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Original Citation

Taket, A., Lavis, Victoria, Nurse, J., Watson, J., Shakespeare, J., Cosgrove, K., Mulley, K. and Feder, G. (2003) Routinely asking women about domestic violence in health settings. *BMJ*, 327 (7416). pp. 673-676. ISSN 0959-8138

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Education and debate

Routinely asking women about domestic violence in health settings

Ann Taket, Jo Nurse, Katrina Smith, Judy Watson, Judy Shakespeare, Vicky Lavis, Katie Cosgrove, Kate Mulley, Gene Feder

Health professionals are ideally placed to identify domestic violence but cannot do so without training on raising the issue and knowledge of advice and support services

The stigma surrounding domestic violence means that many of those affected are reluctant or do not know how to get help. A systematic review of screening for domestic violence in healthcare settings concluded that although there was insufficient evidence to recommend screening programmes, health services should aim to identify and support women experiencing domestic violence.¹ The review highlighted the importance of education and training of clinicians in promoting disclosure of abuse and appropriate responses.¹ We argue that a strong case exists for routinely inquiring about partner abuse in many healthcare settings.

Size of problem

Domestic violence includes emotional, sexual, and economic abuse as well as physical violence. The different

forms of abuse may occur together or on their own, although always in the context of coercive control by one partner over the other. To reinforce the fact that domestic violence does not necessarily involve physical violence, we prefer the term partner abuse. Abuse can continue after the partners have separated.

Partner abuse occurs in all types of relationships, both same sex and heterosexual.² Although about one in seven men in the United Kingdom report experiencing physical assault by a current or former partner,³ these incidents are generally less serious than those reported by women, and men are less likely to be injured, frightened, or seek medical care.⁴ The context and severity of violence by men against women makes domestic violence against women a much larger problem in public health terms.^{2,5} Worldwide, 10-50% of women report having been hit or physically assaulted by an intimate partner at some time.^{w1} In the United Kingdom, 23% of women aged 16-59 have been physically assaulted by a current or former partner, and two women are killed every week.³ This article therefore focuses on routine inquiry of women accessing health services.

Effects on health

One reason for making domestic violence a health service priority is that it greatly affects the health of those in abusive relationships (box 1). In addition, children growing up with domestic violence are 30-60% more likely to experience child abuse^{6 w2 w3} and have higher rates of problems such as sleep disturbance, poor school performance, emotional detachment, stammering, suicide attempts, and aggressive and disruptive behaviour.^{w4-w7} Children who witness domestic violence learn to accept violence as an appropriate method of resolving conflict and are more likely to repeat patterns in adulthood.^{w8}

Routine inquiry or screening?

Screening, as defined by the UK National Screening Committee, refers to the application of a standardised question or test according to a procedure that does not vary from place to place. Routine inquiry is a more

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BMJ 2003;327:673-6



References w1-w17 are available on bmj.com



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Box 1: Health effects of domestic violence

- Injuries from assault
- Chronic health problems such as irritable bowel syndrome, backache, and headaches^{w9}
- Increased unintended pregnancies, terminations,^{w10} and low birthweight babies^{w11}
- Higher rates of sexually transmitted infections, including HIV^{w12}
- Higher rates of depression, anxiety, post-traumatic stress disorder,^{w13} self harm, and suicide^{w9}

suitable approach for domestic violence. In routine inquiry, procedures are not necessarily standardised but questions are asked routinely in certain settings or if indicators of abuse arise. Further research is needed to clarify when routine inquiry is appropriate and how best to implement it.

Why do we need routine inquiry?

Box 2 lists some of the advantages of routine inquiry about partner abuse. The rates of disclosure of abuse without direct questioning in healthcare settings are poor. The high prevalence and health effects of partner abuse therefore make it important for health professionals to ask directly about domestic violence. Pragmatically, routine inquiry is the only way to increase the proportion of women who disclose abuse and who may benefit from intervention. It has a high level of acceptability, both among women who have experienced domestic violence and among those who have not,^{1 7 8} although a minority of women do not like the idea.¹

Health services are the best place for routine inquiry because they have the most frequent and widest contact with the population of all public services. Most women regularly access services such as contraception advice, cervical and breast screening programmes, maternity care, and care for their children. In addition, women experiencing domestic violence access health services more frequently. A Canadian study found that they were three times more likely to access emergency health services than women who had not experienced abuse.⁹

In the United Kingdom, over 90% of the population comes into contact with primary healthcare services within five years. This places primary healthcare professionals in a unique position to identify women experiencing abuse and empower

Box 2: Advantages of routinely inquiring about domestic violence

- Uncovers hidden cases of domestic violence
- Changes perceived acceptability of violence in relationships
- Makes it easier for women to access support services earlier
- Changes health professionals' knowledge and attitudes towards domestic violence and helps to reduce social stigma
- Helps maintain the safety of women experiencing domestic violence

them to access support by providing information about or referring them to local services. Women report that it is difficult to find out about public and voluntary services for partner abuse.

Health benefits of routine inquiry

Although there is little research measuring women centred outcomes of health service based interventions,¹ substantial qualitative evidence indicates the potential health benefits of routine inquiry. Most evaluations of routine inquiry have focused on process indicators, such as the quality of staff training, the number of women asked about domestic violence, referral to support agencies, and documentation. However, several studies have shown the benefit of use of specialised support services for women and children, and routine inquiry enables access to such services.

One study evaluated an advocacy service for women experiencing domestic violence using a randomised design. Women were interviewed six times over two years, and women in the intervention group reported a higher quality of life, decreased difficulty in obtaining community resources, and less violence over time than women in the control group.^{10 w14}

Another study of 200 women who had used domestic violence outreach services, found that 46% were living in situations of domestic violence when they first contacted the service. All of these women reported that the outreach services had helped them to leave the abusive relationship—a valued outcome for them.⁶ Qualitative evidence of positive outcomes in healthcare settings,^{8 11 w15} is complemented by studies of specialised support services outside health services.^{6 12-14 w16 w17}

Implementing routine inquiry

The best way to implement a system of routine inquiry depends on the context, including the organisation and capacity of local agencies offering support to women experiencing partner abuse. Women need to be asked about abuse in a non-judgmental manner¹⁵ and to receive clear information on service options, especially about agencies offering support or advocacy services, and help with plans to ensure their safety. Health professionals cannot be expected to undertake this task without training.²

Routine inquiry needs to be flexible. Implementation will be more straightforward in situations where staff take structured histories routinely or in the context of concern about child protection issues. For example, the fifth report of the confidential inquiries into maternal deaths (1997-9) recommends that all women are asked about domestic violence at antenatal booking by their midwife and that they should have the opportunity to talk to their midwife without their partner present at least once during pregnancy.¹⁶ In some general practices, well women clinics carry out regular health checks on all women registered with the practice, and asking about domestic violence forms part of this check. When time with patients is more limited, however, questioning may be more appropriate when indicators of abuse arise in the consultation or to ascertain the cause of injuries or health problems, such as depression.

Barriers to routine inquiry

Although routine inquiry is more flexible than screening, objections are still likely to be raised.¹⁷ One difficulty is the potential risk to the woman being asked about abuse, and interview studies have shown women are concerned about breaches in confidentiality.¹⁸ Safety of women who have disclosed to a health professional must be a priority, and we recommend routine inquiry should be done only by those who are properly trained and when protocols that prioritise safety have been established.

Training of health professionals to respond appropriately to women disclosing abuse and increasing their knowledge of local advocacy and support services has been shown to alleviate their concerns about "opening a can of worms" and to encourage professionals to ask about abuse.^{8 19} Training has also been shown to overcome some of the other barriers to routine inquiry. These include ambivalent attitudes of staff, difficulties in framing questions or seeing the patient alone, recording information, legal implications, confidentiality, child protection concerns, lack of awareness of support services, frustration at survivors' responses, raising expectations of the client, safety, time management, and issues relating to ethnicity and class.^{7 8 19 20}

Time pressure, staff shortages, and problems in sustaining interventions, particularly training, are common in many health settings and require reform at a structural and policy level. We need to appoint local leaders for partner abuse who can provide or coordinate training in all health settings. Although the government has advocated this approach, so far it has not provided any additional resources, targets, or time frames. Action may be easier to achieve if domestic violence forms part of the priorities set for health within local strategic partnerships established by primary care trusts.

Box 3: Resources for women and health professionals

Department of Health. Domestic violence: a resource manual for health care professionals. London: DoH, 2000 (www.doh.gov.uk/domestic.htm)
 Women's Aid Federation website (www.womensaid.org.uk)
 Data source on domestic violence (www.domesticviolencedata.org)

Professional guidance

British Medical Association. *Domestic violence: a health care issue?* (www.bma.org.uk/ap.nsf/Content/Domestic+violence:+a+health+care+issue)
 Royal College of General Practitioners. *Domestic violence: the general practitioners' role.* (www.rcgp.org.uk/rcgp/corporate/position/dom_violence)
 Royal College of Midwives. *Domestic abuse in pregnancy. Position paper 19a.* (www.rcm.org.uk/data/info_centre/data/position_papers.htm)

Local information and training manuals

Camden: www.camden.gov.uk/camden/links/equalities/dm_health.htm
 Leeds Interagency Project (0113 2349090 or admin@liap.demon.co.uk)
 Redbridge and Waltham Forest Domestic Violence Health Project (www.dvhp.org)
 Salford (contact Kim Whitehead, 0161-2124450 or kim.whitehead@salford-pct.nhs.uk)

Summary points

Partner abuse is common and affects physical, mental, reproductive, and sexual health

Routine inquiry in healthcare settings can reduce the effects of partner abuse

Routine inquiry is acceptable to women

Inquiry must be accompanied by information on support services and safety planning

Health professionals need training and protocols to establish routine inquiry safely

Implications for practice

Although national and local health policy and practice must develop and evolve alongside future research, the growing evidence of the health effects of domestic violence means the health sector can no longer avoid its responsibility to take partner abuse seriously. Health professionals can play an important part now by identifying women experiencing domestic violence and enabling them to access further support. Box 3 lists some useful resources available in the United Kingdom. The health sector also has a wider role—for example, in raising awareness by displaying information on partner abuse and support services and in promoting non-violent methods of resolving conflict as part of treatment for substance and alcohol abuse.

Contributors and sources: The authors comprise a diverse range of health professionals and academics. They are all members of the Domestic Violence and Health Research Forum, which meets twice a year to discuss methodological and policy issues and promote research into the health consequences of domestic violence and appropriate interventions in health, social, and voluntary sectors. This article was written in response to concerns about responses to the publication of a systematic review on whether health professionals should screen for domestic violence.

Competing interests: GF's research group could benefit if funding for research into domestic violence was increased.

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(Accepted 14 July 2003)

Role of living liver donation in the United Kingdom

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Patients who need a new liver usually face a long wait. Some die before a suitable donor is found. Living liver donation is offered routinely in some countries. Should the United Kingdom follow suit?

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BMJ 2003;327:676-9

Liver transplantation has become an accepted form of treatment for patients with end stage liver disease and those with an unacceptable quality of life because of liver disease. Despite government initiatives to increase donor rates and surgical innovations to maximise the use of existing donor livers, the number of donor organs is insufficient to meet the existing demand. Living liver donation has the potential to help mitigate the deficit and is offered routinely in many countries in North America, Asia, and continental Europe. Living liver donation is not routinely available in the United Kingdom, although a few living transplant operations have been done led by Roger Williams and Nigel Heaton.¹ We believe that living liver donation should be available on the NHS, although it should not be adopted without full public debate and agreement because of the risks to donors.

Current practice

The United Kingdom has no reliable information on requirements for liver transplantation. Although we have data on the number accepted for transplantation,² not everyone who might benefit from transplan-

tation is referred.³ The rate of transplantation is relatively low compared with other European countries (11.6/million population compared with 19.3/million in France and 24.3/million in Spain). However, we do not know the requirement for transplantation because the burden of liver disease in these countries may differ. Donor rates also vary between countries, but the proportion of potential donors who are offered for transplantation is not known. The number of patients dying from liver disease in England is increasing.⁴

To be accepted on the transplant list in the United Kingdom, a patient must have a survival probability of greater than 50% five years after transplantation, with a quality of life acceptable to the patient.⁵ These criteria were developed to ensure equity of access and best use of donated livers and to match the numbers of donors and recipients. Patients who would benefit from transplantation but do not fulfil these criteria are not offered transplantation. Thus, not everyone who is put on the transplant list receives a graft (box).

In some cases, the use of the liver can be maximised by splitting it (when the larger right lobe is grafted into an adult and the left lobe into a child or small adult) or the liver can be used after removing a lobe or part of the lobe. Use of livers from non-heart-beating donors and domino transplants can also increase the supply of donors. In domino transplants, a liver is taken from a living donor who has a metabolic defect in the liver such as familial amyloidotic polyneuropathy that results in extrahepatic organ disease; the donor receives a graft (from a cadaveric or a living donor) and the diseased liver is transplanted into an informed recipient whose prognosis is unlikely to be affected by the metabolic defect.

Of the 675 liver transplantations in 2001 in the United Kingdom, 18 were reduced grafts and 62 split liver grafts; no domino transplants were recorded. Survival (based on patients grafted between January 1994 and December 1999) is 80% at one year, 73% at three years, and 64% at five years.



Liver transplant operation

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