Abuse: An integrated and coordinated health sector response is needed

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In this issue, Drs Ilnyckyj and Bernstein (pages 801-805) conclude that Canadian gastroenterologists should be routinely asking patients about sexual and physical abuse when taking a history. The results of their survey suggest that, on average, Canadian gastroenterologists understand that a history of abuse is relevant to patient management, but only about half of the respondents to their survey include abuse history in their interviews. The reasons for not asking included time constraints, personal discomfort and lack of resources for referral. They conclude that "Gastroenterologists need to find a resolution to their barriers to abuse inquiry".

Ilnyckyj and Bernstein are among a growing number of health care workers calling for an increased response to the problem of abuse. I applaud their effort, and concur with their recommendation that gastroenterologists take up the challenge of routine screening for abuse.

A coordinated and integrated response would involve responding in terms of clinical practice, diagnosis and treatment of patients with many health conditions. It would also require clinical and health policy research that contributes to the understanding of the impact of abuse on heath and the role of the health sector in prevention. It should also promote advocacy for a society that does not create, condone or otherwise support violence. Programs that encourage gastroenterologists and other health providers to deal with personal experiences of sexual and physical abuse would also be beneficial.

Considerable work in promoting a health sector response has been done in the past two decades. In 1989, the Federal-Provincial Advisory Committee on Institutional and Medical Care Services requested that guidelines be developed on health care related to abuse, assault, neglect and family violence (1). In this report, the identification of abuse and the referral to appropriate resources are stated as "basic to all [health] programs" (page 4). These guidelines were widely circulated, and regional consultations were held with educators and associations of health professionals across the country. Other policy work has also been undertaken; for instance, the Canadian Psychiatric Association approved guidelines for the universal screening of all psychosocial and psychiatric patients (2,3) and the March of Dimes funded the National Preceptorship Program (4). Professional associations have developed guidelines (eg, Canadian Nurses Association) (5,6). In the United States, bodies such as the Joint Commission on Accreditation of Healthcare Organizations (7) recommended policies for emergency departments, and the American Medical Association (8) established the National Coalition of Physicians Against Family Violence. For many years, Health Canada has coordinated intergovernmental violence prevention initiatives and the electronic information database of the National Clearinghouse on Family Violence.

One lesson from the Ilnyckyj and Bernstein paper is that while many health professionals recognize the need for screening for sexual and physical abuse histories, action is less frequent. The negative impact of sexual and physical abuse on the health of individuals and their families is well documented, and many undergraduate and graduate medical curricula now include courses on violence prevention. According to Ilnyckyj and Bernstein, this information seems to have reached gastroenterologists. Despite the policy work and widespread knowledge of the significance of the problem, implementation of the protocols for screening for a history of violence is not common, often not routine, and may be dropped once started (9-12). The body of research on the screening process has grown substantially, yet continues to be insufficient (10). The results of the Ilnyckyj and Bernstein study support my own view that system-level variables that affect implementation and maintenance of screening programs (eg, factors affecting the time

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available to take histories, and lack of intersectoral collaboration) need greater attention. We need to look at the characteristics of the setting (13) and social context (14), and variables such as gender and victimization in order to understand how to improve uptake and maintenance of screening programs.

A coordinated and integrated response from the health sector would be beneficial, by taking some of the focus off the performance of individual practitioners. Professionals would be supported in their work symbolically and practically. An integrated response would mean close collaboration with those services outside of the health sector that have developed considerable expertise. Ilnyckyj and Bernstein stress the importance to patient outcomes and clinical practice, and that significance should not be minimalized (15-19). Screening is itself, however, a preventative and an educational intervention, conveying to the population that physical and sexual abuse have serious health consequences and can and should be discussed openly. The door may be opened for the patient to discuss abuse with the clinician or with other people in their lives. By implementing screening, professionals deliver the message that abuse is unacceptable to society (20-23). I congratulate Dr Ilnyckyj and Dr Bernstein for their contributions to understanding what can be done by gastroenterologists in this regard.

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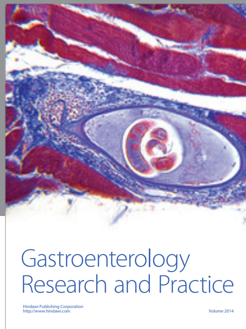
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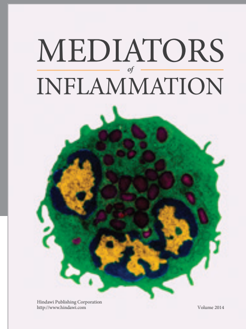
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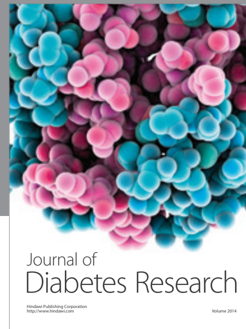
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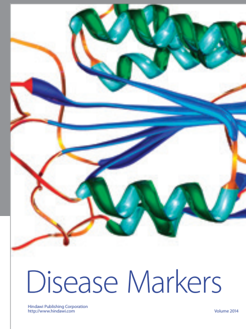
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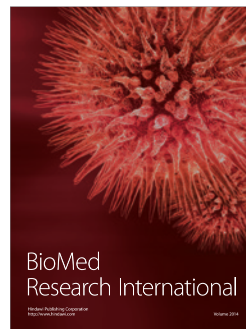
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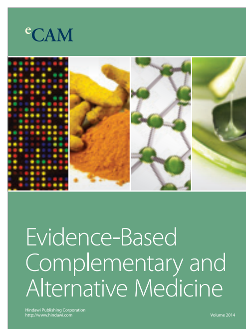
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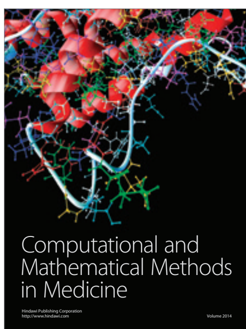
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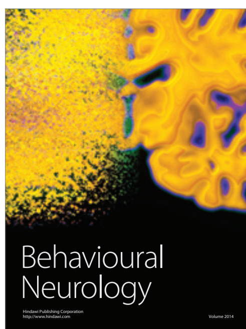
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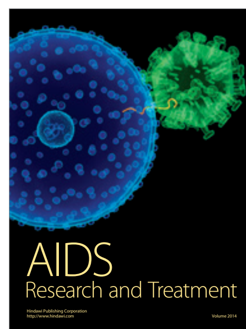
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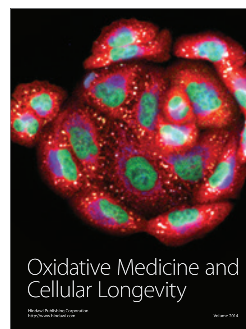
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