Reporting domestic violence in emergency- medicolegal issues

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Citation: Verma V. Reporting Domestic violence in Emergency- Medicolegal issues. *Int J Eth Trauma Victimology 2018*; 4(2):32-38. doi.org/10.18099/ijetv.426

Article history

Received: Dec 24, 2018
Received in revised form: March 19, 2018
Accepted: April 13, 2019
Available online: May 25, 2019

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Abstract

As emergency physicians now recognize that social behaviors such as tobacco, alcohol, and substance abuse have enormous medical implications, we have also come to appreciate that domestic violence is an epidemic that has to be addressed by us. The Indian Department of Women & Child development estimates that women & children on average experience 35 episodes of domestic violence before seeking help. Many of these victims will present to emergency departments as a consequence of this abuse. This literature review & case report is intended to inform emergency healthcare providers, who are caring for these victims of domestic violence. Emergency physicians who are more aware of the distinguishing features of the battering syndrome and provide appropriate crisis intervention may help victims to seek early legal and social aid, thereby preventing development of a chronic situation or a personal tragedy.

Keywords: Domestic violence, abuse, post-traumatic stress disorder, legal liability.

Introduction

Each year more than 1.5 million victims worldwide seek medical care for injuries resulting from domestic violence (1). Domestic violence is a not a new problem, prior to 1824, a householder was socially allowed in past to batter his/her partner/child, provided the stick he/she used was smaller in diameter than human thumb, thus giving rise to the expression "Rule of thumb." There is no accepted definition of domestic violence in the medical literature and there is wide variation in the terms used to describe the phenomenon; abuse, intimate partner abuse, interpersonal violence, wife battering, or violence against women are all in common use. Terms such as "wife beating" and "violence against women" are unsatisfactory as they imply that abuse is only man against woman. While most domestic violence is directed at women by their male partners, a significant proportion of domestic violence occurs against men in heterosexual, and against men and women in homosexual relationships. There is also great disparity in what constitutes "violence". Significant proportions of the public and medical community restrict the term violence to physical assault. While this definition of violence is usually valid for violence perpetrated by a stranger, usually resulting from conflict, it has less validity for assaults perpetrated by an intimate partner. Violence within a relationship usually results from coercion and comprises controlling behavior, verbal abuse, and economic control, in addition to physical assault. This is acknowledged by the World Health Organization who define violence as "the intentional use of physical force or power, threatened or actual...that either results in, or has a high likelihood of resulting in injury, death, psychological harm, mal-development, or deprivation" (2). The Survey defines "domestic" as "all intimate relationships, whether or not there has been co-habitation' and 'violence' as 'wounding and common assault." This does not include non-physical manifestations of domestic violence because this survey is concerned with those acts that fit the legal definition of a crime (2).

Definition of Domestic Violence as per Protection of Women from Domestic Violence Act (DV act) 2005 (3).—For the purposes of this Act, any act, omission or commission or conduct of the accused shall constitute domestic violence in case it—

(a) harms or injures or endangers the health, safety, life, limb or well-being, whether mental or physical, of the aggrieved person or tends to do so and includes causing physical abuse, sexual abuse,

verbal and emotional abuse and economic abuse; or
(b) harasses, harms, injures or endangers the aggrieved person with a view to coerce her or any other person related to her to meet any unlawful demand for any dowry or other property or valuable security; or
(c) has the effect of threatening the aggrieved person or any person related to her by any conduct mentioned in clause (a) or clause (b); or
(d) otherwise injures or causes harm, whether physical or mental, to the aggrieved person (3).

Definition of physical & sexual abuse as per DV act, 2005 (3):
(i) "Physical abuse" means any act or conduct which is of such a nature as to cause bodily pain, harm, or danger to life, limb, or health or impair the health or development of the aggrieved person and includes assault, criminal intimidation and criminal force;
(ii) "Sexual abuse" includes any conduct of a sexual nature that abuses, humiliates, degrades or otherwise violates the dignity of woman (3).

"Exclusion of liability" of informant doctor reporting "bodily injuries" during domestic violence in DV act

Any person who has reason to believe that an act of domestic violence has been, or is being, or is likely to be committed, may give information about it to the concerned Protection Officer or Police officer of the jurisdiction of incidence. No liability, civil or criminal, shall be incurred by any person for giving in good faith of information. No suit, prosecution or other legal proceeding shall lie against any service provider or any member of the service provider who is, or who is deemed to be, acting or purporting to act under this Act, for anything which is in good faith done or intended to be done in the exercise of powers or discharge of functions under this Act towards the prevention of the commission of domestic violence (3).

No doctor is a domestic violence expert, neither a forensic medicine specialist nor a gynecologist/pediatrician. However, as is the case when their patients have other medical problems, emergency physicians need to be aware of in-house and community resources available to victims of domestic violence.

Case report: A 45 years old Chinese women tourist with known case of mental depression on antidepressants, was brought in emergency in conscious oriented asymptomatic state with wet lower clothes smelling foul suggestive of urination in clothes, by his interpreter cum tourist guide from her hotel with history of uncontrollable frequent bed wetting since past 3 days and abnormal behavior of excessive laughing/ crying without any reason since one day. Patient had come from her native place in china 3 days ago on tourist visa to travel north India along with her friends. No family member accompanied patient to India. Patient reported no complain of fever/vomiting/ trauma/ seizure/ loss of consciousness/ pain anywhere. Bedside triaging female nurse routinely examined her vital parameters including blood pressure, pulse and respiration. While applying BP cuff, nurse noted extensive reddish blue bruise over both arms posteriorly. Patient denied any history of injury. On further examination, patient had multiple bruises of reddish blue & green color all over the body for different duration. (Figure 1 & 2). Patient had bilateral raccoon eyes suggestive of subcutaneous ectopic bruise of reddish blue color, probably due to blunt head injury. On extensive interrogation via her interpreter, patient gave history of physical assault by her partner 4-5 days ago, thus she left her and came to India with her friends.

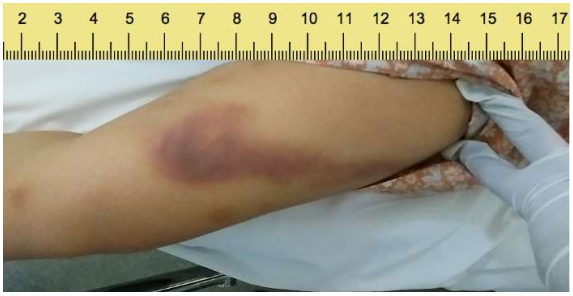

Fig. 1. Extensive bruise over left upper limb of patient

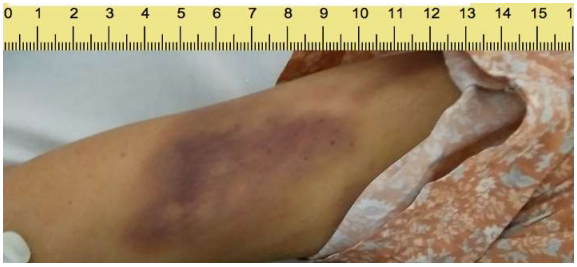

Fig. 2. Extensive bruise over right upper limb of the patient.

BP= 130/80mmHg, Pulse rate= 86/min, SPO2= 98%, Random blood sugar= 98. On local examination, Chest Bilateral Breath sounds, Abdomen was distended below umbilicus with

palpable mass in lower abdomen. On further enquiry via interpreter, patient told that she had amenorrhea since 5 months. Gynecological examination by Gynecologist & ultrasound examination of pelvis revealed that she was pregnant with 5-month intrauterine live fetus. But patient denied any history of recent sexual encounter, and showed unawareness regarding her pregnancy. Orthopedician examined the patient's limbs and had no localized tenderness or deformity, thus ruled out underlying fracture/ dislocation. Psychiatrist enquired further and patient revealed history of domestic violence by her partner, and after perusal of all the expert medical opinion & routine investigations (which were all within normal limits), patient was diagnosed as a suffering from post-traumatic stress disorder related to antepartum domestic violence, so she ran away from her home, and came to India to prevent further domestic violence. Urinary incontinence was the result of mid-term pregnancy, gravid uterus causing pressure on urinary bladder. Patient was advised regular antenatal checkup, pregnancy safe antianxiety medications & counselling was done, to relieve her stress, and was discharged in stable condition in guardianship of local social support group in association with local police & her country's immigration authority for future safety form domestic violence from her abusive partner, and was discharged from emergency in stable condition.

Case Discussion

Since domestic violence crosses international borders, racial, socioeconomic, and cultural lines, and since it is so common, all women should be screened periodically for violence during emergency visits. While victims do not generally spontaneously disclose abuse, there is ample evidence that they will respond when asked and that they are grateful for the opportunity. Simply asking a victim about domestic violence and then offering the patient a nonjudgmental, compassionate response can, in itself, be a powerful form of intervention. The physician must resist the impulse to urge the patient to leave his/her abusive partner at once. Abused patients are more likely to be seriously injured or killed at the time they attempt to leave their partner than at any other time. Furthermore, leaving an abusive relationship is a process, not an event. We expect lifestyle changes, such as smoking cessation, to take time and to require multiple messages and strategies, and this is the case with addressing violence, as well.

Instead, assure the patient that he/she does not deserve to be abused and help is available. Recommend that she take measures to ensure the safety of herself and her children. Getting the patient to leave a violent relationship is not the goal; helping the patient to be safer, on the other hand, is of paramount importance.

Many studies have demonstrated that the incidence of domestic violence increases during pregnancy and the postpartum period. This fact, along with frequent doctor visits during pregnancy and a woman's concern for the safety and well-being of her child, make pregnancy a particularly important time for domestic violence assessment (4).

Improving detection of domestic violence

While the evidence does not support screening for domestic violence, it is still important that emergency physicians know how to create the opportunity of a patient disclosing domestic violence, so that self-reported victims of domestic violence can be offered help. This process is distinct from a screening program. Ideally all consultations should take place in a private room with, initially, only the patient and the doctor. This simple step is not widely applied; often the partner is encouraged to be part of the consultation process. If exclusion of the partner became standard, then the partner who insisted on staying with his or her partner would look more suspicious. This may be particularly difficult in cases where the patient does not speak English, is confused or where a witnessed history is vital, for example, syncope. It is inappropriate to rely on family members to interpret; official interpreters should be used where possible. The Confidential Enquiry in Maternal Deaths recommends that every woman is interviewed alone at least once during the antenatal period and this sensible step could be extended to emergency medicine (5). Simple, direct, non-judgmental questions are the best way to inquire about domestic violence if this is felt appropriate (6).

Screening form for domestic violence (as per MOHFW guidelines, 2014) (1)

Please tick mark [√] the column applicable
Domestic Violence: Yes/No

If Domestic Violence, then:

Initial resuscitation/First Aid given: Yes/No
Information about available service: Yes/No
Medico-legal certificate: Yes/No
Safety Assessment: Yes/No

Informed Protection Officer: Yes / No
Counselling done: Yes/No

Physical violence

Hitting, Slapping, Punching, Pinching, Pushing, Throwing objects

Painful bending & twisting of limbs

Physical restrain by tying limbs with cord, handcuffs, locked in a room

Keeping Hungry - Not providing food & water for nutrition

Electric shocks & burns

Causing skin burns with flame of fire / cigarette butts / heated utensils / acid throwing

choking / strangulation / Hanging

Denying the victim needed medical care, depriving them of sleep or other necessary functions.

forcing the victim to engage in drug or alcohol use against their will

Attempted suicides by victim, often admitted in the hospitals as accidental consumption of poison

Sexual violence

Forced sexual intercourse

by Husband, father, uncle, relative, neighbor

Unnatural Sexual intercourse (Buccal / anal coitus)

Penetration by penis/ finger/object in vagina/ anus/ mouth

Forced to watch pornography or other obscene material

Forcibly using you to entertain others

Any other act of sexual nature, abusing humiliating, degrading or otherwise violating dignity.

Verbal and emotional abuse

Accusation /aspersion on your character or conduct, etc.

Insult for not bringing dowry, etc.

Insult for not having a male child

Insult for not having any child

Demeaning, humiliating or undermining remarks/ statement

Ridicule / Abusive Name calling

Forcing you to not attend school, college or educational institution

Preventing you from taking up a job or business

Preventing you from leaving the House or premises

Preventing you from meeting any particular person

Forcing you to get married against your will

Preventing you from marrying a person of your choice

Forcing you to marry a person of his/their own choice

Signs & symptoms in suspected child sexual abuse

Pain on urination and /or defecation

Abdominal pain/ generalized body ache

Inability to sleep

Sudden withdrawal from peers/ adults

Feelings of anxiety, nervousness, helplessness

Inability to sleep

Weight loss

Feelings of ending one's life (1)

In one hospital in the USA the rate of detection of domestic violence among female patients increased from 1% to 18% after patient charts were modified to include screening questions for domestic violence (7). Screening occurred less often at night, with sicker patients, and with patients presenting with a primary psychiatric diagnosis.

Management of an identified victim of domestic violence in Emergency

As always the priority is to treat the physical injury. Injuries should be meticulously recorded and photographs taken if appropriate. Specific inquiry should be made about the presence and age of children living in a violent household. Attempts should be made to find out whether any children are at risk of abuse, both by direct questioning and use of the child protection register. Any concerns for child safety should lead to the activation of local child protection procedures (8). Interestingly women were more likely to disclose domestic violence to female nurses despite the male nurses asking the same proportion of patients (9).

"**Medicolegal Liability**" of Hospital receiving victim of domestic violence (as per DV act 2005) (3).

If an aggrieved person or, on her behalf a Protection Officer or a service provider requests the person in charge of a medical facility to provide any medical aid to her, such person in charge of the medical facility shall provide medical aid to the aggrieved person in the medical facility.

Incidence and prevalence: Most common age groups were between 20 and 30 years in both males and females who were victims of such domestic violence (10). It is realistic to assume that the incidence and prevalence rates derived from interview based surveys are underestimates as studies relating to domestic violence are

invariably hampered by the reluctance of victims to disclose information. In one cross sectional study by PP Gupta et al (2018), 11.7% of victims visiting a variety of emergency departments were there because of acute injury or stress related to domestic violence. The most striking finding in this paper was the lifetime prevalence rate for domestic violence of 54.2% in victims attending emergency departments. Husband's alcoholic habit was the root cause of dispute and violence. The reason behind this increased prevalence in young women is due to practicing of marriage in early age, which is quite high in the country. Another factor for higher incidence in females of fertile age groups is infertility (11).

Citing data from the National Family Health Survey (NHFS), SAHAJ came out with a report which said about Twenty-seven per cent of women aged 15 to 49 years have experienced physical violence since the age of 15 years (12). National Crime Records Bureau (NRCB) statistics show that cruelty by a partner or his relatives (46.8%) and dowry-related crimes (7.1%) account for more than half of the crimes related to domestic violence (13).

Injury patterns: There are injuries and injury patterns that have a high positive predictive value for child abuse. There are no such injuries or patterns that reliably predict domestic assault. Head, face, and neck injuries seem to be more common. However, the predictive values, specificities, sensitivities of these injuries are probably too low to reliably identify or exclude patients. Repeated attendance is more common. Most of the victims that were physically assaulted were beaten by fist, bamboo stick, iron rod, and shoes (11).

Consequences of domestic violence: Domestic violence is increasingly being recognized as a significant public health issue. Domestic violence is associated with more than just the physical injury. There is cohort evidence that female victims of domestic violence have increased use of all forms of medical care, not just trauma and mental health services.

How do a health care provider refer a patient who's been abused?

First, assure the patient that she does not deserve to be abused, that the situation is likely to get worse, and that if she is being hurt, her children are being hurt as well. Social workers may be able to offer counseling and help with information regarding "protection from abuse" (restraining) orders, shelters, etc.

Virtually every community has a domestic violence advocacy organization, as well, many of which print information that may be kept in clinicians' offices. All violence-related materials should be available in patient restrooms. If the patient has a partner who refuses to leave the examining room, the restroom may be the only site in the office where she has privacy.

Routine referral for couples counseling is to clinical psychologist/psychiatrist is recommended. If the patient discloses feelings of anger, for example, in a counseling session, her partner's abusive behavior may escalate. After the violence and the threat of violence has ceased, joint counseling-in some cases-may then be an option.

While clinicians are not expected to be domestic violence experts, they should have access to names and phone numbers of local hot lines, shelters, and other resources. There is also a national number by National Commission of Women & Child development, offering 24-hour information, counseling, and referral for victims of domestic violence and caregivers: Toll free Number: **1091** (14).

Screening for domestic violence: It seems that history taking and clinical examination is unsatisfactory for diagnosing domestic violence. Screening has been suggested for every patient who presents to an emergency department. This view is supported by numerous Indian agencies, including the Department of Women & Child development and the Indian Medical Association. The Department of Health & family welfare advocates that “routine enquiry”—that is, screening—for all women should be considered by healthcare professionals (2). Whether domestic violence fulfils the criteria for screening is controversial. Domestic violence is certainly an important condition, and certainly carries significant health consequences. Screening is probably acceptable to most patients attending an emergency department. It is less clear whether screening is acceptable to physicians and nurses. It could be argued that we do not know enough about the natural history of domestic violence to institute formal screening programs. We also do not know enough about the effectiveness of the interventions and organizations designed to help identified victims of domestic violence. Indeed, most studies of interventions to reduce domestic violence do not consider important outcomes, such as reduced exposure to violence. Many of the

organizations that help victims are charitably run and whether they could cope with the increased workload that a screening program would cause is unclear. Once domestic violence has been identified, there is a risk that interventions may provoke further violence, specific measures need to be in place to prevent this. At present it does not seem that there is enough evidence to support screening all patients or even all women attending emergency departments for domestic violence.

Medicolegal reporting of domestic violence

- Section 357C Criminal Procedure Code - Both Private & Public health professionals are obligated to provide treatment to injured (15).
- Denial of treatment by Hospital to survivors of physical assault with acid vitriolage & sexual assault survivors is punishable under Section 166 B IPC with imprisonment for a term which may extend to one year or with fine or with both (15).
- As per Section 164(A) of the Criminal Procedure Code, any Registered Medical Practitioner can conduct a medico-legal examination for injuries & abuse (15).

"Domestic maid violence"- medicolegal issues: Domestic maid violence is an assault and coercive behavior, which mainly includes physical, psychological and at times sexual too, by employer or household members of employer against a person(male/female) hired as a domestic help. There is no law to safeguard interests of domestic help in India, as it does not come under DV act. In the absence of a law to safeguard the rights of domestic workers, the employer can be booked under laws preventing child labor if a child below 14 years is employed as domestic help. For a child between 14 and 18 years of age, the Juvenile Justice Act comes into play. For crimes reported during medicolegal reporting by doctors in which the domestic help is an adult, various sections of the IPC under S. 320-328 IPC for physical assault & S. 375 IPC for sexual assault can be invoked by local police.

Key points: domestic violence

1. The highest risk for serious injury/death is when and after the abused leaves.
2. The incidence of domestic violence increases during pregnancy and postpartum.
3. Domestic violence screening involves asking a few simple non-judgmental questions each visit.
4. Once a patient divulges a history of domestic violence, she should be assured that she does not deserve to be abused and made aware of local resources for abused women.
5. The treating physician should resist the impulse to encourage the patient to leave the abusive relationship.

Conclusion

Domestic violence is often not disclosed to medical or nursing staff in emergency. Interviewing patients alone increases the chances of detection of domestic violence. If a patient discloses domestic violence, then the possibility that there are children at risk should be considered. It should be explained to victims of domestic violence that assault is illegal and unacceptable. Contact with the police and voluntary organizations should be offered from the safety of the emergency department. Future research should aim to describe the epidemiology of domestic violence and further evaluate the effectiveness of interventions. It is through these areas that the quality of care of victims of domestic violence can be improved.

Conflict of interest

None

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