

Commentary

Chronic care specialists should consider in-person visits for victims of intimate-partner violence an essential service

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Clinical activities to do with non-life-threatening disease were deemed nonessential to controlling the COVID-19 outbreak. Nursing and paramedical staff were dispatched to acute care settings, and patient visits in most of the sectors that manage chronic conditions were suspended. Despite the initial difficulties of setting up telecommunications so that I, a physician specializing in headache medicine, could provide health care services remotely, most of my patients were grateful for the option of telehealth; it became a means for them to safely maintain medical contact with me.

However, I also realized this new model of care was not in the best interests of all my patients.

There is widespread concern about the detrimental effects of confinement in vulnerable patient populations that lack social network support groups.¹ In particular, victims of domestic abuse have reported increased risk of violence.² Because I care for patients who are not only predominantly female but also have an innate brain hypersensitivity to aversive stimuli, I am often entrusted with sensitive information about headache triggers, such as emotional distress caused by conjugal violence.³

The COVID-19 pandemic contingency directives did not authorize in-person medical visits for victims of intimate-partner violence (IPV). In-person medical visits have been limited to physical examinations in the case of an acutely fatal condition, such as a thunderclap headache suggestive of an intracranial bleed, or hardware

malfunctions of technology-based therapeutic devices, for example, parenteral drug delivery systems and implantable nerve signalling modulators.^{4,5} Fortunately for these patients, my hospital's institutional authorities were receptive to my request to maintain in-person medical visits, regardless of their headache status. Of course, these patients are screened for COVID-19 infection 24 hours or less prior to the appointment, and safety measures such as hand hygiene, mask wearing and physical distancing are mandatory.

A non-urgent or non-life-threatening service does not equate to a nonessential service. For victims of IPV, accessing health care involves challenges related to cost, fear of facing prejudice and discrimination, the controlling tactics of abusive partners and a low sense of self-efficacy.⁶⁻⁸ Contingency regulations necessary to control the pandemic have further increased vulnerability to IPV, through the crises created by job losses and displacement as well as social isolation caused by mandatory physical distancing.

Despite a predicted rise in IPV incidents, emergency response support services have seen a decrease in the numbers of victims reaching out, likely a consequence of IPV victims' concern at potentially exposing themselves and their loved ones to infection as well as being entrapped with their abuser.⁹

The pandemic has also decreased access to safe havens. Most shelters are operating at reduced capacity, travel is restricted, public transportation has been reduced and curfews imposed.¹⁰ Also, as the majority

of health care centres no longer authorize walk-ins for consultations, victims may be threatened when booking an appointment online or by telephone in the presence of the perpetrator.¹¹ In addition, IPV victims who are from marginalized ethnic communities may have an enhanced sense of mistrust of law enforcement authorities as a result of police officers handing out financial sanctions for breaching confinement; such negative perceptions of the judiciary system often translate to distrust of medical institutions.^{12,13}

Sexual and reproductive health clinical activities are being maintained for victims of domestic abuse in order to screen for collateral damages caused by pandemic-related social isolation.¹⁴ But victims of IPV whose access to their chronic health care provider is restricted may struggle to trust and seek help from unfamiliar health providers. Patients likely want to avoid hurried appointments and professionals' lack of understanding in acute care settings, for example. Also, they may feel guilty about wasting critical services in emergency departments that are at capacity. They may also feel uneasy speaking about sensitive topics in an unfamiliar setting, especially if they are on a hallway stretcher or in a noisy emergency department with limited confidentiality.

Chronic care physicians across all sectors should be encouraged to consider their services essential for patients at risk of violence by current confinement measures. Managing chronic health issues, often over several years, implies long-term follow-up that forges a therapeutic alliance with patients; this makes it more

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likely that patients reach out for help at times of crisis. Such alliances generally reflect the quality of communication between the patient and the health care provider, encompassing a personal relationship and collaborative work.¹⁵

With the patient–physician relationship central to their role, family physicians often build such alliances with their patients through comprehensive coordination of care that extends beyond focus on the disease.^{16,17} The patient–provider alliances that are unrelated to sexual or reproductive health include long-term management of endocrinopathies, autoimmune or inflammatory disorders, chronic kidney disease, and respiratory or cardiac conditions, to name a few.¹⁵ The proposed approach may be valuable in the context of an established relationship with a patient who has disclosed a history of violence and abuse.

With health care reorganized during the pandemic, physicians aware of patients with a history of domestic violence should, as long as logistics permit, arrange at least one in-person visit. Although most physicians are likely to have discussed the topic of seeking help, such discussions are generally superficial and limited to encouraging the patient to seek community resources; many physicians are constrained by heavy workloads and lack the self-confidence to support these patients.⁶ However, repeated interventions by a physician the patient trusts, in a safe environment, is enabling and favourably viewed by patients, while follow-up telephone calls are not.¹⁸

This in-person visit is not meant to screen for IPV—the patient has previously disclosed this information—but to assess their chronic illness and to offer them an opportunity to be put in touch with IPV resources in the midst of an epidemic and psychosocial health crisis. Should the patient need a safety plan, the physician must recognize the limitations of their expertise in IPV and determine if other professionals need to be contacted.

Since the start of the COVID-19 pandemic, many institutions have implemented an on-call social crisis support team for health care workers who need guidance and expertise in assisting their patients. Examples of some practical tips and points to discuss with a victim of IPV during an in-person assessment can include the following:

- For patients who are not tech-savvy or have restricted access to a computer, allocate time during the visit to tell them the locations of the shelters nearest to their home and the hospital as well as other resources such as a cultural community centre. Print out paper copies of the maps for the patient if necessary. Make sure that you give the patient current information about these resources and any pandemic-related operational/organisational changes.
- In planning for the next follow-up, ask the patient when is the best time to call to find her alone to discuss health issues.
- In those institutions where medical notes are still handwritten, make sure that the emergency plan discussed with the patient is electronically typed and legible for all health care professionals should the patient present to an emergency department. This will also reassure the patient that they will not have to provide lengthy explanations during triage, especially if accompanied by the aggressor.
- Tell the patient the exact date and place in the chart where the emergency plan is filed. This can allow them to discreetly and rapidly refer a triage nurse to it.
- Stay up-to-date with a list of cancelled or no-show appointments to ensure that these patients are not removed from the waiting list without your knowledge. Some institutions only permit a certain number of cancellations, failed attempts to reschedule or no-shows before automatically removing them.
- Avoid describing patients as victims of IPV to your clerical staff. Many survivors avoid such a labelling, and as there are many reasons why patients would be seen in person, such as the need for a physical exam if a red flag presents during a telehealth interview (for example, transient vision loss accompanying headache in the field of neurology), there is no need to share the reason for a confidential visit with non-medical staff and personnel not involved in the patient's care plan.

Following this in-person visit, the physician can decide on the frequency of and way to maintain medical contact, but if the patient's reason for contact is related

to domestic abuse, efforts should be made to put the patient in contact with IPV experts who can best make the argument on delivery of care. If the patient and physician prefer to continue care through telehealth, the physician could send the patient a letter with a tentative post-pandemic in-person appointment date. The patient could place this letter in sight, to serve as a reminder to all household members that they are cared for by a health professional who expects to assess their well-being and examine them after the pandemic.

To quote Mechanic and Schlesinger,¹⁹ “the success of medical care depends most importantly on patients' trust that their physicians [...] give their patients' welfare the highest priority.” As it will likely take some time for public health authorities to put in place initiatives aimed at reducing the gendered impacts of the COVID-19 pandemic, we must ensure that our vulnerable patient populations are not neglected.²⁰ Despite the ethical challenges posed by COVID-19 contingency measures balancing public safety and patient-centred care, we must recognize situations where we need to advocate for our patients, especially for those who do not or cannot advocate adequately for themselves. As health care providers, we must share our front-line perspective with public health authorities, such as important factors that might affect the decision about offering in-person visits during the current pandemic. These factors often go beyond the usual practical issues of how much a physical exam might be needed or how easily the patient can access the requisite technology for virtual care.

In this article I highlight the importance of maintaining medical contact, including in-person visits when possible, for victims of IPV who have previously disclosed domestic abuse. This is particularly valuable if we have built a therapeutic alliance with the patient, through long-term management of a chronic health condition, for example. Although the perspective of this article is through the practice of headache medicine, these issues can apply broadly, irrespective of the clinic's specialty, its patients' sex-ratio and its staffing shortage due to COVID-19 redeployment. Physicians in sectors nonessential to the COVID-19 direct response and who have seen a change in their usual clinical activities should consider maintaining their services as essential care for these patients.

As many community social crisis services are seeing drastic increases in wait times, it is important that we remain flexible towards our patients. Moreover, the patient's primary care physician should be involved in the care plan if the patient consents. It is not unusual, however, for a clinician involved in the care of a chronic condition, particularly for complex tertiary level medical illnesses, to have a stronger therapeutic alliance with the patient because of more frequent medical contact.

Finally, as public health authorities aim to improve the reorganization of health care during the global pandemic, physicians are encouraged to collaborate with other institutional specialized teams when limited by their own expertise, in particular with psychosocial staff in assisting marginalized and vulnerable populations. This can be especially useful for victims of IPV, where a well-thought-out safety plan takes into account the complex dynamics of living in an abusive situation that goes beyond the experience of violence.

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