Commentary

The physician's role in the prevention of femicide in Canada

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■ Cite as: *CMAJ* 2021 December 6;193:E1844-5. doi: 10.1503/cmaj.211324

In Canada, a woman is murdered every 2.5 days — ranging from 144 to 178 murders each year between 2015 and 2019[1,2] — and in 2021, the rate of femicide is trending even higher.[3] A person has been accused in these killings in 90% of cases reported since 2015; 90% of the accused have been male. Of the women murdered, 50% were killed by intimate partners and 26% by family members.[1,4] Ending the relationship does not end a woman's risk of death: 20%–22% of intimate partner femicides were perpetrated by estranged spouses within the first 18 months of separation.[5,6]

Women account for 80% of reported incidents of intimate partner violence (IPV), which affects all ages, races, ethnicities and socioeconomic strata.[7] Women at highest risk are those who are young (15–24 yr), immigrants, refugees, Indigenous or living with disabilities. Furthermore, data on femicide in Canada show alarming trends among nonurban and Indigenous women.[4] From 2016 to 2019, women living in nonurban areas accounted for 42% of femicides in Canada, even though only 16% of Canadians lived outside of cities, and one-quarter of all murdered women in Canada are Indigenous.[2,5] In 2020, the proportion of total femicides committed in rural areas increased to 54%.[1]

The intersection of IPV, gun violence and the legal system reveals clinical and advocacy opportunities for physicians to reduce femicide in Canada. Although murder of men is equally worthy of attention, intervention and advocacy, male homicide victims in Canada are killed, most often, by casual or criminal acquaintances, or by strangers.[1,2,4] Thus, opportunities for direct intervention by physicians to prevent male homicide are less clear. Gender identity as a variable was first collected in homicide data in 2019 in Canada. Inconsistencies remain in the reporting of sex and gender nationally and worldwide; thus, commenting on femicide and IPV rates for transwomen in Canada is currently difficult.

In 2018, the United Nations reported on the findings of a global study, stating "Home is the most dangerous place for women."[8] Canadian data reinforce this finding. In the 5 years from 2016 to 2020, more than 50% of victims of femicide in Canada were murdered at home, and 83%–90% were mothers.[1,3]

Notably, 45% of murdered women presented to a health care provider for an IPV-related injury in the 2 years preceding their death.[9] Thus, physicians have opportunities to affect the trajectories of the lives of women experiencing IPV and who are at risk of femicide.[7] Many Canadian resources, including educational platforms and validated tools, exist to help physicians identify IPV, manage disclosures and build programs.[7] The EDUCATE program (www.ipveducate.com/the-educate-training-program) has multimodal training resources for surgeons and clinic-based practices. REAL Talk (Recognize, Empathize, Ask, Listen; https://realtalk.sagesse.org/) provides online training and workshops. Domestic Violence Education (http://dveducation.ca) contains online, self-paced modules that clinicians can use to achieve clinical competency. A recent article highlighted the danger to women from IPV during the constraints of the COVID-19 pandemic and summarized approaches that physicians might use to address IPV in this setting.[7]

In Canada, public reports show that 37%–42% of women and girls were killed with a firearm in 2019 and 2020.[1,5] Data on murders committed by licensed firearm owners, using a registered firearm or with firearms that were previously seized, are not collected or available. As a result, it is not possible to estimate the effect of gun registration policies on femicide. The presence of a firearm at home increases the lethality of IPV fivefold.[10] Asking about the presence of firearms at home can help physicians in Canada to develop a safety plan for those in at-risk situations.

Key points

- Femicide occurs every 2.5 days in Canada, frequently follows intimate partner violence (IPV) and disproportionately affects Indigenous women and women living in nonurban Canada.
- Nearly half of murdered women present to health care for an IPV-related injury 2 years before their death, which suggests that physicians have an opportunity to identify and support those at risk.
- Resources exist to educate physicians in identifying IPV and support them to inquire about firearms at home, manage disclosures, develop safety plans and contribute to building programs.
- Intimate partner violence is not currently a specified offence within the Criminal Code of Canada, and physicians cannot simply rely on the legal system to ensure patient safety.

Data from other jurisdictions demonstrate that asking patients about firearms is acceptable, effective and recommended for at-risk populations; the "5 Ls" mnemonic (is a firearm in the home "loaded" or "locked"; are "little" children present; is the operator feeling "low"; and is the operator "learned"?) is one proposed framework.[11] Canadian research to determine the impact of questioning from physicians about firearms is needed and requires funding.

Data consistently show that a history of male violence in a relationship is the strongest risk factor for subsequent femicide.[1,5,6,8,12] A review of domestic homicides in Ontario found 72% of cases from 2003 to 2014 included a history of violence between the perpetrator and their victim.[12] Case studies in Canada often show interaction with courts before the murder.[5] However, measuring trends is challenging, as the Criminal Code of Canada currently has no specified domestic violence–related offences.[13] Sentencing and judgments related to domestic violence and IPV are concerning. A study on homicide in Ontario showed that men who commit intimate partner or familial femicide received lighter sentences than men who commit other femicide, raising suggestion of an "intimacy discount."[14] Furthermore, violent and aggressive behaviour toward female partners is not always weighed heavily enough to change outcomes during decision-making in Canadian family court, such as child custody cases.[1]

Bill C-3, an act to amend the *Judges Act* and the Criminal Code, received royal assent and came into force in 2021. It mandates training for Superior Court judges regarding sexual assault and includes amendments to specify that the social context includes systemic racism and discrimination. However, suggested amendments from the Federal Ombudsman for Victims of Crime regarding the intersectionality of domestic violence were not included. In addition, this law does not apply to Provincial Court judges, who hear most sexual assault and family law cases (involving child protection, custody and access) in Canada; training should be mandated for all judges who make decisions on IPV-related cases.

Physicians should engage with policy-makers to advocate for improved transparency regarding domestic violence–related offences within the Criminal Code of Canada, improved data collection, and improved reporting on gun violence to capture firearm type, location, ownership and registration status. Curricula should also be developed and implemented for all levels of physician training to educate health processionals to recognize and support women at risk for IPV.

Home should not continue to be the most dangerous place for women,[8] and physicians in Canada cannot simply rely on the legal system to ensure the safety and prevent the deaths of patients who experience violence in current or former relationships. We have work to do — as clinicians and advocates — to effect change that makes Canada safer for women and girls.

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Competing interests: Najma Ahmed reports being a board member of Canadian Doctors for Protection from Guns. Dr. Ahmed is also a member of the Trauma Association of Canada and the American College of Surgeons, organizations that advocate for gun violence prevention. No other competing interests were declared.

This article has been peer reviewed.

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Contributors: All of the authors contributed to the conception and design of the work, and the acquisition, analysis, and interpretation of data. All of the authors drafted the manuscript, revised it critically for important intellectual content, gave final approval of the version to be published and agreed to be accountable for all aspects of the work.

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