CENTERVIEW
THE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER
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Dr. Gay in the lab

FUNCTIONAL CURE

Pediatric HIV specialist helps rid Mississippi toddler of dreaded virus

By Jack Mazurak

In the middle of a global media tornado of interest surrounding Dr. Hannah Gay's functional curing of an HIV-infected child, the quiet, thoughtful Mississippi pediatrician never faltered.

Under TV studio lights and in front of lens after lens, she answered questions pleasantly, spoke in smooth, matter-of-fact tones and gave answers that were as thorough as they were concise.

The storm of interview requests from local, national and international media hit in early March after Gay and her two collaborators discussed their findings in the Mississippi-born infant's case during a major infectious diseases conference in Atlanta.

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RESPONDING TO ABUSE

Family medicine physicians expand treatment scope of domestic violence victims in Mississippi

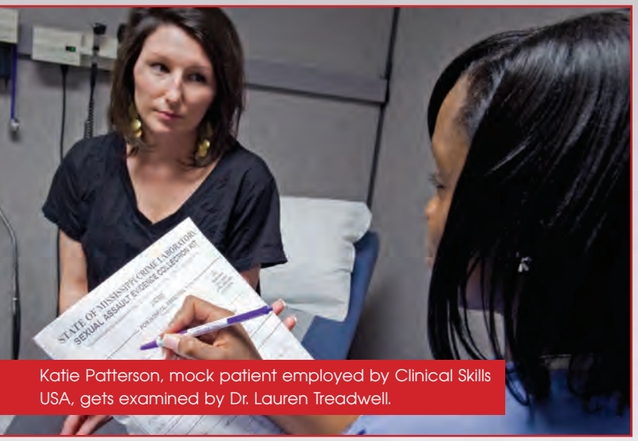
By Gary Pettus

She didn't break away from her boyfriend until after he broke her teeth, pulled her hair and forced her into his car, where he kept a gun.

Even after she escaped from him that night, Nicole Hanks wouldn't admit the truth about her busted mouth.

"It was the first time in my life when I didn't know if I was going to live or die," she said. "But I told my friends I fell on the concrete."

Hanks is one of many victims of domestic and sexual abuse who have been beaten into a passive pattern of lies or silence – an enduring problem faced by physicians and other health-care providers who are otherwise in a position to help them.



Katie Patterson, mock patient employed by Clinical Skills USA, gets examined by Dr. Lauren Treadwell.

Sifting through their terror should be an important part of every physician's work, or so advise several professional medical organizations – counsel that Dr. Diane Beebe takes to heart.

"Our job is to find it before it's on the news, before they're shot," said Beebe, chair of the Department of Family Medicine at the University of Mississippi Medical Center. "But we don't do this routinely, or very well."

Beebe has performed her own research on domestic abuse, which includes psychological cruelty.

"Some older studies show that physicians identify less than 10 percent of battered women," she said.

Beebe has delivered numerous talks about domestic abuse and has helped promote relevant training for nurses, ER workers, EMTs, police officers and others.

Her commitment to finding help for victims grew from this disheartening realization: "That this was a pervasive problem often underreported," she said.

This is part of what is reported: During one 24-hour period in September 2011, 281 Mississippians sought help from 10 local domestic violence programs. Most sought refuge in emergency shelters or traditional housing.

That day, more than 90 appealed to the domestic abuse hotline.

Because poverty is an underlying cause of violence, and this is one of the country's poorest states, "the bottom line is that Mississippi has a huge child abuse problem and a huge domestic abuse problem," said Dr. Scott Benton, medical director of the Children's Justice Center.

Locally, the Pearl-based Mississippi Center for Domestic Violence, which serves a 10-county area that includes Hinds, averages 500 crisis calls each year.

"Last year, the total was 612; the year before, it was 594," said Sandy Middleton, the center's director.

"We often get referrals from emergency room physicians and social workers."

Some are men, although women are the predominant victims.

"Domestic violence for an adult is different from child abuse, though," Middleton said. "When a child is a victim of violence or sexual assault, then doctors, nurses, social workers and others have a duty to report it.

"For the adult victim, it's up to (him or) her to report it."

For her part, Hanks never reported it to anyone. She was afraid, she said. The only medical attention she sought was from a dentist to repair her chipped teeth.

But when she saw doctors for other issues, she said none ever mentioned domestic abuse to her. One could only imagine the stories she could have told them: about slashed tires, stolen money, damage to her body and self-worth.

"He wanted to control who I was with, how long I was with them, what we were doing when I was with them," Hanks said. "When people bring you down long enough, you start to believe you're no good. You start thinking that violence is the norm. That it's your fault because you made him mad.

"I was a victim at a very young age and still in some ways am affected by it."

She was 19 when it started, 21 when it stopped. She's now 32.

"Finally, one day, a bomb went off in my head: 'Get with it, girl. This is not normal. If I don't get out of this, where will I be a year from now?' I knew I didn't want to be there.

"I finally told him, 'I am better than you.' And I think any woman is better than that."

Unlike Hanks, many victims don't get wise in time. That's why it's crucial for physicians and others to uncover abuse, Beebe said.

The Journal of Family Practice and the American Congress of Obstetricians and Gynecologists are among the publications and organizations that concur: Physicians should routinely screen women for domestic violence, they say.

Jumping on board in January was the U.S. Preventive Services Task Force, updating its guidance to read: "All women of childbearing age should be screened for abuse, and physicians should help victims find intervention services, such as a shelter."

"Domestic violence is broader than women of child-bearing age," Beebe said. "It's a good start, though. Domestic violence with your partner doesn't usually start at age 70.

"To recognize that this problem is so big that we should ask women about their relationships is a step forward."

But it's a tricky one.

"There's so much to do in a short time, during an office visit," Beebe said. "There's also the time the physician may spend in court because of legal ramifications.

"And there is a lack of training on how to approach a patient about it, and what to do if the abuse is confirmed."

Many physicians feel "powerless" to deal with the problem, Benton said.

"A person who walks in your office with an issue of domestic violence requires a lot more resources than the typical earache or sore throat."

As do those who have suffered a sexual assault, a closely related issue tackled in February by family medicine residents at UMMC.

At the bidding of Dr. Shannon Pittman, Department of Family Medicine residency director, the residents underwent four hours of sexual assault response training offered by the Georgia-based Clinical Skills USA (CSUSA).

"Physical violence and sexual violence are now considered the same thing," said Isle Polonko, director of the Gynecological Teaching Associate Program at the University of Medicine and Dentistry at the New Jersey Medical School, who works with CSUSA in staging sexual assault-response training. "It's about power and control; it's not about sex.

"Sexual assault also happens in families. Kids who come from homes where there is spousal abuse are 1,500 times more likely to be victims of child abuse in the same home, compared to the national average. Women who are victims of domestic violence are more likely to abuse their children."

At the Children's Justice Center, juveniles are the main concern, but adults are also screened for abuse, Benton said.

"If there is violence to the child, there also may be violence to the mother or father," he said. "One of the questions we ask them at the center is, 'Do you feel safe in your own home?'"

By comparison, procedures for dealing with rape victims are more detailed. Dr. Lauren Treadwell, one of the residents who took the sexual assault response training last month, met with a woman portraying a victim, asked her a series of thorough questions and learned how to collect evidence and to document it.

"I feel comfortable now if I had to interview a sexual assault victim," said Treadwell, a third-year family practice resident. "It was very helpful to have that dedicated, focused training,"

As for screening victims of domestic violence specifically, it's "recommended" during medical training, she said.

Students and residents do benefit from lectures on domestic abuse, at least in family medicine, Beebe said. Ob-Gyn students learn how to recognize and manage domestic abuse, as do emergency room personnel, she said.

"I am not sure of other students and specialties, but, overall, physicians do a poor job of identifying victims, particularly if there are no physical signs."

Bruising and attempts to hide it are obvious red flags, she said.

She also looks for certain warnings of emotional abuse in the patient: low self-esteem, depression, eating disorders, frequent no-shows, an overprotective partner during visits.

When alone with the patient, Beebe asks a set of non-threatening questions, such as "Most couples fight from time to time: When you and your partner argue, does it ever turn violent? Are you ever afraid? Has it ever gotten out of hand?"

For Hanks, the answer to each of those questions would have been "yes" 10 years ago. But if a physician had ever posed them, she isn't sure she would have told the truth.

Still, she believes physicians should ask. And she's ready to tell the truth now.

"I want to talk about it," she said, "because a lot of people like me have dreams, and they're taken from them. I would like to tell victims some real-life stories of people I know who overcame this. And I'd like to show them pictures of those who didn't get the chance to see what the next year would be like.

"My message is, 'What you're going through is not normal.' And I'd like to paint a beautiful picture of what is normal."

Treadwell speaks with a patient

DOMESTIC VIOLENCE CENSUS – Mississippi

Sept. 15, 2011

Victims: 281

Adults: 141

Children: 140

Hotline calls: 92 (nearly four per hour)

Source: National Network to End Domestic Violence: 2011 National Census of Domestic Violence Services

APPROACHING VICTIMS

Ask: Develop a set of non-threatening questions.

Reassure: Tell the patient it's OK to talk about it, that no one deserves to be abused, that resources are available.

Give info: Physicians can't force people to leave the situation, but they can refer them to the crisis hotline, shelters, counseling and other resources.

Assess the patient's safety: Is it safe for the patient to go home? Are there firearms in the house? If she or he is considering leaving, provide information on how to make a plan and what to take along.

Source: Dr. Diane Beebe, chair of the UMMC Department of Family Medicine

24-HOUR MISSISSIPPI HOTLINE: 1-800-222-8000 (TOLL-FREE)