



CAEP Position Statement Executive Summary

Where is the love? Intimate partner violence (IPV) in the Emergency Department (ED)

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Introduction

IPV transcends socioeconomic classes, ethnicities, gender and sexual orientation, and physical borders: the World Health Organization (WHO) estimates the prevalence to be 1 in 3 women worldwide, with no significant difference between continents (WHO) [1–3, 6]. Women exposed to IPV are twice more likely to suffer from depression and alcohol use disorders and 38% of all murders of women worldwide are IPV-related [1–3, 6].

The COVID-19 pandemic has worsened the prevalence of IPV with shelter-at-home orders, increased calls to police and community support, and decreased recognized presentations in the ED [26].

A 2008 study found that 44% of women murdered by their intimate partner had visited an ED in the last year; 93% of these victims visited specifically for IPV-related injury [4]. ED physicians identified 5% of IPV cases; only 13% asked about domestic violence, despite almost 40% of females presenting with violent injuries [5]. The stereotypical “battered

woman” is often the only image that comes to mind when thinking of IPV, when it can encompass things like stalking, threats to take away their children, workplace sabotage, or blackmail. In addition, multiple visits for the same presentation, chronic pain syndromes, mental health concerns and substance use are highly associated with IPV.

Canada

Statistics Canada identified that IPV accounted for 1 in 4 police-reported crimes in 2011 [7–13]. Among these, ex-partners were involved 30% of the time. Between 2009 and 2017, there were a total of 22,323 incidents of police-reported same-sex intimate partner violence in Canada—that is, violence among same-sex spouses, boyfriends, girlfriends, or individuals in other intimate partnerships. This represented approximately 3% of all police-reported incidents of IPV over this time period. There is an increased risk of homicide after separation; leaving is the riskiest action patients take and they often find refuge in the emergency department during this transition period. A 2009 General Social Survey found 22% of victims report incidents to police; thus the IPV statistics discussed are significant underestimations [7].

Economic impact

Estimating the economic impact of a social phenomenon naturally would help policy-makers with resource allocation and program funding. A Justice Canada costing study published in 2012 estimated the cost of IPV to be \$7.4 billion dollars [14]. The study estimated that the cost of ED IPV-related visits was 30 x more costly than Family practice visits, and patients are three times more likely to visit

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the ED than their own family doctor for IPV-related health concerns. Comparatively, \$7.4 billion dollars is equivalent to the Gross Domestic Product (GDP) of Bermuda and is double what is spent on care of congestive heart failure patients in Canada [15].

The ED is the setting for helping patients with IPV as a point of entry to the healthcare system, often seeing patients who do not regularly see a physician. IPV survivors come to the ED more often and they come at the most vulnerable times as they try to leave toxic relationships.

Recommendations

Universal screening should be performed in the ED

Screening is encouraged in the ED. The literature on screening women for intimate partner violence is controversial, with some studies showing strong evidence for screening and others lacking evidence to screen. A 2008 study found that ED physicians were only able to identify 5% of IPV cases with only 13% ever asking about IPV, despite almost 40% of females presenting with non-accidental injuries [4]. We cannot identify IPV if we do not ask patients. Furthermore, an empathetic response to a disclosure of IPV results in a sixfold reduction in substance use and mental health symptoms (particularly PTSD) post-assault [16–19].

A 2013 systematic review in *Annals of Emergency Medicine* concluded that screening is beneficial, low risk and low cost, but intervention of the screening was not studied [20]. Screening itself works, health professionals are able to identify patients with high sensitivity/specificity using numerous validated screening tools such as the Woman Abuse Screening Tool (WAST). With regards to whether screening benefits patients, the literature lacks studies on intervention and outcomes after intervention.

A Cochrane review evaluated 8 studies of over 10,000 women and found that overall the screening rates were low compared to the best evidence of IPV population prevalence [21]. They concluded that screening increases the identification of IPV in healthcare settings but found no evidence of an effect for other outcomes, such as referral to a specialized IPV service, health measures or harm arising from screening.

Taking all of the evidence into account, screening is low cost, low risk (safe) and can detect a high prevalence of previously undetected abuse in the ED, where patients are presenting for care. Incorporating screening into medical care requires training of staff on what questions to ask and what local resources are available if someone screens positive.

Appropriate medical care

Injuries should be assessed and treated in the usual manner. Medical care always comes before any forensic considerations. Perform a physical examination as guided by the clinical interview—a full head-to-toe exam is not necessary and can be traumatic for patients. Using a trauma-informed approach to your examination is ideal. This consists of informing the patient of what you will be doing for each step of your exam, never approaching a patient from behind, and allowing the patient full control to halt the examination at any time. Provide analgesia and tetanus updates as per the usual guidelines. Pursue imaging and provide analgesia and tetanus updates as per standard practice. Patients presenting with a possible strangulation injury need evaluation for any signs of significant force, such as a loss of consciousness, vascular injury signs, neurological injury or changes in phonation that may indicate an airway injury. Imaging should be a CT angiogram of the head and neck [25]. If the patient is stable, this patient can be imaged when a safe transfer can be arranged.

Referral to specialized care centre

Specialized care services are a team who provide private and confidential trauma-sensitive medical care to any person who has experienced sexual or intimate partner violence in their region. Patients must consent to care from the specialized team - there is no assumption of implied/emergency consent in these cases.

Hospitals in most provinces have a Memorandum of Understanding with a specialized Sexual Assault and Domestic Violence treatment centre. In Ontario, the locations can be found at <https://www.sadvreatmentcentres.ca/> under the “Get Help” box. The International Association of Forensic Nursing maintains a worldwide list of forensic programs at <https://www.forensicnurses.org/> In addition, hospital Social Work services can act as an expert consultant for managing the complex social safety aspects of the patient’s care. All of these services are recommended to be consulted for these patients, should they consent to this, as their care encompasses a multitude of social, forensic, psychological and safety aspects that are difficult to manage in a busy ED.

In Canada, you cannot call the Police without the express consent of the patient, even if you are concerned for their safety. The only way you are allowed to break confidentiality is in cases where children are in the home (even if they are not victims of the abuse), elder abuse in a long-term care setting or gunshot wounds.

Documentation

Once an emergency doctor has identified a case of IPV, the assumption should be that the medical records may be summoned to court and documentation of the events should be clear and legible to any. In a 1999 study published in *Annals of Emergency Medicine*, a chart review of ED documentation of intentional assault showed that two-thirds of charts had no documentation of who the patient reported the assailant to be and in over one-third of cases the object used and type of assault was not documented [4]. Many other studies have shown a lack of recognition and coding of ED visits for IPV, which impacts population information on the burden of this disease and downstream funding for IPV specialized care programs [22–24]. With just small adjustments to medical charts, they can be much more accurate and useful in court. Here are some pointers in documentation for your charting:

Using words like ‘patient states’ or ‘patient reports’ remain factual and non-judgmental. Writing “patient was punched in face” may obscure the identity of who is speaking. Avoid commenting on any speculated mechanism of injury, if not explicitly told.

Do not use words like ‘claims’ or ‘alleges’ as they imply skepticism and are legal terms that should not be used. Avoid commenting on suspected age of injuries such as bruises. Avoid the use of terms such as “old bruising” as this has been shown to be inaccurate and can be controversial in court. Simply describe the location, size and colour of any injuries seen.

Write legibly; if the average person is unable to read the documentation, it is unlikely to be helpful in court and you may be subpoenaed to explain your charting.

If your observations have clear discrepancies with the patient’s statements it is still very important to remain factual and write the HPI as per what the patient reports. Have your sexual assault team take photographs of the injuries. Never take photos yourself as there is a specific way to take photos for them to be permissible in court. Record the time you see the patient, the time you examine the patient and the approximate time as per the patient states of when the injuries/events occurred. Write out the patient's vital signs and always *describe* the patients’ demeanor. Write whether the patient is tearful, shaking, crying, angry, agitated, calm or indifferent. Writing “NAD” aka no acute distress does not accurately describe your patients’ demeanor.

For the final diagnosis, if the patient came in for IPV-related injuries then one should have the Final Diagnosis as Intimate Partner Violence or Domestic Violence. Diagnoses like ‘assault’ or ‘social situation’ do not help

the hospital’s coding process which has implications for funding, community resources and research.

Summary of recommendations

IPV should be recognized as having similar presentations as non-accidental traumas or child abuse. IPV transcends social economic status, race, age and gender and should be considered in all demographics.

IPV should be considered in patients presenting multiple times for the same complaint, chronic pain syndromes, mental health concerns and substance use disorders.

Universal screening is encouraged in the emergency department. The idea that there is “No evidence for screening” is based on literature that never studied intervention.

We recommend treating IPV-related injuries in the same manner as we do as any accidental traumas.

Referral of all consenting patients to a specialized IPV treatment centre is recommended, as their complex care is difficult to achieve in a busy ED.

In documenting IPV-related charts, avoid legal words and use clear and factual statements.

Your final diagnosis should contain IPV to capture accurate data for the population prevalence in your area. This also has important funding implications for specialized treatment programs.

Conclusion and next steps

IPV is prevalent worldwide and Canada is no exception. The ED is where these patients commonly seek care. Screening itself works and the idea that there is “no evidence for screening” is based on literature that never studied intervention. IPV-related injuries should be treated the same as any other traumatic injury and chronic, substance use or mental health complaints may be clues to IPV. Referral to a specialized care centre will ensure the complex needs of IPV patients are met.

Declarations

Conflict of interest All authors declare that they have no conflicts of interest.

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