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The Role of Family Physicians in the Early Detection and Reporting of Domestic Violence: A Forensic Medicine Perspective

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Abstract

Domestic violence is a significant public health concern with an alarming global prevalence. Victims of this epidemic frequently seek health services, making healthcare providers primary points of contact. Family physicians, who are trained to address sensitive and complex issues, play a crucial role in the initial identification, documentation, and reporting of domestic abuse. These responsibilities are consistent with the principles of forensic medicine, which focus on recognizing, quantifying, and monitoring violence and abuse. Unfortunately, numerous barriers currently impede the effective management of domestic violence cases. Family physicians have an ethical and legal obligation to contribute to efforts aimed at reducing the incidence and impact of violence, thereby strengthening community and public health.

Sexual and gender-based violence affects almost one third of women worldwide (Usta & Taleb, 2014). According to estimates from the World Health Organization, 30% of women aged 15 to 49 years have experienced physical and/or sexual intimate partner violence, or sexual violence by a non-partner. In Egypt, 22% of married females reported experiencing domestic violence; in Jordan, 31% of women and 70% of men believed that women have no right to refuse their husbands' sexual advances; and in Lebanon, while 80% of women experienced domestic violence, 66% of them remained unaware that they had such an experience. The Arab region is characterized by a lack of recognition of domestic violence as an important public health issue, low reporting rates, and dominance of the global view that violence against women is a normal factor in society. Accordingly, all healthcare providers and especially general practitioners and family physicians who act as first-line providers need to be aware of the prevalence of domestic violence and learn how to effectively identify, counsel, and refer.

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1. Introduction

Domestic violence (DV) targeting women and children remains a critical public health concern within society. Epidemiological studies indicate that approximately 1 in 7 women experiences DV, with lifetime victimization rates reaching 20-40% (Usta & Taleb, 2014). The lifetime prevalence of violence against women and children varies significantly across regions, cultures, and national contexts. Beyond physical injury, DV inflicts high levels of emotional and psychological trauma, contributing to a large and growing worldwide mental health burden. Furthermore, an extensive number of studies substantiate that primary care physicians serving as gatekeepers across health systems frequently encounter patients subjected to violence; up to one-third of abused women disclose their victimization in the context of healthcare visits. Evidence informs that a coordinated community approach involving all stakeholders and s74f0e853-228d-4862-8c8f-3bd7da3dfe43ined outreach to women at risk contributes significantly to combating DV. Thus, primary care services, as cornerstone institutions within communities, play a crucial role in addressing this pressing issue.

2. The Problem of Domestic Violence: A Forensic Perspective

There are several important aspects of recognizing domestic violence throughout the lifespan. A public health approach is essential because many women do not recognize themselves as battered, even if violence is repeated, and because of the considerable social service resources often needed for protection from a batterer. Family physicians are among a cadre of important professionals whom battered women likely will contact regarding injury. They are aware of injury patterns associated with domestic violence and can assess the plausibility of explanations provided. Nonetheless, as many as 92 percent of suspected cases of battered women go unrecognized because of common misunderstanding, denial of severity, lack of time, or discomfort with issues of violence. Because family doctors see patients with chronic medical problems, including unexplained symptoms, multiple medically consulted problems, and substantial psycho-social problems, there also is an opportunity to identify underlying abuse in these cases. Domestic violence is a prevalent public health issue affecting women, children, and some elderly individuals, with alarming prevalence in several regions, including the Arab region. Studies report that 19.2% of women in Aley-Lebanon, 87% in Jordan, and 15% in Syria disclose domestic violence. Health consequences are extensive and varied and much more widespread than indicated by the number who present with recognized lesions for medical attention. Many restricted health problems—such as general bodily pain, gastric disturbances, complex psychological disorders, social problems, and marital problems—with

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associated low health satisfaction are due to violence. Because victims frequently seek healthcare for violence-related health problems, they present domestic violence as an urgent public health issue that primary healthcare physicians must recognize and manage.

Battered women do not seek assistance for many reasons, including shame, humiliation, fear of loss of children, fear of the act being trivialized, self-blame, minimization of danger, fear of exacerbating the situation, and the belief that their experience is too culturally, socially, or personally specific to deserve assistance. Even when they do identify domestic violence as the main issue, other influential factors persist, considerably obstructing the possibility of revealing such violence to physicians. Traditional cultural principles contribute to silence and denial of such health problems. Domestic violence is however a priority health issue. Despite obstetricians/gynaecologists having the second most important role, family physicians are the second most commonly involved practitioners after general practitioners. Physical violence may take many forms, including pushing, shaking, physical restraint, slapping, punching, kicking, biting, stabbing, shooting, and use of weapons.

3. The Role of Family Physicians in Early Detection

Domestic violence (DV) is a major public health issue that disproportionately affects women and children, often resulting in physical injury and emotional harm. Many victims are frequent users of health services but remain unrecognized by family physicians. Lack of training on managing DV cases and providing support is a common barrier. The incidence of DV varies widely across geographic regions; estimates indicate a high lifetime prevalence. Many primary care physicians encounter victims of violence in their practice, and reported disclosure rates range from 7% to 87%. DV has a significant impact on mental health, making early detection by family physicians crucial for comprehensive care (Usta & Taleb, 2014).

Family physicians are often the first healthcare professionals to identify domestic violence (DV) and must document relevant physical and/or psychological injuries for legal proceedings.

Research indicates that 60% of victims of DV turn to a family member and subsequently a physician. About 38% access health care services before contacting law enforcement.

3.1. Patient-Physician Communication and Trust

If a patient exhibits signs of domestic violence, supportive dialogue is a prerequisite for exploration of the subject. The regulations to which family physicians must adhere in general practice create obstacles to the kind of open communication necessary to foster a trusting relationship. During the first medical encounter, new patients often meet with a practice nurse, but findings show that physical and mental symptoms are rarely disclosed until the family physician later takes over (Usta & Taleb, 2014). Garimella et al. found that many

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female victims of intimate-partner violence (IPV) approach health-care providers with psychosomatic complaints without revealing the underlying cause, and that the first opportunity to intervene often arises in follow-up consultations (N. Garimella et al., 2002). Addressing the emotional challenges that practitioners of family medicine encounter when considering women who refuse to disclose the reality of their suffering is essential for determining an appropriate approach.

3.2. Routine Screening and Risk Assessment

Routine screening for domestic violence is essential as it increases the rate of detection and reporting (A Wahl et al., 2004). Regular inquiries regarding exposure to violence, specifically at the hands of a spouse or older intimate partner, can circumvent the "addiction" label that patients may fear will otherwise prohibit them from receiving interventions related to exposure to violence (D. McLennan & L. MacMillan, 2016). Offering and completing the questionnaire about domestic violence, or about addiction if a history of addiction is formally documented, enables the monitoring of that condition in a manner that respects confidence.

The American Academy of Pediatrics recommends that physicians include questions about domestic violence as part of routine anticipatory guidance for children, since intimate partner violence (IPV) affects children exposed to it whether directly or indirectly. The academy's guidelines advocate routinely asking IPV-related questions of every patient at every visit and directing universal interventions or services in order to identify children living with IPV, regardless of whether they are being physically abused. Domestic violence, whether it occurs in childhood or adulthood, has repetitive cycles. Many adults who were involved with or exposed to child abuse continue to allow it in their intimate relationships during adulthood. Routine screening assists in identifying individuals still living under abuse and helps perpetrators gain awareness of their violent behaviors with the thoughts of changing.

3.3. Documentation Standards and Forensic-Quality Records

Indications of domestic violence and intra-familial sexual violence should be documented in line with legal requirements and forensic standards for the inspection and treatment of victims. Proper forensic documentation increases the chances of successful investigation and prosecution of perpetrators by ensuring that any evidence collected is retained in accordance with the chain of custody (Walz et al., 2023). Medical documentation must meet legal and procedural criteria that vary between legal jurisdictions, though there are common core elements. These core elements include identifying particulars (the name of patient, treatment facility, health professional); incident particulars (date and time of the examination; date and time of the incident); details of the perpetrator (name and other particulars if known); body map indicating the location of injuries; photographs of visible injuries; and a detailed medical

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narrative covering circumstances of the incident, description of injuries, and proposed causation of such injuries (Reynaldos et al., 2018).

3.4. Safety Planning and Referral Pathways

The absence of a clear safety plan that enables patients to leave an abuser during an ongoing incident, and to remain safe afterwards, hinders effective intervention against domestic violence. Family physicians can assist by offering a safety plan tailored to the patient's unique circumstances, indicating where to go and establishing signals for neighbours to intervene (Usta & Taleb, 2014).

Clinical considerations for safety planning include all necessary logistics—accommodation, transportation, safety in transit—especially when children are involved. Specific areas in the home that are unsafe during violent incidents can be identified, and avoidance of weapons and tools that can be used for self-harm. Version control is important, updating the plan as the situation evolves. The evolving preparation for change is critical; discovery and recovery arise when readiness for concrete action has developed.

3.5. Legal and Ethical Considerations

Domestic violence (DV) can pose significant both legal and ethical dilemmas for family physicians. Legal concerns include the definition of DV, mandatory reporting requirements, and potential civil and criminal liabilities, whereas ethical concerns relate to respecting victims' confidentially and autonomy, and balancing these against public safeguarding and third-party obligations (M. Geiderman & A. Marco, 2020). Each jurisdiction has its own legal definition of DV, but many statutes require family physicians to report suspected or confirmed incidents of abuse against minors, the elderly, or persons with disabilities. In cases of positive identification or serious harm, reporting to police should also be considered, especially if future access to the same patient is unlikely (Usta & Taleb, 2014)

4. Reporting Mechanisms and Legal Obligations

Patient-physician confidentiality is a fundamental ethical principle in medicine and is enshrined in physicians' codes of conduct. However, it can be overridden by laws requiring mandatory reporting of certain injuries or events. In domestic violence cases, such laws may exist at the municipal, county, or state level, or not at all. Even when statutory reporting is mandatory, physicians may fulfil their legal obligations by notifying other parties without the victim's consent. Local social service agencies or child protection agencies may provide clarification on these reporting obligations.

Nationally, various groups have developed guidelines concerning procedures for victims of domestic violence. The most relevant of these guidelines, which pertain specifically to the physician's role, set out certain principles: the well-being of the victim takes precedence over

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that of the perpetrator; the physician must protect the victim's physical safety; there can be no justification for injury to any person; the physician must comply with mandatory reporting requirements; there must be explicit consent prior to any other report (Reynaldos et al., 2018).

4.1. Mandatory Reporting Frameworks

Internationally, family physicians may be classified as mandatory reporters of domestic violence under Safe Haven laws. The introduction of mandatory reporting legislation generally aims to generate a systematic response to the early detection and prevention of maltreatment involving vulnerable individuals (Nadine Moreira & Pinto da Costa, 2024). Often, however, mandatory reporting applies to health status changes or situations where safety is perceived to be at imminent risk. In an analysis of the barriers and facilitators underpinning reporting by family physicians in Portugal, Reynaldo Moreira et al. found that healthcare professionals typically consider only life-threatening cases as warranting notification under existing legislation (Reynaldos et al., 2018). Legislation further stipulating which types of violence, health indicators, symptomatology, or medical conditions presumptively confer the status of mandatory reporter holds potential for strengthening compliance. Indeed, broadening mandatory reporting requirements to include cases of psychological or emotional maltreatment would expand significantly the public health impact of such legislation.

4.2. Confidentiality vs. Public Interest in Safety

At the patient-physician interface, the ethical duty to maintain patient confidentiality competes with the requirement to act in the public interest where safety is at risk. Legislation intended to enhance victim safety often does not require an emergency room physician to notify the police, unless the victim is not mentally competent and declines to authorize the report. Family physicians involved with many different states and potential reporting agencies, have differing and sometimes ambiguous legal obligations concerning domestic violence. In Portugal, many family physicians support mandatory reporting laws, yet they expressed reluctance (Nadine Moreira & Pinto da Costa, 2024). Concerns included the possibility of encouragement for retaliation against the victim and a perception that involuntary notification could undermine the patient-physician relationship. Family physicians may be reluctant to document suspected domestic violence when doing so would also trigger mandatory reporting.

4.3. Interaction with Forensic Medicine and Law Enforcement

In diverse settings and cultural contexts, health professionals are frequently the first to encounter acts of domestic violence, both in individual and community forms, and deal with issues surrounding the health risks and battered persons. Health professionals, and in

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particular family physicians, are expected to be aware of domestic violence in their practice, as they can assess the impact on their patients' health and refer cases appropriately (Usta & Taleb, 2014). Family physicians' role in the handling of domestic violence is discussed in terms of routine screening and risk assessment, documentation and reporting mechanisms, alarming signs, and their civil responsibility to declare such information according to the law (Reynaldos et al., 2018).

5. Forensic Implications of Domestic Violence Documentation

Domestic violence (DV) is a public health concern, and physicians encounter multiple victims within their practice. These professionals are essential in documenting abuse in the clinical file and generating forensic-quality medical reports (Usta & Taleb, 2014).

Clinicians are the first witness to the crime, and health professionals and legal experts are expected to participate in the medical-legal consultation. Since the legal framework and rules for forensic investigation are sometimes imposed on the medical-legal report, the physicians should cooperate closely with the health institutions (Nadine Moreira & Pinto da Costa, 2024). The signed deposited clinical record and the report establish a forensic chain of custody for the information contained, and when the report is produced quickly, the physician is in a good place to analyze and interpret the situation. Additionally, the signed deposit and the report connect the clinician to the victims not actively participating in forensic investigation, allowing to confirm, reinforce, or challenge the information collected by others. The clinician is then able to contribute further into the investigation and give relevant advice on the health of the individual victim. The victim may even be referred for an examination at an intermediary stage.

5.1. Evidence Integrity and Chain of Custody

Documentation of suspected domestic violence by family physicians retains forensic significance, impacting evidence integrity and chain of custody. Depending on the circumstances, a physician's documentation may constitute the first and sole record and a qualifying medicolegal document yet remains inconsistent (P Loots & Saayman, 2019). Evidence integrity encompasses the documentation's authenticity and unaltered condition, and the chain of custody denotes history and custody continuity from first handling to presentation in court (Walz et al., 2023). Established procedures may not occur until after police intervention or a medicolegal examination, during which intervenors build on the physician's documentation, and safeguarding those records as qualified evidence under expert protocols is crucial (Reynaldos et al., 2018).

5.2. Medical-Legal Expert Testimony

Early detection is imperative for a successful patient-physician communication and trust. Domestic violence often escalates over time and a high proportion of women do not disclose

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violence to health care professionals, even when prompting questions are asked. To address this issue, formal recognition of the problem by society, including the health care system, is pre-requisite and the effect of violence on health should be included as part of the routine standard screening. The evidence also shows that non-routine intervention strategies are more likely to significantly promote disclosure of male-to-female violence than routine questioning. Routine screening for domestic violence offers a wide range of benefits for both health intervention and health information investigation. Documenting injuries and contributing to forensic evidence is fundamental for prevention and amelioration of domestic violence, facilitating every stage of health care, governmental inquiry and medico-legal care.

Documentation of domestic violence is not only important for forensic purposes and chain of possession but also for several other forensic, health and legal goals. Medical record is typically the first or the only source of information accessible to a health authority, a medical expert, a commissioner of a forensic examination or a verification system after the first intervention. Medical records and the evidences contained in them are often the only documents available to determine the nature, the gravity and the actuation of an inquiry or examination following a court order, a health alert or a governmental surveillance. It is considered by a prominent professional association that the medical professional has the obligation to remain involved in the intervention, support the patient for the further steps and furnish voluntarily and free any information likely to avoid misinterpretation by the authorities on what occurred until the closing appeal.

5.3. Case Review and Quality Assurance

Medical and social responses to domestic violence in family-practice settings were analyzed through a review of health records. The collection of case information by primary-care providers can help ensure that abused individuals receive timely and appropriate care. Research emphasizes that health professionals—including clinicians, nurses, and reception personnel—are vital for detecting and intervening in partner, child, and elder abuse. Studies reveal numerous physical and psychological symptoms in battered women, as well as a variety of health problems linked to violence. Physicians' knowledge, attitudes, and practices concerning wife abuse remain critically important. For example, conflict-assessment scales enable clinicians to measure the level of intrafamily violence. Consequently, the need for effective detection, intervention, and resource provision is urgent. Integration of domestic-violence questions into routine patient-history formats is recommended to enhance detection and facilitate departmental follow-up (G. Saunders et al., 1993). Family-violence indicators for use in quality-assurance programs are lacking.

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6. Training and Systemic Support for Primary Care Settings

The training and support of physicians in early detection and reporting of domestic violence can benefit from established curricular resources and collaborative structures already applied to other high-confidentiality medical conditions. Online and in-person programs, academic curricula, and clinical observerships promote assessment of patients for domestic violence and increase individuals' management of identified cases (Usta & Taleb, 2014). These existing resources can serve as reference points for the adaptation of similar curricula addressing the specific needs of media workers exposed to domestic violence risk. Interdisciplinary teams can support the participation of family physicians in early detection and reporting of domestic violence, increase knowledge of prevention approaches, and share experiences using a collaborative approach with other stakeholders. Family physicians can document cases of suspected and identified domestic violence in electronic health records (EHR)—especially items relating to assessment, management, referral, and case closure—using predetermined standard definitions. Any relevant data standardization can facilitate systematic property analysis of domestic violence cases and support ongoing research to inform primary care practice and population health.

6.1. Curriculum for Medical Education

The World Health Organization classifies domestic violence as a major public health problem. Training curriculum addressing the role of family physicians in the early detection and reporting of domestic violence should be integrated into medical education. As primary health-care providers, family physicians are often the first and only medical contact, and may work with clients outside a specialist setting. Domestic violence continues to be an underreported crime. Improving training guidelines for primary health-care professionals will increase the detection rate, and ensure that the appropriate organizations are informed. Limited training on the topic remains a significant barrier to reporting domestic violence. Enhancing knowledge in this area of medicine correlates with the adequacy of a report on domestic violence. Basic training on the guidelines and responsibilities of family physicians who document cases of domestic violence aids in the early detection and reporting of the issue. Family physicians should be aware of the indicators of domestic violence, and the methods of preserving evidence in the case of sexual assault (R. Insetta & Christmas, 2020).

6.2. Interdisciplinary Teams and Collaboration

Interdisciplinary collaboration with various health and social services is essential for supporting victims of domestic violence (Usta & Taleb, 2014). Such collaboration provides medical professionals with direct access to multidisciplinary teams and specialists equipped with expertise in detecting, documenting, and managing domestic violence. Family physicians trained to identify and document domestic violence injuries can effectively refer

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victims to these supportive services. Evidence-based research indicates that these interdisciplinary approaches and collaborations to assist victims of domestic violence should begin in medical school, continue through postgraduate training, and be incorporated into family medicine, public health and hospital policies (N. Garimella et al., 2002). Improvements in domestic violence educational strategies, especially those that help the entire care team undertake the required documentation and reporting efforts, are also needed. Existing training strategies remain predominantly didactic, failing to prepare practitioners to recognize and address the accompanying problems faced by many health and social care professionals who attempt to assist victims of this widespread form of violence; the health and social services sector must develop strategies to avoid negative experiences related to domestic violence work and to prevent professionals from subsequently withdrawing personal support for victims. Furthermore, most studies on the attitudes of family physicians and primary care clinicians with respect to domestic violence remain at the national level; additional larger multisite studies are needed to confirm existing findings.

6.3. Electronic Health Records and Data Standardization

Most countries have established electronic health record (EHR) systems, which provide a unique opportunity for the standardized reporting of domestic violence at the primary-care level, especially when interventions focus on the enhancement of data input and the standardization of definitions in the form of metadata. Such an approach is necessary because a common language that underpins domestic-violence data is limited and the documentation practices of family physicians remain heterogeneous (Usta & Taleb, 2014).

7. Public Health Impact and Preventive Strategies

Domestic violence (DV) constitutes a serious public health issue with significant health implications, especially for women and children. The prevalence of DV among women attending various healthcare facilities has been estimated at between 20 and 55% (Usta & Taleb, 2014). Health consequences of DV include injuries, mental health disorders, chronic pain syndromes, and reproductive health complications. Abuse that women experienced in childhood, adolescence, and adulthood is associated with a range of health problems. Women who are abused are less likely to seek preventive care and experience higher levels of frustration regarding their health than those who have not been abused.

A structured strategy for the identification and prevention of DV has been proposed by the Centers for Disease Control and Prevention. This model identifies individual and environmental determinants of DV, specifies intervention points at different systemic levels (community, institutions, and individuals), and emphasizes the collaboration of government organizations, community agencies, and the private sector. Implementation of the model

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entails training programs to empower health professionals and allied providers to identify women facing difficult situations .

7.1. Community Outreach and Awareness

Domestic violence constitutes a serious public health dilemma across multiple nations, impacting a growing number of women, children, and, more recently, members of the LGTBQ+ community. Family physicians have emerged as essential players in the early detection and appropriate referral of domestic violence and sexual assault cases through preventive education. Enhancing community knowledge, combined with the ability to recognize the early signs of domestic violence, is crucial in combating this widespread and often concealed activity. Enabling the reporting of such violence, even if voluntary and/or anonymous, plays a vital role in curtailing this scourge. Furthermore, collaboration with a wide range of organizations—including clinicians, the local police department, the Department of Family and Protective Services (DFPS), and interested community members—has proven effective in many urban and rural areas.

Approximately one out of every four women and one out of nine men will experience severe intimate partner physical violence during their lifetime, with three women being killed daily by an intimate partner (Usta & Taleb, 2014). Victims of domestic violence frequently visit primary healthcare facilities, underscoring the need to develop efficient screening and intervention strategies. Family physicians can work to strengthen community outreach and awareness regarding domestic violence.

7.2. Policy Implications and Health Equity

Addressing domestic violence requires recognition and action from the public and policy-makers, with emphasis on health, justice, rapport, education, prevention initiatives, and resources (Usta & Taleb, 2014). Much policy dialogue is conducted, but differed in effectiveness. Public health perspective provides a broad view, linking health with social, educational, and economic determinants. Health-related public policy influences health and health-related practices. Framed within foundational principles of equity, access, prevention, comprehension, and co-operation, influential factors toward and away from domestic violence are highlighted, with examination of documents from various countries which have undertaken public assessments of domestic violence and its impact on personal and community health.

7.3. Monitoring, Evaluation, and Research Gaps

Effective monitoring, evaluation, and research related to the early detection and reporting of domestic violence remain scarce. No systematic evaluation has examined the primary care context in Portugal, where family physicians document domestic violence in the electronic health record system only during patient consultations. Most family doctors consider

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domestic violence a relevant issue for their practices, yet far fewer engage in early detection, demonstrating a gap in linkages between recognition and documentation. Understanding how drivers such as knowledge, attitude, or behaviour influence early detection and reporting can provide valuable insights for improving family physicians' detection and reporting practices (Nadine Moreira & Pinto da Costa, 2024) ; (Vonkeman et al., 2019).

8. Conclusion

Domestic violence (DV) seriously affects health, wellbeing and safety, and family physicians are ideally placed to conduct early detection and reporting (Usta & Taleb, 2014). DV victims often seek professional help for physical and psychological problems yet remain unidentified (Nadine Moreira & Pinto da Costa, 2024). Effective communication is required for family physicians to detect and act on suspected DV cases within the confines of laws governing professional secrecy and mandatory reporting, which vary among different locations.

Family physicians play an essential role in the early detection of domestic violence and are in a privileged position to address this scourge. Strategies that foster confidential communication and a climate of trust are key for encouraging patients to disclose sensitive information. Training in communication skills, patient-centered interviewing, violence prevention and safety planning, along with familiarization with local legislative frameworks is needed to support family physicians engaged in early detection and reporting of domestic violence.

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