

Position paper

Domestic violence position paper

Introduction

Domestic violence is defined as the actual or threatened abuse by a current or former domestic partner. The abuse can be physical, sexual, emotional, verbal and/or financial. It is used interchangeably with terms such as intimate partner violence and family violence, which covers violence experienced between familial relations and kinships.

Violence can affect people irrespective of gender, relationship type, socio-economic status, religion, ethnic or cultural background, age or geographic location. In Australia, females are three times more likely to experience at least one incident of physical and/or sexual violence by a current and/or former domestic partner compared to males (17% compared to 6.1%) (1). In New Zealand, 35% of females reported experiencing physical and/or sexual violence in her lifetime (2). Domestic violence homicide events resulted in mostly the death of the female (68% in New Zealand and 79% in Australia) with males being the main aggressors (76% in New Zealand and 80% in Australia) (3,4).

Most victims of domestic violence are repeatedly abused. Among those who have experienced violence from a domestic partner in Australia, 54% of females and 65% of males have experienced more than one incident (5). Furthermore, rates of hospitalisation following assault by a domestic partner were reported to be ten-fold higher in females compared to males (6). Of the domestic violence related homicides, 99% of the deceased female victims had a history of domestic abuse (3).

Some groups are at greater risk of domestic violence. These include females who are Aboriginal, Torres Strait Islander (ATSI) or Māori, young, pregnant, disabled, and/or experiencing financial hardship, or are adults who faced domestic violence as children (5). The prevalence of domestic violence is about two times higher among Māori and Australian Indigenous populations compared to non-Māori and non-Indigenous groups (5,7).

Domestic violence is a major contributing risk factor to mental and physical ill health, and homelessness (5). It contributes to the highest burden of disease in females aged 25 to 44 years (higher than other well known risk factors such as smoking or alcohol). Among Māori and ATSI populations, domestic violence is estimated to contribute five times more to the burden of disease compared to the non-Indigenous (8).

In many cases, healthcare providers are the first professional contacts for victims of domestic violence. As most incidents of domestic violence go unreported in healthcare settings it is not possible to measure the true extent of the problem. Barriers to disclosure generally relate to the perceived inappropriateness of the setting; time constraints; lack of a specific line of questioning when treating patients; and the attitudes and training needs of health professionals (9).

Keywords

Domestic violence; abuse; trauma; non-lethal strangulation; victim support; perpetrator

Clinical indicators of domestic violence

While general practitioners are more likely to see the chronic and insidious side of domestic violence, practitioners in emergency and hospital settings are more likely to treat acute trauma and more severe injuries. Surgeons and Trainees, especially those specialising in

trauma, general surgery, otolaryngology head and neck, orthopaedics, vascular, obstetrics and gynaecology and neurosurgery, plastic and reconstructive, oral and maxillofacial, and dentists are best placed to assess the patient's risk of serious harm to life. They therefore are a key bridge between a victim whose life is at risk and support services such as police, legal authorities and the social support system.

Table 1. Potential presentations of domestic violence observed on victims.

Physical		Psychological
<ul style="list-style-type: none"> • Lacerations, abrasions and bruising • Injuries to the head (eyes and ear) and neck • Brain injury • Perforated ear drums • Fractures and sprains • Loss of consciousness • Genital trauma • Self-harm 	<ul style="list-style-type: none"> • Sexually transmitted infections • Chronic pelvic pain • Chronic abdominal pain • Chronic headaches • Chronic back pain • Numbness and tingling from injuries • Lethargy 	<ul style="list-style-type: none"> • Insomnia • Depression • Suicidal ideation • Anxiety symptoms and panic disorder • Somatiform disorder • Post-traumatic stress disorder • Eating disorders • Drug and alcohol abuse

Link between domestic violence and acquired brain injury

The majority of hospital cases due to domestic violence involve injuries to the head and neck (13,14). These can be sustained through assault by bodily force or by using blunt or sharp objects. Analysis of hospital data for all domestic violence related attendances found that around 40% of victims admitted had sustained a brain injury (15). However a review found that more than 80% of female victims who attended hospital had facial injuries, highlighting that traumatic brain injury is often overlooked and seldom diagnosed (16). Brain injuries can develop over time and are often cumulative as a result of multiple assaults to the head which can lead to significant disability (15). Mild brain injuries and concussions can be difficult to detect by CT and MRI scans, but are identified by symptoms, cognitive testing and history of physical trauma (16–18).

Non-lethal strangulation using either hands or objects is commonly used by perpetrators as a symbol of their power and control over the victim. Around 30% of female victims have experienced domestic violence assaults involving strangulation (19). Stable appearing victims often present no obvious external marks on the skin, though a history of strangulation is considered a high risk of future fatality. As a consequence of strangulation, victims can develop serious brain injuries in the weeks after the assault due to deprivation of oxygen to the brain (17,19–21). Victims who report a loss of bowel or bladder function when being strangled may have high risk of severe co-existing brain injury (18). It has been reported that some victims die in the following days with few symptoms (22). It is recommended that victims with suspected brain injuries be referred to brain injury units (18).

Delivery of care to a victim of domestic violence – screening and risk assessment

It takes significant courage for victims to disclose and seek support from their predicament. Victims often find it easier to seek help from medical practitioners due to the relationship of trust, compared to others such as the police. While there are varied opinions on universal screening for domestic violence or targeted screening of at-risk groups in healthcare settings, the treating practitioner should be extra vigilant when assessing a patient with injuries that may have been inflicted from domestic abuse (23). Treating practitioners should be sensitive that from a victim's point of view, any disclosure made has to be balanced against the risk of further threat to their safety and the safety of any children, if their perpetrator found out about such a disclosure. This may happen even if disclosure starts a cascade of system action that, though well intentioned, in the end fails to adequately protect the victim and their children.

Table 2 lists a number of effective questions that can be used to screen (11).

Table 2. Questions and statements to make if you suspect domestic violence.

<ul style="list-style-type: none"> • Have you ever been physically threatened or hurt by your partner? • Do you have a tense relationship with your partner? How are arguments resolved? • Sometimes partners react strongly in arguments and use physical force. Is this happening to you? 	<ul style="list-style-type: none"> • Are you afraid of your partner? Have you ever been afraid of any partner? • Have you ever felt unsafe in the past? • Violence is very common in the home. I ask a lot of my patients about abuse because no one should have to live in fear of their partners.
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Surgeons and Trainees should approach the matter in a non-judgemental manner displaying respect and confidentiality, validating the victim’s disclosure (14). The role of the treating practitioner is to not only care for the immediate injury, but also to sensitively provide information and identify resources in their hospital and in the wider community which can support victims.

However there may be instances where the patient will choose not to accept it nor take immediate action.

Following disclosure of domestic abuse, practitioners should inquire about the safety of the victim. Risk assessments of their safety can be carried out by asking questions listed in Table 3 (11,21,24,25).

Table 3. Questions and statements to assess the immediate safety of the victim of domestic violence.

<ul style="list-style-type: none"> • Does the patient feel safe to go home today? • What does the patient need in order to feel safe? • Has the patient ever been strangled or ‘choked’? • Has the frequency and severity of violence increased? • Does the perpetrator have a history of alcohol and drug abuse? 	<ul style="list-style-type: none"> • Has the patient ever been beaten while pregnant? • Is the perpetrator obsessive about the victim? • How safe are the children of the patient? • Has the perpetrator ever harmed pets? • Does the perpetrator have access to any lethal weapons? • Has the patient been threatened with a weapon?
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Documentation of domestic violence in the patient’s medical record must be kept confidential. It should include any health complaints, clinical observations of symptoms, behaviours and physical injuries. Practitioners should counsel the patient and refer them to domestic and family violence support services. Organisations that can provide services include 1800Respect, Lifeline Australia, Lifeline New Zealand, Samaritans, National Network of Stopping Violence, Shine and Women’s Refuges (26–30).

Working with a domestic violence perpetrator

Males are the main perpetrators, accounting for 75% of all reported domestic violence cases in Australia, and for 76% in New Zealand (1,3). Becoming a perpetrator can be associated with a number of factors including societal issues (gender-based power); history of childhood abuse; mental or personality disorders; diagnosed with acquired brain injury; drug and alcohol abuse (11,15) or simply a history of bullying and difficulties respecting boundaries.

Separate practitioners should treat the victim and the perpetrator. This is recommended because it minimises any risk and conflict associated with counselling both individuals and the potential to inadvertently disclose medical information (11).

It is important to not generalise and present negative attitudes when dealing with a perpetrator. Being open to providing support to perpetrators is important in providing successful treatment. Perpetrators can be referred to services such as MensLine Australia, No to Violence, Shine and Man Alive for further counselling (30–33), though

some perpetrators may never access help, display insight or remorse of their actions.

When a colleague is suspected of being or is known as a perpetrator, it is important that their behaviour does not harm patient outcomes. Should their behaviour jeopardise public and patient safety, this conduct could trigger mandatory reporting. It is important that RACS collaborates with key stakeholders to support new initiatives and laws addressing this issue as they change in Australia and New Zealand.

Fellows working under the duress of domestic violence

Fellows and Trainees who manage the lives of others may be doing so under stress of their own experience of domestic violence in the workplace. Various scenarios raised by Fellows include:

- A female Trainee victim works at the same hospital as her perpetrator. She fears that reporting her matter to the police would only exacerbate her risk of harm. Upon disclosing an illness to her course supervisor, her perpetrator stalks her electronic medical records and threatens to harm her while she is seeking treatment at the hospital.
- A victim (Fellow) develops anxiety and depression due to suffering domestic violence. The perpetrator threatens to report the victim's mental illness to the Medical Board / Council if they leave them. This causes more distress as the Fellow fears loss of their registration if found to be psychologically impaired.
- A victim is unable to fully focus on the care of others as whilst at work she is receiving threats by her perpetrator about harm to her and her children when she gets home. The Fellow/Trainee feels unable to disclose this to her colleagues/supervisor for fear of showing weakness or attracting negative judgement that may adversely impair her professional standing in a male dominated workforce.

Any Fellow and Trainee experiencing domestic violence should be able to work and train in a compassionate supportive environment. This can be underpinned by supervisor and collegial support. The implementation of a domestic violence awareness policy is essential for acknowledgement of the issue and to remove the stigma and shame of being a victim. Victims should have access to psychological support through Employee Assistance Programs at their workplaces (34). Institutions should introduce a mandated entitlement to family violence workplace leave (35,36).

Educational programs for medical practitioners

It has been recommended by the 2016 Australian Royal Commission into Family Violence that workforce training in family violence should be a mandatory component of registration (14). RACS has been actively raising awareness of domestic violence and its key issues with past position papers. More recently, RACS has been targeting unacceptable behaviour through its Building Respect, Improving Patient Safety and Operating with Respect practical initiatives (37). RACS is working closely with universities and other institutions to introduce education at undergraduate and postgraduate levels, though as yet there is no dedicated educational platform in the surgical training program specific to domestic violence.

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