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Women attending an accident and emergency department after assaults

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SUMMARY

Assaults on women are a distressing aspect of A&E work. In a combined prospective and retrospective study, covering a 6-month period, 282 female victims were identified (0.75% of attendances). Although most of the injuries were relatively minor the recording of historical and social factors was poor. Attempted follow up for counselling and support proved ineffective. Better education of the doctors regarding the documentation for such patients, assessment of the social dimensions of their needs and requirement for improving both their immediate care and long term follow-up are discussed.

Key words: accident and emergency, assaults, women

INTRODUCTION

We live in an increasingly violent society.[1] Health care professionals have become aware that the management of patients who have been assaulted often addresses only the physical injuries sustained, and fails to deal with the underlying causes of the assault.[2–4]

Whilst more men than women are assaulted[5] the latter are often in greater need of extended help, including the provision of an immediate place of safety away from the attacker. Previous reports in the United Kingdom and North America have concluded that this help is frequently lacking and subsequent more serious episodes of violence may not be prevented.[2,3]

We have studied our own practice, the A&E Department of Glasgow Royal Infirmary, to ascertain the clinical needs of these patients and the adequacy of our response.

METHODS

A prospective study was performed over a 3-month period, during which time, all female patients attending the A&E department of Glasgow Royal Infirmary had a pro forma inserted into their card on registration, to remind the doctor to ask whether they had been assaulted. If a positive response was obtained the pro forma was completed by the attending doctor. Concurrently, a retrospective review of the records of all female patients who had attended in the preceding 3-month period was performed. A similar pro forma was completed where the notes indicated an assault.

The information collected included the patients' registration details, the cause and mechanism of the assault, the place where the incident occurred, injuries sustained and the treatment required. Additional information was obtained about the assailant, whether the patient was accompanied to hospital and by whom, and where they went on discharge. The use of alcohol or drugs by either the victim or assailant was noted.

During the prospective part of the study each woman was given a printed sheet offering help and support from the hospital social work department and from the local branch of Woman's Aid. The appropriate telephone numbers were included. In addition all assault victims admitted to the hospital were routinely visited on the ward by a social worker, as had been the standing practice for some time.

RESULTS

Over the 6-month study period 282 female assault victims were identified, 139 retrospectively and 143 prospectively, representing 0.75% of all attenders. The details of the ages of the two groups are shown in Table 1, and the day and times of attendance are shown in Tables 2 and 3. It was found that the characteristics from the two groups were very similar, and the results will be considered as combined figures except where differences require discussion.

Most assaults occurred at home (37%), 15% occurred in the street and 6% in public houses. The place of the assault was not recorded for 94

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Table 1. Age distribution of patients

Age range (years)	Prospective group	Retrospective group
10–14	2	5
15–19	19	26
20–29	48	44
30–39	37	32
40–49	18	19
50–59	10	10
60–69	4	1
70+	3	0
Totals	141	137
Unknown	2	2

Table 2. Day of attendance

Day	No. of patients
Monday	33
Tuesday	30
Wednesday	30
Thursday	38
Friday	36
Saturday	59
Sunday	55
Total	282

Table 3. Time of arrival

Time	No. of patients
0000–0359	70
0400–0759	19
0800–1159	26
1200–1559	52
1600–1959	46
2000–2359	69
Total	282

(33%) patients (19% of the prospective group, and 48% of the retrospective.)

The relationship of the assailant to the victim is shown in Table 4. Overall, 70% were known to the victim, 48% being either the partner or a close relative. A total of 28% of victims lived with their assailant, 52% lived separately, but for 17% this aspect of the social history was not recorded. The identity of the assailant was recorded for 92.3% of the prospective group, but only 46% of the retrospective group. Details of the person accompanying the patient to hospital were available in 55% of the prospective group, but only 10% of the retrospective group.

Table 4. Relationship of assailant fo victim

Relationship	No. of patients
Spouse	54
Partner	42
'Ex'	10
Neighbour	2
Acquaintance	61
Relatives partner	5
Sibling	12
Parent	1
Other relative	9
Unknown	86
Total	282

The reason for the assault was not recorded in 74% of cases (prospective 66% and retrospective 83%). Of the 73 patients where details were given the cause of the assault was recorded as an argument in 41 (56%) and as unprovoked in 17 (23%).

Alcohol had been consumed by 156 (55%) of patients. In the prospective group the assailant was said to have been drinking in 87 of 143 cases (61%). Drugs did not appear to be a major factor, affecting only eight cases overall. Sixty-one (43%), patients in the prospective group, admitted to having been assaulted on previous occasions.

The method of assault is shown in Table 5. The distribution of injuries to the major anatomical regions is shown in Table 6. The majority of injuries were not serious, with more than half requiring no specific treatment (Table 7). A total of 33 (12%) of patients were admitted, 34 (12%) required referral to other specialties, 31 of these for management of facial fractures. One patient required surgery for a penetrating eye injury, and one patient died after being stabbed in the heart by her husband. Fourteen (5%) of patients discharged themselves against medical advice.

Altogether 213 (76%) of patients were discharged home, either directly from the department, or from the wards. Of these patients, 26% were recorded as living with their assailants. The destination of the patients on leaving the hospital was unknown in 15% of cases. Overall 36 (25%) patients in the prospective group expressed a wish for further support after discharge. All those admitted were routinely visited by the hospital social worker. Only two patients reattended at the hospital social work department and no patients were identified by Woman's Aid as having used our contact information.

Table 5. Mechanism of assault

Mechanism	No. of patients
Hand	108
Foot	40
Glass or bottle	9
Knife	27
Blunt object	37
Push	7
Drag	2
Bite	6
Unknown	46

Table 6. Anatomical region of injury

Region	No. of patients
Head	69
Face	150
Neck	13
Hand	22
Upper limb	49
Chest	31
Abdomen	7
Back	7
Lower limb	20

Table 7. Type of injury sustained

Type of injury	No. of patients
Closed soft tissue	164
Lacerations	76
Fractures	
Closed	39
Open	2
Stab wounds	11
Bites	6
Eye Globe	2
Unknown	22
Total	322

Note: Some patients received more than one injury.

DISCUSSION

Our study confirms that an inner-city A&E department can expect to see significant numbers of assaulted women. Our figure of 0.75% of all attenders is similar to Fothergill's figure of 0.9% and may represent some 8000 assaults a year in Scotland. A previous study reported that only 5% of victims of domestic violence were identified as such and it has been suggested that this was because doctors do not ask women about violence. It is possible that some women conceal the true nature of their injuries through fear, embarrassment or feelings of isolation despite being given the opportunity to discuss it.

Many of our results bear striking similarities to those of Fothergill.[5] Seventy per cent of women knew their attacker, 37% of the assaults occurred at home. This matches the incidence found by Smith[4] who looked at violence at home only. However, our study shows that much domestic violence may occur outside the home. There would therefore appear to be little difference in the pattern of these events between the inner-city and more urban areas. Unsurprisingly, alcohol was a factor in over 50% of the assaults. Drugs did not appear to be a significant influence in this patient group, although a previous study showed that injuries sustained in an assault are a common reason for drug abusers to attend A&E department.[7]

The most worrying aspect of our findings was the failure of the attending doctors to record information properly about the both assault and the surrounding social circumstances.[2–4] The nature of the assault was unrecorded for 16% of patients despite the fact that this may have great relevance to the management (e.g. glass injuries). The differences between the retrospective and prospective groups show the positive effect of highlighting the subject, and could perhaps be maintained by using a pro forma. Fifty-four per cent of assailants, 48% of locations of assault and 90% of escorts to the department were unrecorded in the retrospective group. This may make it very difficult to ensure that the patient is discharged to a safe place. Indeed over a quarter of patients sent home lived with their assailants and were therefore exposed to possible further risk.

The major concern to health care workers, after the immediate physical problems have been treated, is the need to try to reduce the risks of further assaults. Few of the patients seen had injuries which would cause lasting suffering, although the single murder, and a penetrating eye injury are testament to the potential for seriousness. A recent report from Victim Support suggests that over 100 women die each year after assaults.[8] Although much more difficult to measure, the long-term effect on the mental health of the woman may be enormous. It is significant that 43% of patients admitted to having been the victims of previous assaults, although we do not know if the assailants were the same. This emphasizes the recurrent nature of woman battering and highlights the need for effective social

intervention. It is very worrying that, despite 25% of patients expressing a wish for support after leaving hospital, only two actually used the contact numbers we gave them.

It is important that doctors acknowledge and recognize that abuse has occurred, that it is wrong and that help is available, if further psychological as well as physical damage is to be avoided.[2,3] Battered women, especially in the 30–39 year age group have higher admission rates than controls for a variety of medical problems, with trauma accounting for only 20% of these admission.[9] Therefore, frequent admissions to hospital without obvious cause may be an indicator of abuse.

This study has highlighted the inadequacy of information recorded. We must educate doctors working in A&E departments to consider both the possibility of an assault in any woman presenting with an injury, and the psychological and social needs of the victim once identified.[10,11] This should be part of the introductory training course. Better collection of historical and social details will help prevent clinical mistakes, because of the failure to comprehend the mechanism of assault, and should help identify the patients most at need of follow up.

Smith pointed out the need for further studies to investigate ways of improving the after care of these patients.[4] As our results have shown these patients are either unable or unwilling to subsequently contact help agencies. This may, in part, be a result of financial and childcare pressures at home or simple fear of their assailant.[8] Therefore, we must aim to try to identify those patients who need help removing themselves from the environment that led to the assault. Our study suggests that, for this to be effective, we need to identify these patients whilst they are still in the department and deliver the help to them there. This conclusion is in contrast with that of another recent study,[4] which suggested that secondary referral for support at a later stage might be adequate.

The task of delivering immediate social support is rendered more difficult by the fact that the majority of these patients present outside normal office hours, and often when the department is busy, making it more difficult for adequate discussion, psychological support and appropriate onward referral to take place.

The numbers of patients involved however are not too great for a suitable process to be set up. A quiet room where the interview could occur would be desirable. This interview could be carried out by a nurse or other suitable professional, rather than doctor. Some patients may not be capable of participating in the interview because of their emotional upset or alcohol intoxication. These patients may well benefit from 'social admission' to hospital in order to allow arrangements to be discussed on the following day. Unfortunately, some of these patients will take an irregular discharge.

We agree with Smith[4] that A&E departments need to have clear guidelines for dealing with battered women. These guidelines need to refer to a primary support system, as we have shown that secondary follow-up is unlikely to work. Pro formas should be used to ensure more accurate recording of relevant information, both for the patient's benefit and for medicolegal purposes. The interview should not only try to identify the patients who wish help, but should be capable of actually initiating that help. We must remember that the patient who has returned home may be unable to make any further contact themselves, because of fear or restraint. Appropriate literature about professional and voluntary support groups, such as Woman's Aid, should be displayed prominently and be readily available together with local contact numbers. There should be clear local arrangements for organizing immediate short-term safe accommodation when necessary. Close liaison between A&E departments, social services and voluntary agencies is mandatory for managing these patients.[12] The patient should also be encouraged to report any assault to the police. Adequate communication with the patient's general practitioner is essential to provide full psychological as well as social support for the patient.

We believe that the above standards of complete and immediate care of assaulted woman should optimize the eventual outcome, and reduce the risk of the patient experiencing further episodes of violence.

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