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Addressing domestic violence: the surgeon's role

Introduction

Domestic violence is one of the most urgent social and public health issues of our time. People of all walks of life are affected by domestic violence, irrespective of gender, postcode, demographic, creed or ethnicity. 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.

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 past domestic partner compared to males (17% compared to 6.1%).[1] In New Zealand, 35% of females have reported experiencing physical and/or sexual violence in their lifetime.[2] Females are more likely to die during a domestic violence related assault (68% in New Zealand and 79% in Australia) with the man being the main perpetrator (76% in New Zealand and 80% in Australia).[3,4] Certain communities are at greater risk of domestic violence. These include females who are Aboriginal, Torres Strait Islander or Māori, young, pregnant, disabled and/or experiencing financial hardship, or are adults who faced domestic violence as children.[5,6]

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 25–44 years (higher than other well-known risk factors such as smoking or alcohol). Among Māori and Aboriginal, Torres Strait Islander populations, domestic violence is estimated to contribute five times more to the burden of disease compared to the non-Indigenous.[7]

Healthcare providers are often the first professional point of contact 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.[8]

Clinical signs associated with domestic violence

While general practitioners are more likely to see the chronic and insidious side of domestic violence, health practitioners in emergency and hospital settings are more likely to treat acute trauma and more severe injuries. Surgeons, especially those specializing in trauma, general surgery, otolaryngology head and neck, orthopaedics, vascular, obstetrics and gynaecology, neurosurgery, plastic and reconstructive, oral and maxillofacial 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.

Injuries may be physical or psychological.[9–11] Some of the common physical injuries may include but not limited to injuries of head (eyes and ear) and neck, brain injury, perforated ear drums, fractures and sprains, loss of consciousness, sexually transmitted diseases, genital trauma, chronic pain in the pelvis, abdomen and back, numbness and tingling from injuries, lethargy and self-harm. In addition, victims may display psychological injuries such as depression, suicidal ideation, anxiety symptoms and panic disorder, post-traumatic stress disorder, eating disorder as well as drug and/or alcohol abuse. Treating practitioners should be suspicious when a clinical history relayed by the patient is inconsistent with the injuries sustained, the patient presents repeatedly with changing history on each occasion, a partner who answers the questions for the patient or insists to stay even when asked to leave. Less severe injuries, such as a tympanic membrane perforation or chronic pain, are not likely to be present at hospitals, but they may be observed in an outpatient setting or as a concurrent second injury during a hospital admission. However, given that the head and neck region is often associated with emotion and a more common target area for assault, specific trauma-related injuries or non-specific complaints are often observed in victims at outpatient clinics. Signs of chronic pain and depression are more prevalent in older victims (over 55 years). Awareness and education of specialists in these areas is necessary such that if an injury in one area of the head and neck is identified, then a more thorough examination must be conducted of other areas of the head and neck to assess for other injuries even if it is not related to the immediate trauma. Due to the repeated and chronic nature of violence, it is possible that the victim may not remember or even report injuries not related to the immediate presentation.

Prominence of acquired brain injury in domestic violence victims

The majority of hospitalisations from domestic violence involve injuries to the head and neck.[12,13] 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.[14] 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.[15]

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.[14] Mild brain injuries and concussions can be difficult to detect by computed tomography and magnetic resonance imaging scans, but are identified by symptoms, cognitive testing and history of physical trauma.[15–17]

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.[18] Stable appearing victims often present no obvious external marks on the skin, though a history of strangulation is considered high risk marker 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.[16,18–20] Victims who report a loss of bowel or bladder function when being strangled may have high risk of severe co-existing brain injury.[17] It has been reported that some victims die in the following days with few symptoms.[21] It is recommended that victims with suspected brain injuries be referred to brain injury units.[17]

Fellows working under the duress of domestic violence

Surgeons and trainees who manage the lives of others may do so under stress of their own experience of domestic violence in the workplace. Any surgeon or 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. Surgery continues to be a male dominated and highly competitive profession. Factors preventing disclosure of violence may include a fear of shame, fear of being labelled with a psychological disability such as depression, fear of being considered a burden on the team or fear of negative impact on career progression. Further, a perpetrator may even use these fears and potential negative impact on career as a tool to further control and abuse of the victim. A victim or their children may also be under duress whilst at work and these risks maybe increased if the perpetrator is also employed at the same hospital. All of these aspects can have further negative impact on performance and patient care. 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, especially as a safe and respectful workplace is correlated with better outcomes for patients.

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. Culturally diverse and older victims are unlikely to disclose abuse because of the cultural and societal mindset that domestic violence is a private matter. 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.[22] 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. While mandatory reporting does not extend to victim's self-report of violence, it does apply to 'at risk' children. Therefore, clinicians must be respectful that the victim may further not

Table 1 Questions and statements to make if you suspect domestic violence

- Do you have a tense relationship with your partner? How are arguments resolved?
- Is your partner controlling of you? Is this controlling behaviour becoming more frequent?
- Sometimes partners react strongly in arguments and use physical force. Is this happening to you?
- 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.
    - Has your partner ever done things to you, of a sexual nature, that made you feel bad or physically hurt you?
    - Do you have any pets? Has your partner ever threatened to or harmed or killed a pet?
    - Have you ever been physically threatened or hurt by your partner? Has your partner ever threatened to hurt you with or used a weapon? What objects and where did you have the injury?
        - Has your partner ever pushed, choked, strangled, suffocated you or tried to do any of these things to you?
        - Has your partner ever threatened to kill you? Do you have an escape plan?
            - What other injuries have you sustained during previous assault? Have you had any injuries to your head, neck, abdomen, limbs? Have you ever wet yourself during an assault or lost consciousness? Have you ever had a hoarse voice or lost hearing after an assault?
    - Do you have any children? Has your partner ever threatened to harm the children?
    - Do you have any support? Family or friends who could support you when you feel unsafe? Do you have access to your finances?
        - Have you ever sought help from the police? Have you ever applied for an Apprehended Violence order (AVO)? Has your partner ever been served with or breached an AVO? Is there a current AVO in place to protect you or your children?

Table 2 Questions and statements to assess the immediate safety of the victim of domestic violence

- 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 drugs abuse?
- 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?

disclose violence for fear of losing care of children, if the children were classified 'at risk' due to exposure to the violence. If violence is suspected, clinicians should develop strategies to take a history and examine the patient away from the perpetrator who may insist of being present at the clinical assessment. Therefore, documentation alone of the violence maybe the only action that is necessary to be taken in some cases, so at least during repeat presentation, appropriate risk assessment can be made without repeated need of disclosure. Table 1 lists some questions that can be used to screen.[10]

Surgeons and trainees should approach the matter in a non-judgemental manner displaying respect and confidentiality, validating the victim's disclosure.[13] 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. If suspicious, the treating practitioner should respectfully probe and prioritize their safety and confidentiality. However, there may be instances where the patient will choose not to accept it nor take immediate action.

Following the 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 2.[10,20,23,24]

The 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. Organizations that can provide services include 1800Respect, Lifeline Australia, Lifeline New Zealand, Samaritans, National Network of Stopping Violence, Shine and Women's Refuges.

It has been recommended by the 2016 Victorian Royal Commission into Family Violence that workforce training in family violence should be a mandatory component of registration.[13] Royal Australasian College of Surgeons (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.[25]

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Conflict of interest

ET is an employee of the RACS; PM is Chair Elect of the RACS NSW State Committee.

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