Screening for Intimate Partner Violence:

Emergency Physicians' Experiences in Atlantic Canada

September 2016 – May 2018

Rebecca Nuttall, BSc, MHA

Faculty of Medicine

Memorial University of Newfoundland

230 Elizabeth Ave.

St. John's, NL A1C 5S7

The Author declares that there is no conflict of interest.

The Author received no financial support for the research, authorship, and publication of this article.

Wd Count: 2571

Abstract

BACKGROUND: Intimate partner violence (IPV) results in poorer health outcomes and greater system costs. IPV screening protocols are recommended in emergency departments (EDs) where intervention is critical, yet there is limited literature investigating ED-specific IPV screening health outcomes. This study aims to identify trends in emergency physicians' experiences screening women for IPV and to investigate associated IPV screening outcomes.

METHODS: This was a qualitative research design with ethics approval. An emergency physician who had performed at least one IPV screen on a woman of childbearing age presenting to the ED was eligible for interview. Each participant was asked eight predetermined questions addressing their IPV screening experiences with allotted time for discussion. Recorded interviews were transcribed and underwent Braun and Clarke's six phases of thematic analysis.

RESULTS: There are no official IPV screening protocols in place at the investigated hospitals. IPV is often missed and perceived incidence may vary by gender or experience. Allied health professionals are crucial to IPV patient care. Outcomes are predicted to not improve post current interventions. The greatest challenge to IPV management is eliciting disclosure of abuse.

CONCLUSION: These findings indicate that physicians believe formal ED screening protocols would likely help IPV victims. Unfortunately, there are none currently in place at three EDs in Atlantic Canada. The incidence of patients who present to the ED due to IPV should be determined. The identified population could be analyzed for common features. These features could be used as indicators for formal, evidence-based, IPV screening protocols, which may increase identification of victims.

Introduction

Intimate partner violence (IPV) is defined by Statistics Canada (1) as violence committed within an intimate relationship by spouses or ex-spouses and current or former dating partners. It can occur in the form of physical, emotional, verbal, sexual and financial abuse (1). IPV victims and their children experience poorer physical and mental health relative to non-victims, resulting in greater system costs (2). In 2013, approximately 27% of police-reported violent crime in Canada was IPV-related, women accounting for approximately 80% of the victims (2). Newfoundland and Labrador (NL) have an estimated IPV rate higher than the national average and it is estimated that only 10% of women who are victims of IPV in NL will report it to the police (1,3). Although patients may recognize healthcare settings as a place to disclose abuse, the healthcare provider must consistently screen for IPV (4). "The emergency physician in particular has a unique opportunity to identify patients who are victims of IPV, as many IPV patients may have limited medical contact" (5). One study found that 44% of women murdered by a partner had visited the emergency department (ED) within two years of their death – the majority (93%) for an injury (6). In fact, studies across multiple countries indicate that 40-70% of murdered women were killed by their male partner (2).

Canadian professional organizations recommend highly feasible screening protocols to identify victims of IPV in healthcare settings, where IPV Screening is defined as "universal routine inquiry: a standardized assessment of patients, regardless of their reasons for seeking medical attention, aimed at identifying women who are experiencing or have recently experienced IPV" (7). Although IPV screening is a widely accepted practice that provides a platform for management of associated health problems (8), there is insufficient evidence supporting a

significant contribution to better health outcomes or improvements in quality of life for patients (9). A narrative review investigated evidence of benefits to IPV in ED-specific settings. The target population was women of childbearing age who were victims of IPV visiting the ED. IPV screening was the intervention of interest. All reported outcomes of IPV screening interventions were the outcomes of interest. Three articles met the study criteria, confirming major gaps in the literature when exclusively looking at ED-specific IPV screening health outcomes for women (10-12). This study aims to identify trends in emergency physicians' experiences screening women for IPV and to investigate associated IPV screening outcomes.

Methods

The research project began after ethics approval in August 2017. Participants were asked during a telephone or face-to-face interview (participant preference) eight predetermined questions regarding their experiences screening women for IPV (Appendix A). The semi-structured interview process allowed follow-up questions and discussion to gain as much insight as possible. Each interview was allotted thirty to forty-five minutes. Two audio devices were used with informed consent to record each interview and then transcribed verbatim. Multiple audio devices allowed for technical error in recording. The audio and transcribed files are kept under password protection by the project's supervisor in St. John's, NL. It was determined that data collection would continue until results were saturated or ten interviews were complete. Data collection ended in June 2018.

Participant recruitment required personally contacting two known emergency physicians at the Moncton Hospital in New Brunswick (NB) and St. Clare's Mercy Hospital in NL. The respective

physicians provided contact information of emergency physician colleagues. An email describing the study, eligibility criteria, and participation requests was sent to each participant with an attached consent form and interview questionnaire (Appendix A). Each physician who had performed at least one IPV screen on a woman of childbearing age presenting to the physician's ED was eligible.

Thematic analysis of semi-structured interviews allowed for study scope to expand past the individual experiences of interviewees to more easily achieve research objectives. Braun and Clarke's (13) six-phase approach to thematic analysis was used, which encourages moving back and forth between phases. Phase 1 required becoming familiar with the data by conducting the interviews, transcribing the recordings, and rereading the transcriptions. Phase 2 required generating codes – or interview excerpts – and organizing codes based on interview questions or the primary investigator's perceptions of emerging themes (13). There were no pre-set codes prior to initiation of the coding process, so this study used open coding; codes were developed and modified along the way (14). According to Maguire and Delahunt, "a theme is a pattern that captures something significant or interesting about the data and/or research question" (14, p.3356). Themes should be coherent and distinct from each other (14). Phase 3 required searching for themes, Phase 4, reviewing or modifying themes, and Phase 5, defining themes, or "identify[ing] the 'essence of what each theme is about"(13, p.92). Phase 6 comprised discussion of results (13).

Results

The emergency physicians at St. Clare's Mercy Hospital and the Health Sciences Centre in St. John's, NL work interchangeably, so data acquired pertained to both hospitals, which was in addition to data acquired from those employed by the Moncton Hospital. Most emergency physicians in St. John's were contacted and invited to partake in the study. Approximately six physicians were contacted from the Moncton Hospital. Altogether, there were ten willing participants, and only six interviews were conducted due to time constraints. The average interview length time was 16.4 minutes and five themes were identified to answer the main research objectives.

Theme 1: There is a lack of formal IPV screening protocols in place at St. Clare's Mercy Hospital, the Health Sciences Centre, and the Moncton Hospital EDs. That being said, the overall approach to IPV suspected by physicians was similar across hospitals, and the child safety protocol was adhered to, in that they reported suspected violence occurring around children. Most IPV screening approaches were initiated by one of three triggers: the patient admitting they were a victim of IPV, a discordance between the patient's story and presentation, or observation of an overbearing potential abuser. Next, physicians ensured patient privacy, confidentiality, and safety in the ED, then explicitly asked about abuse. Various physicians used the advantage of time that procedures provided to develop rapport before asking about IPV. In some cases, if IPV was confirmed, the patients were referred to specialized nurses or social workers who were well versed in available community resources. In other cases, the physicians provided appropriate resources themselves. In cases where increased discretion was required for

patient safety, a few physicians provided the patient with a lipstick or compact that contained an emergency number hidden within, supplied by the ED.

Theme 2: While it is agreed that IPV may often be missed in the ED, the perceived IPV incidence could depend on physician characteristics, such as gender and experience. Although there were only six physicians interviewed, those that interviewed at the same hospital provided different perceived incidences, with increased incidences reported by female physicians. This may be because most victims of IPV are women and therefore more likely to tell their story to female physicians. Additionally, physicians with greater years of experience tended to report a higher incidence of IPV in their department, meaning more work experience may increase awareness of actual numbers. Despite the varying reported incidences of IPV, the majority of interviewees felt that IPV is underreported. One physician suggested to remind oneself and colleagues to be on alert for red flags indicative of IPV to increase perceived incidence and subsequent identification.

Theme 3: Inter-professional collaboration is important to achieving appropriate patient care of IPV victims. Many interviewees consulted specialized mental health nurses or social workers when they were managing IPV. Many mentioned that the nurses and/or social workers were experts in recognizing and interacting with a victim of IPV. Furthermore, time constraints that physicians experience with more complex patient cases, such as those experiencing IPV, are alleviated by allied healthcare professionals stepping in and providing the counselling and referral of community resources.

Theme 4: Physicians agree that the most probable outcome for these women after visiting the ED is that they remain in the abusive relationship. Many agreed it is difficult to predict the outcomes, as follow up is not involved due to the nature of emergency care. One physician suggested implementation of a system for flagging patients for suspected or confirmed IPV, so that other physicians could note it on the chart the next presentation. Unfortunately, most believed the women do not report IPV, and that they ultimately will return to their partner, despite receiving help from ED healthcare providers.

Theme 5: The greatest challenge to IPV patient care is effectively providing a platform for patients to disclose IPV. Indicated barriers were patient or emergency department related.

Subtheme 5a: Reported ED related barriers were privacy, pace of department, lack of resources, and lack of official screening protocol. The nature of the ED presents many barriers to a patient receiving privacy. Many physicians attempted to achieve privacy with patients suspected for IPV involvement; however, this was not always possible, and patients may have feared being overheard.

Because of the fast pace of the ED, physicians speculated that they likely miss some IPV cases while treating the physical problem. If patients are private about the actual cause or red flags are missed, interviewed physicians agreed that some patients are not screened for IPV when they may benefit from a screen.

Lack of human resources is an issue among emergency physicians and complex patient cases. As aforementioned, the nurses and social workers are key to an IPV case. One physician explained that due to the nature of IPV cases, they often occur after hours, while social workers work Monday to Friday, approximately 8AM to 4PM. On-call persons help, but it is often not the same as having them on the ground. This may be an area where IPV patient care could be improved.

Another potential area for improvement is with implementation of official IPV screening protocols, supported by most interviewed physicians. One physician speculated that it would be inefficient to screen every patient, however if data was collected to help determine common presentations of IPV patients (i.e. mental illness, specific injuries, or patient accompaniment (abuser nearby)), then a screening protocol could be used upon patient presentation. It was also suggested that IPV questionnaires could be handed to patients waiting in triage. Ultimately, official IPV screening protocols could help to increase the number of identified IPV victims.

Subtheme 5b: Reported patient-related barriers were safety, mistrust in confidentiality, abuser present, fear of persecution for both patient and abuser, and patient pride. Physicians indicated that patients needed to feel safe, to believe what they said was confidential, and to believe their abuser would not find out about the disclosure. This was not always easy to achieve due to the nature of IPV and the time it takes to build rapport with a patient. Sometimes the abuser was present, which made it more difficult for the patient to feel safe even after the abuser was made to leave. Some physicians speculated that patients feared their abuser would be punished or that the patients themselves would be punished by authorities, as sometimes additional illegal activities are happening in the home. Sometimes the abuse is reciprocal. Finally, many

physicians agreed that patients may be too ashamed to admit who caused them harm. One physician told an unfortunate story where a woman acquired a disability from IPV, waiting too long before seeking help to avoid embarrassment.

Interpretation

Five themes were identified from six interviews with emergency physicians discussing their experiences screening patients for IPV. The physicians worked at either the Moncton Hospital in New Brunswick or both St. Clare's Mercy Hospital and the Health Sciences Centre in Newfoundland and Labrador. If a physician had performed at least one IPV screen on a woman of childbearing age presenting at their ED, they were eligible. Themes revealed that there are no official IPV screening protocols in place at the investigated hospitals. IPV may often be missed, while gender and experience may determine perceived incidence of IPV. Often, nurses and social workers are crucial to the care of IPV patients. Unfortunately, outcomes for these women are predicted to remain the same as when they arrived at the ED. And finally, the greatest challenge to IPV patient care is eliciting the patient's true history, which is influenced by both ED and patient related factors.

Predicted limitations were interviewee recall biases as well as primary investigator bias when interviewing physicians, as the interviews were semi-structured. Sample size was small (six) and bias may have been present in those willing to participate versus those willing to not. The benefit of flexibility in thematic analysis can lead to primary investigator bias and a lack of coherence in developing themes. As the interview transcriptions are not fully reported, relevant data may not

be incorporated in the analysis. Finally, EDs were limited to three in Atlantic Canada, so results did not provide a comprehensive picture of IPV screening in the Atlantic Provinces.

These findings indicate that physicians believe formal ED screening protocols would likely help IPV victims. However, there is limited available literature to compare these results. A randomized controlled trial in an urban New Zealand ED investigated how effective IPV screening is in reducing short-term re-victimization (11). It provided insignificant support for IPV screening benefits yet determined that IPV screening does not cause harm. A survey-based and observational study by Glass et al. (10) concluded that they were in support of IPV screening. A third study acquired anecdotal evidence also in support of IPV screening (12). Thus, it is likely important that IPV screening protocols be implemented in EDs and their efficacy evaluated for quality improvement purposes. The incidence of patients who present to the ED due to IPV at hospitals in Atlantic Canada should be determined. The identified population could be analyzed for common features. These features could be used as indicators for formal, evidence based, IPV screening protocols, which may increase identification of victims for further management.

References

1. Statistics Canada. Family violence in Canada [A statistical profile]. Ottawa: StatCan; 2013 [cited 2015]. Available from: https://www150.statcan.gc.ca/n1/pub/85-002-x/2014001/article/14114-eng.pdf

2. World Health Organization. Understanding and addressing violence against women. Geneva: WHO; 2012 [cited 2016 Nov 30]. Available from: http://apps.who.int/iris/bitstream/10665/77432/1/WHO_RHR_12.36_eng.pdf

3. Government of Newfoundland and Labrador. Violence prevention initiative. St. John's; 2008 [cited 2015]. Available from: http://www.gov.nl.ca/VPI/facts/violence_against_women_fact_sheet.pdf

4. Phelan M B. Screening for intimate partner violence in medical settings. Trauma Violence Abuse. 2007;8(2):199-213.

5. Scoccimarro A, Waseem M. Intimate partner violence - An emergency department perspective. emDOCs [Internet]. 2015 Jun 19 [cited 2015];Practice updates:[about 1 screen]. Available from: http://www.emdocs.net/intimate-partner-violence-an-emergency-department-perspective/

6. Daugherty J, Houry D. Intimate partner violence screening in the emergency department. J. Postgrad Med. 2008;54(4):301-5.

7. MacMillan H L, Wathen N C, Jamieson E, Boyle M H, Shannon H S, Ford-Gilboe M, et al. Screening for intimate partner violence in health care settings. JAMA. 2009;302(5):493-501.

8. Jewkes, R. Intimate partner violence: The end of routine screening. Lancet. 2013;382:190-1.

9. Hegarty K, O'Doherty L, Taft A, Chondros P, Brown S, Valpied J, et al. Screening and counselling in the primary care setting for women who have experienced intimate partner violence (WEAVE): A cluster randomised controlled trial. Lancet. 2013;382:249-58.

10. Glass N, Dearwater S, Campbell J. Intimate partner violence screening and intervention: Data from eleven Pennsylvania and California community hospital emergency departments. J. Emerg. Nurs. 2001;27(2):141-9.

11. Koziol-McLain J, Garrett N, Fanslow J, Hassall I, Dobbs T, Henare-Toka T A, et al. A randomized controlled trial of a brief emergency department intimate partner violence screening intervention. Ann. Emerg. Med. 2010;56(4):413-24.

12. Koziol-McLain J, Giddings L, Rameka M, Fyfe E. Intimate partner violence screening and brief intervention: Experiences of women in two New Zealand health care settings. J. Midwifery Womens Health. 2008;53(6):504-10.

13. Braun V, Clarke V. Using thematic analysis in psychology. Qual. Res. Psych. 2006;3(2):77-101.

14. Maguire M, Delahunt B. Doing a thematic analysis: A practical, step-by-step guide for learning and teaching scholars. AISHE-J. 2017;8(3):33501-14.

Appendix A

Semi-structured Interview Script between Participants and Primary Investigator

1. Can you describe the IPV screening process(es) that you/your organization uses?
2. Is follow-up/counselling referral involved?
3. How often do you encounter female patients whom you suspect of experiencing IPV in your emergency department?
4. What are the challenges/barriers that you've faced when screening women for IPV? Please describe your experiences.
5. When faced with those challenges/barriers, what do you do to attempt to overcome them?
6. To the best of your knowledge, what do you predict are the most probable outcomes of screening your patients positive for IPV?
7. Do you have any suggestions for improving health outcomes for women screened for IPV in the emergency department (macro and/or micro)?
8. Any final thoughts on this study and IPV in general?