MEDICAL AND SOCIAL ASPECTS OF THE HEALTH CARE MANAGEMENT IN TRAUMA PATIENTS AFTER INTERPERSONAL VIOLENCE

Author: Sanda Dura
PhD candidate “Lucian Blaga” University of Sibiu

STUDY HYPOTHESIS. According to WHO, each year worldwide, about 5 million deaths are caused by injuries, a value representing about 9% of all deaths. Of these, more than 1.600.000 are caused by violence. Data from countries with high income levels shows that for each deceased person by serious injuries, approximately 30 people are hospitalized for non-fatal trauma and 10 times more people are treated in hospital emergency departments without being hospitalized. The attention paid to preventing violence by the public health experts has substantially increased, the number of publications on violence listed in Medline registering a growth of 550% over two decades. However, nowadays, preventing violence is not generally considered a legitimate activity of the ministries of health.

THE PURPOSE OF THE RESEARCH is to assess the medical and social consequences of the domestic violence as a part of the interpersonal aggression phenomenon.

METHODS. I conducted a prospective study on a sample of 106 female adults, who addressed the Forensic Department of Sibiu County, between 1.12.2010 and 30.11.2011, in order to confirm the mechanical injuries caused by domestic violence. Sample structure: mean age 38.6 years old with extremes 18-82 years old; origin environment with statistically insignificant differences (44.55% urban, rural 55.55%), average high school education (63%), occupation - technician/worker/unemployed being represented in approximately equal proportions (about 33%); middle income equally distributed (about 33%) in intervals “below minimum wage/between minimum and average wage/no income. The method of study is the sociological inquiry based on the assisted questionnaire with pre-formulated and open answers given face to face after obtaining the respondents’ consent to participate in the study. The questionnaire was constructed based on the model used by the Mina Minovici National Institute of Legal Medicine (Bucharest, 2007-2008, quoted by Cornea et al.).

RESULTS AND DISCUSSIONS. Almost half (48%) of the women who have suffered physical violence in the family were regularly abused since the early years of cohabitation. Only one third of the victims were assaulted “several times” and 8% were victims of a single abuse. The author of the aggression deeds was in most of the cases the current partner (48%) or the former partner (28%). Violent behaviour triggers are represented by: tensions arising from the poor family wealth (poverty, overcrowded house, unemployment) - over 70%; alcohol abuse - nearly 70%; tendency to dominate the family climate by the partner - 44 %; learnt violent behaviour - 26%. The reason of not leaving the domicile is in equal percentage: the lack of money, lack of available home, the hope that the situation will change and the everyday problems. During a violent episode, the victims were hit with the hand or fist (93%), slammed to the wall/floor (50%) and/or injured by a cutting/stinging object (16%). Two thirds of the injuries are located at the level of head and neck, one third at the level of abdomen and a quarter in the chest and limbs. Most victims did not resort to medical care after the previous violence deeds (86%), although sometimes they considered it would have been necessary. Fear and shame are the reasons most frequently invoked. The women who reported physical violence complain about fatigue (79%), anxiety (68%), sadness (56%), nervousness (57%) and sleep disorders (41%). Over a third of the victims consumed tranquilizers in the month previous to the inquiry. 11% of the respondents were hospitalized at least once in a mental hospital. One of two victims thought more than once of suicide.

CONCLUSIONS. The study highlights the magnitude of the phenomenon of interpersonal violence and its impact on the health care sector. The solutions go beyond the field of action of the social control factors (police, justice, administration) and involves a multisectoral response, including from the health sector and the public. Public health sector has an important responsibility in ensuring the availability of the emergency and long-term care. Efforts are required from the government bodies and NGOs to provide an answer that integrate the medical, legal, social services from the moment of crisis of before it, until the victim’s reintegration in the family social and professional life.