Covert COVID-19 crisis: how can rising domestic abuse and violence against women be counteracted in orthopaedic surgery?

It is well known that the 2019 coronavirus (COVID-19) pandemic has caused widespread morbidity and mortality across the United Kingdom (UK) and the world. The recent sobering milestone of 100,000 COVID-19-related deaths in the UK generated fierce debate and discussion across myriad industries, from policy makers to scientists. So far, the battle against the virus has yielded novel pharmacological treatments, unique hospital COVID-19 pathways and brand-new vaccines, along with national lockdowns across the whole of the UK. However, behind the headlines and literally closed doors, there has been an insidious resurgence of domestic abuse and violence (DAV) cases as a consequence of the pandemic.

DAV is a broad term which describes any behaviour deemed to be controlling, coercive, threatening or violent from any family member or an intimate partner in adults aged 16 and over. The types of abuse are not limited to physical violence; they can include psychological, emotional, economic and sexual abuse. Mixed ethnicity, low income, disability, urban dwelling, poor mental health and low levels of education are just some of the independent risk factors for DAV. Since the onset of the COVID-19 pandemic and the consequent national lockdown, there has been a 7% rise in domestic abuse-related offences reported to the police. Of this increase, the period between April and May 2020 demonstrated the worst rise at 9%, with 30 homicides occurring as a direct result of DAV between just April and June 2020. In the UK, official government statistics demonstrate 88% of domestic homicides are committed by men towards women, demonstrating an evident female victim preponderance. More up-to-date estimates from the second national lockdown are not yet reported; however, the trend so far likely demonstrates a further increase in DAV.

These data suggest a stark problem, and it is a problem which firmly crosses the threshold of an orthopaedic department in the form of trauma secondary to interpersonal violence. According to the most recent prevalence estimates, 1 in 50 women who present to an orthopaedic clinic with an injury have suffered physical violence as a result of DAV. The reason for this is due to the nature of physical injury inflicted by perpetrators, which affects the musculoskeletal system. Such injuries comprise the most prevalent physical manifestation of DAV, second only to head and neck trauma, and can therefore be a powerful indicator of abuse. Bhandari et al identified sprains and fractures as the most frequent orthopaedic presentations of DAV. With an overall increase in case numbers during this pandemic, the number of patients attending any one orthopaedic centre will indubitably be higher.

The responsibility of an orthopaedic surgeon in the detection, sensitive enquiry and onward referral of DAV victims is therefore important. It stands to reason that good education is necessary in order to uphold the highest standards of care. Current evidence highlights that misconceptions remain rife among orthopaedic surgeons despite their close contact with DAV victims. Even more disconcerting is the majority of the misconceptions focus on victim-blaming, as opposed to addressing the actions of the perpetrator. This merely serves to reinforce the control paradigm between the abuser and the abused. Currently, there is a scarcity of both a national screening programme and a consensus guideline in the UK for orthopaedic involvement with DAV, which is likely due to a lack of support from high-quality evidence. Interestingly, however, direct questioning has demonstrated greater efficacy over existing screening questionnaires. Yet, in practice, it has been shown that only 2% of members of the orthopaedic multidisciplinary team routinely screen patients for DAV through direct questioning. This could be due to a reluctance to engage with a screening process as a result of lack of time or awareness, along with a potential, innate assumption that asking patients about DAV is not incumbent on an orthopaedic surgeon. Ultimately, it seems inherent prejudice, low levels of confidence in sensitively enquiring about DAV and a lack of awareness of the safeguarding referral process are the cardinal reasons for such low concordance in screening patients for DAV. This, therefore, highlights an urgent need for education and support for clinicians working in orthopaedic surgery to better recognise and safeguard victims of DAV.

As part of the effort to help bolster the confidence of clinicians working in an orthopaedic department with DAV, this article encloses some simple recommendations for readers in the form of a DAV Toolkit. The toolkit has been synthesised from currently available resources to help readers begin to learn about DAV and how they can help victims in a clinical setting. DAV Toolkit: simple, applicable strategies for you to improve your knowledge and management of DAV

Adapt your orthopaedic workup

It is a good idea to first familiarise yourself with the safeguarding referral process at your hospital for victims of DAV. During a consultation, include a routine enquiry about DAV into your clinical history. There may be some clues in the history that can aid with the identification of a potential victim of DAV. Look out for the following:

- Inconsistencies in the history of presenting complaint.
- Multiple injuries/ unusual pattern of injuries.
- Previous history of DAV.
- Repetitive presentations/‘frequent flyer’.
- Severity of injury inappropriately corresponds to reported mechanism.

Management

The management options are relatively simple and do not require you to personally intervene in the situation. However, the following steps are important to complete:

- Document all your concerns for DAV carefully and thoroughly (this could help with any eventual criminal proceedings).
- Ensure consultation in the absence of the perpetrator to facilitate any disclosure.
- Offer support irrespective of disclosure if safe to do so.
- Complete a safeguarding referral.

Education

DAV educational resources exist freely available on national e-learning platforms, such as e-Learning for Healthcare and the General Medical Council website. These resources provide a structured way to learn more about DAV in a healthcare setting and how to do manage suspected victims as front-line clinicians. Some useful links to develop your knowledge are as follows:

https://www.gmc-uk.org/ethical-guidance/learning-materials/disclosure-when-there-is-suspected-domestic-abuse
https://www.gmc-uk.org/ethical-guidance/learning-materials/disclosure-when-there-is-known-domestic-abuse
Audit Perform a plan–do–study–act cycle to audit the efficacy of the safeguarding referral pathway at your orthopaedic department and produce an integrated screening system comprising direct questions as an intervention. This not only offers audit experience but also infers a direct improvement to the service offered to victims of DAV through the inclusion of direct questioning in the routine orthopaedic review.

Familiarise yourself with your trust policy on DAV This is important to know about as it can provide you with a professional and legal framework with which to safely conduct your management plan for suspected victims of DAV.

Familiarise yourself with your legal and ethical duty from your indemnity providerSimilar to the previous point, this is an important issue from a legal standpoint to ensure you are aware of your professional duty and limitations of safe practice. An example from the MDU is available online (https://www.themdu.com/guidance-and-advice/guides/domestic-abuse-your-legal-and-ethical-duty).

Like most other less commonly discussed topics, more research needs to be conducted to re-evaluate the most up-to-date prevalence estimates and elucidate the optimal, universal, multifaceted strategy to implement in orthopaedic surgery. The DAV Toolkit outlined in this article forms a small yet effective component of the systemic interventions which need to be established. It is important to bear in mind that the role of a clinician working in orthopaedics is not to directly provide victims with psychological support, but to correctly recognise, sensitively support and refer patients to safeguarding. The management of DAV cardinaly involves a multidisciplinary approach, with integrated, specialist psychological support for victims to reduce the future risk of further harm. Despite attempts to highlight the urgent need for greater awareness of DAV in orthopaedics, there nevertheless remains a paucity of specially curated safeguarding education for surgeons. Fortunately, current programmes are under way in the North West of England to educate foundation year doctors about how to detect and manage DAV through the provision of a level 3 safeguarding course. The national rollout of a similar scheme in conjunction with the inclusion of safeguarding as a key competency for orthopaedic surgeons could be a powerful solution to help DAV victims. With the recently resubmitted domestic abuse bill reaching the House of Lords, hailing a turning point in the legislative efforts to counter DAV, the compelling narrative which connects orthopaedics to DAV now calls for crucial additional input from individual clinical departments to collectively bolster the effort to help victims of the covert COVID-19 crisis.

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