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RESEARCH ARTICLE

Medicolegal response to domestic violence cases: Qualitative insights from a tertiary care hospital in West Delhi, India

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Abstract

Background: *Domestic violence is a pervasive public health issue in India, significantly impacting women's health and well-being. Disclosures of domestic violence frequently occur during healthcare encounters, making hospitals and related settings critical spaces for inquiry. In this context, the aim of the study is to explore the social and medicolegal dimensions of domestic violence within a hospital setting through the lens of healthcare documentation and understand the role of healthcare providers in managing and recording these cases.*

Methods: *This study examined the medicolegal classification and documentation of domestic violence cases in a tertiary care hospital in West Delhi by manually reviewing medicolegal case registers, the quality of case documentation, and assessing standard operational procedures of hospitals. Interviews were also conducted with healthcare professionals to gain insights on the same.*

Results: *The findings reveal that poor documentation practices in medical records compromise the reliability of evidence, hinder the assessment of prevalence and patterns, and obstruct effective interventions. Despite the existence of a comprehensive legal framework, cultural challenges significantly impede the effective identification and documentation of domestic violence incidents. Healthcare providers reported multiple barriers in identifying and documenting domestic violence, including high patient loads, resource limitations, lack of training, and the overarching challenge of integrating healthcare with medicolegal requirements.*

Conclusion: *Insights from the study underscore the urgent need for improved recognition, training, and standardised documentation practices to enhance the response to domestic violence within healthcare settings.*

Keywords: *medicolegal, medicalisation, domestic violence, healthcare, standard operating procedures.*

Background

In the Indian cultural milieu, the prevailing discourse portrays domestic violence (DV), particularly marital violence, as something to be socially tolerated [1]. The legal definition of DV includes physical, sexual, verbal, emotional and economic abuse of women in a domestic (consanguineal or affinal) relationship [2]. However, within the Indian legal framework, only DV against married women by husband and/or his family has garnered legal support. For this paper, "DV" refers to violence against married women, aligning it with marital violence, as commonly understood in India.

The role of the healthcare systems is pivotal in addressing DV through a multisectoral approach [3]. DV survivors typically seek help from healthcare providers before approaching the criminal justice system, with a notable correlation between healthcare visits and reported DV cases [4-6]. Research studies have highlighted how healthcare encounters such as visits to emergency, prenatal and psychiatric clinics, often coincide with disclosure of DV [4,6]. In particular, government hospitals or primary and community healthcare centres are approached, being more accessible in terms of geography and cost. Further, some studies have underlined the role of healthcare professionals in identifying DV through injury patterns and patient presentations such as multiple injuries or fractures to arms, abdomen, craniofacial and musculoskeletal injuries, delayed presentation, referral by a general practitioner, pregnancy, and history of loss of consciousness, etc [7-11]. Thus, healthcare providers are well positioned to identify and respond to DV against women [11-12].

Despite this, the healthcare response to DV is often inadequate [13]. There is a tendency among medical practitioners to focus on physical injuries sustained by DV survivors (patients), often overlooking the broader spectrum of the impact of DV, such as unexplained injuries, mental health issues (such as anxiety, depression, emotional breakdowns and post-traumatic stress disorder (PTSD)), sexually transmitted diseases, gynaecological problems and chronic conditions/ symptoms (such as headaches, abdominal pain, fatigue etc) all of which are secondary indicators of potential DV [14-17]. Stark et al observed that medical records often treat DV injuries only as physical symptoms, overlooking the underlying abuse. These physical symptoms can translate into long term health issues, particularly impacting the mental health of survivors. As a result, survivors may be labelled with psychiatric diagnoses, which can undermine their credibility and cause their concerns to be dismissed in a legal setting [18]. The narrow focus on physical symptoms can result in misdiagnosis or underdiagnosis, complicating the legal and medical response to DV.

Bhate-Deosthali and Lingam [19] criticise the biomedical approach to DV for its inadequacy in capturing its complexities and emphasise that societal perceptions of DV

as a private matter impede DV disclosure by survivors and hinder effective healthcare interventions (also see [20]). Therefore, it is crucial for healthcare providers to adopt a more holistic approach that recognises the complexity of DV, addressing both the physical and psychological dimensions to better support and validate survivors' experiences.

Exploring the medicolegal dimensions of DV within hospital settings is crucial, as areas such as documentation, reporting requirements, evidence collection, confidentiality and privacy, legal testimony, and training of medical professionals remain relatively underexplored. Additionally, identification of DV often relies on patient disclosure and is influenced by cultural and social barriers, systemic support (such as institutional protocols), and various legal and ethical considerations that affect the reporting and management of these cases [4].

Under Section 397 of the Bharatiya Nagarik Suraksha Sanhita, 2023, and Sections 211 and 239 of the Bharatiya Nyaya Sanhita, 2023, healthcare practitioners are required to report medicolegal cases (MLCs) to the police. However, failing to report, investigate, or treat DV injuries may not always result in liability, even though such omissions could constitute medical negligence [21]. Moreover, courts often consider medical evidence as subjective rather than definitive, as indicated in Section 39 of the Bharatiya Sankshya Adhiniyam, 2023. When DV cases are not recognised or classified as medicolegal, this reduces the responsibility of healthcare facilities to provide adequate care or justice for survivors [24], resulting in a significant gap between medical practice and legal accountability.

By analysing hospital records on MLCs and healthcare practitioners' experiences with DV cases, this study will determine whether current systems accurately capture the extent of DV and how physicians' attitudes and standard operating protocols (SOPs) affect patient care.

Methods

SOPs available on the website of six hospitals were reviewed to understand the guidelines related to MLCs, particularly those concerning DV, followed by a retrospective record-based study conducted at a 640-bed tertiary care hospital in West Delhi. This research was part of a doctoral study, with the hospital serving as the secondary field site. The primary field site was a non-governmental organisation (NGO) conducting the main investigation into the role of NGOs in DV cases. Due to geographical accessibility and under jurisdictional requirements, medicolegal examinations were performed in this hospital. The hospital was also chosen for the study due to convenience and familiarity. MLCs documented by the hospital's emergency department (ED) were reviewed to identify DV cases, and those reported at the One Stop Centre[i] (OSC). This involved exploring how the DV cases were documented (in terms of nature of injuries and case history), and SOPs followed in such cases.

For this purpose, the MLC registers maintained by the ED were manually scoped to determine number of reported cases of DV against women. Interviews with on-duty physicians (N=5) and nurses (N=3) at the ED were conducted to gain insights into MLCs, representation of DV cases as a MLC, SOPs followed in such cases, their perceptions of DV, and challenges (if any) they encounter while handling such cases.

Ethics approval for the study was obtained from the Department of Anthropology, University of Delhi, India. Permission to access MLC registers and collect data was obtained from the hospital's administrative department under the clause that privacy and confidentiality of patient data and the hospital's identity would be maintained. The hospital's medical record department was approached for MLC records for the period 2018-2020.

Results and Discussions

A total of 1075 MLCs were reviewed, of which 265 were related to men, 809 to women and one to a transgender person.

Review of SOPs revealed that while cases of road traffic accidents, physical assault, sexual assault, burns, and poisonings etc were classified as MLCs (Table 1), the SOPs failed to recognise the medicolegal significance of DV cases (also see [24]). Only two SOPs explicitly categorised DV as an MLC. These SOPs while standardising examinations and evidence collection for sexual assault cases, do not specify whether this includes sexual assault within marriage or cohabitation. Moreover, retrospective studies consistently show a lack of distinct categorisation for "domestic violence" in medicolegal case profiles across Indian hospitals [25-27]. The insufficient documentation of DV-related injuries and outcomes has been partly attributed to the lack of guidelines or protocols [15].

Table 1. Review of standard operating protocols for medicolegal cases (MLC)

Institute	Domestic Violence considered as an MLC category (Yes/No)
Department of Forensic Medicine and Toxicology, AIIMS Mangalagiri, Andhra Pradesh	No
Department of Forensic Medicine and Toxicology, AIIMS Bhopal, Madhya Pradesh	No
Department of Forensic Medicine and Toxicology, AIIMS Kalyani, West Bengal	Yes
National Health Systems Research Centre (NHSRC), India	Yes
Government of Odisha Health & Family Welfare, Department Odisha	No
Employees State Insurance Corporation (ESIC)	No

In a detailed examination of MLCs involving women, only 32 MLCs were shown to involve "physical assault" against married women by husbands or in-laws (for the period of Mar-Dec 2018, n=18; for the period of Jun 2019-Jul 2020, n=14) (Table 2). These cases were "self-reported" by the women with mean age of approximately 26 years.

Table 2. Retrospective data on domestic violence and physical assault cases at an emergency department of government hospital in west district of Delhi (N=1075).

MLCs	March – December 2018 (Common MLC register)	June 2019-July 2020 (Women & Child MLC register)
Total number of MLCs analysed	620	455*
Cases reported by married women as 'alleged physical assault'	160 (25.80%)	439 (96.48%)
Self-reported cases of domestic violence by married women, also labelled as 'alleged physical assault' or poisoning by husband**	18 (2.90%)	14 (3.07%)
***Notes:** * Includes incidents of Acid Attack (n=1) and Sexual Assault (n=1); ** Poisoning cases reported by adult married women (n=12); MLC: medicolegal cases.*		

Insights on how DV cases registered as MLCs are handled were gathered from physicians at hospital's ED. Physicians in the ED follow the same SOP for DV incidents as for sexual assault cases, requiring medical examination and injury documentation to support legal proceedings. No separate guidelines exist for documenting DV as MLCs, and the resultant medicolegal reports are used as evidence alongside medical expert testimony (Table 3).

Table 3. Number of domestic violence and physical assault cases reported by women at the One Stop Centre at a government hospital in west district of Delhi for the period 2018-2020.

Year	Domestic Violence cases	Physical Assault cases
2018	47	226
2019	41	240
2020	54	195

The physicians elucidated that MLCs are primarily initiated and documented in the ED and subsequently directed to specialised units like orthopaedics, general surgery, dermatology, gynaecology, and obstetrics. Depending on the nature of the injury, these departments also see a substantial influx of patients due to DV. Access to ED and the OSC of the hospital was restricted due to Covid-19. Only the annual count of DV cases reported to the OSC from 2018 to 2020 (Table 3) was available with no documentation on these cases. It was unclear from the available data whether women first seek help at the OSC or the ED, or if DV cases are documented by both, leading to potential double reporting.

Documentation

In the MLC form, details such as patient's name, age, sex, person accompanying, and medical history including nature and description of injuries (simple or grievous, size, colour and affected body part), weapon type (sharp or blunt force trauma), and their correlation with the patient's clinical record were routinely noted. Based on the information recorded by the physicians on the MLC form, two contact points were identified: police complaints and cases self-reported by the women (since the form allowed for noting whether the patient was accompanied and by whom). When a potential medicolegal dimension is identified in a case, the healthcare practitioner communicates this to either the ED or the designated social worker of the hospital.

Two copies of MLC records were maintained with patient identification and thumbprints collected on the same form. The protocols for medical examination and documentation of sexual assault cases also applied to DV cases. For instance, in sexual assault cases [28], it is recommended that DV survivors' injuries are documented within 72 hours (3 days), extendable to 96 hours (4 days) post-assault. This is because the value of such evidence diminishes significantly after the initial three-day period (particularly in cases of sexual assault) [29].

According to a junior resident (Physician 1 or P1), classifying a case as an MLC or a DV is challenging due to the lack of concrete evidence about the injury's origin or discrepancies between patient's narratives and diagnoses. For this reason, all documented cases of DV in the emergency department exhibited an "alleged history of physical assault" (Table 2). It was also observed that cases with clear indications of a natural aetiology were also documented as an MLC. This included injuries from accidental falls of children and those at residential or workspaces, insect bite-related complications, and burn injuries due to electrocution. The practice of recording MLCs for all types of incidents in the same register with DV cases, indicated that DV cases were recorded and treated as a conventional medical condition, potentially disregarding the underlying cause of the injuries or recognising the medicolegal aspects involved. Thus, lack of clear demarcation between clinical cases (where individuals seek medical care for health conditions without legal implications) and MLCs, along with incomplete medicolegal records (lacking demographic details and case history) may lead to inconclusive reports. This highlights the need for guidelines on documenting DV cases for physicians.

Nature of domestic violence injuries from medicolegal case reports

In our study, MLCs recorded from March to December 2018 (Table 2), demonstrated that all physical assault and DV cases reported by married women involved blunt force traumas,

according to the physicians' documentation. The prevalent sites of injuries observed were as follows:

(a) The cranio-facial region, such as eye swelling, ear pain, dental issues, and nasal injuries, was identified in 38 instances;

(b) The trunk region was involved in 22 patients, 21 of whom experienced abdominal pain (comprising four instances of abdominal kicks and nine cases of neck injuries).

(c) In 35 patients, injuries were localised to the limb region.

Among the 18 documented domestic violence cases within this timeframe, 16 incidents involved physical assault by the husband, and four cases also involved the parents-in-law. Four women reported instances of coerced sexual intercourse by their husbands, while two women disclosed incidents of physical assault related to dowry issues. Furthermore, two women reported physical assault by their husbands while under the influence of alcohol, and one woman reported forced poisoning by her husband. Additionally, two women reported coercion by their husbands to ingest specific intoxicating substances. These findings underscore the physical and sexual dimensions of DV, as well as the involvement of extended family members (parents-in-law) and substance abuse in certain assaults.

Perceptions of physicians

Physicians as well as patients share apprehensions about dealing with medicolegal issues [30]. According to an ED physician (P2), lack of knowledge and misconceptions around medicolegal examination prevents survivors from undergoing it. Police involvement is a primary concern, as it marks an MLC as a post criminal event. Association with the criminal justice system invokes fear and stigma in people. An attending doctor (P3) at the ED admitted that physicians often recommend psychosocial care and counselling for patients who have experienced trauma (such as DV). However, survivors fearing police involvement, may focus only on immediate medical treatment, and choose not to engage with these services, avoid follow-ups, scans or blood test. Moreover, when patients come for medicolegal examinations — accompanied by an investigating officer (police), through NGO support or after self-reporting — standard medicolegal protocols are followed including comprehensive gynaecological examinations. However, according to a general physician (P4), in cases where survivors are accompanied by their family members (such as husband, parents, and in-laws), they may not disclose DV. Additionally, due to lack of space in OPD and increased patient volume in government hospitals, physicians are unable to dedicate the additional time that may be required for patients to disclose DV.

Challenges involved in retrospective studies using medicolegal records

Medicolegal case reports hold evidentiary value, and receiving permission to access them comes with confidentiality and data privacy concerns, making it the foremost challenge in pursuing the study. Since medicolegal consideration in DV cases is limited to death due to DV acts and dowry related fatalities [31-33], identifying DV (based on physical assaults, burn injuries and poisoning) solely from MLC reports can be inconclusive, unless explicitly indicated and recorded by the examiner in their findings. Insufficient documentation of medical and counselling records, and poor maintenance of these records make it difficult to ascertain the actual number of DV cases reported as MLCs.

This study involved personal limitations in manually reviewing the MLC registers. The actual representation of DV cases as MLCs could not be ascertained due to the lack of separate documentation on DV cases, as only a few MLCs explicitly mentioned "domestic abuse" as a cause of injury. The records also lacked socio-demographic details of the patients. Nevertheless, MLC registers maintained by the ED for the period 2018–2020 were a valuable data source.

Another fundamental challenge is underreporting of DV in medical settings. Practitioners' lack of understanding and training to address patients' mental health requirements [34], concerns about patient attrition [30], fear of legal entanglements, and increased patient caseload may hinder DV reporting. On the other hand, survivors' might obfuscate facts or experiences of violence due to their socio-economic precarities (financial dependency on spouses, prioritisation of children's welfare, lack of family support). A survivors' avoidant adaptive strategies may cause them to face inquiries by state/non-state agents regarding the delay in seeking help. The stresses caused by domestic disputes may hinder a survivor's ability to accumulate substantial evidence. In such cases, medical reports are crucial evidence in legal proceedings, and the medicolegal examiners may be called for their expert opinions. This underscores the significance of examining minor injuries or symptoms to avert the inadvertent neglect of authentic DV cases [35-36].

Insufficient support from police and physicians, and stigma related to DV may deter survivors from reporting DV. For instance, during the data collection for our study, a woman with two young children reported DV to the police at the ED. Police dissuaded her from filing a complaint and reminded her of potential repercussions if her husband is informed about it. She was advised to seek medical treatment. The physician registered her case as a MLC, documented her injuries, prescribed her treatment, and asked her for follow-up, without probing her reasons for her condition. This highlights the significant of likelihood of DV cases going unprobed and unreported.

Limitations of the Study

One of the primary limitations of the study is insufficient information on how Indian healthcare professionals address DV and if physicians are sensitised or trained to respond to DV cases during their medical education [37-38]. Due to the unavailability of all MLC registries maintained by the ED for a

specified time period and the physical demands involved in their retrieval limited the scope of this study. Lack of data on socio-economic status and personal histories of patients prevents formulation of definitive conclusions regarding the social-demographic characteristics of women survivors of DV. Further, Covid-19 restrictions and the busy schedules of healthcare practitioners impeded the establishment of rapport with them and conducting interviews. Consequently, no DV cases reported at the ED could be observed, which would have yielded valuable insights into the procedural aspects associated with reporting medicolegal cases of domestic violence.

Recommendations

Examination of medical records is essential to reveal injury patterns in DV cases and women's healthcare symptoms, both chronic and acute, that can be correlated with their experiences of DV [39]. It can inform DV-related intervention strategies, diagnoses, provision of care, quality of life, and preventing future health issues, while also contributing to post-treatment monitoring, instrumental in breaking the cycles of violence.

Documentation practices adopted in medicolegal records need critical attention. Medically describing domestic abuse injuries as "alleged" and "physical assault" absolves perpetrators of guilt. It casts doubt on the survivor's accounts and can potentially weaken cases and increase the burden of proof required to prove DV. This reinforces a culture of disbelief which can discourage survivors from seeking further help or reporting abuse. Additionally, oversimplifying domestic abuse as "physical assault" shifts the focus away from socio-cultural root causes (eg gendered power dynamics in marriages) [40-41]. Inconsistent use of medical terms such as "cut" and "laceration" can obscure injury mechanisms, while vague descriptions like "beaten up" can obscure the recognition of acute injury patterns [34]. Whereas recurrent injuries (eg unexplained black eyes or unusual bruises) may indicate domestic abuse, demanding careful attention. Therefore, healthcare professionals and law enforcement should carefully consider terminology to accurately reflect the nature of DV, validate survivors' experiences, and ensure perpetrator accountability [42].

Studies indicate that physicians without forensic specialisations tend to have limited training or experience in forensic cases or in the documentation of MLCs [24, 43]. This highlights the need for enhanced training and standardised documentation protocols. Lentz [44], BMC Domestic Violence Program [45], and Rudman [46] have proposed guidelines that could be adapted to develop a standardised documentation protocol for DV cases in India. Large patient volumes and limited resources in government hospitals make it a necessity to extend gender sensitisation and DV trainings to police, social workers and all healthcare staff including nurses and attendants; and primary and community healthcare (such as *mohalla*[ii] clinics, health dispensaries) which are more economically and geographically accessible. Hospital-based advocacy programmes and gender-focused training models such as the *Dilaasa*[iii] programme can enhance accessibility, facilitate early detection of DV, and promote integration across healthcare systems [12,47-49]. However, the success of these programmes relies on healthcare practitioners' engagement, knowledge, attitudes, and training [50]. Thus, to improve the effectiveness of health sector based DV interventions, insights from survivors and organisations fighting gender-based violence can prove beneficial.

Digitising medical records is the need of the hour, as it could safeguard against tampering, loss, misfiling, and make the information more accessible. For instance, the unique health identifiers provided under *Ayushman Bharat Digital Mission*[iv] (ABDM) could facilitate systematic screening of DV survivors by analysing medical records for patterns of repetitive or frequent injuries but not without privacy and confidentiality related ethical concerns [51]. This is because, these records may include injury patterns, psychological assessments, and personal disclosures. If this data is digitally accessible, it increases risk of unauthorised access, data breeches or misuse. Furthermore, surveillance like monitoring will be possible from such data, violating principles of autonomy and informed consent. Survivors may potentially be labelled or flagged causing stigmatisation, re-traumatisation or even lead to unnecessary stress or legal implications in cases of false positives. Thus, while digitalisation can help in the early detection of abuse, there is need of stringent privacy safeguards and survivor-centric consent protocols for transparent governance frameworks.

Conclusion

This article reflects on the inadequacies in documentation of domestic violence cases reported as medicolegal cases within hospital settings. Despite the various limitations of this retrospective study, it underlines the importance of: identifying domestic abuse as a distinct medicolegal category; using appropriate terminologies to describe domestic violence injuries; standardising documentation protocols in medicolegal cases; gender sensitisation and training of physicians and facilitating hospital-based intervention programmes on DV. Comprehensive measures to strengthen medico-legal frameworks through accurate documentation can enhance the evidentiary value of medicolegal reports. Such documentations can also assist in prioritising cases of survivors with potential life-threatening risks. It can not only deter the misuse of domestic violence related legal provisions; but can substantiate or refute allegations of domestic violence, especially when predicated on medical conditions such as miscarriage, abortion, and other physical and gynaecological injuries, including chronic psychological problems.

Thus, based on the analysis of medicolegal cases, the study recommends a socio-medical framework for identifying

domestic violence in healthcare settings that is sensitive to social and medical determinants (the former includes cultural norms, economic disparities, and interpersonal relationships, while the latter includes physical and psychological health assessments) for an integrated approach to enhance the prospect of effectively recognising and documenting domestic violence cases.

The insights gained from the documentation will inform targeted training programmes, effective screening processes, and supportive services for survivors. It is hoped that this information will guide policy reforms, standardise reporting mechanisms, and ensure comprehensive legal and social support for survivors. Ultimately, the goal is to strengthen DV interventions in healthcare settings through comprehensive and empathetic approaches.

Notes:

[i]One Stop Centres (OSCs) were established at hospitals under India's National Mission for Empowerment of Women in 2015 by the Ministry of Women and Child Development (MWCD), Government of India (GoI). These centres work in conjunction with other departments of the hospital. The objective of the OSCs is to provide psychosocial, medical, shelter, and legal support to women survivors of violence under one roof [52].

[ii]Mohalla (trans. Community) clinics are primary health care centres in the union territory of Delhi (India), particularly for marginalized populations in the city [53].

[iii]Dilaasa (trans. reassurance) project is an initiative of the Centre for Enquiry into Health and Allied Themes (CEHAT) and the Municipal Corporation of Mumbai (BMC), India which led to the establishment of a Dilaasa Centre (a redesigned one stop crisis centre) at Bombay's KB Bhabha Hospital in 2001. The objective of this Centre is to provide psychosocial support to women survivors of domestic violence; train hospital staff and build the training capacity of hospital staff and establish networks with organisations for mutual support [16].

[iv]The Ayushman Bharat Digital Mission is a GoI initiative aimed at establishing a comprehensive digital healthcare infrastructure across the nation. Its primary goal is to connect various participants in the healthcare system using digital pathways, thereby reducing disparities in healthcare access.

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