THE CHALLENGE OF INVOLVING MEDICAL DOCTORS AS IMPORTANT FRONTLINE RESPONDERS IN FIGHTING DOMESTIC VIOLENCE

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Abstract
For victims of domestic violence, medical problems in the short-term are injuries and in the long-term health issues such as mental health problems, consequences of untreated sexual transmitted diseases or stress-related health issues evolving from the abuse they've experienced by a partner or any other family member. This inevitably makes victims seek the help of the medical profession sooner or later. The medical profession is therefore an important stakeholder in the group of frontline responders detecting and intervening domestic abuse. Unfortunately, the medical profession is often not an active partner in frontline responder networks based on interviews (n = 296) we conducted in the IMPRODOVA project[1]. In this article, problems cutting medical professionals out of the networks of frontline responders and reasons why they should be integrated are presented. The paper also discusses what needs to be changed in order to better integrate the medical profession in the circle of frontline responders working against domestic violence.

Keywords: *domestic violence, medical profession, domestic violence fighting networks, multi-professionalism, health problems*

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The medical profession and domestic violence

Domestic violence is an immense individual tragedy and social problem that burdens society, economy, government, and individuals (DeRiviere, 2015). Not surprisingly, domestic violence, violence against women, and violence in close relationships is a topic that seems to gain increasing attention.

Although measures are taken at different levels to combat domestic violence, the victims of domestic violence are more likely to talk with friends and relatives than with members of the professional help system about the abuse (WHO, 2005). Thus, one of the most important goals in the fight against domestic violence should be to draw more victims into existing help systems/networks and to have all relevant frontline responder groups (e.g., the police, the medical profession, social work, victim protection shelters, law enforcement, and counselling centres) actively involved at all levels to comprehensively deal with a case.

Networks of various professionals detecting and intervening domestic violence consist of these different frontline responders. This circle of various professionals and agencies tackle domestic violence together, for instance, by organizing frequent meetings discussing single cases or coordinated approaches to fight domestic violence in general or in a special location. A system called Multi-Agency Risk Assessment Conferencing (MARAC) that is implemented in e.g. Scotland, Austria and Slovenia, which aims to identify victims who are at serious risk by combining information from a wide range of partners is a good example for interagency cooperation (Robbins et al., 2014; Robinson & Tregidga, 2007). This type of collaboration enhances the effectiveness of prevention, detection and intervention as the partners in the network learn from each other. Meeting and face to face communicating generates trust between the parties and improves the exchange of information that is particularly important in the assessment of cases with high risks of violence (Chatzifotiou et al., 2014; Vogt, 2020) as already set as standard by the Istanbul Convention (Council of Europe, 2011; Article 7 (2)).

Of the direct costs of domestic violence, medical costs that stem from medical diagnostics and treatment are the highest (De Sousa et al., 2015). This includes costs of treatment, mental health problems (e.g., alcohol and drug dependence, depression, anxiety), increased rate for non-communicable diseases (e.g., cancer, cardiovascular diseases, type 2 diabetes mellitus) and reproductive health problems (e.g. unintended pregnancy, HIV) and other sexually transmitted infections, low birth weight babies and spontaneous abortion (Chandan et al., 2020; De Sousa et al., 2015).

Victims have a choice whether they want to report the incident to the police or speak to a counsellor of an NGO, but when they definitely need help because of injuries or have

long-term health consequences requiring medical treatment, they have to see a physician. In addition, due to other non-domestic violence related health issues (e.g. control appointments at the dentist, diabetes management, skin cancer screening) they do have doctor's appointments more frequently and at this point their physician/dentist might detect signs of domestic violence although it was not intended by the victims. Amongst health professionals, general practitioners, emergency physicians, emergency paramedics, gynaecologists, midwives and nurses as well as dentists (Ellis, et al. 2019) are those potentially encountering victims of domestic violence the most.

Consequently, they are often the first beside friends and family, who either hear about the incident of violence or they are the first ones seeing indicators and symptoms pointing towards a potential incident of domestic violence. Victims who do not report to the police still are in touch with members of the medical profession.

The medical profession is already mentioned in the Istanbul Convention (Council of Europe, 2011; Article 18 (114); Article 20 (127); Article 22 (132); Article 25 (141)) as an important stakeholder. A higher involvement of the medical profession is furthermore highly recommended by authors of different research studies (e.g. Alsaedi et al., 2017; Jenner et al., 2016; Piterman et al., 2015).

In this paper we focus on the question to what extent the professional response to domestic violence of the medical system has been already integrated in help networks in eight European countries and what obstacles and advantages doing so have been reported.

The IMPRODOVA project and its methodology

The IMPRODOVA project[2] is a multidisciplinary research project with partners from eight European Countries that was funded by the European Union and started in May 2018 with a duration of 36 months. In this project, researchers work together with practitioners from different fields aiming to mitigate domestic violence focussing on the work of frontline responders including the police, the medical profession and social services.

Standards are promoted (e.g. Istanbul Convention; Council of Europe, 2011) by international organisations on how to address domestic violence including standards regarding the interorganisational cooperation whilst only little research is done on how good these are integrated in frontline responders' everyday practice. IMPRODOVA therefore used a three-tiered approach addressing this gap: As a first step, existent national and

2 www.improdova.eu

international guidelines, risk assessment tools, training formats and further information were gathered in the different IMPRODOVA countries by robust desk research as an orientation to identify the present regulatory frameworks that shape the response to domestic violence including the status quo of the medical profession. Secondly, 296 standardised interviews with frontline responders from the police, the medical profession and social services were conducted in the eight IMPRODOVA countries Germany, Austria, Hungary, France, Finland, Scotland, Slovenia and Portugal, examining the extent to which standards are converted into practice regarding different aspects including inter-agency cooperation, which actors are involved and how successful multi-professional approaches are. It was decided that two locations per respective country should be examined in addition to a good practice location with a good way of interdisciplinary working. Structured interview themes including cooperation were agreed beforehand. This enabled us to identify the status quo regarding existing help networks. As a final step, we will develop new, implementable solutions for practitioners and policy makers meeting the needs on the ground. See Vogt (2020; in press) for further information about the IMPRODOVA project.

Results

The results reflect the overall situation in all IMPRODOVA countries. The medical profession was in none of the case locations examined a regular partner of a networked response to domestic violence. It was frequently mentioned by other stakeholders that they are not as active as they could be. Their attitude has been described in the interviews as being rather passive and it was frequently mentioned that they only take an active role in reporting domestic violence if they cannot avoid it. General practitioners are seen as not being trained sufficiently in domestic violence. Our research indicates that knowledge about symptoms and signals of domestic violence is limited in the medical sector. In addition, many are also not aware of the network and their important role within the network.

Based on the information conducted from interviews with medical professionals, they often did not feel being sufficiently informed and knowledgeable about services and support available to the victim when they were the first point of contact for victims of domestic violence.

Another major finding after analyses of interviews with various frontline responder groups as part of IMPRODOVA fieldwork was reports of frustration on both sides: non-medical frontline responders in existing help networks and physicians, respectively. One reason which was mentioned was mistrust resulting non-communication on both sides. In interviews conducted, we were also told by non-medical frontline responders that it is very difficult to integrate the medical profession, because they do not participate in trainings

and do not seem to be too interested in domestic violence topics. Therefore, physicians are not invited to be partners in networks by other frontline responders anymore, because they feel that physicians are not coming anyways and that they do not want to be integrated. On the other hand, physicians reported that they are frustrated that victims of domestic violence have the "revolving door syndrome" - coming back repeatedly after new incidents of domestic violence without changing their situation. This may also be related to too little knowledge about the dynamics of domestic violence.

Reasons why they often are not part of help networks

Even though there would be a mutual benefit for the medical profession as well as for members of the network of frontline responders if working closely together, reality often looks quite different. Numerous reasons have been brought forward in the interviews, ranging from diverging professional and organisational interests to conflicting professional and organisational cultures as well as simply a lack of time.

The reasons named in the interviews and issues to be addressed to increase the number of physicians and their level of activity in domestic violence support and service networks can be summarised as follows:

1. Knowledge about domestic violence, symptoms and red flags are often not part of the mandatory curriculum for physicians or at medical school for medical students in most European countries. The topic is not prioritised in the education of midwives, nurses or physiotherapists and psychotherapists.
2. Each profession wants to preserve its autonomy and refuses to be used as a mere "instrument" by another profession. The police and the medical profession, for example, are relatively closed systems that have rather strict internal structures and processes. Both can work and achieve their primary goals without much interaction with other professions. Linking both professions would mean that both have to give up some of their autonomy and self-determination. Collaboration and building trust and reciprocity is often difficult. A better understanding of the other cooperation partners' working methods, prioritisation of tasks and ways of communication is needed. Professional groups also need to understand their own role in the totality of professionals working against domestic violence and helping the victims.
3. Another important aspect is that the victim is, first and foremost, a patient to the physician. The medical profession gives priority to their most valued goal: to restore the health of their patients. Thus, to reach this goal it is not necessary to investigate how the patient was injured, or to interpret the legal implications of the injuries. Physicians do not need to deal with the problem domestic violence behind the physical injuries in order to reach their goal. When they for example need to fix a broken arm, the treatment chosen is not dependent on the cause (car accident or domestic violence). If a patient needs also psychiatric or psychological treatment and care, the

question of domestic violence and abusive relationship could have a more direct bearing on physician's work.

4. Because of the tight schedule of physicians and the shortage of human resources, physicians frequently have second guesses to take further steps like speaking with the victim about domestic violence or even being a part of a broader network of frontline responders helping the victim. Every step in this direction requires more time and attention, which are already in short supply for physicians.
5. Another significant issue concerns the professional confidentiality: The physician can only talk about information regarding a domestic violence incident if the patient gives his/her consent. Otherwise, all information is concealed by the doctor-patient confidentiality and any violation in this area is considered a violation of professional secrecy, which can be sanctioned based on the criminal code. The victim decides whether a physician can share important medical or other information, which can be an important add-on to the information already acquired by other network partners. If the physician cannot talk about the patient, then meeting with other frontline responders could be frustrating for the partners representing the medical profession. They want to help, they know how to help and know who exactly needs that help, but they are not allowed to do so. On the other hand, they have the compulsory duty to inform the police or the youth welfare system when the victim is in self-endangerment or a third party, like a child, is at serious risk. Therefore, they are often in a conflict between secrecy and the need to share information.
6. The work of physicians in the field of domestic violence is not regulated by any kind of specific legal regulation in the locations we examined. Therefore, as a first step, it would be most helpful to draft guidelines and to develop the necessary working processes to facilitate the integration of the medical sector into frontline responder networks. Setting up guidelines and working processes can be time-consuming, which is always an issue for all partners in the network.

Why it would be important to have them involved

Unfortunately, even though many victims of domestic violence consult a physician, domestic violence is seldomly addressed at practice visits to the physician. Physicians too rarely consider themselves as frontline responders to domestic violence based on our findings.

In addition to the opportunity to attract more victims into the help system in general, a number of other points were raised in the interviews:

1. Physicians have an opportunity to identify victims of domestic violence relatively early and establish a contact between the victim and other frontline responders in their network. This would increase the likelihood that victims receive the individual support they need much faster. Although their first duty and most important goal

are to treat injuries resulting from domestic violence, medical staff would have the opportunity to stay in contact with victims afterwards and follow-up their situation. Having medical knowledge and expertise, they could intervene long before victims would make the decision to leave the perpetrator or report the incident to the police.

2. The medical professions' general knowledge about domestic violence-related injuries and long-term adverse effects on health could be included in the training of other frontline responders to domestic violence to raise awareness about health-related topics.
3. In addition, medical professionals could function as contact persons who are experts in health- and domestic violence-specific topics for victims.
4. Being actively part of first line responder networks would train and sensitise physicians about other important non-health related aspects associated with domestic violence. This would improve the awareness of domestic violence in medical and health care settings and no doubt would increase detection rates by physicians and other health care staff.
5. Ensuring that securing of evidence by a physician would be done in such way that it can be used as evidence in court. When other non-medical professionals were the first point of contact, they would be fully aware that they could refer the victim to the physician being part of their network to secure the evidence in a court-proved manner. They would also know that these physicians have a deeper understanding of medical problems associated with domestic violence and could act accordingly.
6. In cases the domestic violence-combating network has enough funding, it could pay a physician being part of their network for the securing of evidence or for treating of injuries and the victim's health insurance would not be informed. Thus, the incident could remain anonymous until the victim is ready to take it forward to court etc. This would also facilitate the anonymous securing of evidence: evidence would be secured and stored for a few years regardless whether the victim feels ready to report the case to the police or not. Evidence could be used later at the court when the case is prosecuted. This possibility is also stipulated by the Istanbul Convention (Council of Europe, 2011; Article 25 (141)). Anonymous securing of evidence is also possible when the victim comes to a general practitioner that offers anonymous securing of evidence and is not part of a network, but it can only stay anonymous if the general practitioner is willing to report a diagnosis and related treatment in such a way that the health insurer does not know that this is related to domestic violence. And the question still remains, who covers the costs for securing and storing of evidence.
7. Last, but not least, involving more physicians in those networks would give domestic violence a new and higher priority in the medical practice, which would certainly benefit victims.

Possible approaches to involve the medical community in interdisciplinary networks

Our recommendations are as follows: it should be mandatory to teach at medical schools major aspects related to domestic violence with a focus on health and how to deal with the cases of domestic violence. Currently this is not included in the mandatory curriculum. Therefore, medical schools and other institutions that train students and medical professionals such as physicians, nurses, etc., need to make domestic violence a high priority topic from the start of their education. First studies show good results regarding the identification of domestic abuse following trainings (e.g. Edwardsen et al. 2011).

Moreover, since different projects and umbrella organisation do provide templates of how to deal with cases of domestic violence, these have to be spread more widely and specifically targeted at the medical profession. The absence of a systematic response to domestic violence in health care services continues to be a serious problem. An early study conducted by McLeer & Anwar (1989) already indicated that protocols enhance the identification of female victims of domestic violence.

There are a number of good pilot projects and best practice examples, which could be tailored and adapted to local needs. For instance, in some countries (e.g. Germany) programmes exist that promote the involvement of the medical profession in domestic violence fighting networks (e.g. ProBeweis e.V.[3] in the HAIP network[4] in Hannover) and it was shown that the network brings about good results. The problem with these projects, however, is that they are regionally, financially and temporally limited so that they cannot be extended easily. Therefore, governments and local authorities need to increase financial support for programs that foster the cooperation between the medical profession and other frontline responders to combat domestic violence.

Physicians and other health care staff could gain a new perspective on the victim's situation and talk in a team about their own frustration, which may help them to re-gain their motivation because of mutual understanding. For example, when talking to police officers from the domestic violence-combating network, medical professionals could learn that police officers share their anger about the revolving door syndrome, too.

3 www.probeweis.de/

4 Information in German: https://www.hannover.de/Leben-in-der-Region-Hannover/Verwaltungen-Kommunen/Die-Verwaltung-der-Landeshauptstadt-Hannover/Gleichstellungsbeauf%C2%ADtragte-der-Landeshauptstadt-Hannover/Wir-f%C3%BCr-die-B%C3%BCrgerinnen-und-B%C3%BCrger/Hannoversches-Interventionsprogramm/%C3%9Cber-HAIP

Conclusions

International guidelines (e.g. Istanbul Convention; Council of Europe, 2011) strongly recommend that frontline response should be implemented in such a way that it includes coordination and cooperation among all relevant agencies, institutions and organisations which are responsible for detecting and preventing domestic violence and providing services to victims including the medical profession. As there are different access points for victims to contact physicians, it is crucial to train more physicians in domestic violence-related topics mandatory from early on and invite them as partners in support networks. All frontline responder groups would profit from their integration because of numerous reasons as explained above. Based on our research results in the IMPRODOVA project including almost 300 interviews with frontline responders, this has not been successfully implemented so far. Tensions between the various professions were mentioned more often than successful cooperation. Different approaches to improve the current situation were suggested in this paper e.g. such as to raise awareness that many more victims could get help and how much money could be saved by an effective intervention to domestic violence. The political motivation to finance corresponding programmes with a focus on interagency cooperation in a sustainable way needs to be increased. Additionally, further research needs to be carried out: even so research can be found regarding the role of the medical profession in domestic violence and health consequences in general and is cited in this paper, only few research is done and published on the interagency cooperation between the different frontline responder groups.

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