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POSTER ABSTRACT

The integrated intimate partner violence education in DMS program: policymaker, health facilities and health provider

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Introduction

IPV (Intimate partner violence) is a critical public health issue that causes morbidity and mortality worldwide.

DMS (Diagnostic Medical Sonographer) can play a crucial integrated role in assisting radiologists providing IPV services. Because radiologists have limited personal contact during Virtual Health, but DMS encounters patients directly.

Health facilities include Education institutes, clinics, health care networks for integrating-coordinating of delivering IPV services. However, Patient-centred teams have health care providers, families, and patients responsible for engaging people-centered, comprehensive, continuous, and coordinated IPV services.

Educating prospective DMS about IPV presents challenges, as DMSs have limited knowledge and guidelines for integrated IPV services.

Aims Objectives Theory or Methods

Explore the feasibilities that Policymakers provide integrated IPV care guidelines for DMS education. Health facilities (Educational institutes and clinics) accommodate integrated IPV care guidelines into the DMS curriculum. As a result, health providers (DMS) are aware of IPV's risks and health consequences against women and participate in integrated healthcare proactively.

Methods:

The comprehensive literature search for PubMed/MEDLINE, Scopus, Google Scholar, and DMS association website from Jan 2018 to June 2021 was conducted. Varying combinations of keywords “domestic violence” “intimate partner violence” “Diagnostic medical sonographer curriculum” was searched. Publications were collected manually and meticulously reviewed for contained data relevant for

Highlights or Results or Key Findings

First, DMS professional standards from CPSO, practice parameters from ARDMS, Sonography Canada, and guidelines from CMRITO reveal no DMS educational contents to address integrated IPV care strategies.

Second, the DMS association website does not contain integrated IPV information, which is already underreported.

Third, the DMS program from college tends to de-emphasize the IPV issue, which is not necessarily included in the DMS curriculum according to the National competency profile.

Fourth, IHF (Independent Health Facilities) hire Virtual Health that requests radiologist's off-site consultation, limiting the opportunity to see bruises or other signs of IVP physical trauma. In addition, remote telemedicine hampers the ability of radiologists to gather nonverbal cues.

Fifth, without knowing the risks and health consequences of IPV against women, DMS cannot proactively participate in integrated IPV first-line support, assist the radiologists in identifying victims, and refer them to the radiologist for appropriate support services.

Conclusions

Policymakers should update essential DMS educational guidelines to address integrated people-centered IPV services.

Health facilities and DMSs must overcome inconsistently screening due to limited time and resources, reluctance to possibly offend the patient, insufficient training, and strained reimbursement. Furthermore, it is essential to acquire adequate government and institutional policymaker's support.

Implications for applicability/transferability sustainability and limitations

This single institute research has limitations to address full-view integrated people-centred IPV services. Further multiple institute study needed.

Integrating guidelines and Health facilities policies into the DMS curriculum need widely accepted for IPVs screening and intervention.