Emergency department patients’ opinions of screening for intimate partner violence among women


ORIGINAL ARTICLE

Background: Universal screening for intimate partner violence (IPV) in the emergency department (ED) has been advocated by many medical institutions. Policies implemented for IPV screening have met with numerous obstacles. One such obstacle is the perception by emergency personnel that patients might be offended by such screening if they presented to the ED for problems unrelated to trauma.

Objectives: To assess opinions of adult ED patients regarding a policy of universal IPV screening for women presenting to the ED.

Methods: This study was conducted in EDs in Halifax, Nova Scotia, and St John’s, Newfoundland. Patients were questioned as to whether it was appropriate for all women to be asked if they had experienced violent or threatening behaviour from someone close to them. Patients in significant pain or in extremis were not approached.

Results: The data consist of a convenience sample of 514 adult ED patients, aged 16–95 years. Two (0.4%) were excluded from the analysis. Of 512 analysed, 442 (86.0%) answered “yes” to the question, 53 (10.3%) answered “no”, 17 (3.3%) had no opinion. There were no significant differences between the proportion of “yes” and “no” answers in the male and female groups.

Conclusion: Universal screening for IPV of adult female patients presenting to the ED was supported by most patients. Patient objections should not be seen as a reason to withhold questioning on this issue.

METHODS

This study was conducted in EDs at The Queen Elizabeth II Health Sciences Centre in Halifax, NS (QE II), and the Health Sciences Centre in St John’s, NF (HSC), both tertiary care centres with an ED census of 75 000 and 42 000 visits a year, respectively.

Data collection occurred in 2000 at QE II (over one year) and in May 2001 at HSC. Patients were approached during both daytime and night time hours, although time of day was not recorded for data analysis. All aspects of this study were reviewed and approved by human investigation and ethics committees at the respective institutions.

Patient consent was obtained before surveying and no identifying data were recorded. On an a priori basis, a sample size of 500 was chosen. After obtaining verbal consent, the subject was read the following standardised script and asked to answer “yes”, “no”, or “no opinion”:

“We know that women often experience abuse or violence committed by people close to them. Emergency departments are often the only place where these women can be identified and offered help. Right now we do not currently ask every patient about abuse and violence. We would like your opinion as to whether it is appropriate for the doctor to privately ask all women coming to the emergency department if they have experienced violent or threatening behaviour from someone close to them.”

Patients recorded their age, sex, and responses privately and completed surveys were placed into a sealed envelope. Patients were not asked to disclose personal experiences with violence.

Subjects included non-critically ill patients, aged 16–95 years who presented to the ED during specified data collection time frames. All potentially eligible patients in the waiting room were approached individually during these time frames. Subjects who refused or were in distress were not included. Medical students administering the survey did not interfere with the active medical care of patients and were not aware of the presenting complaint.

Data were entered into SPSS and analysed using descriptive statistical methods. A $x^2$ analysis of the relation between

Abbreviations: IPV, intimate partner violence; ED, emergency department
opinion and sex was performed. A \( t \) test was used to determine any association between opinion and age. An \( \alpha \) level of 0.05 was used.

**RESULTS**

In total, 514 undifferentiated ED patients, (mean age 39.4 years) were surveyed; 250 at QE II and 264 at HSC. No language barriers were identified. Altogether 304 (59.1%) were female and 210 (40.9%) were male. A total of 442 (86.0%) answered “yes” to the survey question, 53 (10.3%) answered “no”, and 17 (3.3%) had no opinion (table 1). Two (0.4%) subjects were excluded; one became volatile and refused to answer questions while the second was found incapable of responding because of medical reasons.

A \( \chi^2 \) analysis was completed to review the relation between opinion and sex. There were no significant differences between the proportion of “yes” and “no” answers in the male and female groups (\( p>0.05 \)). Because the data followed a normal distribution, a \( t \) test was used showing no significant differences between age and opinion when sex was reviewed separately or combined (\( p>0.05 \)).

There were no significant differences found between the data collected at each centre.

**DISCUSSION**

The medical community has recognised IPV as a significant public health issue. Female victims who present to the ED, often have non-traumatic presenting complaints and frequently choose not to disclose IPV unless asked directly by a physician or other healthcare professional in a safe and private setting.\(^1\) \(^2\) A 1997 survey found that of all domestic violence victims, 36% of women would only divulge domestic violence if asked directly.\(^3\) By not inquiring about the risk of violence victims, 36% of women would only divulge domestic violence. This may represent a source of further selection bias.

During daytime and night time hours cannot be determined. To ensure that all times of the day were represented, these data were collected at each centre.

Many barriers to intervention have been described. Our survey questioned whether ED patrons believed all female patients should be screened for IPV. Research shows an IPV prevalence rate of 13% inflicted by women upon men.\(^4\) Restricting the screening group to women only, may allow abuse of elderly people, disabled persons, and men to go undetected.

To direct medical curriculum and ED protocol development, further research into current attitudinal barriers regarding domestic violence is necessary, including the impact of patient characteristics such as sexual orientation, socioeconomic status, and cultural beliefs.

In conclusion, universal screening for IPV of adult females presenting to the ED was supported by most patients. Fear of patient objections or offence is not a valid reason to withhold screening for IPV.

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