PART 3 I ETHICS AND COVID-19

Domestic Violence During Quarantine: A Family Physician Challenges

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The world health organization (WHO) defined violence as "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal development, or deprivation.[1] Violence can be classified as Self-directed violence, Interpersonal violence and Collective violence.[2]

Domestic Violence (DV) is a common world problem. It is part of interpersonal violence which include a range of abuse and violence occurring within a domestic context in any form including, child, gender based, women and elderly abuse and neglect.[1] Figure (1)

Intimate Partner Violence (IPV) represents a serious, highly prevalent, and preventable public health problem worldwide.[3] The most common forms of domestic violence and abuse include physical, sexual and psychological abuse (WHO, 2002); however, it can also present as financial, social abuse and coercive control.[4] Globally, 30% of women experience physical or sexual violence by an intimate partner in their lifetime (World Health Organization, 2017).[5-7]

Identified risk indicators for IPV include lower socioeconomic status, inadequate social supports, low education level, substance abuse, mental illness, younger age, unintended pregnancy, financial dependency and employment status,[4] the risk factors can be categorized as following:

- Individual Risk Factors: (Low self-esteem, Low income , unemployment, Low academic achievement/low verbal IQ, Young age, Aggressive or delinquent behaviour as a youth, Heavy alcohol and drug use, Depression and suicide attempts, Anger and hostility, History of being physically abusive).[6]

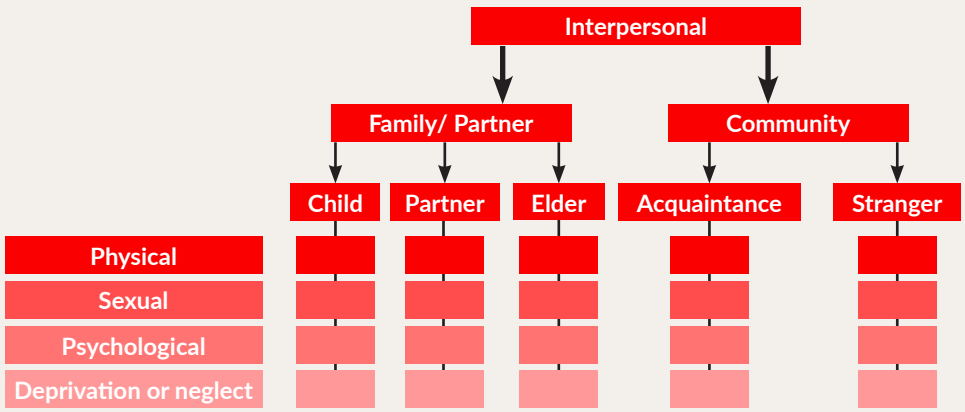

Figure 1 | Typology of Interpersonal violence according to WHO[1]

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- Relationship Factors: (Marital conflict–fights, tension, and other struggles, Economic stress, Witnessing IPV between parents as a child, History of experiencing poor parenting as a child).[7]
- Community Factors: Poverty and associated factors (for example, overcrowding, high unemployment rates, Poor neighborhood support, High density of places that sell alcohol, Weak community sanctions against IPV).[6,7]
- Societal Factors: (Traditional gender norms and gender, Cultural norms that support aggression toward others, societal income inequality, Weak health, educational, economic, and social policies/laws.[6]

Intimate partner (physical, sexual and emotional) and sexual violence cause serious short- and long-term physical, mental, sexual and reproductive health problems for women. They also affect their children "silent victims"., and lead to high social and economic costs for women, their families and societies. [3,7,8] A Global estimates published by WHO indicate that about 1 in 3 of women worldwide have experienced either physical and/or sexual intimate partner violence or non-partner sexual violence in their lifetime.[7] According to Iraq Women Integrated Social and Health Survey (I-WISH) (2011); Iraqi women were victims of VAW during the past year in different places and by different people. About 46 percent of girls 10-14 years were exposed to violence at least once by a family member (father, mother, brother, sister) during the month preceded the survey. Furthermore, about 36% of currently married women were exposed at least to one of psychological/moral/emotional violence from husbands (e.g.preventing socialization, controlling movement, ignoring, not providing enough money, anger if talked to other man, etc), 23 percent to verbal violence (e.g insults, humiliation, intimidation, etc), while about 6 percent to physical violence (e.g. beating, pushing, etc).[9]

Domestic violence prevalence can be molded by social, economic, and cultural backgrounds, but it is nonetheless extended to all demographic groups. The same can be said about gender and sexuality, but women in heterosexual relationships appear to represent the overwhelming majority of victims.[3]

Data suggested that the incidence and prevalence of violence against women tends to increase in any stressful event or emergency whether it is natural disaster, humanitarian crises.[5,3] Since the outbreak of COVID-19, Emerging data shows that reports of intimate partner violence (IPV) have increased worldwide as a result of mandatory "lockdowns" to curb the spread of the virus.[10]

The COVID 19 pandemic has certainly caused a lot of stress, economic difficulties, and disruption in social networks and to normal life. It also isolated people and affected their ability to move freely and access support which in turn exacerbated the risk for those experiencing violence.[5]

By understanding the dynamics of a violent relationship and the factors associated with IPV, we can also understand how Covid-19 can exacerbate those factors leading to an escalation of violence and even new types of abusive behaviour.[11-13]

Research and evidence have shown that family violence can become more frequent and severe during periods of emergency.[14] The current pandemic has provoked a crisis mentality in much of society including the Iraqi society, both men and women have been thrust into traditional roles. As a result, the pressure on Iraqi women is enormous. There is effectively a double expectation: women must tend to all the family requirements and care for all household details while simultaneously maintaining their professional roles from home.[15]

Public health and community containment measures introduced to reduce the spread of COVID-19 such as 'social distancing' and self-isolation, as well as increased financial insecurity.[4] Moreover, the availability and access to specialized services may be compromised or considerably changed but times of stress and hardship are never an excuse for violence and all people deserve to live free from fear and family violence.[3, 14]

There are a growing number of well-de-

signed studies looking at the effectiveness of prevention and response programmes of violence. More resources are needed to strengthen the prevention of and response to IPV, including primary prevention – stopping it from happening in the first place.[16-20]

These 7 strategies (RESPECT) are effective for preventing violence against women:[21,22]

R –relationship skills strengthened

E –empowerment of women

S –services ensured

P –poverty reduced

E –environments made safe

C –child and adolescent abuse prevented

T –transformed attitudes, beliefs, and norms.

Many preventive strategies to prevent the spread of the COVID 19 virus had been applied including self-isolation, social distancing, and lockdown. These measures challenging health professionals including doctors, nurses, midwives, and other frontline practitioners and family physicians to manage domestic violence situations during the pandemic.[3]

Health care providers, although facing the need to learn many new skills related to COVID-19, they need to be trained to be able to assess risk in remote and face to face consultations to ensure provision of appropriate and compassionate care.[5] Must also maintain awareness of domestic violence, seek opportunities for self-education, develop strategies for discussing IPV and become familiar with currently available local resources for patient referral.[4, 5, 14]

In usual circumstances the health professional involved in primary care, plays a vital role in recognizing and identifying cases of family violence and abuse.[23] They must deal with acute presentations and chronic sequelae of domestic violence.[24]

Health care providers are usually the first professionals to offer care because a medical appointment has long been considered a private setting in which a patient could safely disclose violence and abuse.[16]

Family physicians provide an essential service and are generally accessible to survivors of domestic violence. They are in a unique position to be able to ask about violence, validate survivors, assess survivors' safety and support survivors during this difficult time.[25]

In usual clinical setting when doctor and patient are in face to face encounter, a high index of suspicion during history taking, and recognizing the common signs of abuse are necessary.[23] Moreover, evaluating injury patterns, understanding factors that increase the risk for violence and making use of specific interview questions and techniques will aid family physicians in the difficult task of assessing and managing patients living in abusive partnerships.[24] Once a case of abuse is identified and the victim has made disclosure, the family physicians needs to know how to respond. He must acknowledge the disclosure, as it is a very difficult step for the victim, and provide support and assurance in a conducive environment.[23]

It is critical for the family physicians to exercise caution in detecting a suspected child abuse case. Children who are vulnerable to abuse, would require the necessary professional intervention and assistance to protect their interests.[23, 24] Detailed medical record-keeping with a focus on patient safety is critical. The family physicians must then make use of his available resources and know when to refer the patient to the appropriate agencies.[23]

This role is especially true during the current coronavirus pandemic, when individuals and families are isolated from potential sources of help and support, it makes each of those steps more difficult and need new approaches and tools to provide such services.[5,16]

The United Nations has urged governments to continue combatting IPV in the time of COVID-19, ensuring continued access to legal services, safe shelters and support phone lines for individuals who have experienced IPV . All health care providers must be prepared to address the increase in IPV associated with the COVID-19 pandemic and its aftermath.[4]

Information and communication technologies (ICTs) have great potential to address some

of the challenges faced by both developed and developing countries in providing accessible, cost-effective, high-quality health care services.[26]

Telehealth, e-health, telecare and Telemedicine all are sevives uses ICTs to overcome geographical barriers, and increase access to health care services. They use the remote delivery of healthcare services, including exams and consultations, over the telecommunications.[27]

This is particularly beneficial for rural and underserved communities in developing countries – groups that traditionally suffer from lack of access to health care and when patients can not undertake the normal face to face clinical visits (in-person visit).[26]

The term telehealth is referring to health information services, health care education, and health care services in a broad sense, the term telehealth is an all-encompassing one. In fact, telecare and telemedicine are generally covered within the broader scope of the term telehealth. [27, 28]

Telecare is the term that relates to technology that enables patients to maintain their independence and safety while remaining in their own homes. This technology includes mobile monitoring devices, medical alert systems, and telecommunications technology like computers and telephones. Continuous remote monitoring of patients enables telecare to track lifestyle changes over time as well as receiving alerts relating to real-time emergencies. [28]

Telemedicine refers to the use of information technologies and electronic communications to patients at distance. This remote clinical services ranged from the exchange of valid information for diagnosis, treatment and prevention of disease and injuries, research and evaluation, and to the continuing education of health care providers, all in the interests of advancing the health of individuals and their communities.[26, 27, 29]

During a telehealth visit, the patient and physician use phone calls, video chats, emails, and text messages.. Because no physical exam is possible, telehealth is most appropriate for patients who need routine follow-ups with their providers.[27]

However, telemedicine affords continued medical care while adhering to strict social distancing the online conversations will also minimise the need of patients coming to hospital, thus minimising the spread of infection.[30]

Family physicians in most centres in the country have provided dedicated numbers or other means through which they could be reached by patients. They then identify those who need to come to the hospital. Telephonic appointments have also eliminated overcrowded waiting areas as patients are told when they are required to come. Over 60% of patients would be able to carry out telephonic consultations with their FPs.[30, 31]

Telemedicine does not necessarily replace the in-person visit; it could be an addition to the in-person visit, but it is important to let the patient that such a service is available and could replace a normal clinical visits in an emergency situations like in case of corona epidemic.[32]

Preparation of the setting of an appropriate telemedicine follow-ups visit is one of the challenges that face the family physicians to detect domestic violence during the quarantine or lockdown. During isolation at home, phone or videoconference follow-up with patients often occurs in an environment where the perpetrator of violence is also present.[4] The possibility that some survivors will not be able to disclose during telephone or video calls, as they may be monitored by their abusers. For a family physician or GP, it is difficult to tell exactly who is on the other end of a call.[27,33]

On the other hand using distance consultations in place of face-to-face consultations, making it more difficult for doctors and nurses to ask about abuse and patients to disclose due to lack privacy.[11] The health care provider needs to gauge if the patient is in a private space or is within earshot of others. That's important not just for intimate partner violence screening, but also for asking about health concerns in general since these discussions are best done in private.[27,16, 33]

It is still crucial that primary care clinicians continue to ask about domestic violence, but telehealth may require this to be done in a new way.[11] During telehealth appointments, it is beneficial to use closed questions in order to determine the safety of the discussion. Questions such as, 'Are you alone?' and, 'Is it safe for me to ask about how you are going?' allow survivors to answer yes or no in case their conversation is being monitored.[25]

Safety planning may also change in the context of COVID-19. Survivors may find that their current plans are not able to be enacted because of changes in social supports. Family physicians or GPs should enquire as to the safest time to organize follow-up and may use safe words with survivors or, for example, the wearing of a certain colour of clothing as a signal that a survivor is concerned about their risk.[14]

In some circumstances, when assessing patients virtually, if there is still concern for the survivor's safety, watch for nonverbal signs such as bruises, and changes in behavior such as substance use or requests for testing it may be advisable to offer patients appropriate in-person visits to the clinic or hospital for follow-up to make an excuse for the survivor to their household.[16] It is still possible, however, to give general advice via telehealth about supports even if the survivor is unable to talk at present and assist survivors by referring them directly to local services with updated inventory of local resources including channels and means of offering support during Covid-19 is also essential.[16, 25]

In the era of telemedicine, confidentiality cannot always be assured. Phone calls and video chats are not necessarily private, and a victim of domestic violence may not be able to voice their concerns from home, within presence of their abuser.[16]

Support organizations now give preference to contacts not in-person like phone calls or email. Even when access is not a problem, when living with the perpetrator of violence, calling for help may not be that easy.[3]

Calls to support lines or health care services can be controlled and overheard by the perpetrator, or victims forced by the perpetrator to allow them access to their email and other online accounts, compromising their capability to look for help either to formal support services or even to friends and family members.[3, 34]

Regarding screening for intimate partner violence, technology provides another way to address these new challenges during the pandemic. Patient self-administered or computerized screenings are as effective for disclosing intimate partner violence as talking with a clinician.[3] Patients can complete this online form on their phones or other devices to safely and confidentially report threatening situations while in the bathroom. Patients are instructed to close the online form once it is complete, and it is designed so no text message or other electronic trail is left on the patient's phone.[16]

Recurring to friends and family for support may be seen as undesirable by the victims that fear to possibly infect those close to them.[3]

Shelters generally provide home and isolated place for victims of violence however these places could be affected by the pandemic of covid 19 as many victims may refuse to use these services for fear of catching the virus.[13] This same fear can be extended to seeking health care in the context of abuse, and victims may feel that they should not put more strain on an already overwhelmed health system. Furthermore, many support organizations are financed by donations, which can diminish during a period of predictable economic recession.[3]

Among safety measures advised to patient to take at home is to use adequate planning to minimize harm in the event of violence in the household and keep a telephone always charged. Asking for help from a close relative, friend or neighbour is important. The victim can keep some items and important documents packed in case he/she needs to leave the home under emergency circumstances.[34]

Health care professionals and institutions can make use of online services and social media to disseminate essential available services (hotlines, shelters, legal counselors, and other IPV specialized services). This information can

be disguised among other Covid-19 information so that patients can access it without raising suspicions about what they are genuinely looking for.[3]

However the GP should not encourage the victim to leave the spouse immediately (unless he/she is in imminent danger), as this could lead to problems or even increase the danger. Evidence suggests that women are at high risk of injury or even death when they leave their violent partners. Assess if there is any immediate danger and provide support, and refer her to the necessary agencies.[34, 35]

COMPREHENSION QUESTIONS[36,37]

CASE (1): A 42-year-old woman presents to your office for evaluation of chronic abdominal pain. She has seen you multiple times for this complaint, but the workup has always been negative. On examination, her abdomen is soft and there are no peritoneal signs. She has no rash, but does have a purpuric lesion lateral to her left orbit.

Which of the following is the best next step in management?

A. Ask the patient about physical abuse and report suspicions to the local police.
B. Ask the patient about physical abuse and provide information about local support services.
C. Exclude a bleeding diathesis before inquiring about abuse.
D. Order an abdominal x-ray.
E. Refer to psychiatry.

CASE (2): A 25-year-old woman comes to the office for a new patient visit. Her complaints are 6 months of constant pelvic pain and low back pain, intermittent myalgia, insomnia for "many years," and feeling tired. When you ask about bruises of varying ages on arms, legs, and face, she notes that she is clumsy and bumps into things a lot. Her husband accompanies her to the visit and refuses to leave the room for the physical examination.

On pelvic examination, purulent cervical discharge is noted, along with cervical motion tenderness. Her husband inquires as to why you are using so many tubes for laboratory specimens.

Which of the following is not a common presenting symptom or complaint in a victim of IPV?

A. Back pain
B. Abdominal pain
C. Headache
D. Dyspareunia
E. IPV itself

CASE (3): A 31-year-old woman with 6 years of education post-high school presents at the emergency department with bruises, severe pain in the left forearm,and symptoms of depression. When the emergency department calls you regarding the patient's presence, you recall that she has had three appointments on your calendar but all three had been canceled at the last minute.

Her husband is a laborer and often will not allow her to keep a physician's appointment unless he can accompany her. You indicate you will come in to see the patient. After discussion and examination, you are convinced that this patient is a victim of IPV.

Which of the following statement about screening by primary care physicians is true?

A. It is not necessary for the primary care physicians to screen such patients for IPV.
B. Refer the patient to psychologist with no screening for violence to avoid problems.
C. Referrals to a women's shelter ensure the safety of victims
D. Clinicians should be alert to physical and behavioral signs and symptoms associated with abuse or neglect in all patients and give the necessary support.
E. Try to protect the patient with direct confrontation with her husband without taking her consent.

ANSWERS:

CASE (1): **(The Answer is B)** It is appropriate to discuss your concerns in a non-accusatory,

nonjudgmental way with your patient. Waiting for her to bring up the subject may result in her suffering further abuse. You should offer assistance, evaluate her safety, and provide her with information regarding available services in the area.

CASE (2): **(The Answer is E)** Although injury is a common presenting complaint in the emergency department, physicians often hear complaints of somatic symptoms in the primary care setting. When the patient is a victim of IPV, rarely is the IPV a presenting complaint.

CASE (3): **(The Answer is D)** IPV screening is necessary for such a women of child bearing age with such a medical history, education level, missing visits attendance and husband attitude as she considered at risk for more abuse and neglect in the future.

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