physician cannot and should not be the "savior." We can present her with options that she can explore. Of course, if she is imminent danger, then we need to act. Until then, we have some time for problem solving with Melinda.

Physicians who are not equipped to help need to refer. This might be as simple as referring the patient to a social worker or crisis line as a first step. It may require researching the resources and options that are available locally. Obviously, it can be more complex.

Physicians may have another issue to contend with: their own uneasiness discussing sex and intimacy with patients (or with their own partners). Admittedly, not all physicians are interested in or willing to discuss these topics with patients (or in their own lives). Medical school and residency training programs often do not teach these skills. Without some experience exploring our own biases and learning about alternatives, we fall back upon our own life experiences and moral beliefs. In the same way as we learn about normal variations in blood pressure, we need to learn about "normal" variations in sexual interests and practices. We want to avoid clueless or unintentionally inflammatory statements.

Ideally, a short sexual history is part of every new patient history and physical. The purpose is to uncover information that may have medical ramifications and to establish a level of trust, so the patient feels comfortable confiding in us if a new sexual concern presents itself. I ask a series of questions scattered through the history:

- Do you have sex with men, women, or both? (Remember, it's what a person does—*not* how she or he identifies—that impacts risk.)
- Are you partnered? If yes, do you have sex with anyone besides your partner? (Remember, romantic partnerships can be between two men, two women, or man and a woman. Some people also use the term "marriage" to describe relationships that involve more than one partner.)
- Any sexual concerns? (Just three words that I believe should be part of any review of systems.)
- Do you have medical questions about any of the sexual activities in which you engage or want to engage?
- Is there anything else you want me to know about your sexual interests that will help me give you the best care possible? (It is also important to ask patients a similar question about gender.)
- Would you like me to test you for sexually transmitted infections today? (You need to clarify which orifices need to swabbed for gonorrhea and chlamydia.)

Aside from eliciting information, all these questions let the patient know that you are open to discussing and treating sexual concerns. Patients sometimes want to talk about sex but are uneasy discussing all the "gory" details. Here is a technique that promotes openness when a patient indicates reticence. It also can be used to broach "alternative" sexual behaviors or lifestyles: "I do not need to know the specifics about what you do sexually, but are you having the type of sex that you want to have? If not, could you have that type of sex with your partner? Is the problem related to your partner specifically, or would it be a problem with all partners?" Talking about problems abstractly and seeing how you handle the information builds trust to discuss specifics.

The theme of this issue of *Virtual Mentor* is "validating sexual norms." For me, that raises the question: *should* physicians be validating sexual norms and on what basis? Probably the most common sexual question that physicians and sex therapists hear is, "Am I normal?" but normal has many meanings. It can be statistical, but blond hair is statistically abnormal. It can be natural, but if it occurs in nature it is natural. "Usual" is misleading; most individuals that we think of as sexually unusual respond to the usual stimuli as well. Normal can imply "healthy," but there are no data to suggest atypical sexual interests are per se unhealthy [4]. The concept of "normal" also varies across groups or subcultures.

Without an evidence basis, are we acting as professionals or just promulgating our personal biases? There are a great many "normal" heterosexuals who experience a variety of sexual and relationship problems. A great many people who do not fit the

sexual norm do not suffer from these problems. Do not make the assumption that a problem is due to the individual's unusual sexual interests. Individuals with problems seek us out; those without problems do not. Correlation is not causation.

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