**Inside Pandora's Box:
Addressing Abuse Screening Practices of Health Care
Providers in the Emergency Department**

By

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Abstract

This dissertation examines health care providers' experiences with screening for woman abuse at one hospital's triage unit. Health care provider views on the utility of the Emergency Department's screening tool, the resistance to, and barriers associated with applying the tool, and associated Emergency Department protocol are explored. Twenty-five interviews were conducted with health care professionals, including physicians, nurses, and social workers. This was supplemented with a review of 61 Emergency Department charts of abused women. A feminist, woman-centered, medical-model approach guided the data collection, analysis and explanation.

Using the analogy of Pandora's Box, analysis of the health care providers' experiences revealed numerous difficulties with the design of the tool, its implementation, and related hospital protocol. Unanticipated insight was gained into the Emergency Department's problematic organizational structure in that it negatively impacted the screening process for woman abuse in the triage unit.

Throughout the various stages of the abuse screening tool and protocol (identification to documentation), providers navigate and often switch between the medical model and a woman-centered approach. Specifically, triage nurses routinely use a woman-centered approach when discussing psycho-social issues, when inquiring into abuse, and when asking health-promoting questions. Conversely, physicians often refer to indicator-based methods for abuse screening and use clinical documentation styles, suggesting that physicians tend to conform to the depersonalized medical model of treatment. In situations where infection control policies and practices were implemented in the Emergency Department, such as the protocol accruing to severe acute respiratory syndrome (SARS), the medical model was upheld and routine abuse screening abandoned by all health care professionals.

In conclusion, this study presents suggestions for maintaining an abuse screening tool, and presents areas for future research including policy implications.

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Introduction

“Pandora, one of the most beautiful maidens in Greek mythology was taught woman’s work, endowed with beauty, given a deceitful nature and adorned with flowers, and a crown of gold. She was given the name Pandora because all the gods of Olympus showered her with gifts. Upon her marriage, Pandora received a box as a dowry, but was instructed never to open it. One day Pandora yielded to her curiosity and opened the box”
(Avery,1972).

While we know what happens next, that Pandora unleashed all the evils of the world and supposedly brought misfortune to humanity, the point to be taken from this is how exploring an issue or examining one object can lead to uncovering multiple concepts and ideas. Borrowing from Pandora’s analogy, this thesis examines one screening tool which uncovers unexpected themes that impact how the screening tool fits into the Emergency Department setting, and more generally how woman abuse is managed by health care providers in the Emergency Department setting.

Woman abuse is a serious health problem, and the hospital Emergency Department has an important role in helping woman abuse victims. While violence¹ is now recognized internationally as a health problem², incorporating appropriate routine screening tools³, protocols⁴, and programs⁵ into the Emergency Department has been met with challenges, criticisms, and debate. In Canada, hospitals have been slow in

¹ Throughout this dissertation the term woman abuse will encompass violence, violence against women, intimate partner violence, domestic violence, family violence, abuse, battering, and wife abuse as described in the literature.

² *World report on violence and health: summary*. Geneva, World Health Organization,2002.

³ A routine abuse screening tool refers to the method of asking about abuse.

⁴ A routine abuse protocol refers to identification, documentation, treatment, safety planning, and referral.

⁵ Domestic violence and sexual assault treatment programs may be instituted into the ER. Currently, there are 33 Sexual Assault and Domestic Violence Treatment Programs in Ontario.

responding to woman abuse.⁶ A review of the health sector's response conducted by Health Canada in 1993 revealed that very little was being done in hospitals to address woman abuse, and that the hospital sector had shown "little or no leadership" on this significant health issue (Hanvey & Kinnon, 1993).

Forms of screening

Screening⁷ for abuse is broken into two forms: universal screening (routine inquiry), and indicator-based screening. In routine screening health care professionals ask every person over a given age about their current or past experience of abuse (Middlesex-London Health Unit, 2000). Indicator-based screening means a health care professional notices one or more indicators of abuse and, referring to the indicator(s), asks the patient whether abuse caused the injury or condition (Middlesex-London Health Unit, 2000).

Routine questioning of woman abuse in the Emergency Department encompasses elements of a woman-centered approach. While identification may be important for a woman-centered approach, it is the non-judgmental and compassionate manner in which professionals approach screening questions and the initial contact made in a private setting which constitutes the first steps to success. A 'successful' outcome must be redefined and measured by initial contact with a health care professional allowing the woman to feel empowered and able to take control, provide social support, and maximize safety.⁸

⁶ This dissertation refers to the abuse of women, since 90% to 95% of partner abuse victims are women (Hyman, 1995).

⁷ Screening is a scientific and biomedical term, which can be defined as: "The systematic, population-wide application of a test to identify symptom-free individuals considered to be at sufficient risk of a specific disease or disorder to benefit from further investigation or direct preventative action" (Lawler, 1998).

⁸ The Hastings & Prince Edward Counties Health Unit and the Domestic Violence/Sexual Assault Response Program with Quinte Health Care have developed a Routine Universal Comprehensive Screening (RUCS) in Spring 2003 which incorporates asking all women over the age of 12 a routine question about abuse. Routine screening is done on a consistent basis, whether or not indicators of abuse are present.

A woman-centered approach values and advocates for identification and documentation strategies when screening for abuse. However, these are not the only goals of this approach. Consequently, this thesis explores medical interventions for abused women proceeding from the assumption that the emphasis on security, advocacy, and empowerment is also the most appropriate for health care providers (Kurz & Stark, 1988).

Evidence suggests that asking women about abuse, validating that it is a health issue and not their fault, documenting abuse, providing resource information and supportive counseling, may be enough to result in fewer episodes of violence (McFarlane, Soeken & Wiist, 2000). Raising the topic routinely in the clinical encounter informs women that this is an important health issue and that abuse is not normal and is a criminal offence. Shaw (2003) suggests that to do nothing or ask only on an indicator basis is an unacceptable alternative while we wait for future research on how to provide better care for this population. Furthermore, key findings in the Ontario Hospital Woman Abuse Report (2003) found that 96% of abuse survivors supported screening all women for abuse during health care visits.

The indicator-based method of abuse screening aligns with a medical model as physicians only screen according to clinical presentations resembling physical symptoms of abuse. While indicator-based methods require privacy in order to identify abuse, the goals for the medical model and a woman-centered approach are different. Successful interventions in the medical model are based on indicator-based methods, around identification of abuse, pressing charges, arranging counseling, and reporting that the woman leaves the abusive relationship. This process is not necessarily time-consuming as physicians and nurses act more like fact-finders than counselors, but it also misses many of the subtle signs and symptoms of abuse. The medical model falls apart because

it does not link violence, gender, or oppression, and cannot solve or stop the abuse. Even if privacy is ensured, the medical model does not address the social and/or cultural aspects of abuse. Rather, it stresses identification and referral.

Routine abuse screening using a woman-centered approach (initial contact and asking questions in a non-judgmental manner) is effective and can be successful when applied under appropriate conditions: the screening questions are tailored to the ER environment; the woman does not have physical injuries requiring immediate medical treatment; the woman is alone and privacy is ensured; there is adequate time; the term domestic violence is defined for the woman; and/or when providers have been trained in abuse. Ideally, satisfying all these elements engenders optimal conditions when routinely screening for abuse. While not all these conditions will be met, the most essential conditions when utilizing a woman-centered approach require privacy and sufficient time on the part of the provider. However, this remains difficult in an urgent-care environment where providers are rushed for time. Yet, under these conditions, initial contact with a health care provider who is non-judgmental and compassionate can constitute a successful intervention. While a woman-centered approach may not automatically stop the violence, connections are made between abuse, gender, culture, and society.

Empowerment and autonomy are key concepts which guide a woman-centered approach. If privacy is not ensured, empowering an abused woman is impossible and reflects a negative environment wherein asking about abuse is harmful to a woman. How can you empower an abused woman when her perpetrator is standing next to her? Empowerment only works in a positive environment. For example, initial contact after separation starts the empowerment process, thus, a key component in a woman-centered approach is empowerment through forced separation in order to secure privacy. The term

forced separation means having a health care provider separate the patient from all visitors and obtaining a private area. Having health care providers spend enough time with abused women is critical in order for the woman to establish trust and build a rapport. Under these positive conditions women are empowered and more likely to disclose abuse.

While routine screening can be implemented in a departmental and/or on a hospital-wide level, it is usually implemented at the departmental level. At the hospital, screening for abuse has been implemented in the Emergency Department but is not occurring in any other department. Currently, triage nurses at the hospital are mandated to routinely screen for woman abuse. For physicians, the majority screen on indication or when the situation allows for privacy and lends itself to asking about abuse.

Research question

This dissertation examines health care providers' experiences with screening for woman abuse at one hospital in Eastern Ontario. Health care provider views on the utility of the Emergency Department's⁹ screening tool, resistance to, and barriers associated with utilising the tool, and Emergency Department protocol are explored. The goal of the study is to describe issues around identification and screening practices¹⁰ from the perspective of nurses and physicians. The intent is to be able to abstract commonalities and differences in participant responses so that they can be compared with similar research on the experiences of other health care providers.

In a woman-centered approach, it is important to understand how the abuse screening tool is viewed by providers and approached with patients. This study suggests that throughout the various stages of the abuse screening tool and protocol, providers

⁹ Throughout this thesis the term 'Emergency Department' will be shortened to 'ER'.

¹⁰ The Woman's Health Directorate mandated universal screening for woman abuse in the ER at the hospital. The screening tool was implemented February 2003.

navigate and often switch between the medical model and a woman-centered approach when abused women present to the ER.

The impetus for this research arose from an interest in whether hospital emergency departments across Canada had abuse protocols or guidelines, and if so, whether these protocols adequately address and provide appropriate gender sensitive interventions for abused women. Specifically, I wanted to interview health care providers to explore their perceptions of, and experiences with, abused women, and to identify characteristics that facilitated or acted as barriers to screening practices, and to assess rates of abuse in the ER population.

Theoretical frameworks

This dissertation makes a contribution to an understanding of the effectiveness of abuse screening tools within the ER setting as well as health care providers' roles and responsibilities during the patient encounter. The medical model and feminist theory (a woman-centered approach) provide a theoretical context for exploring screening practices and behaviours, and the patient encounter as they relate to findings of this study. This study also draws from the sociology of professions, Weber's bureaucratic ideal type, a health promotion approach¹¹, sociology of nonverbal communication, and grounded theory.

The screening tool at triage uncovers information about the tool and the organizational structure of the ER, such as hospital hierarchy, health promotion, provider barriers, and severe acute respiratory syndrome (SARS). The theoretical frameworks help to explain the reasoning and motivation behind screening ideology. The frameworks

¹¹ Health promotion is both a theme uncovered in the interviews and used as a theoretical framework.

will also inform the findings by showing how health care providers' professional identities, roles, and mandates impact upon the patient encounter.

Revisiting the background and assumptions about screening methods in the medical sciences uncovers contradictions that exist surrounding the health care system's mandate for woman abuse screening. Similarly, these debates and discourses at the government and institutional level also filter down to the ER and professional level. As study findings suggest, health care providers struggle with the same issues as government agencies and the Canadian Task Force on Preventative Health Care (CTFPHC)¹²; these include whether to screen, and how, who, and when to screen.

Evidence suggests that physicians and nurses often receive contradictory and confusing messages regarding screening. For example, while hospital guidelines may support screening, the CTFPHC does not see sufficient evidence for screening. Thus, institutions and professional agencies arriving at different conclusions can impact upon the screening behaviours and practices of health care professionals in the ER.

The medical model, a woman-centered approach and a health promotion approach, are sociological perspectives in health and illness with different ideologies concerning health, treatment, and delivery of care. The medical model and a woman-centered approach often conflict with each other. The contrasts are in the delivery of care for the patient. The issue of woman abuse in the medical model is often renamed as 'family violence' so the gendered nature of the abuse is lost (Warshaw, 1993). The medical model of screening does concur with what is known about woman abuse. For example, it is difficult by most definitions to consider woman abuse as a disease, yet this was the premise on which the criteria for screening programs was based.

¹² The Canadian Task Force on Preventative Health Care reviews screening activities and makes recommendations "based on the quality of evidence for the cost and effectiveness of screening, diagnosis, and treatment" (Jenicek, 1995:109).

Borrowed from feminist theory, a woman-centered approach (patient or client-centered) focuses on safety, confidentiality, and the respect for choices. Rather than being expected to 'fix' a woman's life or to 'save' her, advocates see the importance of putting a woman at the centre of her care. This means allowing a woman to make choices in her treatment and care, and changing the power dynamics in the clinical encounter.

Health promotion was a theme uncovered in the data, and will also be used as a theoretical framework when discussing the organizational shift occurring in the ER. Health promotion is an approach which gives people the tools to improve their own health in the form of information to help individuals take care of themselves (Health Canada, 2003). Under this approach, individuals are more involved in their care and treatment, and the health care provider acts more like a facilitator rather than a professional power of authority. Theoretical frameworks such as a woman-centered approach based on an empowerment model of care are gaining momentum in an era where health promotion strategies are becoming well-regarded. Consequently, the medical model of care based on the curative and clinical approach is undergoing an organizational shift in the hospital setting.

The sociology of professions explores the study of work and regards occupations as social roles (Pavalko, 1971). This research informs study findings related to the ER culture. Occupational roles can be ascribed or achieved; they are a link between individuals and the social structure, and they are also a major source of personal identity. Applied to the hospital setting, occupational roles and the organizational structure serve to support a hierarchy and maintain an informal segregatory pattern in the ER. Furthermore, Weber's concept of a bureaucracy applies to the hospital's organizational structure as policies and practices are upheld and followed.

Drawing from the nonverbal communication literature, this study examines interpersonal skills in the ER setting, which inform study findings related to SARS and abused women. Communication in the patient-physician encounter revolves around verbal and nonverbal communication. However, when health care providers are unable to interpret a social cue such as nonverbal communication, this impacts identification of abuse and has potentially harmful effects for an abused woman.

Supporting these theoretical frameworks is grounded theory which is both a theory and a method. Generating grounded theory is a way to arrive at theory suited to the actual data. Since this study was exploratory in nature, data gathering and theory generation were conducted using an inductive approach. Rather than having a set of fixed questions and a hypothesis to test, I went into the interviewing process without knowing what direction the interviews would take. This research was conducted holding only a few preconceived themes¹³ before data collection, and as a result much more was discovered about the ER climate than anticipated.

Objective of the research

It is expected that this research will facilitate the development of emerging themes which will enhance screening questions and techniques, and which can be refined in subsequent research. This research will also allow for a critical examination of some of the findings which have been produced by previous studies touching upon screening practices for, and behaviours of, abused women. As previously mentioned, the primary motivation in undertaking this research is not the verification of theories. Rather, theories are used both as contrast and counterpoint to my own discoveries. The theoretical explorations of others provide the background for my research agenda without

¹³ Refer to Chapter 2 for a brief outline of my Masters research, which informs this dissertation.

determining it. They also provide the basis for my dialogue with the wider discipline of sociology.

This study allows for an opportunity to expand upon current literature on relations between health care providers and the delivery of health care for abused women as they occur in the ER. This is accomplished by providing a sociological analysis of the experiences, interpretations, and responses of the participants. Participant interviews, observations in the ER, a chart review, and secondary sources are used to show how past difficulties with implementing abuse screening in the ER have formulated belief systems about the present, while current hospital situations work to shape existing practices and an anticipation of the future.

The data gathered during the research will also complement the work already undertaken at the hospital^{14,15} and will aid health professionals in providing better quality care and delivery of health care services to abused women in the ER. Specifically, this research will be useful for health care providers involved in planning and organizing partner assault programs. Both the sexual assault treatment program (SATP) and the domestic violence treatment program (DVTP) are struggling to provide theoretical links between the medical model and a woman-centered model. Thus, this study will provide a theoretical link by showing how providers navigate between the medical model and a woman-centered approach when screening for woman abuse.

In this dissertation, violence against women and abuse are defined as, “an abuse of power that results in harm to women, including acts of psychological and financial abuse, physical and sexual assaults, gang rape, trafficking of women and sexual

¹⁴ 1998 *Final Report of a Community Needs Assessment Project*. Civic campus. Ottawa Hospital, Ottawa, Ontario.

¹⁵ Lucey (2003) “*Scratching the surface: Domestic Violence and Emergency Screening at the Civic ED*”. Powerpoint presentation made to medical students at the Civic campus.

harassment in the schools or workplace” (Status of Women Canada,2002:2). There is an extensive amount of literature supporting screening women for all forms of abuse (Grunfeld,1997; Middlesex-London Health Unit,2000). Thus, physical, sexual, and emotional abuse are forms explored in this study. Despite exploring these three forms of woman abuse, triage nurses only ask about physical and sexual abuse of female patients (Refer to Chapter 7). Furthermore, the EPIS database where the chart review data was gathered only collects information on physical and sexual abuse (Refer to Chapter 2).

Several research methods were used to enable a broad analysis of violence and health. Data were obtained through qualitative and quantitative methods. A chart review of 61 women who were identified as being abused was conducted to understand about hospital screening practices prior to routine screening and to explore patient characteristics. A sample of 25 health care provider interviews provide first-hand accounts and interpretations of social, political, economic, and cultural conditions associated with the abuse screening tool and protocol. Observations were noted in the ER which comprised the fieldnotes. Secondary sources such as descriptive statistical information were used to provide an overview of woman abuse and screening practices in Canada.

Through the triangulation of data, four themes were uncovered: patient characteristics as reported by the participants; health promotion in the ER; provider barriers in responding to woman abuse (hospital hierarchy); and how severe acute respiratory syndrome (SARS) impacted the ER environment, which has implications for the abused woman.

Using the analogy of Pandora’s Box, analysis of the health care provider’s experiences with screening for woman abuse revealed numerous difficulties with the design of the tool, its implementation, and related hospital protocol. Strengths were

uncovered in applying health promotion principles at triage. Unanticipated insight was gained into the problematic organizational structure of the ER which negatively impacted screening practices for woman abuse in the triage unit.

Three of the above themes were unexpected. These included hospital hierarchy, SARS, and health promotion in the ER. These themes developed through analyses of the interviews and observations in the ER.

Setting the scene

While many hospital emergency departments in Canada are establishing Task Forces on Abuse,¹⁶ generally these task forces encounter difficulty organizing and developing effective and appropriate screening practices and protocols. In Canada, few interventions to expand upon and/or improve the public health approach¹⁷ of screening have been systematically evaluated and reported in the published literature. Health care professionals and researchers are primarily dependent on clinical reports and assumptions about the benefits or the negative impacts (Thurston et al.1998). Consequently, there remain contradictions couched around appropriate emergency physician and/or nursing responses, and whether current screening protocols for woman abuse are effective, reliable, and valuable in helping survivors. With such uncertainty surrounding screening for abuse in the ER, as well as fiscal constraints, many hospitals have not made violence a priority in their mandate or budget. Thus, there remains the lack of co-ordination and the fragmentation of abuse programs and services in many ERs. Furthermore, even when physicians attempt to screen for abuse, these clinical interventions strictly apply a

¹⁶ The hospital had a Task Force (Jan 2003) to address screening issues related to abuse.

¹⁷ According to the National Clearinghouse on Family Violence, Ottawa, and the Centre for Disease Control (CDC) in Atlanta, the public health approach seeks to understand abuse in epidemiological terms with four scientific steps characterizing this approach: analyzing surveillance data, looking for causes and risk factors, identifying and evaluating interventions, and employing interventions in the community, state and national prevention programs (Saltzman & Johnson,1996).

medical model and fail to use alternative theoretical frameworks as a basis for understanding screening behaviour, screening practices (Thurston et al.1998;Gerbert et al.1999a; Gerbert et al.1999b), and the role of women in society.

Currently, screening for abuse in Canada is akin to a ‘double-edged sword.’ There are professionals advocating routine screening, yet according to the Canadian Task Force on Preventative Health Care (CTFPHC), Ontario Ministry of Health, Royal College of Physicians and Surgeons, Royal College of Family Physicians, Canadian Council on Health Services Accreditation (CCHSA), Ferris (1997), and Ramsay et al. (2002), there are not enough evidence-based studies exploring the patient-physician relationship, the cost-effectiveness analysis of abuse, and the abused woman’s experiences in the health care setting.

In contrast, as is the case in most Canadian ERs, relegating the physician to screen on an indicator-based approach is insufficient and perhaps more harmful for the abused woman in comparison to routine screening. Therefore, many advocates are demanding the CCHSA and the CTFPHC endorse clinical guidelines to increase routine screening. However, without research support professional bodies and organizations are not making violence a priority resulting in hospitals screening sporadically and on indication only.

The following chapters provide a discussion of the literature and theoretical work related to the themes in this study. Chapter One provides background details about the prevalence and health outcomes associated with woman abuse. Additionally, screening practices in Canada are examined with focus on a key Ontario study.

Chapter Two outlines the methodology of this study. Grounded theory and the approach used in gathering the research are described. The research question is discussed and the themes described in Chapter One are developed and defined. This chapter is divided into five sections with emphasis on the chart reviews and interviews. These

sections describe the research design, data collection, hospital setting, sample characteristics, ethical considerations, position of the researcher, research relationships, and limitations.

Chapter Three is a theory chapter and examines the literature around the ideology of screening. The medical model and a woman-centered approach are used to explore screening practices for abuse. Since the research question probes identification and screening practices, it is necessary to explore the origins of screening.

Chapter Four offers results from the chart review whereby the health impacts of violence are examined. Here, findings from the chart review informed the interview process. The chapter reports on issues such as the identification of abuse in the ER, demographic information, completeness of ER charts, and reproductive, mental and physical health. The descriptive statistics generated from the chart review add a quantitative layer and provide context for the interview data.

Chapters Five, Six, Seven, and Eight address the research question including insights derived from the themes. The presentation of findings is organized around the four major themes identified: patient characteristics as reported by the participants; health promotion in the ER; provider barriers in responding to woman abuse (hospital hierarchy), and how severe acute respiratory syndrome impacted the ER environment, which has implications for the abused woman.

Informed by the chart review, Chapter Five examines the characteristics of the abused woman as perceived by participants. Here, descriptive statistics from the chart review are compared with the interviews from health care providers. This chapter explores characteristics and attributes such as ethnicity, alcohol use, psychiatric problems, police intervention, and socio-economic status in relation to the abused

woman. These concepts from the chart review were combined into one major theme for the thesis entitled, “patient characteristics.”

Chapter Six explores the debates and discourses with the screening tool at triage. Two different forms of abuse screening are explored, along with the context and format for screening. Here, the concept of health promotion is explored as this has implications for the format of questions at triage. Also examined are who and when to screen for abuse, and whether identification has increased since the inception of the screening tool. The provider screening rate of abuse among the ER population is also explored.

Chapter Seven addresses barriers limiting provider recognition of abuse in the ER. For this chapter, provider barriers are divided into three typologies: structural, professional, and personal. Within these typologies are sub-categories which further explore provider barriers. Chapter Eight examines how SARS impacted the ER environment, which has implications for abused women. The concluding chapter summarizes the empirical problem, method and research question findings, and makes recommendations for future research.

Each of these chapters give examples of the participants’ common experiences. These experiences are analyzed in light of how the participants made sense of these experiences and how we can understand the participants’ behaviour as a social phenomenon.

Chapter One

Woman abuse: prevalence, health outcomes, and screening practices in Canada

This chapter will present a brief epidemiology of woman abuse in Canada and will provide a rationale for undertaking this study of violence and the health care system. Abuse is well-recognized as a serious problem financially impacting the health care system (Day, 1995; Greaves et al. 1995). The issue of woman abuse is particularly important as it is a cause of injury, illness, addiction, and even death (Bain, 1991). To put the health care response into context, the prevalence¹⁸ and health outcomes of woman abuse in Canada is described, followed by Canadian and relevant international studies on hospital screening for abuse.

Epidemiology

Prevalence of woman abuse

A recent critique of Canadian prevalence studies by Clark & Du Mont (2003) indicates the annual prevalence of intimate partner violence (IPV) in Canada ranges between 0.4% to 23%.¹⁹ While this result is striking, one should note that it has been generated from a small number of studies most dating back to the 1980s. In an

¹⁸ Prevalence refers to the proportion of individuals in a population who have been abused. Incidence refers to the number of new cases of abused women in a population at risk or identified during a specified time interval (Hennekens & Buring, 1987).

¹⁹ There are several methodological caveats when examining data on the incidence of woman abuse. One of the most controversial problems facing researchers is eliciting accurate woman abuse data (DeKeseredy & Hinch, 1991). Research definitions of woman abuse have been inconsistent due to differences in legal mandates, professional practices, and cultural values, which can significantly affect reported rates of occurrences. This inconsistency makes comparisons between studies difficult and contributes to controversy over the scope of the problem (Crowell & Burgess, 1996).

international context, the prevalence and incidence of violence against women in Canada is similar to those in the United States.^{20,21}

Johnson (2000) conducted a Canadian population-based survey and found 5-year rates of 8% for intimate partner violence. In Canada, 1-year rates in 1999 were reported at 3% (Statistics Canada, 2002). British Columbia has the highest reported incidence of violence against women in Canada (Kerr & McLean, 1996) however this may be due to the existence of more screening protocols and programs compared to the rest of Canada.

Health care screening practices

Women are asked about abuse in many different health settings. In settings where screening is a recommended guideline but done infrequently, findings show 7% to 15% of women are being asked about abuse (Venis & Horton, 2002). In settings where screening protocols are in place and proper training has occurred, reported screening rates rise to 20% to 35% (Thompson et al. 2000). A study measuring the rate of screening three months after implementing routine screening found that without sustained training, the screening rate decreased to baseline levels (Harwell et al. 1998). Two studies of ERs suggest that without specific violence screening protocols, recognition is less than 2% of all cases of abuse (Kutz & Stark, 1988; Warshaw, 1993).

Prevalence of woman abuse in the ER population

Determining the proportion of abused women who seek medical attention is difficult, but clinical studies estimate 8% to 39% of abused women seek care (Ferris et al. 1997). With a screening program, Grunfeld and Associates (1994) reported a 6%

²⁰ Tjaden P. and N. Thoennes. (1999) *Prevalence, Incidence, and Consequences of Intimate Partner Violence Against Women: Findings from the National Violence Against Women Survey*. Washington, D.C., National Institute of Justice, Centers for Disease Control and Prevention.

²¹ Dearwater et al. (1998). Prevalence of intimate partner abuse in women treated at community hospital emergency departments. *Journal of American Medical Association*, 280(5):433-438.

prevalence of violence in women presenting to the ER during a one-year period. Recent estimates found identification rates from 0% to 4% in outpatient primary care and obstetrical clinics, and 5% to 10% in ERs (Ernest & Weiss, 2002). Thus, with and without protocols, identification rates remain much lower than the number of abused women.

Reliance on formal and informal network supports

According to recent national figures published by Statistics Canada (2002), 22% of victims of spousal violence confide in a doctor or nurse, 10% use a crisis centre or crisis line, 10% use a community centre or family centre, and transition homes were used by 11% (refer to Table 1). This shows that abused women may seek medical attention in greater proportions than health care providers realize. Therefore, it is necessary to focus on the health care setting, specifically the ER, where victims may first appear for treatment (Grunfeld, 1995) and some suggest emergency professionals are in the best position to help abused women (Ferris et al. 1997).

In addition to seeing a health professional for injuries, abused women also seek out health professionals on a more routine basis for check-ups and general ailments (Rodgers, 1994). In a London, Ontario study, Tanis Day (1995) found that more abused women on average see health professionals than those who have not been abused, over 6 more consultations in a one-year period (Day, 1995).

Costs associated with woman abuse

While there have been few cost-analysis studies examining the health-related costs of woman abuse, results indicate the cost is substantial. Although dated, the estimated annual cost of medical treatment of abused women in Canada range from \$408 million (Greaves et al. 1995) to \$1.5 billion (Day, 1995). Estimated in-patient hospital

costs related to violence range from \$37.8 million to \$70.7 million (Statistics Canada, 1993).

Table 1: Highlights of the 1993 Canadian Survey on Violence Against Women (N=12,300)

- 51% of all Canadian women have experienced at least one incident of physical or sexual violence since the age of 16.
- Almost half (45%) of these incidents resulted in injury.
- 29% of Canadian women who have ever been married or lived with a man in a common-law relationship have been assaulted by a marital partner.
- Approx. four-in-ten women injured by a marital partner saw a doctor or a nurse for medical attention.
- 45% of women reported violence by men known to them while only 23% reported violence committed by a stranger.
- Children witnessed violence against their mothers in almost 40% of marriages with violence.
- Alcohol is a prominent factor in wife assault. Women were at six times the risk of violence by partners who frequently consumed five or more drinks at one time, compared to women whose partner never drinks.

**Source: Statistics Canada. Only behaviour considered in the Canadian Criminal Code was addressed in the Violence Against Women Survey.*

Types and severity of abuse

The types and severity of violence committed are well-documented in Canada. The General Social Survey produced by Statistics Canada (1999) found that of those women who reported abuse by former partners, 20% had been sexually assaulted by their ex-partner during the abusive relationship. Similarly, 13% of these women had been threatened with a knife or a gun, 20% choked, 25% beaten, 23% hit with something, 33% reported being kicked, bitten, or hit, 40% reported being slapped, and 81% reported being pushed, grabbed, or shoved by the offender (Statistics Canada, 1999).

Health impacts of abuse

Research literature clearly demonstrates the profound negative effect violence has on a woman's physical and mental health. Research has shown abused women have more illnesses than do non-abused women (Thurston & O'Connor, 1999). For example,

abused women suffer disproportionately from chronic conditions including headaches, pain conditions, physical disability, depression, alcohol and substance abuse, and chronic gastro-intestinal conditions such as irritable bowel syndrome (Ferris et al.1997; American Medical Association,1992; World Health Organization,1995). In addition to the illnesses caused by abuse, abused women also suffer from injuries. These injuries include, but are not limited to, dental injuries, lacerations, fractures, burns, and internal injuries (e.g., perforated ear drum, damaged spleen or kidneys, retinal detachment).

The management of other chronic illnesses such as seizure, diabetes, hypertension, and asthma may also be problematic in women who are being abused (Family Violence Prevention Fund,2002/1999). According to the literature, asthma among abused patients is commonly cited as a chronic health condition (Wright & Steinbach,2001). Wright and Steinbach (2001) describe cases which exemplify a temporal association between exposure to violence and the precipitation of asthma exacerbations in four urban pediatric patients. Violence exposure may contribute to environmental demands which tax both the individual and their communities to impact the inner-city asthma burden. At the individual level, intervention strategies aimed to reduce violence exposure, to reduce stress, or to counsel victims or witnesses to violence may be complementary to more traditional asthma treatment in these populations (Wright & Steinbach,2001).

Furthermore, the effects of abuse can be devastating to a woman's reproductive health and to other aspects of her physical and mental well-being. Women with a history of physical or sexual abuse may also be at increased risk for miscarriage and/or mistimed pregnancy, unintended pregnancy, sexually transmitted infections, increased risk of HIV/AIDS, injuries to her anal, vaginal and pelvic areas, as well as adverse pregnancy

outcomes (World Health Organization, 1995; Ferris et al.1997; Ferris et al.1999; Dechief,1999).

The effect on an abused woman's mental health is as important as that on her physical health. Research indicates abused women typically encounter a variety of mental health difficulties including acute anxiety disorders, panic attacks, Post-Traumatic Stress Disorder, depression, sleep disturbance, sexual dysfunction, eating disorders, and suicidal ideation (World Health Organization,1998). The 1999 General Social Survey which documented the emotional consequences of abuse on women who had experienced violence in the previous 5 years in Canada found almost half (44%) reported feeling upset, confused and/or frustrated, 34% angry and/or fearful, 23% reported a lowered sense of self-esteem, 21% reported depression and/or anxiety attacks, and 15% felt ashamed and/or guilty.²²

Screening in Canada

Canadian and international studies examining behaviours of abused women and screening practices for abuse have been done (Shaw,2003; Ramsay et al.2002; Wathen & MacMillan,2003; Grunfeld,1997; Grunfeld & Mackay,1997; Ferris et al.1997; Baer,1997; Martin & Younger-Lewis,1997; Hotch et al.1996; Lent,1997; Venugopal,2001; Williamson-Milroy,1999; Shaw & Quita,1993; Trute et al.1998; Gerbert et al.1999a/b; Gerbert et al.2000; Hayden et al.1997; Hathaway et al.2002; D'Avolio et al.2001; Thurston,1998), although most of the research on violence and the health care setting has been undertaken in the United States, Australia and Britain. Specifically, the United

²² The methods used to identify cases of woman abuse and the narrowly-defined inclusion criteria of the 1999 General Social Survey may have limited the number of cases of woman abuse the survey was able to identify.

States has large research centres devoted to studying violence and health, due to private donations, funding from government agencies and large institutions.

The most comprehensive, published Canadian research addressing screening practices was undertaken at the Vancouver General Hospital in 1994.²³ Since then, organizations and pockets of researchers have examined issues related to violence and women's health. In 1996, for example, the Federal Government funded 5 Centres of Excellence in Women's Health Program located in Halifax, Montreal, Toronto, Winnipeg, and Vancouver. The Centres are dedicated to improving women's health by disseminating information and policy advice to make the system more responsive to women's distinctive needs. Moreover, the Centres have produced numerous publications and research on women and violence.²⁴

Overviews of violence and women's health in a Canadian context are also found in dissertations by Janice Wilson (1998), Janice Defehr (1997), Colleen Varcoe (1997), Pamela Ratner (1995), Jennifer Robohm (1997), Holly Johnson (1998); and research by Dorothy Shaw (2003), Clark & Du Mont (2003), Wathen & MacMillan (2003), Ramsay et al. (2002), Morrison et al. 2000, Ferris (1997), Rodgers (1994), and the Status of Women Canada (2002).

The comprehensive M.Sc. thesis by Linda Dechief (1999) is an evaluative study of one hospital's woman abuse response program. Dechief (1999) relies on in-depth interviews conducted with health care professionals, and is descriptive rather than

²³ Grunfeld Anton, Ritmiller S., Mackay K., Cowan L and D. Hotch. (1994) Detecting Domestic Violence Against Women in the Emergency Department: A nursing triage model. *Journal of Emergency Nursing*, (20):271-4.

²⁴ For more information on the 5 Centres of Excellence in Women's Health Program refer to <http://www.cwhn.ca/cewhp-pcesf/index.html>

theoretical or explanatory. Dechief's (1999) evaluation of the response program focused on rates of screening, disclosure, and referrals. Dechief found that after multiple training sessions health care providers increased their comfort level with screening for abuse. Consequently, screening was occurring on a routine basis. However, once the training sessions became less frequent, motivation to screen decreased and identification rates fell.

In terms of screening practices across Ontario, the Woman Abuse Council of Toronto (WACT) conducted a study in 2003. The study included mailing surveys to all Ontario hospitals asking about screening practices for abuse, and conducting consultations across the province.²⁵ Ninety-one of one hundred and sixty-four hospitals participated in the survey (a 55% response rate). Thirty-eight percent (35/91) of hospitals surveyed reported having organizational policies. Fewer than half (45%) indicated their hospital screens women for abuse. Of these hospitals, 20% indicated they screen universally for abuse (however, this does apply to all departments in the hospital), while 58% of the hospitals screened on an indicator-based approach. Of all 41 hospitals that screen for abuse (both universal and indicator-based), 85% screen in the ER, 49% screen in the maternal/newborn department, while 20% screen in gynecology and family medicine.

This chapter provided an outline of the annual prevalence and health outcomes associated with abuse. The prevalence of abuse and screening practices in Canada was examined by exploring clinical populations and national surveys. Also examined was the proportion of women seeking medical attention for injuries related to abuse and health-

²⁵ The Ontario Hospital Association, the Women Abuse Council of Toronto and Education Wife Assault. Ontario Hospital Women Abuse Accreditation and Training Project: Promoting an Effective Response to Women Abuse in Ontario Hospitals (May 2003).

related costs associated with woman abuse. Abuse was shown to have a profound negative effect on a woman's physical and emotional health. Such health outcomes may be subtle and can be missed by health care providers, or may foster provider barriers which impede identification of abuse (refer to Chapter 7). A brief overview of Canadian researchers undertaking abuse screening was also presented. The next chapter will discuss the methodological approaches used in conducting this study.

Chapter Two Methodology

This chapter describes the methodological processes employed. The chapter is divided into five sections with emphasis on chart reviews and interviews. The first section provides a description of grounded theory and outlines the data collection sources. Here, the process of how the research question was formulated is presented. The second section describes the hospital setting where the data was collected, and how SARS affected data collection. The third section describes the methods used in the chart review. It outlines the organizational structure of the health records department in the hospital, and describes the sample and the coding of the derived variables. The fourth section describes the methodology used in the interviewing process. The position of the researcher and social relations between participants and the researcher are outlined. The interview sample is also described and ethical considerations are discussed. This section also describes how the research findings were documented, organized, and presented. The fifth section highlights the limitations of the study.

Since a collection of data slices is desirable to strengthen and contextualize a piece of research, both quantitative and qualitative methodologies were employed. Quantitative data was collected by a chart review using the EPIS/NACRS database (National Ambulatory Care Reporting System), while qualitative data was gathered by conducting 25 semi-structured interviews with various ER staff. In undertaking qualitative research, the aim was to go beyond examining chart statistics to explore relationships and their meanings, motivations, and interpretations of experiences and actions through the realm of the personal (Armstrong & Armstrong, 1983:31). Qualitative methods were chosen as best-suited to explore the participant's experiences, as these methods can generate important insights in relatively new areas of inquiry.

An integral part of methodology can be the personal reflections of researchers as they are important instruments of the research (Hill,2001). Consequently, we should be reflexive in understanding how our own experiences influence and impact on the research. Given that researchers' own voices, thoughts, and opinions are embedded in the research, documenting our presence by discussing the circumstances and influences relating to data collection can contextualize the findings. Consequently, field notes were kept throughout the data collection phase. Evaluating these experiences and thoughts enable a richer understanding of the dialogue, experiences, and actions of those researched (Cotterill & Letherby,1993; Oakley,1981).

Grounded Theory

Qualitative research was undertaken using the grounded theory approach formulated by Barney Glaser and Anselm Strauss in *The Discovery of Grounded Theory* (1967). Glaser and Strauss assert that the most effective way to generate theory is from the data itself through an inductive process of simultaneous collection and analysis. They reject theories pieced together from borrowed concepts. In this approach, the researcher generates an abstract analytical schema of a phenomenon, a theory that explains some action, interaction, or process (Creswell,1998). This is accomplished through collecting interview data, making multiple visits to the field, and attempting to develop and integrate categories of information (Strauss & Corbin,1990). This research methodology is especially useful in studies such as this one where little is published in the substantive area, and it is necessary to allow for the development of new categories and themes to emerge to produce meaningful information. By adopting a strategy that does not commit to a particular perspective in advance, Glaser and Strauss suggest that the likelihood of producing conclusions with genuine relevance to the material being studied is increased.

Glaser and Strauss emphasize that researchers attempting to generate grounded theory should not confine themselves to a single type of data or a single data collection instrument. Rather, they suggest the image of a research project as a pie with a number of 'data slices' (1967). Textual research and interview transcripts might be one data slice, while field notes and deciphering chart material another. For this research I am comparing and integrating results collected from a number of different methods. Triangulation occurs when different research sources are combined to verify reports, create new avenues of exploration, and validate findings (Denzin,1978). The advantage of triangulating data is that similarities and contrasts in a category may become visible or more elaborate, and that the use of a number of different methods and data sources will help compensate for the weaknesses inherent in each.

The grounded theory method appears to be well-suited to providing health care professionals with a more holistic understanding of health and illness. Specifically, there has been a shift in the nursing literature from quantitatively-structured interviews to using a more grounded theory approach (Sheldon,1998). In particular, grounded theory methods seem to be well-matched to providing nurses with an understanding of social behaviours to enhance patient care (Sheldon,1998).

Grounded theory is a class of theory derived inductively from data. It is the end result of the method. Generating a theory from data means that most hypotheses and concepts not only come from the data, but are systematically worked out in relation to the data during the course of the research (Glaser & Strauss,1967). For this study, the following themes emerged from the data: patient characteristics, health promotion, provider barriers (hospital hierarchy), and SARS. Theoretical frameworks such as a woman-centered approach, the medical model, Weber's bureaucracy as an ideal type,

sociology of professions, health promotion approach, and the sociology of nonverbal communication were used to interpret study findings. Theory and theoretical frameworks are used to organize, make sense of, and interpret data. For more “positivistic” social science, theory is employed to generate testable hypothesis (as well as organizing and interpreting data).

Data sources

Originally, the intent was to locate and interview a sample of abuse survivors through the examination of their medical charts. This was not feasible for several reasons. Principally, the hospital Ethics Review Board strictly enforces a policy that only health care providers who are directly involved in the management of the abused women’s care can contact them. Due to methodological and ethical issues, access to survivors of abuse was not possible. For more information on why survivors were not included in this study and how the research question was formulated, refer to Appendix A.

The research was undertaken using theoretical sampling: jointly collecting, coding, and analyzing data to develop theory as it emerged. The research began with some general concepts. As the researcher, I was aware that abuse is a major health issue and that the ER at the hospital is piloting a screening tool for abuse at triage. I was also aware of both positive and negative reactions to implementing an abuse screening tool. This in turn provoked me to question how health care providers view abuse in the medical setting, and how abuse and the screening tool are negotiated, constructed, and contested in the ER. These concepts were the basis for further exploration of the research problem and allowed categories to emerge from the data to create theories about responses (Glaser & Strauss, 1967). A triangulation approach was used in gathering the

data. Several research sources were used: literature review, chart review, descriptive statistics, and semi-structured interviews.

Setting

Information on abused women visiting the ER between January 2000 to December 2001 is presented below. The hospital where the data was collected is a comprehensive provider of 'patient-centered' health services with an emphasis on tertiary-level and specialty care. The hospital is a 1,060-bed academic health science center (teaching hospital) and is affiliated with a university. Its services are concentrated on three campuses. The hospital is a large teaching hospital in Canada and provides bilingual health care services to over 1.5 million residents of Eastern Ontario. The hospital also serves residents in northeastern Ontario. For this study, chart review and observational material were collected at one campus location.

In terms of health care utilization, the hospital sees 136,752 emergency visits and 25,588 ambulance visits annually where 3,100 nurses and 1,200 physicians manage patient care.²⁶ Two of the three campus ERs serve approximately 150 patients per day and remain open 24 hours.

There are 5 emergency departments serving the region. The Acute Care Medical Centre at the one local campus closed September 27th 2002, so the public is now redirected to the closest ER.

Currently, there are 125 ER health care workers employed at the campus where data collection occurred: 32 emergency physicians, 1 clinical nurse manager, 90 emergency nurses and 2 emergency social workers. The hospital has several mechanisms in place to ensure high quality care for patients. Within the first 15 minutes of arrival in

²⁶ Refer to the hospital's web site for hospital statistics: <http://www.ottawahospital.on.ca/about/stats-e.asp>

the ER, patients are seen by a triage nurse who assesses and classifies them based on the Canadian Triage and Acuity Scale.²⁷

ER nurses are skilled in triage, a system used to ensure that the most serious medical conditions and injuries are treated immediately. During the history taking, nurses utilize the in-take form and question patients about their complaint, and document both the physical and social natures of it. To assess the patient's physical condition, the triage nurse asks questions about the reason for the emergency visit, allergy status, and medication history. If necessary, the nurse will check vital signs such as temperature, pulse, and blood pressure and provide care. On the in-take form, nurses also note the patient's emotional status. Following this assessment, a decision is made regarding the seriousness of the injury or illness using a five-point scale (Resuscitation, Emergency, Urgent, Less Urgent and Non-Urgent). Depending upon the severity of the condition the triage nurse will either escort the patient immediately into the department or ask the patient to register and wait in the waiting room. This triage system allows patients to be seen according to the urgency of their condition. This process allows the triage nurse to promptly identify patients requiring immediate care, determine the appropriate area for treatment within the ER, provide continued assessment or re-assessment of waiting patients, and give information to patients and their families.

As of February 2003, nursing staff at the hospital screen all female patients for abuse with three questions: 1) Are you currently being abused?; 2) If yes, what type of abuse are you experiencing (physical, sexual and/or emotional)?; and 3) Do you fear for

²⁷ The Canadian Emergency Department Triage and Acuity Scale (CTAS) developed by the Canadian Association of Emergency Physicians in 1998 has been recognized as a significant improvement in standardizing triage for Canadian ERs. Since its publication, an increasing number of Canadian ER's have implemented the CTAS. The objectives of the CTAS is to "more accurately define patients' needs for timely care and to allow ERs to evaluate their acuity level, resource needs, and performance against certain operating objectives."

your safety? These questions provide another layer of information for the physician. In cases of identified or suspected abuse, patients are immediately directed to a cubicle in the department instead of being asked to wait in the waiting room.

How Severe Acute Respiratory Syndrome (SARS) affected data collection

SARS surfaced during the data collection phase of the study (June to September 2003) and threatened to compromise my ability to gain access to medical charts in addition to halting the interview process. When SARS came on the scene I was in the preliminary stages of collecting chart review data in the Health Records Department. Due to issues of privacy and confidentiality, charts cannot be removed from Health Records. In the event that I was unable to gain access to the hospital, I would not have been able to access the ER charts. Thus, SARS had the potential of delaying the data collection stage by several months.

Having to work out of the Health Records Department, I had to wear an identification tag identifying me as a researcher in Health Records. The identification card allowed me to gain access to the hospital through the staff and physician's entrance. Otherwise, I would not have been permitted in the hospital as visitors had only one entrance which was closed for a period of 4 weeks in April. Only staff could gain access to the hospital. Furthermore, as part of the SARS screening policies, all staff and visitors – myself included – using the hospital and ER entrances were greeted by a SARS screening nurse and asked to wear surgical masks, wash their hands and to fill out a SARS screening form.

Chart review

Health records

The initial strategy was to get patient charts from the two campuses. However, the two campuses maintain different filing systems. There were two reasons why the one campus was selected for data collection. First, I knew the co-ordinator of the Sexual Assault and Domestic Violence Treatment Program and she was aware of my research. Second, the campus is more centrally-located in the city, and it arguably sees more patients from all socio-economic backgrounds than the other campus which is located in the east side of the city.

The campus where data collection occurred follows a decentralized filing system whereby departmental charts are kept together, and charts for a patient are in each appropriate department. Thus, a patient who has visited different hospital departments will have several charts all filed in different locations. Specifically, ER charts, charts from the OB/GYN clinic, inpatient, and hospital admissions for each patient are all separate files.

For researchers, working in a decentralized system where one patient's files can be scattered across many departments can be very time-consuming, for obvious reasons. The other campus files patient charts according to a centralized system and all a patient's information is contained in one file.

There are pros and cons associated with each method. With a centralized system, if the chart is in use the researcher must wait until the chart is filed and not in use,

sometimes taking up to three weeks. The Health Records policy states that all charts can only be signed out for a maximum of three weeks, which can delay data collection.²⁸

Originally, my data collection strategy was to look at all the charts from the list of abused patients that were seen in the ER between specified dates, comparing them to charts of patients who were not abused. However, I was unable to do this with ER patients who were abused as there was no demographic data in their files. This ER file reporting system changed the focus and direction of the chart review. Instead, I examined the quality and completeness of the abused woman's charts.

Since hospitals in the local area have separate filing systems, determining whether an abused woman presented at other local ERs is difficult. There is no uniform reporting database where this information is housed. The only way to obtain this information is to request the ER and hospital charts of a particular patient at all 5 hospitals.

The EPIS database generated abuse codes for 64 females and 4 males. Charts from 3 women were omitted because they were active and in circulation. Additionally, this study focused on females because the EPIS database generated 4 cases of male abuse and abuse screening was mandated for women. Thus, for the chart review medical charts of abused women was the focus.

Importantly, the women represented in the chart review were not offered the abuse screening tool. The screening tool was implemented almost two years after their ER visit. In contrast, however, the interviews of health care professionals occurred

²⁸ Ethics approval for the chart review was granted by the hospital's Ethics Review Board and Carleton University December 2002.

during the initial stages of screening, which is also when hospitals encountered SARS.

Sample

My sample for the chart review was obtained through the EPIS/NACRS database (Emergency Patient Information System/National Ambulatory Care Reporting System). This database is maintained by Health Records at the hospital and collects information on patients who have used services in the ER and have been identified as being abused.

The EPIS database generates a patient list including the parameters requested by the researcher. For example, after ethics approval was granted, I requested a patient list of all domestic violence and sexual assault cases between January 2000 and December 2001 (refer to Appendix B). The EPIS database uses the International Classification of Disease system (ICD-9); the codes for abuse are 995.81,3.

To generate this list, the EPIS database locates ICD-9 codes for abuse which were coded into the EPIS system by a health analyst in Health Records. The ICD-9 codes may be located in several fields on the ER chart such as in the complaint field and/or in the instructions and final diagnosis field. Thus, it was necessary to examine the entire ER chart, as details of abuse may be located in several locations in the chart.

Physicians document abuse either in the complaint section, instructions and/or final diagnosis section. ER charts are then sent up to Health Records where they are coded according to ICD-9 classifications and entered into the EPIS database along with other injury surveillance information. When researchers request injury statistics, health analysts managing the injury surveillance database extract the appropriate information according to the ICD-9 codes.

The total sample for the chart review consisted of 61 women who sought help in the ER due to abuse, ranging in age between 18 to 84 years. When looking at sexual assaults, the EPIS list generated 4 sexual assaults.

Hospital records were obtained to abstract patient data for patients who were coded as being abused, including limited demographic characteristics, abuse history, injuries due to abuse, and admission information where appropriate. While this study does not employ a hypothesis, in order to pass through hospital ethics, a formal hypothesis was required to satisfy quantitative study design and methods on the hospital's ethics application. Thus, the hypothesis being 'tested' stated:

The medical documentation, treatment, and follow-up for patients who have been identified as abused is incomplete according to general protocols published in the abuse screening literature.

However for my purposes, this formal hypothesis was turned into a broader working question. Consequently, the research examines completeness of the medical charts of those women who were identified as abused.

The purpose of a chart review was to identify a study population using demographic information, to assess abuse detection rates, and to evaluate the documentation of cases in the ER. Specifically, comparing the completion rates between the emergency reports, triage assessment, social work assessment, psychology assessment, and the ambulance report (refer to Appendix C for a copy of these emergency forms). As well, retrospective designs are critical for identifying variables of interest which can then be explored in greater detail in the interview process.

Charts meeting the following conditions were selected as eligible cases in the chart review:

- 1) English speaking
- 2) have been physically or sexually abused by either an intimate partner or stranger²⁹
- 3) were able to provide a detailed account of at least one abusive incident with a health care provider
- 4) not mentally impaired (able to relay their injuries to a health care provider)

The definition for a positive chart was established as any reference to past, present, or probable abuse in the ER chart, the emergency report, the triage assessment, the social work assessment, or the ambulance report. However, all charts indicated abuse either in the complaint or in the final diagnoses. The descriptors included assault, abuse, domestic violence, battered, spousal abuse, partner violence, physical assault, and sexual assault. A standardized abstraction was used so the researcher was not blinded to the objective of the study. Specifically, as the researcher collecting chart review data, I was aware of the study objectives and knew what to look for in the charts. For the chart review, descriptive statistics were used to analyze the data. To add dimension and depth to the chart review data, direct quotes of the women that were taken by health care providers are provided. Most of the quotes are sexually graphic and detail disturbing content.

Coding- derived variables

In total, information was collected on 39 variables, all of which were recoded (refer to Appendix D for the coded data and for a Percentage Table). While 39 variables were recoded, 4 were not included in the results due to incomplete information.

Complete information on 35 variables was collected.

²⁹ For the data collection period (Jan 2000 to Dec 2001), the EPIS database only collected information on physical and sexual abuse.

Some of the variables had multiple responses, thus multiple response categories were created. Despite attempts at creating these response categories, quantifying this data may change the context and meaning. Variables with multiple response categories included previous and future visits, injury location, the abusive episode, medical history, past history, medications prescribed by physicians for the ER visit, instructions, and final diagnosis. Most of these fields on the emergency report listed more than one instruction. Under these circumstances, I selected the first instructions the physician listed as they most often pertain to the most serious or severe injury, according to the Chief ER physician. The variable, 'the abusive episode,' was easier to classify because all my response categories were able to capture multiple responses for the abusive event. The most difficult variables to create response categories for were injury location, medications prescribed, physician's instructions, and final diagnosis.

For injury location, I grouped injury location into 6 categories: head, face neck and eyes; torso, stomach, back, shoulders, arms, wrist and hands; breasts, vagina and buttocks; legs, knees, ankles and feet; not stated; and motor vehicle accident.

For the variables, 'past history and medical history,' I attempted to create multiple response categories according to the data. However, there were patients who cited a history of abuse, suicide ideation, and depression and may have been suffering from both a chronic condition and a psychiatric disorder. According to my categories this documentation is problematic. In these cases I selected the first item noted in the chart. In most charts, there was one past history or medical history condition which was commonly described in the chart, and this condition was selected.

The categories 'medical prescriptions, physician instructions, and final diagnosis,' also included multiple responses. In the event a patient was prescribed Tylenol and a

toxicology screen, I would cite only the first medical prescription, otherwise my response categories would have been too long and unmanageable. The same rules were applied to 'physician instructions and final diagnosis.' If the items did not fit according to my response categories, I selected the first instruction or final diagnosis, as these are often the most important instructions and diagnosis for physicians in treating the patient. Again, when physicians document their instructions and state a final diagnosis, they must prioritize the condition and cite what they believe is the main complaint to be addressed in terms of the biophysical condition. Therefore, it is appropriate to select the first condition in these fields on the ER report.

Interviews

The chart review supplemented and informed my interview guide and the interviews. Interviews allowed the participants to address selected issues in more depth and in their own words. This provides a means to check the appropriateness of the categories that appear to have emerged from the chart review data.

The position of the researcher

Part of being reflexive³⁰ as a researcher is to be open to the possibility of self-disclosure. Interviewer self-disclosure takes place when the interviewer shares ideas, attitudes, and experiences concerning matters that might relate to the interview topic in order to encourage participants to be forthcoming (Reinharz & Chase, 2000). In terms of self-disclosure, research indicates when the researcher is asking for a great deal of openness from the participants, s/he is unlikely to get that openness by being closed, impersonal, and neutral towards issues. Accordingly, self-disclosure during interviews is

³⁰ Reflexivity is the means of overcoming the gendered character of supposedly value-free objectivist discourse (Denzin & Lincoln, 1994). Participants are not so much repositories of knowledge as they are constructors of knowledge in collaboration with interviewers (Holstein & Gubrium, 1995).

a good practice (Reinharz,1992).

Self-disclosure also initiates “true dialogue” by allowing participants to become “co-researchers or coequals” instead of repositories of facts and knowledge (Bristow & Epers,1988). Accordingly, such collaborations should produce better interviews (Oakley,1981). Additionally, some researchers argue that being open about themselves to the participants is both fair and practical (Rubin & Rubin,1995).

With these results in mind, I tried to bridge the gap between the professional and the personal. The researcher knows the degree of self-disclosure to bring to the interviews only in the field. I am a researcher seeking to gain knowledge for academic purposes but I am also a co-investigator with the other participants.

Research relationships

Before starting the interviewing process, I realized revealing my identity and outlining my research objectives was a vital factor in establishing a rapport (Gubrium & Holstein,1997; Shaffir,1991; Shaffir, Lorenz Dietz & Stebbins,1994; Shaffir, Stebbins & Turowetz,1980). As the research proceeded, I came to realize that some of my personal identities enhanced rapport with participants while others did not. I was honest with participants about my various identities (e.g., government worker and student). Yet in some cases, I felt I should emphasize some identities and de-emphasize others, or simply not volunteer them unless I was asked. I managed my various roles and identities of student and government employee, determining the appropriateness of revealing any one of these identities. I was mindful not to offer information about myself that could have been detrimental to rapport (e.g., government worker or graduate student).

In particular, I found that my identity of ‘student’ acted to create ease and openness with nurses, while knowledge that I was a doctoral student appeared to disrupt

the ease and openness I was trying to establish. In interviewing physicians, I found that my identity of a doctoral student acted to create an ease and openness.³¹

Not being a staff member and trying to gain access to participants at the hospital requires a great deal of time, patience, and effort, and writing multiple ethics drafts for approval. The Hospital Ethics Review Board requires the researcher to have a hospital supervisor or hospital affiliation. Coming from the 'outside' and securing a supervisor, in this case, the co-ordinator of the Sexual Assault Treatment Program was necessary.

Thus, being identified as 'an outsider' brought benefits and limitations. Being 'an outsider' with few connections makes gaining entry into hospitals difficult. Hospital organizations limit outsider access to preserve staff privacy and confidentiality.

According to the Chief of Staff in the ER, there are also hundreds of research projects going on at the hospital. The ethics board is very selective about the quality and quantity of research projects which use hospital staff and resources. Since the staff at the hospital is involved in numerous studies, clinicians are asked on a regular basis to participate in studies; they have expressed they sometimes feel like research vessels. Therefore, it is not surprising that I initially encountered hesitation and resistance. Being 'an outsider' is less likely to cloud my perception of the relevant data than if I were employed at the hospital.

Sample

The interview sample was a convenience sample and created with the criterion that participants had to currently work in the ER at the hospital as of September 2003. The convenience sample is representative of the views of the health care providers

³¹ Refer to Shaffir, William (1991). Managing a Convincing Self-Presentation. In *Experience Fieldwork: An inside view of qualitative research*. Willaim Shaffir and Robert Stebbins. (Eds). Pp.72-81. California, Newbury Park: Sage.

interviewed. In qualitative research, a representative sample denotes findings which are consistent with the literature and where a triangulation approach is used (Glaser & Strauss, 1967).

The clinical nurse manager at the hospital provided me names and telephone numbers of the nursing staff. I contacted potential participants and arranged times to meet either at their homes or at the hospital. However, after initially contacting several nurses, I was informed by the clinical nurse manager that some complained about a researcher contacting them at home. Furthermore, the clinical nurse manager neglected to inform nurses that I would even be calling. Consequently, a few times I was met with a chilly reception, as these nurses were not aware of my research, my work, or that I was given their home numbers from their supervisor. However, as word spread that I was a researcher with ethics approval and legitimate research goals, nurses granted interviews.

Physicians were contacted via e-mail, as the chief of the ER did not feel comfortable handing out physicians' home numbers to researchers. The mass e-mail I originally sent out yielded three replies, but not the number of responses anticipated. I contacted the chief of the ER again and he was helpful in supplying me with not only a list of the physicians who would be interested, but the work schedules for the residents and ER physicians. With this information, I was able to individually e-mail these participants suggesting a time and day when they were working and I was available.

Interviews were conducted over a three-month period, during the months of June, July, and August of 2003. After completing 25 interviews with 17 women and 8 men (13 female nurses, 1 male nurse, 4 female physicians, and 7 male physicians), I had established a set of premises built around the previously-conducted interviews. I felt confident further interviews would yield similar findings, so a saturation point had been

reached (Glaser & Strauss, 1967). Consequently, I would ask different probing questions and look for emerging themes or ideas in the interviews. Also, obtaining the same information in the interviews was also a method to verify and check the reliability and validity of qualitative data.

Semi-structured interviews were conducted with open-ended questions. The phrasing and the order of questions were subject to change depending upon the flow of the interview. An interview guide with questions (refer to Appendix E) was developed. The purpose of the interview guide was to elicit information about the abuse screening tool, to invite participants to reflect on relevant past experiences, and to provide them an opportunity to discuss their health care experiences around abused women. These questions were flexible in that any of them could be not used if they appeared to be inappropriate. In addition, participants were encouraged to discuss issues they felt were important.

Initially, my intention was for the discussions to guide the interviews, instead of the interview questions directing the discussion. While this format seemed to work for nurses and social workers, this was not the case for physicians. Perhaps due to their medical training, physicians expected that I would provide a list of questions for them to answer in a clinical manner. When answering interview questions physicians rarely deviated from the questions and provided little anecdotal evidence. Physicians rarely speculated about issues. Instead, physicians quoted statistics and underscored personal viewpoints. Consequently, this may not have been an effective way to interview physicians. Conversely, nurses were eager to share anecdotal evidence and were much more likely to make guesses or assumptions about things they seemed unsure about.

The interview guide was developed in several stages. A draft version was produced based upon my familiarity with the screening literature, informal conversations with health care professionals, and extensive reading both in the substantive area and around interviewing techniques. The first draft was submitted for review to the coordinator of the Sexual Assault Treatment Program and Domestic Violence Program (SATP and DVTF) at the hospital. A second draft of the interview guide resulted and was sent to the dissertation advisory committee and to the hospital supervisor.

The semi-structured interview was frustrating at times: due to time constraints I was unable to probe deeper and engage in more unstructured interviewing. Nurses preferred to be interviewed during one of their 45 minutes breaks. Two participants preferred to be interviewed at home, the remainder at the hospital. The majority of nurses said that once they had finished a shift they preferred to leave work behind and not think about their job. This was not the case for physicians. Due to more autonomy and flexibility in their job, physicians were able make special arrangements to be interviewed while they were working, or before or after their shifts.

Sometimes strong negative emotions were expressed. A case in point was when one nurse was very angry about being forced to screen routinely for abuse when there was no evidence that it helped patients. At times I sensed her anger was directed towards me. During emotional discussions, I tried to ensure that my own reactions did not hamper participants' disclosures. In these circumstances I tried not to ask judgmental or accusatory questions which might have made the participants feel like they are 'under attack.' As a result of the interviews, I found I became closer to the subject matter and often carried participants' accounts away with me.

Interviews ranged from 20 to 45 minutes and took place in a private office in the hospital or at the participant's home. There was one focus group consisting of six social workers and sexual assault nurses and was counted as one interview. Here, I found group dynamics differed from individual interviews. Participants in the focus group often encouraged, refuted, and prompted each other. This interview was more difficult for me as establishing a rapport with all of them at once was challenging, and two or three participants did most of the talking.

Consent & confidentiality

Ethical issues are important for establishing parameters for acceptable practice in research. Ethical codes such as the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (2000) were adhered to for ethics approval.

Verbal and written information was given to those invited to participate. Before enrolment, verbal consent was obtained for participation. In accordance with the Tri-Council Article 2.4 this study provided prospective participants with the information they needed to give free and informed consent on whether to be involved in the research project.

Before beginning each interview, I discussed why I was interested in talking to them and what I planned to do with the information. Participants were told that portions of the interview would be used for the dissertation and possible publication. Only those individuals who agreed to these conditions were questioned, and a respondent may have declined to answer at any time. I stressed that potential respondents were under no obligation to participate in the study, and they may withdraw from the study at any time without providing a reason. This ensured that a prospective participant's choice to participate was voluntary (Tri-Council, Article 2.2, 2.4d).

I carefully discussed these issues and provided participants with a written consent form³² (refer to Appendix F) to ensure an informed decision to participate. I proceeded to ask participants if they would permit the use of a tape recorder during the interview. All of the participants consented.³³

To ensure there were no breaches of patient privacy³⁴, all data and information collected during the study remained private between the researcher and the participant, and the field notes did not include identifying markers of the respondents (Tri-Council, Article 2.3). These field notes are secured under lock and key in my home office. I have access to the original data as does the supervising committee. I also have the only key to the files in my home office. As well, the names were separated from the interviews, and codes replaced the names of the participants.

Participants were debriefed following the interview. I asked them if they had any questions or concerns about the study, and offered to send them a copy of the dissertation abstract following completion of the dissertation. The majority of physicians usually asked for an update of the results before the interview was over, while nurses did not show much interest in the findings.

Documenting, organizing, and presenting the research

Field notes

I found that 'memo-ing' or keeping field notes assisted the process. Through the process of making field notes (casual notes), I was able to uncover how SARS impacted

³² Copies of the consent form were signed. I kept one copy and offered the participants another copy if they requested it. However, most physicians had an electronic copy since I e-mailed it to them as part of my initial contact. I did not e-mail nurses the consent form, as I contacted them via telephone.

³³ The interview tapes will be destroyed 6 months after the thesis has been successfully defended. If participants want their tapes, they were instructed to contact me.

³⁴ The only time confidentiality can be breached is if the participant indicates there is a risk or harm to an existing child. In Canada, the Child Protection Law requires in all jurisdictions except the Yukon that persons must report cases of alleged or suspected child abuse or neglect to a child and family services authority.

the hospital environment and the professionals working in this setting. After consulting the field notes, I noticed that SARS came up in every interview. Thus, what I had originally dismissed as 'background talk' evolved into a major study finding. Through participant observation and interviews, I uncovered three unexpected themes: hospital hierarchy, health promotion, and SARS.

In the field I documented everything ranging from the physical surroundings to ER traumas. I reflected upon the research and participants' responses and the feelings these interviews evoked. I kept track of relevant quotes, specific incidents, issues of personal biographies and emotions, and behavioural dynamics of both myself and the participants. Similar to Hill (2001), I also examined verbal and nonverbal actions to better understand what had occurred in the interviews. For example, if a discussion stirred positive or negative feelings, I recorded it and used it to reflect upon my emotions and bring new insight to the research.

Transcription

The purpose of transcribing and presenting the research was to ensure the material did not misrepresent participants' intentions, or become distorted (Hill, 2001). After completing the interviews, I transcribed the tapes to review the total interactions. An interview generally took three hours to transcribe. The transcription of the focus group took longer as there were 6 voices and oftentimes several people spoke at the same time. During data analysis, the interview responses were coded into meaningful categories using QSR NUD*IST Vivo (Nvivo) software, in which concepts and themes arose. Nvivo represents the latest version of an evolving software and is associated and compatible with grounded theory. NVivo is designed to code information, write memos, search text, develop and link concepts in a geographical format. The software made the

research easier to present and analyze by compiling related topics (refer to Appendix G for a listing of the nodes). Information was classified into 'nodes' which assist the user in classifying information into meaningful categories. This study created 139 nodes around four themes reflected in chapters 5, 6, 7, and 8.

Presenting the results

The qualitative interview method is beneficial in obtaining first-hand evidence of experiences and interpretations. However, as Hill (2001) suggests, it also has some unique characteristics which should be taken into account. A difficulty in documenting qualitative research is that it is not static. The information derived may be shaped by current events, such as how SARS screening changed the ER environment. As well, the same person can provide different details about his or her experiences depending upon when the interview is conducted and by whom (Hill, 2001). There may also be inconsistencies not only between sources but also from within sources. Specifically, participants may refer to the same situation in both positive and negative manners. They may also alter times and events in their recollection (Portelli, 1991). The discovery of all these characteristics helps to provide evidence of prevailing attitudes and social change, and reveal participants' interests and emotions (Portelli, 1991). Consequently, the research findings represent attitudes of a group of individuals during a specific time period.

Limitations

Interviews

The ER did not offer abuse screening to the women whose charts I analysed. I went into the research setting with the hopes that I would obtain a representative sample of health care staff. However, there was less representation from minority groups.

Chart review

Several limitations with the data deserve mention. Documenting the exact number of children in a household was not always possible. Although health care providers inquire about this and whether they are safe, approximately one-third of the charts reviewed did not include the exact number of children involved. In most cases the nurse or social worker ask about the children's safety but sometimes neglect to record the ages and the number of children in the house. Having complete information on whether there were children in the home would have provided a better context of the lives of these abused women.

Another objective of the chart review was to provide an estimate of the number of women who had a history of abuse. However, this was not always noted in the ER chart. The chart review of Goldberg & Tomlanovich (1984), found that 34% of abused patients stated that they were involved in an abusive relationship prior to their current abusive relationship. Even when the health care professional cited a past history of abuse, I was unable to determine whether the abuse started in childhood or adulthood.

In the majority of cases, I was unable to deduce from the documentation whether the prior abuse occurred with the current or ex-partner, and how many episodes of abuse occurred with each partner. I was also unable to determine whether the frequency and severity of the abuse was increasing, decreasing, or staying the same. As well, many times the records did not document a timeline of abusive episodes. Consequently, while this may be the first visit to this particular hospital for abuse, it may not be the first ER visit for abuse.

Although I attempted to establish a temporal sequence whereby abuse would precede health outcomes, data for age at the first abusive episode was not available.

Also, I cannot exclude the possibility that those experiencing abuse and seeking care may be different compared to abused women who may not seek care as often. Because counts are low, this study has limited statistical power to detect differences in risks for health outcomes.

In contrast to other emergency chart reviews exploring abuse, I was unable to control for the potential impact of demographic factors, childhood physical or sexual abuse on the association between abuse, and health outcomes. The only demographic information from the charts was marital status and limited information on whether children were in the home. Thus, comparison with other chart reviews was limited. Emergency charts do not collect information on socio-economic factors such as income, employment status, or education. While there are no designated fields for these socio-economic indicators, often the social worker or psychology consult will refer to these indicators in their assessments which are attached to the emergency file.

Data for ethnicity is almost impossible to collect as there is no field located anywhere on the chart. Only three charts mentioned race: one woman was a landed immigrant and the file included her picture, and the other two charts made mention of it in the social work assessment.

The last major limitation of the chart review is with the recording of past and future history, injury location, the abusive episode, medical history, past history, medications prescribed by physicians for the ER visit, instructions, and final diagnosis. Most of these fields on the emergency report listed more than one instruction. Under these circumstances, I created codes with multiple responses. Essentially, this can underestimate the number of multiple responses and over-estimate the findings in the 'other' and 'not stated' categories.

Lastly, due to the sudden acute respiratory syndrome (SARS) outbreak in Ontario hospitals, data collection was limited to examining charts in the Health Records Department. Patient charts which were active or in circulation were not included in this study.

The methodology chapter provided an overview of how data were gathered and documented, and how the findings evolved through the grounded theory approach. Ethical issues and the role of the researcher were discussed. Some personal insights on the benefits and difficulties with the research process were explored. Through the triangulation of data this dissertation provides a perspective of one hospital, its ER staff, and a screening tool for abuse. Semi-structured interviews allowed the experiences of those studied to be the focus of the research. Examination of field notes and participant observations also uncovered unexpected themes, notably hospital hierarchy, health promotion, and SARS. My experiences and identities as expressed in this chapter were closely tied to the research process and affect the outcomes. The next chapter will explore the ideology for screening, and critique the medical model and a woman-centered approach.

Chapter Three

Ideology and theory behind screening for abuse: the medical model and a woman-centered approach

This chapter is divided into three sections. The first section revisits the theoretical background and assumptions about screening questions developed by the health care system; the second section presents the medical model and its critique; and the third presents and critiques a woman-centered approach.

Policy-makers and institutional mandates

For the past two decades, a number of articles written in Canadian nursing, medical, public and mental health journals have stated that violence against women is a significant medical and public health problem, and health care providers are in a position to help (Fogarty et al.2002; D'Avolio et al.2001; Waalen et al.2000). As a result of this increased awareness and recognition, screening women for abuse is becoming a principal goal in Canadian and international health care systems. Screening is increasingly being implemented in antenatal clinics, critical care units, psychiatry, and in ERs. This section discusses the evidence behind screening as it relates to abused women and raises concern about the current focus and strategies.

The history of screening in the public health model centres on epidemiology, deeply embedded in the medical model³⁵ of disease diagnosis and treatment (Jenicek,1995). The main intent of screening is secondary prevention³⁶ through early

³⁵ The medical model refers to the clinical approaches to diagnosis, treatment, and care of biophysical injuries.

³⁶ The model of primary, secondary, and tertiary prevention is borrowed from the medical profession which use it primarily to understand the prevention of diseases or disorders (MacLeod,1994). Primary prevention entails lowering the number of new cases by changing behaviour or environmental factors (Stark & Flitcraft,1996). Secondary prevention includes identification and early interventions. Tertiary prevention of woman abuse requires health care organizations to incorporate and invest in crisis intervention, emergency hospitalization for shelters, counseling, support groups, and advocacy, rather than identification and referral (Stark & Flitcraft,1996).

detection. An implicit assumption underlying the concept of screening is screening tests be “cheap, quick, easy to apply, and acceptable for the patient” (Jenicek,1995). Despite the effectiveness of a screening program in reducing subsequent morbidity and mortality, a program will not be accepted if it cannot be conducted efficiently with minimal inconvenience and discomfort, and at a reasonable cost. The implementation of a screening program, no matter how cost-effective, will not be warranted if it does not accomplish its goal of reducing morbidity and mortality (Jenicek,1995).

Notwithstanding violence against women being recognized by the medical community as a major health problem, the dissemination of such at medical conferences is sporadic. In March 1999, a conference on medical screening was held at the Royal College of Physicians in London. The conference, “Medical Screening: the next five years,” addressed policy issues and current thoughts on screening for prostate, cervical and breast cancer, and antenatal screening, but issues relating to woman abuse screening were not presented. If the literature shows woman abuse as a major health problem, why is it not treated like one and addressed as such in an appropriate forum as a medical screening conference? To answer part of this question we turn our attention to the Canadian Task Force on Preventative Health Care (CTFPHC). Although emergency guidelines recommend that providers routinely screen for abuse (Society of Obstetricians and Gynaecology policy statement,1996; Ontario Hospital Association,1997; AMA Council on Scientific Affairs,1992), screening remains sporadic and responsibility lies with each hospital in Canada.³⁷ In Ontario, groups such as Education Wife Assault and the Woman Abuse Council of Toronto (WACT) have co-developed ‘*Best Practices*

³⁷ Grunfeld (1995) conducted a national survey of hospital emergency departments in Canada and found only 39.4% of the hospitals reported having intimate partner abuse policies or procedures.

Guidelines for Responding to Woman Abuse for Health Practitioners (1997)’ to be used as a template for establishing screening protocols in hospitals. To ensure hospitals across the country adopt these guidelines the WACT lobbied the Canadian Council on Health Services Accreditation (CCHSA)³⁸ to amend existing accreditation guidelines to include the suggested ‘*Best Practice*’ criteria. However, the CCHSA opposed the first draft of these amendments and has yet to endorse the ‘*Best Practices Guidelines*.’ It has been speculated that CCHSA may reject the document until the Canadian Periodic Task Force on Preventative Health Care change their recommendations from insufficient evidence to sufficient evidence for abuse screening.

The Canadian Task Force on Preventative Health Care, formerly known as the Canadian Task Force on Periodic Health Examination, is supported by the Adult Health Division, Health Canada. The Task Force is a scientific panel comprised of experts from diverse medical specialties and related disciplines such as epidemiology and the social sciences. This panel was formed in 1976 at the request of the Council of Deputy Ministers of Health in response to the growing concern about the decreasing marginal benefits of curative medical technology in the context of spiralling health care costs (Goldbloom,n.d.).

The Canadian Task Force on Preventative Health Care reviews screening activities and makes recommendations “based on the quality of evidence for the cost and effectiveness of screening, diagnosis, and treatment” (Jenicek,1995:109). The disease to be detected must be well-defined, common, and serious enough to warrant attention, and be treatable (Thurston et al.1998). Lawler (1998) states that the cost of screening patients

³⁸ The Canadian Council on Health Services Accreditation (CCHSA) is a national, non-profit, independent organization whose role is to help health services organizations across Canada examine and improve the quality of care and service they provide to their clients. CCHSA is the only body in Canada that offers an independent and voluntary review to assess and organizations gain valuable insight and practical advice on ways to maintain and improve the quality of their care and services.

(including diagnosis and treatment) must be economically-balanced in relation to possible expenditure on medical care as a whole. The mandate of the Canadian Task Force on Preventative Health Care, as stated in 2003, is “to determine how the periodic health examination might enhance or protect the health of Canadians and to recommend a plan for a lifetime program of periodic health assessments for persons living in Canada”.

Although there are many screening tools used in the ER in Canada³⁹, responsibility lies with the CTFPHC to systematically review the literature and make recommendations based on the findings. As recently as 2003, under the auspices of the CTFPHC, Wathen & MacMillan published a recommendation statement followed by an academic paper examining the prevention and treatment of violence against women. The recommendation statement asserts that, “there is insufficient evidence to recommend for or against routine, universal screening for violence against either pregnant or non-pregnant women (grade I recommendation); however, clinicians should be alert to signs and symptoms of potential abuse and *may* wish to ask about exposure to abuse during diagnostic evaluations of these patients” (Wathen & MacMillan, 2003). Questions arise as to why the CTFPHC is starting to evaluate screening interventions for violence against women when cost-analysis studies (Greaves et al. 1995; Day, 1995) have been done and health care interventions have been implemented in Canada.

For many years, the Canadian Task Force and its American counterpart, the U.S. Preventive Services Task Force, worked together in a close, constructive collaboration. However, the U.S Preventive Services Task Force (1996:1) states that, “there is insufficient evidence to recommend for or against the use of specific screening

³⁹ Standardized screening tools for abuse include: the Ontario Antenatal Record (2000) -the Ontario Medical Association <http://www.oma.org/phealth/00anten.htm> ; the Routine Universal Comprehensive Screening (RUCS) Protocol (2003) -Hastings and Prince Edward Counties Health Unit ; the Conflict Tactics Scale (CTS) -Straus,(1979); or the Partner Violence Screen (PVS)-Feldhaus et al.(1997).

instruments to detect family violence” (refer to Box 1). However, the Task Force also states that asking a few direct questions about abuse *may* be recommended (U.S. Preventative Services Task Force, 1996:1). Meanwhile, the American Medical Association, the American College of Emergency Physicians, the American Academy of Family Physicians and the American College of Obstetrics and Gynecologists

Box 1. Existing Clinical Practice Guidelines

Canadian Task Force on Preventative Health Care (2003)

- There is insufficient evidence to recommend for or against routine universal screening for violence against either pregnant or nonpregnant women; however, clinicians should be alert to signs and symptoms of potential abuse and may wish to ask about exposure to abuse during diagnostic evaluations of these patients.
- There is fair evidence (level 1) to refer women who have spent at least 1 night in a shelter to a structured program of advocacy services.
- There is insufficient evidence to recommend for or against screening men as potential perpetrators of violence against their intimate partner.

US Preventative Services Task Force (1996, 2nd Edition)

- Insufficient evidence is available to recommend for or against using specific screening instruments to detect family violence, but recommendations to include questions about physical abuse when taking a history from adult patients may be made on other grounds. Clinicians should be alert to the various presentations of child abuse, spouse and partner abuse, and elder abuse.

American Academy of Family Physicians Position Statement (2002)

- The guidelines include routine screening, counseling, and advocacy for all patients experiencing family violence.

American College of Emergency Physicians (1999)

- Recommends screening and referral for patients who indicate domestic violence may be a problem in their lives.

American Medical Association’s Council on Scientific Affairs (1992)

- Guidelines include routine screening in primary care settings and a structured approach to documentation and referral to appropriate community resources.

recommend that “domestic violence and its medical and psychiatric sequelae are sufficiently prevalent to justify routine screening of all women patients in emergency, surgical, primary care, pediatric, prenatal, and mental health settings” (Ontario Hospital Association 1997; AMA American Council on Scientific Affairs, 1992:11-12).

With conflicting messages from the Canadian Task Force and the medical community, health care professionals are confused about how and whether to develop screening protocols for woman abuse. Furthermore, possibly 'insufficient evidence' according to the CTFPHC is a cover-up to justify the cost-effectiveness of implementing routine woman abuse screening in the ER. This leads us to the next implication: costs to the health system due to abuse.

Ideally, both epidemiological and qualitative data on both womens' experiences and health care providers are necessary for helping abused women. However, in order to gather resources for woman abuse screening programs, incidence/prevalence statistics are required by policy-makers to determine the severity for policy-makers. According to Richard Goldbloom (n.d.), Editor and Chairman of the Canadian Task Force on Preventative Health Care, cost-effectiveness analysis is one of the principal criteria for adoption or rejection of an effective preventative measure. Goldbloom admits that although cost-effectiveness analysis has not been a major focus of Task Force evaluation, the issue is inescapable in a time of fiscal restraint. Thus, when preventive manoeuvres are costly, especially if applied universally, the medical community asks how great is the margin of good over harm. Rather, perhaps the question that should be asked is what harm is there in asking about abuse in a non-judgmental and compassionate way, besides offending a woman who screens negative for abuse? The health care sector must carefully re-evaluate the financial cost of implementing routine screening questions for abused women.

Despite applying scientifically-valid and reliable methods to both quantitative and qualitative woman abuse studies, institutional mandates of the CTFPHC and CCHSA suggest the issue of abuse will remain a low priority for health care providers as there is 'insufficient evidence' for routine screening for woman abuse. Without approval from

the Canadian Council on Health Services Accreditation and without any recommendations from the Canadian Task Force, the issue of screening for abuse is tenuous. Without recommendations or guidelines, simply screening on indication in the hospital limits the impact of abuse screening.

Critique of the medical model

Where individual health professionals and departments have established effective and routine screening, they set a benchmark for other health care professionals to follow. However, many of the benchmark programs are based upon the medical model and suggest that detection and referral to counseling or a social service agency is 'treatment' or 'effective intervention' in that it should be sufficient to prevent future "episodes of battery" (Loring & Smith, 1994). Physicians interviewed in Rittmayer & Roux's (1999) study stated their personal agenda was to identify and fix the situation, "...to get her out of the home. For us it's black and white. Get the patient out of the environment... Our problem is to identify and diagnose" (Rittmayer & Roux, 1999:176).

Successful interventions in the medical model are based upon using indicator-based screening methods, identification, appropriate referral, pressing charges, making arrangements for counseling, and reporting that the woman leaves the abusive relationship (Ontario Hospital Association, 1997; American Medical Association Council on Scientific Affairs, 1992). Therefore, screening in order to detect abuse in women's lives will lead to proper "management of abuse" (Parsons et al. 1995).

Currently, there is pressure to make rapid assessments, diagnoses, and treatment recommendations which often causes health care providers (especially emergency physicians) to take charge and maintain control of clinical encounters (Warshaw, 1997). For a woman whose life is controlled and dominated by the abuser, the subtly disempowering quality of many clinical interactions serves to reinforce the idea that this

is what is to be expected and adapted to in order to survive. One of the greatest challenges involves teaching health care providers to relate in non-disempowering ways when medical training links one's sense of competence to being in charge (Warshaw,1997).

Another challenge facing health care professionals is how clinicians and patients define 'quality of care.' This appears to differ when assessing the needs of the abused woman. Definitions of quality regularly conform to the perspective of the providers instead of the users. The general perspective on quality of health is predominately defined by national and international governments, donors and health insurance companies, health care providers and deliverers (Van Wijke et al.1996). The user's view, particularly from the women's perspective, is largely ignored.

Women suffer a stereotypical image, being seen on the one hand as caregivers, and on the other hand as 'over-consumers' of health care service (Van Wijke et al.1996). In medical practice, women are explicitly or implicitly stereotyped as the "sicker sex," suffering from "vague," medically-unexplained physical complaints in addition to emotional problems. Consequently, health care providers rely heavily on differences in prevalence/incidence (availability bias), the male model of symptomatology, risk factors and test results (overgeneralization bias), and patient variables (sex stereotypes). Accordingly, the issue of woman abuse is often depoliticized in the medical model becoming an issue of individual pathology, stress, and 'family' dynamics (Warshaw,1993).

Most medical research on woman abuse is by epidemiologists who prefer to take their data from medical records rather than talk to women (Kaufert,1988). They also prefer "hard" instead of "soft" data; and the objective, quantifiable "facts" to the subjective qualitative experience of women. The result can be inaccurate because it is

fixated on an inadequate understanding of a woman's world (Kaufert,1988).

Consequently, health care professionals tend to concentrate on the physical assault and the medical model, and lose sight of the qualitative aspects of the woman's suffering (Freund & McGuire,1999).

According to the medical community, woman abuse is viewed as a disease and Warshaw (1996) suggests that medical models are thereby limited because they are clinical models. These models do not provide a holistic framework for recognizing the abuser's use of violence, threats, and intimidation combined with social conditions which support gender inequality (Warshaw,1996).

Abused women report higher levels of dissatisfaction with health care providers, particularly physicians, feeling that they do not listen, are difficult to talk to, or are not competent to treat illnesses (McCauley et al.1998). These women cite many reasons for not wanting to talk with health care professionals about abuse; the most common are fear of retaliation by the partner, shame, humiliation, denial about the seriousness of the abuse and concern about confidentiality (Gerbert et al.1999b). Other reasons women relay for not engaging in dialogue with health care professionals include: having an obligation to keep their families together, lack of readiness to change the relationship with the abuser, lacking economic resources to leave the relationship, and fear of police involvement (McCauley et al.1998).

Furthermore, a diagnosis-driven system poses another set of problems for victims and survivors of woman abuse (Warshaw,1996). For abused women, a diagnosis of abuse may create new dangers. Abusers often use their victims' psychiatric diagnosis to "prove" they are right, that the problem is her fault, that she is crazy, or that she is an unfit mother. In seeking treatment, abused women potentially risk losing their children in custody battles and losing their credibility in court (Warshaw,1996).

Critique of a woman-centered approach

Before examining a woman-centered approach in the clinical setting, a distinction must be made about the origins of violence. Throughout this politically-heterogeneous landscape, there are diverse attitudes and agendas regarding violence against women that are revealed when abuse is publicly discussed (Hoff,1994). While it is recognized that women as a group share some common issues and policy concerns, women living in Canada are not a homogenous group. Beyond the general agreement that violence against women is unacceptable and must stop, differently-situated women disagree about what constitutes violence, what causes violence, women's roles in perpetrating violence, and how to deal with those who commit violent acts (Rankin & Vickers,2001).

Because feminists are a heterogeneous group, intra-agency difficulties are apparent within social service agencies, nursing, and social work.⁴⁰ However, feminism is a social movement rejecting totalizing, sex-deterministic explanations for female subordination. Generally speaking, feminists account for the structural and historical complexities of gendered power imbalances and they are committed to social change (Currie,1993).

In this thesis, many nursing and social work models of 'care' align themselves with a woman-centered and health promotion approach. Although both medicine and nursing are clinically oriented and natural science based, models of 'care' are different for these two health care fields.

⁴⁰ While there are a variety of feminist theories of woman abuse, most of them share the view that men abuse women to maintain their control over them (Saunders,1988). For purposes in this thesis, "feminism" and or "feminist" is broadly defined and "views the personal experiences of women and men through the lens of gender" (Macionis & Gerber,1999:316). How we think of ourselves (gender identity), how we act (gender roles), and our sex's social standing (gender stratification) are all rooted in the operations of society. Most feminists support five general principles: 1) the importance of change; 2) expanding human choice; 3) eliminating gender stratification; 4) ending sexual violence and; 5) promoting sexual autonomy (Macionis & Gerber,1999).

The alliance between nursing and a woman-centered perspective evolved due to job requirements and responsibilities. Nursing provides physical and emotional support and care which is congruent with a woman-centered approach to care. Therefore, when referring to a feminist approach and a woman-centered approach, I am also referring to the nursing and social work principles of care and treatment. However, I am not implying that physicians cannot be feminists, or that all nurses and social workers are feminist. I am only referring to the approaches to care and treatment in general.

For those working from a woman-centered approach, the medical model is an inappropriate intervention. The issue of woman abuse is often renamed as family violence so the gendered nature of the abuse is lost (Warshaw,1993). Those working from a woman-centered approach do not work from the assumption that sharing their experiences will automatically lead to improvement in a woman's health and safety whereby the woman will leave the abusive situation or that the abuse will stop (Dechief,1999a). In reality, most abused women leave and return to the abusive situation many times, and most women want the abuse to end, not the relationship (Lazzaro & McFarlane,1991). However, despite the frustration of witnessing a woman failing to leave an abusive situation, "rescuing" such women only reinforces their sense of not being able to do so for themselves. The probability of a woman making independent choices depends on how authority is structured around her, including the authority of her health care providers. Accordingly, effective intervention seeks to realign power in the home and in the helping environment, and to mobilize resources on the woman's behalf (Stark & Flitcraft,1996).

A woman-centered approach focuses on empowerment⁴¹, autonomy⁴², safety, confidentiality, and respect for choices. Rather than being expected to “fix” a woman's life or to save her, advocates see the importance of what they could do by putting the woman at the centre of her care. The first step of success is the initial contact with a health care provider in a non-judgmental manner in private.

Autonomy and empowerment are possible if the woman can feel both strong and cared for at once (Stark & Flitcraft,1996). Woman abuse is not just about being hit. Rather, to recognize woman abuse means to understand the dynamics of abusive intimate relationships – particularly gendered relationships. While aspects of coercive control form the woman’s dominant experience of abuse, coercive control does not always create the types of injury seen by emergency physicians and nurses. Coercive control – the fundamental core of women’s experience of abuse – then ceases to be recognized as an important medical event (Stark & Flitcraft,1996).

Despite the potentially stigmatizing barriers to quality care for abused women, many professionals recognize the health sector has a role to play and screening should take place, although not without reservations. Reservations arise from the history of medicine treating the medical aspects of health care while neglecting the holistic approach to health care. Medicine also participated in the social construction of women as weak, passive, and mentally unstable (Thurston et al.1998). Feminists have struggled to counter this; yet women’s health has only recently received widespread attention and

⁴¹ The empowerment philosophy for abused women focuses on an awareness of oppression based on race, sex, age, class, sexual orientation, and disability (Gutierrez & Parsons,1998). Recognizing the interlocking nature of oppression, this framework acknowledges that woman abuse requires a comprehensive, co-ordinated response. In a woman-centered approach, the health care provider acts as an advocate and facilitates immediate emotional and physical support; re-establishes self-esteem and self-awareness; identifies problems, choices, and goals; and helps victims take an active part in their own recovery (Gutierrez & Parsons,1998).

⁴²Autonomy addresses safety and includes a sense of separateness, flexibility, and self-possession sufficient to define one’s self-interest in interpersonal and public contexts (Gutierrez & Parsons,1998).

there is continued resistance to a gendered analysis of health (Thurston et al.1998).

Moreover, many women's advocates fear that the hard-won recognition of woman abuse as a health issue will prove costly, whereby woman abuse will be medicalized (Retzlaff,1999).

Public health funding and research tend to present the problem in terms of injury statistics and modified gender-neutral scales such as the Conflict Tactics Scale.⁴³ The medical model has been criticized because medicine does not link oppression with woman abuse. Advocates promoting a woman-centered approach focus on issues of oppression and empowerment rather than gender-neutral scales and injury statistics (Retzlaff,1999).

Feminists see potential danger in the classic medical response of "managing" a woman's abuse by prescribing a course of action such as telling the woman she should leave the relationship, telling her to seek shelter in a community resource, or to inform the social work department and have her attend counseling (Dechief,1999a). Being in a relationship with her partner where 'autonomy and decision making are taken away,' and finding these same conditions present in the relationship with a provider who will become frustrated with her and label her 'noncompliant' if she does not follow the imposed solution, is not seen as therapeutic in a feminist framework (Thurston & MacLeod,1997; Warshaw,1997; Hadley,1992; Dechief,1999a).

Similar to an abusive relationship, the experience of frustrated health care providers can convince women they have failed to help themselves (Stark & Flitcraft,1996). Instead of focusing on a woman's helplessness and victimization, a

⁴³ The Conflict Tactics Scale (CTS) is a quantitative procedure that generally consists of eighteen items that measures the use of reasoning, verbal aggression, and physical violence in resolving interpersonal conflicts in intimate relationships (DeKeseredy & MacLeod,1997).

woman-centered approach guides the woman through a reframing process in which even self-destructive behaviours such as suicide attempts are interpreted as survival-oriented. Restoring a woman's sense of current capacity entails reframing her unsuccessful help-seeking initiatives as well as the anger and frustration elicited by inappropriate institutional responses.

Reframing questions and approaches to woman abuse has the potential of fitting into the ER setting. However, this can be accomplished only by ensuring privacy and allowing enough time to address the abuse adequately. The health care team also must be receptive to training sessions led by sexual assault and domestic violence nurses. Although routine enquiry may add more time onto the triaging encounter, there is more harm in not asking than asking about abuse.

Furthermore, identifying and diagnosing victims can have detrimental effects (Taft,2001). If health care providers are not given the proper training, poor interactions with patients can have negative consequences for the victims, such as inappropriate medication, increased hopelessness, or broken confidentiality, all which can contribute to more abuse (Head & Taft,1995).

Drawing from Susan Phillips, a Professor and co-ordinator of the Women's Health Residency Program at Queen's University, the Women's Health Interschool Curriculum Committee of Ontario has developed goals and objectives for physicians. This definition of women's health involves women's emotional, social, cultural, spiritual, and physical well-being. This is determined by the social, political, and economical context of women's lives as well as by biology (Phillips,1995). This broad definition recognizes the validity of women's life experiences and beliefs about experiences of health (Phillips,1995). Thus, improving a woman's health means every woman should have the opportunity to achieve, sustain, and maintain health as defined by that woman

herself to her full potential (Phillips,1995). Operationalizing this definition for abused women means victims and survivors of woman abuse must be active participants in their assessment, and health care providers must take on the role of facilitators.

This chapter provided further insight into the ideology of screening for abuse in Canadian hospitals and the intervention strategies employed by medicine and advocacy groups. Without approval from the Canadian Council on Health Services Accreditation and without any recommendations from the Canadian Task Force, policies for abuse screening remains sporadic.

While the literature suggests educating providers is needed to improve their responses to woman abuse, the two models (medical and a woman-centered) have strikingly differing ideas regarding screening protocols (Dechief,1999) and whose interests are being best-served. Because the medical model sees that insufficient detection of injuries caused by battering, and lack of referral to resources or counseling as the problem, education herein addresses how to reframe the goal of intervention to be a success. In a woman-centered approach, a large part of education is based on redefining 'successful intervention' where the goal for the health care provider is contact, privacy, and establishing a non-judgmental rapport.

Feminists argue that part of institutional responses and interventions to abuse are an attempt by authoritarian governments to win public support for their law and order policies (Radford & Stanko,1996). Feminists must continue to monitor these moves, identify and bring together these developments with a new understanding of practice as well as ideology (Radford & Stanko,1996). This section has not attempted to solve these contradictions, simply to identify and locate them within a theoretical framework. Throughout the thesis, I will return to the medical model and woman-centered approach in analyzing the data.

In the preceding chapters, the findings reveal difficulties and hardships as part of the health care professionals' identity when screening for woman abuse. These next chapters will show how identities and experiences have shaped participants' perceptions of themselves, the screening tool and protocols, and abused women. Consequently, nurses and physicians often oscillate between a woman-centered approach and the medical model when managing the health of abused women.

Chapter Four

Identification of assault in the emergency department: Findings from a medical chart review

This chapter discusses results from the chart review and provides context for the qualitative interviews. Findings reveal that health care providers navigate between using the medical model and a woman-centered approach when managing the care and treatment of abused women. While physicians and nurses create safety plans and make referrals following a woman-centered approach, physicians regularly use indicator-based methods of screening and clinical documentation styles which align with the medical model.

This chapter is comprised of six sections: personal information, demographic information, and pregnancy; completeness of ER charts; HIV, sexually transmitted diseases (STDs) and alcohol use; perpetrator of abuse, history of abuse, and health problems; previous ER visits, body diagram, and police involvement; and sexual assault charts and medical prescriptions.⁴⁴

The purpose of the chart review was to explore demographic information and to assess ER charts. The chart review informed the interview process by providing insight into characteristics of the abused women whose charts were investigated. Concepts and patient characteristics generated from the chart review included ethnicity, alcohol use, psychiatric problems, police involvement, and socio-economic status. These concepts were added to the interview guide. During the interview process participants were asked

⁴⁴ The intent was to analyze the data by age group, however due to small cell sizes this was not possible.

whether they had encountered abused women possessing any of those characteristics. For comparison, Chapter 5 outlines the characteristics of abused women who present in the ER as interpreted and experienced by health care providers.

While physicians and nurses believe abuse is a health issue, identification and documentation in emergency reports prior to February 2003 (when abuse screening was implemented) was lacking. The sample used in the chart review was not offered the abuse screening tool at triage. Results clearly show gaps in the care and treatment of abused women in that identification of abuse was low, documentation styles align with the medical model, charts were incomplete, and follow-up was rare. These results along with evidence in the literature make a strong case for implementing routine screening.

One important area of research concerning violence against women is the identification of women at high risk which can lead to subsequent evaluation and targeted interventions for these women (Dienemann et al.2000). Risk factors identified in previous studies include witnessing violence during childhood, being a woman, young age, of lower socio-economic status, substance abuse by the partner, personality characteristics of the partner, a woman's economic or social status higher than her partner's, and the immediate time period when a woman leaves an abusive relationship (Valente,2002; Hotaling & Sugarman,1990; Straus & Gelles,1990).

By examining hospital utilization by sex, 58,541 females (from a total number of 114,903 or 51%) and 56,362 males (from a total number of 114,903 or 49%) visited the emergency department between January 2000 and December 2001. Not surprisingly, without routine screening the prevalence for the identification of woman abuse in the ER was 0.11% (64 out of 58,541). In total, EPIS found 68 cases (out of 114,903 or 0.05%)

of abuse within 23 months (this figure includes both males and females). Broken down by month, this translates into the identification of approximately 3 females per month. The sample size for the chart review is 61; all the percentages are based on 61 charts, unless otherwise stated.

To examine the distributions, frequencies were calculated which revealed the majority of women visited the ER for assaults during the evening hours, came alone, were single, had complete and well-documented emergency and triage reports, consumed alcohol before, during and/or after the assault, stated the perpetrator was a boyfriend/partner or was common-law, and had police involvement in the hospital (refer to Appendix D for the list of variables and percentages).

Personal information, demographic information and pregnancy

Personal information

Forty-four percent (27/61) of women were under 30 years of age, while 56% (34/61) were 31 years or older (refer to Figure 1). The average age of the respondents was 33.5 years old.

Figure 1: Age Group of Abused Women in the ER
EPIS data 2000-2001, N=61

Eighty percent of the women reported at registration they were assaulted.

Although all of these women were abused, not all stated at the registration desk that they were abused. In many cases women listed a physical complaint such as pain in the head or a laceration rather than stating an assault as the main complaint. This may be explained by the fact that many abused women fear embarrassment and shame and consequently will report that their complaint is an injury. Only when a history is taken does the woman disclose the abusive episode. In these cases the charts will state “injury” for the complaint and “assault” for the final diagnosis.

The majority of women (51%) stated on their personal information to contact a family member in case of an emergency. Thirty-three percent did not provide an emergency contact number during hospital registration. This relatively high number (33%) is not surprising as most abused women prefer to secretly seek help in such a private matter as abuse. Fifteen percent listed a friend, while 2% listed a counselor as a contact.

More than half (57%) of the women seeking help in the ER arrived alone, while 20% were accompanied by a friend, and 15% were accompanied with a family member. While 69% of the women's charts did not state the time of the visit, 16% of abused women came to the ER in the evening hours. Eight percent of abused women presented to the ER during daytime hours. As well, 7% claimed they were assaulted one or more days prior to the date they sought help at the ER.

In 8% of the cases, a social worker or a police officer escorted the woman to the hospital. Under these circumstances the perpetrator was either in police custody where charges were pending, charged or arrested.

Demographic information

The demographic information showed that 53% of women did not report on marital status; 18% reported being single, 16% were married and 12% reported having a boyfriend. Only 5% of the ER charts included information on ethnicity or immigration status. Sixty-nine percent did not state whether there were children at home. However, of those that did, 23% stated having children at home, and all women stated that the children did not witness the assault and were not involved in the incident.

In one particular incident, patient 23 was discussing her abusive experience with her young son and he remarked, *"If a woman hits back, then she's asking for it."* This quote from a young boy suggests a culture of violence whereby violent behaviour is learned. The child may have learned this behaviour through witnessing violence in the home, in the community or from the media. Also, the child may have been a victim of violence, thus perpetuating the cycle of violence.⁴⁵

Pregnancy

Twelve percent of the abused women were pregnant at the time of the ER visit. The nurses often coded all abuse cases as urgent 67%, while only 2% were classified as non-urgent. Twenty-eight percent coded abuse cases as less urgent and 3% were not stated. A Canadian study of pre-natal patients identified a 6.6% rate of abuse during pregnancy, and almost two-thirds reported that the abuse escalated during pregnancy (Stewart & Cecutti, 1993).

⁴⁵ Mark Totten's (1996) Ph.D dissertation explores the culture of violence from the perspective of male youth who are abusive. Totten examines how marginal male youth make sense of their behaviour, and how this behaviour can be analyzed as a social phenomenon.

Completeness of ER charts (ER , triage, social work, psychology, and ambulance forms)

Perhaps the greatest challenge when following an abuse protocol lies in institutional documentation (Stark & Flitcraft, 1996). In terms of completeness of emergency charts, 66% captured complete information documenting the complaint by listing the injuries sustained, the medications prescribed, the final diagnosis, whether consultations were done, and the instructions for treatment and follow-up (refer to Appendix C for all ER forms).

For charts that were complete, they followed the medical model of documentation and were missing many critical elements that should be included in an abused woman's chart. For example, although the ER charts were complete according to the elements listed above, the documentation of injuries was poor, there was an absence of photographs, and the charts lacked direct quotes. These missing elements are key when applying a woman-centered approach to documenting abuse among women.

Documenting the complaint, treatment, and final diagnosis are clinical styles of documentation. In cases of abuse the medical model approach must be supplemented with direct quotes from the woman, diagrams outlining injuries, and other elements noted by the health care provider. Thus, many times physicians would screen on indicator-based methods, incorporating elements of a woman-centered approach and then refer back to clinical documentation styles in the ER charts.

In contrast, 34% of the reports were incomplete and lacking information in one of the fields previously mentioned. In the interviews, while physicians were not asked about this, there are many possible reasons why one-third of the charts had missing data. One reason may be a time-constraint issue, whereby physicians may neglect to record

their orders. Instructions requiring over-the-counter pain medications like Tylenol may not be recorded as diligently compared to instructions for sophisticated diagnostic equipment. Alternatively, the ER on a particular day experienced an increased volume of urgent cases requiring immediate medical attention.

There was also one patient who left the examining room without being seen by a physician and therefore the file was incomplete. The triage assessment was completed by the nurse but the patient left before a physician could assess her. This is an example of how triage assessments as part of the ER charts are complete, while ER reports written by physicians are not.

As well, many times physicians will contact social work and extensive interventions offered but this is not documented in the chart. Consequently, some calculations in this research may be underestimates of the interventions physicians actually offer abused women. There are also instances where physicians did not consult social work or offer interventions for abused women.

Completeness of triage assessments

The triage assessment includes a broad range of health questions covering areas such as the complaint, vital signs, psychosocial field, and urgency level. These assessments by the nursing staff were complete in 93% of the cases. Of the cases where social work was alerted, only 34% of the social work consultation forms were completed. The Regional Sexual Assault Treatment Program & the Domestic Violence Program (SATP, DVTP) house two emergency nurses who are no longer clinical nurses but conduct the duties of a social worker.

Completeness of social work assessments

The social work assessment entails asking questions about the assault, whether any children were involved, and whether the patient has any social supports. Together, the patient and the social worker devise a safety plan and discuss community interventions. Essentially, the social worker's objective is to provide abused women with coping strategies and to increase their social support network. In 66% of the cases, the social work form was not filled out; however this does not mean that social work was not alerted. For instance, in 51% of the time, social work was alerted but in some instances the consultation was not attached to the patient's file.

Completeness of psychology assessments

There was only one instance where a psychology assessment was completed, even though 7% of the women had a past history of suicide and depression, and 15% had a medical history of prescribed psychiatric medications. One woman who was not followed-up by the psychology department told of her battle with suicidal ideation:

"I'm feeling suicidal and would prefer not to be alone tonight. I often have suicidal thoughts and have attempted in the past" (Patient 33).

This patient appears self-aware and realizes she needs professional help. Despite her plea, according to her chart, the woman was not referred to psychology for an assessment. This is an example of a woman requiring help, it's noted in the chart, but follow-up with a psychological assessment is absent. This exceptional case is a reminder that not all women are receiving the appropriate treatments and interventions. Of note, although an abused woman may have been seen by an ER physician with a specialty in

psychiatry, all but one of these cases were referred to psychology by an emergency department physician.

Warshaw's (1989) ER study found that despite having a protocol recommending referral to a social worker or mental health professional, and referrals for shelter, legal aid, and counseling, there was no mental health consultation in 96% of the 52 cases; no social work referral in 92%, and no shelter information or other referrals in 98%.

Warshaw's findings are similar to study findings whereby social work was not always alerted, and social work and psychology assessments were not complete in the majority of woman abuse cases.

Completeness of ambulance forms

Of the 39% of the 24 women who arrived via ambulance, 92% of the forms were complete in terms of listing the primary problem, treatment, and severity level.

Furthermore, 33% (8/24) of women who were transported via ambulance were consuming alcohol and/or illicit drugs before, after, or during the abusive episode.

HIV, STDs and alcohol abuse

HIV and STDs

When examining HIV and sexual transmitted disease status, one woman was HIV positive, one had Hepatitis B and another had contracted Hepatitis C. These chronic conditions were in bold face on all forms in the emergency chart – from the triage assessment form to the emergency report. The blood test identifying the positive results could be found in the charts as well. Literature examining the health effects of abuse cite that women with a history of physical or sexual abuse may also be at increased risk for HIV/AIDS (World Health Organization, 1995).

Alcohol use

While most women (51%) did not offer detailed information regarding the assault, 20% admitted to consuming alcohol and/or illicit drugs before, during, or after the assault. In 10% of the cases both the women and the perpetrator consumed alcohol before, during, or after the assault. In 10% of the assaults, the perpetrator was consuming alcohol and using illicit drugs such as marijuana and/or cocaine. One woman related that the perpetrator had a mental illness and was consuming alcohol at the time of the assault:

“...the assailant is diagnosed with paranoid schizophrenia and has recently stopped taking his medications for this illness. Also he is an alcoholic and was drinking heavily last night”
(Patient 33).

This illustrates that some perpetrators have psychiatric problems, and use alcohol and drugs. In combination this can potentially lead to dangerous situations. The use of alcohol and drugs by the perpetrator and the victim is well-documented in the abuse literature (Statistics Canada, 1999; World Health Organization, 1995; Ferris et al. 1997).

Perpetrators of abuse, history of abuse and health problems

Perpetrator of abuse

Ten percent of the abused women stated that the abuse was precipitated by an argument with their boyfriend or partner, and that there was a history of abuse. Most women (62%) claimed their boyfriend/partner/common-law was the perpetrator in the assault, while 16% stated the husband, 8% identified the ex-partner, and 5% indicated that another family member was the perpetrator of the abuse.

The abuse literature clearly demonstrates that violence against women is more likely to be committed by an intimate partner than by a stranger (Stark & Flitcraft, 1996).

According to Statistics Canada (1994), rates of violence for legal marriages and common-law relationships vary only slightly; 15% of currently married women and 18% of women living in a common-law relationship have experienced violence by their current partner. Marriages of two years or less had the highest rates of violence, while those over 20 years reported the lowest rate.

History of abuse

Findings indicate that 46% of women report a history of their own abuse and substance abuse, while 41% did not state a past history. Although abused women reported a history of abuse, they do not always seek medical attention for their injuries. One woman stated that:

“he [the boyfriend] assaulted me once before Christmas... he was really rough and I think he inserted a beer bottle inside my vagina...I had bleeding after that” (Patient 28).

As in Patient 28's case, it may take a few abusive episodes before the victim seeks medical attention. Research shows that it takes women several visits to a health care provider before they disclose (Stark & Flitcraft, 1979).

From all charts examined, only one ER chart documented a history of abuse. According to the chair of emergency medicine research, a code on the chart indicates the last ER visits for that year. Therefore, when physicians wish to inquire about the last ER visit they refer to the code on the chart. While physicians may not state that they asked about abuse history on the emergency report, they would be aware of this fact from checking that code if the assault occurred within the last year. The ER chief suggests that:

“doctors would be more vigilant to inquire about abuse if there was a record on the chart” (Physician).

According to this statement, if the issue is not addressed on the emergency report, then there is an ‘out of sight, out of mind’ philosophy. By not having a field on the ER form, many physicians may forget to ask, and then only ask when signs of abuse are present. Consequently, indicator-based methods of screening do not accustom physicians to ask about abuse.

Health problems

The triage assessment provides the medical history. Results show that while 54% of the abused women did not have any underlying medical condition, 15% had a psychiatric condition and were prescribed psychotropic drugs, 7% had a past history of suicide and depression, 10% had a chronic condition⁴⁶ and 8% were asthmatic. As Wright & Steinbach (2001) suggest, asthma among abused women is commonly cited as a chronic health condition. Findings also revealed that some abused women were seen in the ER for a history of psychiatric disorders before visiting the ER for abuse.

For neurological status, in 34% of the cases the nurses identified women as alert, oriented, and co-operative. Only one woman was uncooperative and confused. Thirty-one percent were reported as being anxious when examining emotional status. Of those remaining, 20% of the abused women were calm, while 12% were tearful.

⁴⁶ Women with conditions such as cirrhosis of the liver, thyroid disease, hypertension, and Alzheimer’s disease were classified as having chronic conditions.

Previous ER visits, body diagram and police involvement

Previous ER visits

Unlike some abused women who do not seek medical attention immediately or often, this study found that 44% of the women have previously been to the ER. Many of these previous ER visits had been for psychiatric problems. Studies show that women experiencing abuse are more likely to utilize ER services, “drop in” health-care centres, public or community health services, primary care, psychiatric care, psychological care and in-patient hospital care (Plichta,1992). One study found that women continue to require health services at elevated levels in the years following the termination of their abusive relationships (Bergman & Brismar,1991).

Body diagrams

For the emergency report, 21% included body diagrams showing the injury locations, while 79% of the charts did not. Again, not including a body diagram aligns with the medical model, as details in a body map may have consequences beyond the health care system. Physicians must be aware of the criminal justice and legal implications involved when managing the care and treatment of an abused woman. Including a body map is beneficial in the event that the police and criminal justice system become involved as this information can be used to verify events and be used as reliable evidence (Dechief,1999).

For injuries sustained to the body results revealed that the head, face, neck, and eyes were the most commonly injured sites, 49%. Thirty-one percent of the injuries occurred in the torso region, including the stomach, back, shoulders, arms, wrist, and hands. Seven percent of the women sustained injuries to their breasts, vagina and/or

Figure 2: Injury Location** of Abused Women in the ER
EPIS Data 2000-2001, N=61

* MVA refers to Motor Vehicle Accidents

** Injury location as described by physicians in the ER chart

buttocks, while 10% of the women sustained injuries to their legs, knees, feet, and ankles. These results are consistent with other findings (Stark & Flitcraft, 1979) and are displayed in Figure 2.

Police involvement

Police were involved in 53% of the cases; the perpetrator was arrested 8% of the time immediately after the assault. In terms of the 'release of medical information form,' 21% signed this form while 77% did not. This form is signed by patients and allows police and the criminal justice system access to all medical documentation if needed in criminal proceedings. A woman may not sign the form because the police were not

involved, or if the woman was offered but refused to take the step of involving the criminal justice system.

Sexual assault charts, medical prescriptions, instructions, and final diagnosis

Sexual assault charts

Examination of the sexual assault charts suggests that these four women appeared to engage in risk-taking behaviours by consuming alcohol and using drugs. However, it is impossible to determine the temporal pathway of abuse and alcohol consumption. As discussed in the literature, we know that many sexually-abused individuals suffer from post-traumatic stress disorder (PTSD) with symptoms ranging from depression and anxiety, to suicidal ideation. The following quotation captures a young woman's account of the sexual abuse she experienced. This account appears to be the norm rather than the exception in cases of sexual abuse. Patient 28 stated that:

"...my boyfriend and I had an argument, but I don't recall about what...Afterwards he dragged me downstairs while hitting me on the face. He kept hitting my face and head while pushing me against the wall. I tried to reason with him but he was out of control. I feared for my life, because he kept saying, 'I'm going to kill you and I'm going to slit your throat.' He then pushed me down, took my clothes off and vaginally penetrated me without my consent. I was very upset because after beating me up he wanted to kiss me" (Patient 28).

The sexual abuse cases were well-documented and provided excellent patient narrative for criminal proceedings. In all sexual abuse cases (4/4), police were involved. Due to the medical and criminal seriousness of the incident, physicians followed sexual assault protocols and appeared to draw upon a woman-centered approach. These women were offered a balance of both high-quality medical treatment and a feminist perspective

by documenting direct quotes and leaving decisions up to the woman. For example, in one chart the physician noted the woman was asked if she wanted to alert social work or the police. While this type of documentation style is the standard in social work assessments, this is rare in charts physicians complete.

Medical prescriptions, instructions and final diagnosis

When prescribing medication and treatment, 46% of physicians did not prescribe any medications according to the ER chart. The majority (34%) of medications prescribed included analgesics and anti-inflammatory drugs such as Tylenol, Advil, Ativan, Demerol, and Gravol. Most of these medications were prescribed in combination. Physicians recommended STD and HIV screening in 5% of cases.

Under the physician's instructions, 36% listed as the main instruction follow-up with patient and seeking the services of a shelter, social worker, family physician or police. Twelve percent instructed the woman to rest and use over-the-counter pain medication and ice, if required. Eight percent were instructed to return to have their sutures removed, or obtain a CT scan/X-ray. For the final diagnosis made by the physician, 53% stated assault as the main reason for the visit, while 33% listed injury or laceration as the principle cause (refer to Figure 3).

**Figure: 3 Final Diagnosis for Abused Women in the ER
EPIS Data 2000-2001, N=61**

While 80% of the women listed assault as the reason for their visit, only 53% of physicians listed assault as the final diagnosis. One reason for this finding is that if the woman had a severe physical condition due to the assault such as a laceration or a broken bone, physicians will cite the physical condition as the final diagnosis rather than the assault which caused the injuries. These are instances where the physician notes the assault as secondary to the physical cause.

This chapter provided descriptive statistical data on the ER charts of women who have been abused. Study findings indicate that the chart review underestimates abuse by not citing identified cases due to the absence of a screening tool and poor documentation. Study findings also suggest that health care providers navigate between applying the medical model and a woman-centered approach when using the abuse screening protocol.

When physicians examine sexual assault cases, results revealed they use a woman-centered approach by thoroughly documenting the incident and follow the abuse protocols. In contrast, in cases of physical abuse, physicians often switch back and forth between the medical model and a woman-centered approach. Consequently, documentation in ER charts for women who are physically abused is not as thorough when compared to sexual assault cases.

Although physicians generally use indicator-based methods when screening for abuse, having a Domestic Violence field on the ER chart may not automatically increase routine screening. While there is a domestic violence question on the triage form, results in subsequent chapters reveal that not all nurses are remembering to ask the question. Therefore, having a field on the ER form will not solve the screening issue. Frequent training sessions need to reinforce awareness and knowledge of abuse to encourage routine inquiry.

When assessing the prevalence for identification of abuse in the ER, this study found that 0.11% of health care providers identified abused women without routine inquiry. This rate identified in the ER is lower compared with other studies. As the literature suggests, recognition without protocols is less than 2% of all cases of abuse. This demonstrates the importance of implementing routine abuse screening. Without routine inquiry screening will remain sporadic, identification will be low as the findings suggest, and chart documentation will continue to be incomplete.

Ethnic background, alcohol use, psychiatric problems, police involvement, and socio-economic characteristics were denoted in the chart review. Women visited during the evening hours for assaults, came alone, were single, had complete and well-

documented emergency and triage reports, consumed alcohol/illicit drugs before, during and/or after the assault, stated the perpetrator was a boyfriend/partner or common-law, had police involvement, and many were repeat patients.

Demographically, 18% reported being single, 16% were married. Twenty-three percent had children at home, but all women stated that the children did not witness the assault and were not involved in the incident. Police were involved in 53% of the cases and the perpetrator was immediately arrested 8% of the time. As well, 12% were pregnant at the time.

Perhaps one of the more interesting findings is the percentage of times social work was alerted and for which there were completed assessment forms. Discovering that social work was alerted in approximately 50% of the cases indicates that health care providers may have been following abuse protocols, and that these women were declining referrals offered by the staff. However, the percentage of times social work was alerted and provided a complete assessment raises questions about the working relationship between the social work and ER department. Questions that need to be addressed include, "Are social workers accessible to assist emergency physicians and nurses in responding to domestic violence?" and "Does the absence of a social worker after 9:00PM play a role in the low rate of emergency referrals to social work?"

Furthermore, results show a high number of incomplete social work and psychological assessments despite triage nurses indicating almost all the cases as urgent. Study findings suggest social work forms were incomplete because the sample of abused women in the chart review were from a transient population. Many women may have declined social worker intervention; or had a social work assessment and then provided a

false telephone number or none at all. Social workers attempt to follow these women by phone, but after four unsuccessful attempts the case is closed. Consequently, more than half of the social work assessments were incomplete or not filled out.

Study findings found that 20% of abused women in the ER consumed alcohol and/or illicit drugs before, during, or after the abusive episode. Findings also indicated that 46% of women reported a history of abuse and substance abuse. The chart review revealed that 15% had a psychiatric condition. Unlike the findings of Stark and colleagues (1979) which indicate that psychiatric disorders occur following abuse, this study found that some abused women were seen in the ER for a past history of psychiatric disorders *before* visiting the ER for abuse.

Ten percent of the women had a chronic condition and 8% had asthma. The most common physical injury sites included the head, face, neck, and eyes. Sixty-two percent of the women claimed their boyfriend/partner/common-law was the perpetrator in the assault. When prescribing medications and treatments, 46% of physicians did not prescribe any medications. For the final diagnosis made by the physician, more than half wrote assault as the main reason for the visit, while one third listed injury or laceration as the principle cause.

Cases of woman abuse are a major challenge for physicians and nurses. In addition to screening tools and protocols, health care providers must deal with the criminal justice system. As will be discussed in the following chapters, health care providers will continue to alternate between the medical model and a woman-centered approach. Results from this chapter inform the next chapter, which discusses patient characteristics as described by physicians and nurses.

Chapter Five

Can a profile of the abused woman be compiled?

Information for this chapter was gleaned from the chart review and the semi-structured interviews. The first theme relates to patient characteristics as reported by health care providers. Specifically, the chart review identified attributes such as ethnicity, alcohol use, mental illness, police intervention, and socio-economic status relative to the abused woman. Subsequently, participants were questioned about these concepts with regard to their patients. Participants were not used as proxies for the victims of abuse: the intent was to uncover the participants' experiences with abused women in the ER. This chapter explores the possibility of formulating a profile of the abused woman using this method.

Divided into eight sections, this chapter will discuss: socio-economic status, selective screening, patient demographics at the two campuses, ethnicity, repeat ER visits, mental illness, police involvement and sexual assault, and alcohol use.

Socio-economic status

When participants were asked about the abused woman's socio-economic status the majority agreed that abuse crosses all levels of socio-economic status and women from different cultural and social backgrounds visit the ER. The following triage nurse observed that perhaps due to embarrassment, a woman of higher socio-economic status will not visit the ER for abuse as frequently as a woman from a lower socio-economic status:

"I think that without stereotyping, people in lower SES⁴⁷ status have a tendency to come in with complaints of assault more than with somebody from a higher one."

⁴⁷ SES socio-economic status.

And it doesn't mean that people with higher or lower SES are being assaulted more or less. It just means that I think people on the lower end have a tendency to come to the ER more often than someone on the higher end and they would probably hide it more, from more embarrassment, I think. The ER is very skewed in the type of visitors, I mean the patients and clients that we get" (Participant 2, nurse).

Similarly, a physician states that in the ER, physicians encounter abused women who are socially, economically, and culturally disadvantaged:

"..In general the cases that I have seen have been either immigrant women or women with psychiatric problems as a result of abuse, or teenagers who are pregnant, or just people who are disadvantaged in different ways" (Participant 11, physician).

Several researchers have found that abuse victims are at a higher risk for negative mental and physical health outcomes (Coker et al. 2000; Resnick et al.1997; Plichta,1992). For example, Resnick and colleagues (1997) found that many physical symptoms reported by abused women were similar to symptoms for anxiety and depression, further indicating a relationship between mental health outcomes and abuse. Despite this evidence, the physician in the above quote makes the assumption that psychiatric problems precede abuse. While evidence indicates some abused women have psychiatric problems, it is unclear as to which came first, the abuse or the mental illness. The evidence suggests that many abused women in disadvantaged situations present to the ER. This finding is consistent with findings from the chart review where women presenting to the ER for abuse came from disadvantaged situations and living conditions.

Selective screening

Despite the fact that abuse affects women of all ethnic and socio-economic backgrounds, abuse is more frequent and more severe in lower socio-economic groups (Jewkes,2002). According to Statistics Canada's national survey on Violence Against

Women, women with a household income of over \$15,000 reported 12-month rates of wife assault consistent with the national average (3%), while women with household incomes under \$15,000 indicated twice the national average (6%). Rather than routinely screening for abuse, this physician continues to be selective in screening women of a low socio-economic status:

“I think it's easier first of all to ask the question and once you ask the question probably it's more easily identifiable because of the stigma attached to it. Certainly I have identified cases where they have a higher SES as well. So, personally I guess I would still say that for me I probably find it in the lower SES, but I also realize that I don't ask as much of patients from a higher SES. I'm sure it does happen in the higher SES” (Participant 24, physician).

Sugg and Inui (1992) found the close identification of physicians with patients of their own socio-economic background can generate a denial which leads to dangerous outcomes. Firstly, abused women from higher socio-economic groups will not be identified because they will not be asked. Secondly, the notion that abuse is a product of poverty may be perpetuated through selective questioning of lower socio-economic groups. Thus, screening for abuse appears to be inversely related to SES.

Patient demographics at the two campuses

While the last physician was selective in screening, the next quote suggests that the patient demographics between the two campuses are different:

“I'm not sure why I find we see more lower SES patients over at the other campus than we do here. They tend to be more complicated patients with more social issues. I find patients here tend to be a little more upper middle-class” (Participant 22, physician).

This could also be an issue for the Sexual Assault Treatment Program (SATP) and the Domestic Violence Treatment Program (DVTP). If in fact the other campus sees more patients from various socio-economic levels, would these patients still receive the appropriate care and referral to the SATP or DVTP? The other campus does not have an organized abuse program in place. Regional hospitals not able to refer patients to these abuse programs could be one of a few limitations of the programs at this campus.

Ethnicity

Questions regarding ethnicity make people feel anxious or uncomfortable, and participants were no different. Participants described the hospital as serving a large immigrant population including a variety of Arabic cultural groups. Many participants voiced concern over communication barriers and the lack of social supports and community resources available for the immigrant population. For a woman, the combination of being a victim of abuse and an immigrant without a viable grasp of English may make her particularly vulnerable and severely disadvantaged. One physician notes:

"I don't know if it's more common in certain ethnic groups, but it probably limits the resources that those people might have. It might put them in a position of having fewer supports or other avenues and they might be more dependent with fewer options" (Participant 21, physician).

Thus, immigrant women rely more on community services and yet have limited access to these services. Potential language barriers among abused women is also noted by this triage nurse:

"I do worry about the cultural influences. Immigrants are more exposed and that makes it hard too, because then they're the ones where there tends to be a language barrier. And I also worry more about insulting them with the question and it's hard because you don't know if they

understand. Quite often the husband will speak English, but she doesn't speak English. So he will translate and you can't really ask, I mean, I don't anyway. I don't know how I could ask him if he is translating it, if I really think it's a concern" (Participant 20, nurse).

Although the hospital has translating services available, most nurses stated that they would consult the physician before contacting translating services. Furthermore, participants related concerns where staff suspected abuse, but the husband was controlling and always spoke for the woman. One physician describes this as the...

"...classic case of someone with a language barrier and an injury and an overbearing partner who hovers" (Participant 23, physician).

In these situations, asking the husband to leave and asking the woman privately about abuse is recommended. Yet, what happens when the woman reunites with her husband and goes home? Does the abuse escalate because he suspects she disclosed the abusive situation? These are issues that also need to be addressed by health care providers, especially ER social workers. As previously mentioned in Chapter Two, ethnicity was not collected in the ER charts, thus making comparisons between chart review and interview data impossible.

Repeat visitors

Participants suggested that many women who visited the ER for abuse-related injuries do not often return for further abuse. Yet, findings from the chart review revealed that 42% of abused women were repeat visitors to the ER. As discussed in Chapter 4, research indicates that abused women visit medical professionals more often than non-abused women (Day,1995; Ratner,1993).

Some nurses mentioned a few chronic cases where women known to the department repeatedly visited the ER for abuse. However, many other nurses stated that these women do not return due to abuse:

"I don't find that we see a lot of repeat in those situations here. So it's hard for me to answer that question, 'cause I just can't think of any we have that are repeatedly coming in and given all the options and all the inside help" (Participant 1, nurse).

In contrast, another senior nurse recalls her experience with two abused women:

"I can think of a couple of cases. One lady was most definitely a drug and alcohol abuser, it's well-documented and she admits it. And another one that I know of, she had a long-standing history of abuse from her husband and she kept going back. It's just two I can think of right now. They keep coming back unfortunately" (Participant 3, nurse).

For providers, a potential barrier is the perception that intervention is unlikely to change patient behaviour (Lyon & Reeve, 1999; Sugg & Inui, 1992). The highly publicized tendency of abused women to return to the environment of abuse discourages many physicians from investing what they perceive as wasted time. Although an abused woman may keep coming to the ER for help, health care providers working from a woman-centered approach must understand it can take several ER visits before the situation changes. As previously mentioned, a woman knows her situation best; she may not be ready to leave the relationship, disrupt her children's lives, or she may not be financially able to leave the abusive relationship. Again, the goals of a woman-centered approach are initial contact with a health care provider, allowing time and privacy in the patient encounter. Furthermore, the goals are not necessarily identification or changing the living arrangements.

Mental illness

When health care providers were asked about abuse and mental illness, only half agreed that many abused women had psychiatric problems. Interview findings indicated the closure of one of the ER's may have increased the visits by psychiatric patients to the ER where the data was collected. However, I was unable to determine whether this was correct without conducting an extensive comparison study between the hospital sites. Chart reviews and social work assessments showed that 15% of abused women had psychiatric problems requiring psychotropic drugs.

This statement by a junior resident illustrates while physicians are aware of the connection between abuse and mental illness, they are cautious about making assumptions or drawing conclusions without a systematic review:

"I noticed that in the psychiatric patients mostly that they have depression, they smoke, and they have a lot of history of physical and sexual abuse - I have noticed that. But I can't say for sure because I am not systematic on asking everyone that comes in. From what I know for sure about the ones that been abused, I have noticed that they do have psychiatric problems" (Participant 18, physician).

The chart review revealed that 7% of abused women reported suffering from suicide ideation and depression. According to the General Social Survey (1999), 21% of abused women reported depression or anxiety attacks. Clearly, the literature supports the connections and associations between abuse and psychiatric problems.

While a chart audit has not been done regarding abuse in the mentally ill, one triage nurse indicates that some psychiatric patients have a history of abuse:

"We see quite a lot of sexual assaults from group homes. Now I don't mean to stereotype in any way but there are a definite number [of abused patients with a psychiatric disorder], that you notice it. You just notice how many people come in a state

that they've been sexually assaulted and you notice that they are not altogether there. And I find that a little unusual in the sense that why are these people being targeted more so than anybody else? There are quite a few people with personality disorders coming in with this sort of complaint"
(Participant 1, nurse).

Having a mental illness makes one vulnerable in society (Golding,1999; McCauley et al.1995). For example, mentally ill individuals may not have a large social support network; they may have illnesses preventing them from seeking appropriate medical care, a lack of financial resources, and have transportation issues (Golding,1999). Consequently, predators take advantage of these conditions resulting in emotional harm, physical injury, and financial problems.

Many physicians (7/11) confirmed that the hospital sees a substantial number of psychiatric patients. However, physicians prefer not to speculate without statistics:

"We get a heck of a lot of psychiatric patients no question. I'm not sure if they live around here but they come here. I'm not sure they have a much higher prevalence of abuse per say" (Participant 23, physician).

In terms of prevalence, while this physician erred on the side of caution, (4/11) stated that abused women probably have a higher prevalence of mental illness. It could also be that mentally ill women have a higher prevalence of abuse:

"Well, there's probably a higher prevalence in that group that you just mentioned, but not exclusive to that group"
(Participant 25, physician).

When physicians were asked about the type of complaints abused women present, one physician suggests that many times abused women complain about vague psychosocial symptoms and psychiatric problems which makes identification of abuse challenging:

“Patients who have been clearly identified as being in an abusive situation present with charts ‘this’ thick. They are repeat visitors to the ER, not all but many that I see. Along with those come anxiety problems and various stress problems and somatization. They [the women] also come in with abdominal pains or headaches and you don’t find anything” (Participant 24, physician).

This shows how some physicians assess the situation and do not find a clinical problem to treat. This is another reason why routine screening of all patients is advocated, as indicator-based methods miss many patients who come to the ER for subtle and vague symptoms.

Police involvement and sexual assaults

From the nursing perspective, most triage nurses do not encounter many sexual assault victims as they are seen immediately by the sexual assault nursing team:

“We [triage nurses] only get involved with them [sexual assaults] when the sexual assault nurse comes and gets us. So, normally when that happens the sexual assault nurse will say that there is a patient that they would like us to examine and then we do a report and document any injuries. The majority of them do not have physical injuries and so we are only involved with them for a short period of time. So I don’t know if the police were involved or not. In the past, we used to see them [before the program] with the police” (Participant 10, nurse).

If the police are not already involved when the sexually-assaulted woman presents at triage, most nurses use a woman-centered approach and ask the woman if she wants the police involved:

“Certainly we give them the option if they would like the police involved, as abuse is against the law. Most often if it’s an acute case the police are already involved and they’ve already charged the perpetrator” (Participant 6, nurse).

By contrast, the next quotation shows how one physician does not ask, but encourages an abused woman herself to contact police:

“If it's clearly identified that it was an abusive relationship, I encourage her to contact the police. We offer social work and ask them if they are safe and if there's a shelter they need to contact, or if we can call a friend. We definitely try to help them out, including calling the police if it's necessary. If they refuse outright then we can't call the police, we can't breach that patient confidentiality. If the patient forbids us to call the police then we can't” (Participant 16, physician).

Unlike the United States, Canada does not have mandatory reporting laws for domestic violence (Ferris et al.1997). Therefore, health care providers cannot alert the police without the patient's permission. According to the two previous quotes, it appears nurses and physicians use different approaches when discussing police involvement. By asking women if they want police involvement, this aligns with a woman-centered approach. However, encouraging an abused woman to seek assistance from the police takes away her power and control of the situation and follows the medical model.

When comparing chart review data, over half (53%) of abused women visiting the ER had police involvement. Since screening has been implemented, interview findings reveal that health care providers are knowledgeable about mandatory reporting laws in Canada. Participants are asking abused patients about police intervention, but leaving the options up to the woman. However there are physicians continuing to encourage abused women to contact the police, which may not be in the best interest of the woman.

When examining sexual assault protocols, a statement made by a physician suggests that sexually-abused women visit the ER for injuries related to the assault and not necessarily because they were assaulted:

“No, I don't think most abused patients are brought in by the police. Some of them may be referred. Again

a lot of them aren't coming in specifically because of the abuse. Like if this happened at 1:00am, they're not coming in until 8:00am or 9:00am. So they've gone home and had time to think about it and they're worried about what they may have caught. So they are coming in for those reasons. Oftentimes they're not even wanting to press charges and the doctor will talk to them, but they're more concerned about birth control" (Participant 21, physician).

In cases of sexual assault, many women are concerned about contracting STDs, pregnancy, AIDS, or HIV. Thus, they will seek medical treatment and then be referred to the sexual assault nurse for counseling and prophylaxis (preventative) treatment. However, the immediate concern was safety and their health, and not necessarily ending the relationship or seeking help to escape the existing situation.

Alcohol use

Nurses and physicians may also be deterred by stigmatizing attributes such as alcohol on the breath of some abused women seeking help in hospital emergencies (Loring & Smith, 1994). This statement is not implying that alcohol causes abuse or that all abused women abuse alcohol, but rather the literature indicates that some victims of abuse may use alcohol to self-medicate and to cope with their pain and depression (Loring & Smith, 1994). According to Statistics Canada (1994), approximately one-quarter of women who have lived with violence reported using alcohol (12%), drugs (9%), or medication (5%) to help them cope with the situation. Furthermore, battered women are at 16 times the risk of abusing alcohol and have 9 times the risk of abusing drugs compared to non-battered women (McLeer & Anwar, 1992).

Some of the clinical presentations of alcohol intoxication include – but are not limited to – slurred speech, inability to make eye contact, delayed mental functioning, tiredness, and/or aggressive behaviour (Loring & Smith, 1994). When these presentations are observed physicians usually order a blood alcohol test. While alcohol intoxication

was noted in the chart review for 20% of the abused women, participants noted not all abused women screen positive. Moreover, nurses and physicians stated that abused women regardless of the presence of alcohol were referred to social workers and given the same protocol as abused women who did not screen positive.

Substance abuse by victims of violence is most frequently a secondary problem precipitated by chronic abuse and victimization (McLeer & Anwar,1992). Physicians must not assume the situation is less serious if the woman uses drugs or alcohol (McLeer & Anwar,1992). However, medicine has inverted this response by interpreting addictive or self-destructive behaviours as the source of a woman's troubles, including any abuse (Stark & Flitcraft,1996). The re-organization of women's problems in the medical context shapes how women define their situation, limits their access to resources needed for safety, and therefore helps determine the overall progression of their abusive situation (Stark & Flitcraft,1996). Fortunately, this was not the case at the hospital. With heightened awareness and possible training on abuse many stereotypes and myths are being dispelled.

This chapter attempted to reveal characteristics of abused women as reported by health care providers. The experiences of providers reflect opinions and attitudes on screening practices, and show how ER providers manage the care and treatment of abused women. In the study, some medical personnel suggested that as compared to the other campus, this particular campus encounters more abused women in lower socio-economic groups than in the more affluent categories. In general, many abused women in disadvantaged situations visit the ER, and these include immigrant women, psychiatric patients, and teenagers who are pregnant.

In terms of screening, some physicians noted they tend to screen depending upon socio-economic status. For example, women in a lower socio-economic status may get screened more than women in higher categories. As a result, selective screening (or indicator-based methods) miss the subtle signs of abuse in higher SES groups as the injuries may be hidden (e.g., covered by clothes).

Social supports for immigrant women are limited, and adding the potential language barrier can severely disadvantage these women. As well, when asked about repeat visits most health care providers did not encounter repeat visitors due to abuse. Findings remained inconclusive about whether abused women also suffered from a psychiatric illness, as participants were divided about the issue.

Some health care providers encouraged abused women to contact police. This ideology is more in keeping with a medical model framework which changes the power dynamics in the clinical encounter and neglects to let the woman make all her own decisions regarding a safety plan, strategies, and referrals to other services. Furthermore, sexual-assault patients may visit the ER not because of the sexual assault itself but because of the resulting injuries. For example, the immediate concern is safety and health, not necessarily ending the abusive relationship.

Lastly, although alcohol was involved in many chart review cases, physicians and nurses did not indicate that abused women who were positive for alcohol were treated differently than those who had not been drinking. The evidence illustrates how medical professionals did not stigmatize women due to the presence of alcohol, and health care providers did not consider alcohol as a treatment barrier. Thus, all abused women are offered the protocols regardless of secondary issues such as psychiatric illness, ethnicity, or alcohol use.

In terms of switching between theoretical frameworks, the medical model was implemented when physicians conducted selective screening on populations in the lower SES groups, and when physicians encouraged abused women to contact police. Nurses, however, asked abused women if they wanted police involvement, which follows a woman-centered approach.

To conclude, a profile outlining characteristics of an abused woman could not be established. Clinical presentations and demographics of women may not be sensitive or predictive indicators of woman abuse in the ER (Zachary et al.2001). Medical providers cannot rely solely on demographics or clinical presentations for the accurate identification of women who have been abused. Trauma, obstetrical and gynecological syndromes, psychiatric symptoms, and substance abuse are risk factors for recent abuse in the ER (Zachary et al.2001). However, study findings remained inconclusive about these patient characteristics and attributes associated with abuse in the female population. The next chapter examines the debates and strategies around screening for abuse as experienced by physicians, nurses, and social workers in the ER.

Chapter Six

Debates and discourses with the abuse tool: knowing how, who, and when to screen

This chapter examines the common experience of participants in defining their roles, responsibilities, and identities as health professionals in relation to screening practices. Difficulties with the design of the screening tool, and the strengths of health-promoting questions at triage are described.

The chapter is divided into four sections. The first section examines the debates and strategies regarding routine screening versus indicator-based screening. Screening for abuse can be in the form of face-to-face questions or self-administered screening questions, and these are explored. The second section looks at how the screening questions are applied by health care providers in the ER. The third section reveals how the ER is a site of health promotion. Finally, the fourth section explores who is screened for abuse, and when; and describes whether identification has increased since the implementation of routine screening. The rate of screening in the ER population is also examined.

Indicator-based versus routine screening

There is an ongoing debate about whether to screen for abuse on indication or routinely (Ferris, 1997; Grunfeld et al. 1994). All health care providers agreed that abuse is an important health issue and the ER is a place to address it. However, their opinions diverged regarding whom to screen and how to screen. Many providers note the strengths of and weaknesses with each approach to screening for abuse. However, they are uncertain as to what interventions to use:

“We see a huge volume of patients and we know that it’s definitely out there, that patients are being abused and we’re definitely not picking it up. That there’s a huge amount of abuse cases we are missing and so it’s a

hard issue for us as to how we can pick this up better
(Participant 15, physician).

This next physician states how abuse information must be accessible, but remains vague in how to address and manage abuse interventions:

“So I think destigmatizing it and making it, you know, like it does happen and acknowledge that it does happen and it happens to everyone whether low or high socio-economic status. That’s probably the biggest thing and thereby creating more public awareness, things like that. But it also comes back down to management as well. I think that although it is important to identify, I think it’s equally important to manage these problems as well”
(Participant 11, physician).

This physician recognizes there is more to abuse screening than identification, and this is central in the feminist approach to screening. The last two quotes summarize the attitudes and opinions physicians hold regarding screening for abuse. Although ER staff supported screening in theory, resistance or inability to conduct screening was noted in practice.

In ERs with abuse screening tools, the manner and timeliness of identification is different for nurses and physicians. This is due in part because of the job demands. When a hospital ER implements an abuse screening tool, usually this means that triage nurses ask the patient about abuse, while the majority of physicians screen on indication only. Physicians may be aware of existing abuse protocols or programs in the hospital but are not required to use a triage screening tool during the patient-physician encounter. Since triage nurses are required to ask abuse screening questions, they are perhaps in a better position to identify abuse.

For example, if a woman was not asked the screening questions at triage, a physician will not automatically refer to the nursing flow sheet, and see that it hasn’t been asked and therefore make an attempt to ask.

“I think you have to probably retrain a lot of us, because I think we’re all aware that this is a problem and then again I think we’re selective. Personally, my practice over many years has been to ask when I am suspicious” (Participant 17, physician).

This is the view of most physicians which is in keeping with the medical model: to screen for abuse on indication or suspicion only. The medical model promotes screening only when the signs and symptoms of a ‘disease’ are present. Similar to these results, Chamberlain & Perham-Hester (2002) found that most physicians (86%) screen female patients routinely when a patient presents with an injury but they do not routinely screen female patients for abuse. The physician in this next quote reiterates this notion of indicator-based practices and states:

“If the patient denies physical abuse with the triage nurse and denies physical abuse with me and I don’t suspect that this might be, then I won’t pursue unless I have a gut feeling or some signs that would persuade me to go a little further” (Participant 23, physician).

At the hospital there is no set of standard abuse questions for the physicians to follow when using an indicator-based approach, thus some clinicians do more harm than good when attempting to intervene and identify abuse. Often when indicator-based methods are used clinicians have not had the proper training and will miss the more subtle signs and indirect disclosures that abused women often initiate. Thus, while we wait for more published studies, indicator-based methods are not effective in identifying woman abuse; the evidence suggests identification for abuse remain low among health care providers.

The following quote shows how one physician asks about abuse while examining a patient for reproductive and/or sexually transmitted diseases:

“Yes, I would feel comfortable asking, except I do it more when I have a patient with vaginal or lower abdominal pain, STDs or if I see obvious marks on hands or cigarette burns. You know there can be subtle signs of abuse, but I don’t screen systematically. Other times when I see tension between the couple then I’ll ask the husband or the boyfriend to step out and I’ll ask questions and use my instincts sometimes, but not in a systematic manner” (Participant 18, physician).

Building upon this idea of having context-specific guidelines, many physicians approach the issue of abuse when conducting pelvic examinations or when discussing STDs with a patient as these clinical encounter deals with highly sensitive and personal health care matters. However, as this physician states, even in these clinical encounters asking about abuse is not routinely done.

In contrast, the following illustrates a physician who is familiar with the abuse literature. This physician understands the subtle signs of abuse, how patients can present with a host of complaints that initially do not appear to be abuse-related such as a migraine, gastrointestinal problems, addiction issues, and reproductive complaints:

“ I think universal makes sense because indicator-only misses many abused patients. The indicators for abuse are much more subtle, like if you read the literature about abuse, asthma and stress exaserbate abuse. These are non-traumatic but subtle signs that a physician may miss” (Participant 24, physician).

Due to the subtle signs of abuse that may be missed in the clinical encounter, the Woman Abuse Council of Toronto (WACT) promotes routine screening. This method has been shown in research literature to increase identification of abuse and start women thinking more about abuse (Shaw,2003; Ernest & Weiss,2002; Waalen et al,2000). Routine screening can be applied in several ways. Routine screening can refer to asking all individuals entering the ER about abuse (past or present), or apply only to females

within a certain age. At the hospital, only females are asked about abuse, and with a question such as, "Are you a victim of domestic violence?" However, there is no field on the chart indicating whether the abuse is past or present abuse.

Two widely-cited Canadian researchers, Anton Grunfeld and Lorraine Ferris, share a keen interest in the abuse screening but are on opposite sides of the screening debate. Anton Grunfeld, a former Vancouver clinician, is an advocate for routine abuse screening in the ER. Lorraine Ferris, a Canadian clinical psychologist, is opposed to routine screening and promotes an indicator-based model. Ferris believes, "there is no evidence to support this routine practice" (Ferris, 1997). She suggests evidence of the beneficial impact of routine screening on the patient-physician relationship is needed before routine rather than discretionary screening is recommended. For Ferris and others, an evidence-based approach to clinical practice guidelines leads to suggesting that physicians weigh the benefits and possible adverse consequences of screening in individual cases. Ferris is correct in saying that we need to examine the impact of screening on the patient-physician relationship but is not the only criterion upon which to recommend or oppose routine screening.

Shaw (2003) suggests that to do nothing or ask only on suspicion is an unacceptable alternative until additional research is done on how to provide better care. We routinely enquire about many health issues that are less common or deadly. We also ask women if they smoke or drink or use drugs, aware the women may not relay accurate information. As Shaw suggests, "Is this not screening?" According to Shaw (2003), such questions allow us to provide medical information for harm reduction for these women and their children by modifying risk-taking behaviour.

Face-to-face versus self-administered screening methods

In terms of guidelines and context, there is an abundance of literature examining how routine screening should be implemented (Middlesex-London Health Unit,2000; Grunfeld et al,1994; Society of Obstetricians and Gynecologists of Canada,1996; Woman Abuse Council of Toronto,2003). Screening for abuse can be administered either by a health care professional, one-on-one, or through a self-administered questionnaire. Yet the literature indicates lower rates of detection when the tool used is a self-administered questionnaire when compared to one administered by a trained health care provider in a direct interview (Lyon & Reeve,1999; Dutton et al.1996).

A physician who held Grand Rounds on abuse explains why a self-administered questionnaire is inappropriate in the ER setting:

"I don't think a self-administered questionnaire has been proven to work. I mean, I think you can use sort of longer questionnaires to tease out abuse and that may pick up a few more than just answering two questions, but that's very time-consuming and in an ER department I don't think those would ever work. So the JAMA⁴⁸ article showed the 3 questions to ask and namely those two that seemed to pick up the most. "Have you ever been kicked, punched, slapped by your partner?" "Do you feel safe at home?" (Participant 13, physician).

A resident brought up the idea of confidentiality and privacy in the ER, and how self-reports may expose abused women to harm:

"Again there's the issue of the partner, if the partner is sitting right next to them and wanting to know about those questions, there's obviously an issue there. I guess it really doesn't solve the privacy issue because the person has to take that back to the person they're sitting with and show it to them. Essentially, they don't want to say the statements out loud and they don't want someone else to report the answers for them" (Participant 21, physician).

⁴⁸ Feldhaus, Kim, Koziol-McLain, J., Amsbury, H., Norton, I., Lowenstein, S and Jean Abbott. (1997)"Accuracy of 3 Brief Screening Questions for Detecting Partner Violence in the Emergency Department." *Journal of American Medical Association*, 277:1357-1361.

The following senior resident summarizes the issues of disclosure in support of face-to-face administered questions and states why a self-administered questionnaire would not fit into the ER environment:

“I don’t know, because it’s a big trust issue for people to disclose and I don’t know if that would help disclosure or not. I would have to say I’m not sure. My training has been to ask the question from a person-to-person type of point, because the point of asking the question is not necessarily to get them to disclose but to recognize that as a health care professional you’re open to hearing that when they’re ready to tell you. With a piece of paper, they may not know where that’s going or what’s on the paper” (Participant 15, physician).

Due to his training in abuse, this physician touches upon the essential elements in a woman-centered approach such as trust, rapport, respect, empathy, compassion, empowerment, and autonomy. The provider also describes why face-to-face screening is perhaps more valuable than questionnaires or surveys in a clinical environment.

Application of the screening tool at triage

Although there may be variations, all ER screening protocols for woman abuse include four components: identification and assessment; treatment and documentation of injuries; safety plan; and referral. Several standardized questionnaires have been proposed to overcome barriers to direct disclosure and to help identify at-risk patients (Lyon & Reeve, 1999; Feldhaus et al. 1997; Waller et al. 1996; Lazzaro & McFarlane, 1991; Thurston et al. 1998; Gerbert et al. 1999a; Norton et al. 1995).

The hospital developed 3 brief questions based upon the partner violence screen (PVS)⁴⁹ and protocols other Domestic Violence Centres across Ontario have been

⁴⁹ The Feldhaus et al. (1997) PVS screen consists of 3 questions: “Have you ever been hit, kicked, punched, or otherwise hurt by someone within the past year? If so, by whom?;” “Do you feel safe in your current relationship?;” and “Is there a partner from a previous relationship who is making you feel unsafe right now?” (Feldhaus et al. 1997:1358). The 3 brief screening questions will detect 64.5% to 71.4% of women who have a history of physical or non-physical partner abuse (Feldhaus et al. 1997).

using. Developing a screening tool was mandated by the Ontario Ministry of Health and funded by the Women's Directorate. Only routine screening of women was provincially-funded. A sexual assault nurse with the SATP and DVTP states:

"...All we have to provide is the number of patients served and they're divided into categories of sexual assault or domestic violence. So they [the Ministry of Health] receive the number of patients seen on a quarterly basis. In other words, the hospital's goal was to provide service to those who have been identified. Whichever way we go about getting patients identified was up to us, although generally speaking it's becoming more and more the norm that patients all should be screened" (Participant 12, sexual assault nurse).

According to this assessment, the Ministry of Health is more interested in the number identified than the methods for screening. The hospital is interested in developing an effective screening method for identifying abused women and providing services to abused women.

While the statistics are important, an examination of the screening tools is critical. To fully understand increases and decreases in rates of identification, the Ministry of Health also needs to have an understanding about screening behaviours and methods. Screening methods affect identification. Therefore, depending upon the screening tool, different hospitals could obtain different numbers identified in the ER, in turn making general comparisons nearly impossible. Furthermore, although the clinical goal for the government may be to increase identification, for others the goal is increasing an awareness of abuse. While the Ministry of Health may define success around a hospital's increased identification, the hospital staff may measure success more in terms of asking the woman about abuse, validating that it is a health issue and is not their fault, and providing resource information and supportive counseling (Shaw, 2003). Thus, it is possible to arrive at two separate conclusions with the same information.

How to screen for abuse: format & content

On the emergency nursing flow sheet, women are asked if they are experiencing domestic violence, and if so, what type and whether they fear for their safety. These questions can be asked in a variety of ways depending upon the participant's comfort level. There is no standard. The sexual assault nurses who conducted the in-service⁵⁰ training provide examples of 5 different ways of asking the question. Nurses then chose whatever one they are more comfortable in asking. For example, a physician might ask, *"Domestic violence is an important health issue and I am here to help. Is this a problem for you?"* While the more common question for a triage nurse is, *"We have a policy where we ask everyone a question about domestic violence, so I'm going to ask: Have you been physically hurt by someone at home?"* One physician on the hospital task force states:

"The screening tool that we use has been studied in the past and so it has been found to screen most people who have been experiencing domestic violence in their life either past or present. So it's a fairly useful screening tool for that, I think" (Participant 13, physician).

Since not all ERs are organized the same and there is no standard set of questions, health care providers face a number of constraints that affect their ability to provide appropriate care for abused women. There are many limitations and forces of resistance encountered in attempting to establish screening protocols and tools in Canadian ERs. Changing the culture of an ER is not easy or straightforward (Waller et al.1996). Thus, screening protocols for woman abuse must be tailored to the health care setting:

"I think the important thing is to know what questions to ask when screening and a way that would be appropriate."

⁵⁰ In-service training sessions are offered to nurses as part of their continued training. The hospital's educators arrange these training sessions on a regular basis where a wide variety of nursing issues are covered.

This is the most helpful thing for me as an ER doc, which is to have quick questions which are effective in the ER environment” (Participant 21, physician).

While the ‘Best Practice Guidelines’ can be used as a template, questions must appropriately fit into the hospital environment by using input from staff and the hospital administration, and then tested on focus groups of survivors of abuse. For example, protocols in a physician’s office may include a longer list of questions than the screening questions in an ER. Screening questions in the ER must be clear and concise, valid and reliable, and easy to implement. These tools must be developed to fit into the existing ER climate otherwise the screening tool will not be effective or efficient.

The definition of ‘domestic violence’ on the triage form refers to physical, sexual, and emotional abuse. Although this definition encompasses different forms of violence, many times nurses expressed that they were unsure what forms of domestic violence they were screening for. Nurses also did not think patients understand what is meant by ‘domestic violence’. As a result, patients may interpret domestic violence to mean only physical or sexual abuse. Moreover, the majority of nurses only inquire about physical or sexual abuse without mentioning emotional abuse. The following passage illustrates how one triage nurse believes that patients oftentimes do not understand what domestic violence means when asked:

“People have their ups and downs in a relationship and I’m sure there’s lots of emotional abuse out there, there’s all different types of abuse, more than just physical. I don’t think people are understanding the question appropriately, in the sense that, when I say to somebody, ‘Is there any domestic violence?’, they immediately assume anyone getting hit” (Participant 9, nurse).

Thus, the reporting of domestic violence may be underestimated because emotional abuse is not being identified. One triage nurse suggests that emotionally-

abused women may seek help from community services rather than going to the ER for the abuse. This can also explain the under-identification of emotional abuse:

“People coming in that have been assaulted are coming in for their physical injuries, and not because of emotional abuse. They [abused women] seek help at women’s shelters, but they don’t come to the ER for counseling or help”
(Participant 14, nurse).

There is a body of literature suggesting that the majority of abused women seek medical attention in the ER for immediate physical and/or sexual trauma (Ratner,1995). Women who suffer emotional abuse are more likely to seek out mental health services and social services. Ratner (1995) found that women seek help from health care professionals primarily because of physical injuries.

Despite the evidence that some emotionally-abused women may not seek assistance in the ER, Norton et al.(1995) suggests that asking, *“Have you ever been emotionally hurt by your partner or someone important to you?”*⁵¹ is another valid and reliable question to ask of patients.

For example, if a woman visits the ER for injuries and has been emotionally abused, chances are that the emotional abuse will not be detected because providers are not asking about other forms of abuse besides physical and sexual. Many nurses see not asking about other types of abuse as a major limitation and refuse to ask the screening questions. Another triage nurse confirms this experience and suggests the screening questions are too focused on physical abuse and neglect to address emotional abuse at triage:

⁵¹ Women advocates insist in order to be effective, screening questions should avoid stereotypical or stigmatizing words, such as, “abuse,” “victim,” and “violence.” Use of such language will result in systemically overlooking those patients who do not already identify their experiences as violent or abusive, or who are uncomfortable considering themselves to be “battered women” victims of abuse” (Dutton et al.1996:93). Therefore, behavioural descriptions instead of categorical labels are recommended when asking about abuse and violence exposure. Furthermore, these terms should be avoided because women may not have the same interpretation (Walton-Moss & Campbell,2002).

“The question should be ‘Is there any form of abuse in your house or in your home that you have to deal with?’ There’s a lot more emotional abuse out there than there is physical abuse. There are many different forms of it and I don’t think that issue is being addressed at all. There’s a reason why 60% of the population is on some type of anti-depressant or psychiatric glue” (Participant 8, nurse).

Knowledge flow not only refers to information passed from one health care provider to another, but also between health care providers and patients. The last two quotations suggest that staff and patients in the ER may lack an understanding of what domestic violence means. This clearly demonstrates a failure on the part of health care providers to convey what is meant when asking about domestic violence. Therefore, knowledge flow is disrupted. This in turn causes a lack of communication. Further, inaccurate information may pass between staff and patients (refer to Chapter 7).

Study findings suggest that the term domestic violence on the screening tool at triage be defined for women to include physical, sexual and emotional abuse. The issue of asking about emotional abuse has been met with reservation (Ferris et al.1997); emotional abuse can lead to poor health and should be included in the definition at triage. Specifically asking about emotional abuse may not be appropriate, but asking about abuse ‘in general’ and defining it may be a preferred method for screening at triage. For example, an appropriate question may be,

“Have you ever been physically, sexually, or emotionally hurt by your husband, boyfriend, or common-law partner?” The term “intimate partner violence” should not be used with people in the older age groups as they may not understand or identify with this term.

Besides addressing the different types of abuse, nurses questioned the validity and reasons for screening for abuse. In the following quote a triage nurse questions why

nurses were not consulted during the development process of the 3 questions considering they are the frontline workers. This nurse touches on the context in which the questions should be addressed:

“The thing is that when they brought in the screening program of course the people that bring it in are not the ones asking the question. If you’re a triage nurse and have been doing it for year after year and someone says you have to ask this question, you have a lot of questions in your own mind, like this isn’t something that we should be asking at triage. And if it’s something that is asked at triage is it the most appropriate way to ask it and is this the appropriate time?” (Participant 9, nurse).

On the surface, this nurse questions her role and responsibilities as a nurse towards the screening tool. Upon closer inspection, this is also an example of one nurse verbalizing a lack of knowledge flow between the professionals developing the screening tool and the triage nurses implementing it. Developing a tool in isolation from the ER process, structure, and provider attitudes do not empower or promote a sense of ownership among staff.

In the second passage another triage nurse displays her displeasure with the type of screening questions:

“The screening questions that we have, ‘Are you a victim of domestic violence’ and ‘Do you feel safe in your home?’ Those are the only two questions that are on our triage sheet and that’s what our triage nurses have been instructed to ask every patient. But those are not the kinds of questions I think I would personally answer if I were a victim of abuse” (Participant 2, nurse).

Although the nursing form actually has 3 questions (refer to Appendix C), most nurses only acknowledged the first two questions. The third question, the ‘type’ of domestic violence, was almost always forgotten since this question is only asked when a positive response is given. Several points of interest emerge from this passage. First is

the idea that the sexual assault nurses who are training the triage nurses are not providing enough instruction on how to use the tool. Second, nurses appear resentful of the fact they were not included in the development process of the screening tool. Triage nurses feel connected to the questions they ask, and when they are told to add three more questions to the triage process this diminishes their authority and control in the nursing encounter.

Many nurses have their own style of triaging when screening for abuse. One triage nurse explains how she approaches the encounter after a woman discloses abuse. Of note, she is applying elements of a woman-centered approach:

“ I would encourage her to seek help and tell her there’s lots of services out there and that we could provide her with names and numbers and we can give her our social work number. Let her know that there are lots of services and that she doesn’t need to be abused in this day and age. This only takes a few seconds to do ” (Participant 7, nurse).

This quote aligns with a woman-centered approach because the nurse is encouraging and non-judgmental, while at the same time empowering the woman with choices. The noteworthy facet of this encounter is that the nurse is not victim-blaming, but instead puts the woman at the centre of her care by providing options and a supportive environment. These elements are the foundations for a woman-centered approach. Conversely, by using the medical model, autonomy and empowerment are sacrificed.

The following passage demonstrates how one triage nurse was attuned to social issues of her work:

“You try to figure out the social dynamic between the couple. Sometimes people come in and it’s quite obvious who’s in control of the relationship or who wants to be in control of the relationship and isn’t. It’s usually the male who’s a little aggressive in answering

questions for the female and even if you ask them to have a seat they won't sit down. There's always that question in the back of your mind like what's really going on and maybe this person should be asked in private what's going on, and I don't know if that's being done" (Participant 6, nurse).

While the previous nurse was socially attuned to family dynamics, the next passage has one triage nurse explaining the triage process and handling the situation differently:

"We're not supposed to get into details and that kind of thing, because the sexual assault nurse will get into that. I don't always follow that because of my experience I do feel comfortable asking those questions. So if they're willing to tell me then I will hear about it. Otherwise I just basically try to find out whether they're physically injured and whether a doctor has to look after them" (Participant 3, nurse).

While one triage nurse felt comfortable asking about the abuse, another nurse recognizes and verbalizes the implications of the woman re-telling her story over the course of the hospital visit. The following passage illustrates how another triage nurse uses a woman-centered approach and acts more like a compassionate facilitator, while at the same time not minimizing the abuse:

"They [abused women] have to talk about being assaulted to the triage nurse and then they go to registration and then they may see a resident and talk about the assault again. So I try not to get them going because I know they're going to tell the story to someone else and I'm not going to fix it, I just want to get them to the right person. And even with the sexual assault they tell us not to get too involved because anything you're saying now could end up in a court case and the number of times they have to repeat it the more the story can change and you're better to let them tell one person that's going to follow them from the beginning. You don't really want to shut them down, I just explain that you don't need to go into the whole story because you're going to be talking with someone else. I'm just going to get the right person to see you" (Participant 7, nurse).

Social workers and sexual assault nurses usually draw upon a woman-centered approach when counseling abused women, following the principles of empowerment and autonomy. The following passage shows how sexual assault nurses change the power dynamics, enabling a woman to regain power and control; she is in the best position to understand her situation:

“Essentially our role is to provide the person with all of their options (i.e, counseling, to health care and to legal options). We review the options in each choice and try to compare it to the person’s specific situation to help them to make their own decision about what they want, because there’s really very little that we would be recommending to them. Everybody is a different person and everyone has different needs and we try to sort that out with them. The whole purpose of having it [the SATP and the DVTP] is so that they can take control over their lives at the moment that they’re with us. They have a sense of that and they can take that home with them” (Participant 12, sexual assault nurse).

One senior resident expressed how she approaches woman abuse through medical school training and reading the literature:

“It’s important to let women know you’re there to help them and that you’re somebody that they could tell at some point. It’s not necessary to have them disclose at that minute. So I approach it like giving them the opportunity to disclose but more to let them know that this is the place to disclose and that I could be the person they can disclose to and to develop a human connection with that person” (Participant 15, physician).

The health care providers in the two previous quotations approached woman abuse from a feminist perspective, re-assuring women that the ER as a safe environment where they can disclose. This re-emphasizes the fact that identification is not the first step to a positive outcome. Instead, the key is ensuring the initial contact is non-judgmental and private, and the health care provider has the time and willingness to discuss the abuse.

As mentioned by many physicians, the ER must be a place where the abused women can turn and feel comfortable in knowing she can trust the physician:

“My feeling is, is that a woman is going to disclose when she discloses and chances are, she won’t disclose to an ER physician she doesn’t trust. I think the purpose is to let them know that a health care facility is somewhere to go where she can get help if she needs it and that I could be a person she discloses to. They may not know who to tell or where to get help and resources. So I think if you open it up that I am ok if you tell me, then it may encourage them that they can. I think that’s the most valuable thing for screening, not to find out if it’s actually happening, but to give that woman an option. And disclosure will not happen every single time. And that’s very discouraging for some physicians who want to see results” (Participant 13, physician).

In addition, evidence suggests that abused women may seek medical attention several times before disclosing abuse (Lazzaro & McFarlane, 1991). The next quote reveals one physician’s awareness and familiarity with the abuse literature:

“ On average it takes 13 times before they [an abused woman] will disclose” (Participant 16, physician).

As outlined by this physician, there are many indirect and direct benefits to routine screening. Simply asking about abuse in the ER can prompt patients to think more about their particular situation and try to change it. Although these may be intangible or indirect benefits for some physicians to see, these may be the most important issues for the abused woman.

The most important interventions for the ER staff are understanding and awareness (Ernst & Weiss, 2002). Simply asking questions about the possibility of abuse may or may not encourage discussion. When abuse is identified by ER staff, reassurance about seeking assistance and allowing the woman make her own decisions is crucial. For physicians and nurses to obtain successful results at interventions it is important to remind women that abuse is not their fault, reassure them that they deserve better treatment, assure them that all abuse is wrong, and ensure that the ER is there for them

when they are ready for assistance. These are critical objectives of screening from a woman-centered approach. Thus, the medical encounter of screening for abuse must be reframed where successful interventions are based upon initial contact, time and privacy.

In contrast, there are triage nurses who do not use the screening questions because they feel the questions may affect their credibility, and the questions are useless, inadequate, or not asked in the proper context:

“Well, quite personally I think that the screening tool is a waste of time. To just screen anybody and everybody which is what we were instructed to do with the domestic violence questions, it was sort of a useless question. I don’t think it encourages the triage nurse to really look and think and use her experience behind her to pull out the information. I don’t think most women or most men in domestic violence situations are going to come out with a yes or no answer to that question. I think there have to be several questions that kind of lead up to it and just sort of a straightforward question at the end of several - saying “you know it looks like you have several bruises there, how did you get them and really that doesn’t look like it, it looks like you could have had this kind of injury.” For me to ask a 65-year-old man who comes in with an infected incision, post-op, he has a fever and he’s feeling sick and unwell and to say are you a victim of domestic violence? You know, honestly it’s a useless question and all it does is impact my credibility as a triage nurse to pull this question out of the air for somebody who doesn’t present with anything that would indicate that”
(Participant 4, nurse).

While nurses believe it is a good idea to screen for abuse, a few expressed that it was akin to instructing nurses to rely less on their triaging skills and experiences and more on the screening tool. As alluded to in the previous quote, some nurses may interpret the implementation of a screening tool as intimating nurses and physicians are inadequately identifying abuse, reflecting negatively on their skills. By imposing a screening tool on nurses without their input, this can strip the authority, professionalism and autonomy from nurses. While the screening literature supports the view that ER staff

are missing a great deal of abuse and failing to identify abuse victims, many struggle with striking a balance between using their triage skills and using the abuse screening tool.

Although the screening program had only been in use for 5 months at the time of the interviews, a triage nurse with 20 years of nursing experience remarks that not enough women have been identified for her to continue asking the questions:

"Lately I haven't been asking at all. The reason being I haven't got enough yes's in my mind to make it worth while to me. I'm asking little old ladies who I have to repeat the question 3 times to and they don't know what I'm saying. I'm asking little old ladies on stretchers! And lately I think nurses aren't screening, 'cause you don't see it crossed off on any of the triage assessments"
(Participant 14, nurse).

In fact, while this nurse does not consider screening worthwhile, a health care provider's reluctance to acknowledge and address the underlying cause of a woman's injuries can increase her isolation and discourage her efforts to leave the abusive relationship (Stark & Flitcraft, 1996). There are a few triage nurses who think it's important to screen in principle, but don't want to screen:

For actual physical injuries or psychological abuse they would usually present here 'cause we have our psych department here. You know in total, I think yeah, it's a good idea to ask people, but I just don't want to have to do it. (Participant 1, nurse).

Despite some negativity and reluctance to screen on the part of some nurses, many are compliant and attempt to ask the questions in a non-judgmental manner.

When participants were asked what the most important thing was to say, and to never say to an abused woman, most nurses spoke about safety and blaming issues:

"The first thing that I would say and that I have said is that, "You're in a safe place and we'll have someone come and talk to you and work something out for you." As far as what not to say, I'm sure you wouldn't say, "Well you must have done something wrong to cause it." "(Participant 6, nurse).

The second quote expresses the view that offering help is critical to helping a woman. As for what not to say, it is important not to let an abused woman feel like the abuse is her fault:

“I guess the biggest thing I would want to get across is that there is somebody here she can talk to and there are people who can help her. I guess my concern is that even if they decide not to talk to someone today they have the number that they can come back and call at any time, that service is there. I guess the most important thing obviously is not to let them think it’s their fault or that they need to make any decision right away. Whenever they decide, there is no wrong” (Participant 10, nurse) .

This last quote stood out because the nurse advocates reassuring the woman that she did nothing to provoke the abuse and stresses the point that no one deserves to be abused.

These can be powerful words when said in a safe environment to a victim in crisis:

“I would certainly make sure that no matter what they did that this wasn’t suppose to happen. To make sure that they don’t blame themselves. And the one thing I wouldn’t say is what did you do to provoke this, because that’s so ridiculous. As I said, no matter what someone does they do not deserve to be assaulted” (Participant 9, nurse).

Health Promotion

Using the analogy of Pandora’s Box, the second unexpected theme was uncovered, that of health promotion. While the triage encounter is limited, the content of the triaging assessment form addresses a variety of health promoting questions. It was clear that the hospital was continuing to apply the medical model while attempting to embrace a health promotion approach in the ER. Triage nurses have an extensive checklist (refer to Appendix C) to cover in a matter of minutes and many questions cover health promotion and risk-taking behaviours. For example, the following screening interventions already occur in the ER setting at varying degrees, assuming sufficient resources are available:

- alcohol screening and intervention
- fetal alcohol spectrum disorder
- HIV and STD screening and referral (in high-risk, high-prevalence populations)
- hypertension screening and referral
- adult pneumococcal immunizations
- referral of children without primary care physicians to a continuing source of care
- smoking cessation counseling
- depression screening
- motorcycle helmet use counseling
- seatbelt safety
- woman abuse screening
- youth violence counseling programs (Babcock et al.2000)

In reality, all these screening interventions are not always asked. However, many hospitals and Federal and Provincial Ministries of Health have policies and guidelines recommending that health care providers routinely screen for determinants of health in the population (Kennedy & Bensberg,2002).

Definitions of emergency medicine acknowledge that the specialty has more than an acute encounter-based role in the health system (Kennedy & Bensberg,2002). Many physicians are carrying out health-promoting activities in the ER and are aligning themselves more with ‘counselors’ and advocates of healthy lifestyles. Thus, although ERs are grounded in the medical paradigm, a significant organizational shift is beginning to take place in the ER where it is becoming more inclusive of health promotion principles in terms of the delivery of ‘care.’ This approach is also similar to a woman-centered perspective whereby the individual has more control over the physician-patient encounter where the broad spectrum of ‘health’ is examined including the physical, emotional, social, and cultural aspects (Kennedy & Bensberg,2002).

Health promotion maintains a focus on a wide range of health-promoting activities. The scope of health promotion is comprised of three key groups of activities and processes:

- health intelligence (gathering and analyzing information about the determinants of health, and a variety of surveillance activities);
- health interventions (developing policy and strategies);
- and health infrastructure (identifying infrastructure needs such as workforce, training, and development).

This focus is termed “up-stream thinking” and is also characteristic of emergency medicine (Kennedy & Bensberg, 2002). Here is where a health-promotion approach – which is similar to a woman-centered approach – has the potential of successfully integrating into the clinical encounter.

The following triage nurse outlines how the triage flow sheet entails asking an extensive list of questions showing not all of the “How healthy are you” questions get asked:

“So it’s hard. Especially when we’re so pressured to get things down, that they come in complaining of stomach pain or something and you have a checklist of screening questions to go over like whether they smoke, have any STDs, have hypertension, allergies, up-dated immunizations and so forth” (Participant 10, nurse).

In an article describing health promotion practices of emergency physicians, Williams and colleagues (2000) found that physicians held strong beliefs regarding health-promotion, perceived roles in health-promotion, and perceived effectiveness in modifying the behaviour of patients. Over 90% of physicians routinely asked about cigarette smoking and half about alcohol consumption. A minority routinely asked about illicit drug use, diet, exercise, domestic violence or stress. The majority stated they were the main person responsible for patient health education in the ER. Most felt prepared to counsel patients about smoking (68%) and alcohol (59%), although very few described themselves as successful in helping patients change their behaviour. Although

emergency physicians feel responsible for promoting the health of patients, only a minority reported routinely screening and counseling patients around prevention and most were not confident in their ability to help patients change their health-related behaviours (Williams et al.2000).

Although the previous American study showed a lack of routine screening for lifestyle factors by emergency physicians, awareness is increasing for many emergency physicians to keep prevention and the determinants of health at the forefront. As well, many physicians feel responsible for promoting patient health.

In addition to asking various lifestyle questions at triage, plans are underway in the ER to hang posters in the waiting room and in the woman's washrooms, and to offer brochures on health-promoting activities. In the next passage a sexual assault nurse discusses the issue of promoting a healthy lifestyle through print ads in the ER:

"Well we've asked about posters and brochures, and educators and managers have agreed, so it's a matter of doing them and being able to post them. Because abuse is such a sensitive issue, posting them in the woman's washroom is more private and allows the woman to take a moment and read the information without feeling as though people are watching her"
(Participant 19, focus group-sexual assault nurse).

The posters in the ER will provide quick messages in a variety of languages that abuse is wrong and health care providers are willing to talk. Health-promoting posters and brochures will be provided, supplying information and slogans on diet and exercise, fetal alcohol syndrome, mental illness, teen pregnancy, and safe sex. The posters may not be posted at once, however there are plans to post them on a rotating basis.

Health-promotion is the process of enabling people to improve their health (Health Canada,2003). Health-promotion practice understands health in its broadest sense, and is the product of people's behaviour, genetic make-up, social connections, and

environments. “People” may refer to communities and populations, not just individuals. Importantly, determinants of health such as education, environment, culture, and economic factors have a significant impact on this enabling process.

Another aspect of health promotion in the ER is the EPIS/NACRS (National Ambulatory Care Reporting System) database from where the sample of ER charts was obtained. This injury surveillance system has become a standard component of emergency information systems (refer to Chapter 2 for a description of EPIS). The EPIS database generates statistical reports on various injuries which are disseminated to not only professionals but also to the general public.

Whom do we target and when?

This section examines who is being screened according to participants, and under what conditions screening should take place. This section also shows screening and identification during routine inquiry.

Attitudes about the process of whom to screen vary in relation to the amount of time, content training, availability of human and financial resources, organization, and capacity of local agencies offering support to women experiencing abuse (refer to Chapter 7), and the rates of confirmed and suspected abuse detected among the various health professionals (Mezey et al.2003). In this study, there was confusion for nurses and physicians concerning the targeted population for screening. The sexual assault coordinator explained that the domestic violence program had funding to only screen women. However, half the triage nurses were screening everyone while the other half only screened women. The following nurse’s quote illustrates this confusion by stating that screening at triage is all over the board:

“Well, they decided that it was to be asked universally of everyone. I screen everybody, but I don’t know if everybody does. First of all some people don’t even ask

the question and second of all some only ask women and I ask everybody” (Participant 4, nurse).

This next quote is taken from a triage nurse who is only screening women, but recognizes that abuse is not solely a woman’s issue:

“Well, for the time being we’re screening females only, as our trial. But certainly I think there’s a male population - there is a factor out there in the male population where there is abuse as well” (Participant 20, nurse).

Physicians too, are struggling with wanting to screen but are unsure whom to screen. Some physicians believe that only women are screened, while others are under the impression that all people being triaged are asked about abuse. A senior resident states that only women are being screened:

“Right now I think their mandate is to screen women because that’s what the domestic violence tool is addressing. That’s what the government is currently funding for. There’s been talk about universal screening, but I think right now it’s just the women” (Participant 18, physician).

However, another physician states that everyone at the hospital is being asked:

“Well, I think we’re just screening everybody, and I think that’s appropriate” (Participant 22, physician).

While many health care providers were unsure about whom to screen, they were also hesitant and resistant to screen routinely when the patient has a condition requiring immediate medical attention; further, there are language barriers, the patient is not alone, or the injuries are inconsistent or unrelated to abuse:

“The issues are, do you do all men as well as all women and do you do all ages and all complaints? So you have an elderly lady who has clearly been in a car accident or is clearly having a heart attack, it seems like overkill possibly. So I think it needs to be more selective with

some kind of guidelines" (Participant 21, physician).

Clinical studies have shown that screening for abuse is not routinely applied by ER staff (Grunfeld,1997; Worster,2004). In settings where health care staff compliance has been high, it has been short-lived. There is also evidence when patients provide information suggesting abuse it is not always acted upon by health care staff (Worster,2004).

This thesis suggests that routine screening for abuse should not occur under the following circumstances:

- if the screening questions are not tailored to the ER environment
- when the injuries require immediate medical attention (i.e., stroke, heart attack and women in labour)
- if the woman is not alone
- if the provider cannot take the extra time with the patient
- if the triage nurse has not explained the term 'domestic violence'
- if providers have not been trained in abuse.

Ideally, a goal of routine screening is to screen all women. However, due to the factors previously mentioned this goal remains impractical in the ER setting. For these reasons, it is critical that screening questions fit into the existing health care setting and providers understand when and when not to screen while promoting routine screening.

According to the literature, identification increases when a screening tool is implemented, however previous chart audits and evaluations have shown that screening decreases after a couple of months (Grunfeld,1994; Lucey,2003). At the hospital, Lucey (2003) conducted a chart audit four weeks after screening was implemented (March 1st to 10th 2003) reviewing 646 ER charts to examine screening and identification of screening for abuse. Results confirmed that triage nurses were not routinely screening all women for abuse in the ER despite being mandated to screen and having attended training sessions. Lucey (2003) found that despite having a screening tool for abuse, only 26% of

all women were being screened by a triage nurse and out of these women, 5% screened positive for abuse. Lucey's (2003) estimate of 26% of all women being screened is consistent with the literature reporting that with screening protocols established, screening is between 20% to 35%.

Here, a senior physician notes:

"One of my residents did a study in the Spring and found that the screening tool is being applied to certainly less than half the women being seen. This chart review was done shortly after the tool was introduced in the Winter" (Participant 17, physician).

A physician who attended Lucey's presentation on the chart review audit remarks:

"It was a chart audit. I can't remember some of her specific suggestions. I just know that we highlighted this as being a problem. And one of the main things was for physicians to take more ownership of this role rather than it being delegated to a nursing issue. I've heard other physicians saying that this is a nursing issue, not a physician issue, which I find kind of appalling. But short of saying that we should be doing our own screening and not relying upon this tool" (Participant 21, physician).

There are informal plans to conduct another chart audit once the screening tool has been in place for 12 months. Both the sexual assault co-ordinator and the chief of the ER have expressed an interest in having a medical student or a sexual assault nurse collect this data.

Findings in this chapter revealed that while the ER is a place where abuse screening should be encouraged, implementation of effective and efficient interventions remains controversial. Results indicate that screening protocols and guidelines must be context-specific and selective in terms of the targeted population to be screened. Until these and other issues are addressed, many physicians will continue to use indicator-

based methods for screening, relying on signs and symptoms and when the clinical situation lends itself to asking abuse questions.

The strengths of and weaknesses of applying an indicator-based approach versus routine screening were explored. The strengths of an indicator-based approach are that it does not require frequent training sessions and all staff can do it according to their level of suspicion and comfort. The weaknesses come from the inability to ask everyone about abuse, the potential to inflict more harm than good, and the problem with missing the more subtle and vague symptoms related to abuse. The strengths of routine screening include reaching a large population, informing the public that abuse is being addressed in the ER, and increasing awareness that it is a health issue. The weaknesses with routine screening include attempting to hold frequent training sessions and lack of community and hospital resources.

Study findings indicate that some physicians and nurses need to be re-trained and must change their clinical behaviours if the screening tool at triage is to become a priority. Who screens for abuse should not matter as long as patients are asked. As was described by a physician, abuse should not be viewed as a 'nursing issue.' While physicians are not directly using the screening tool, having the knowledge and support from physicians would make the implementation process of the tool more effective for triage nurses. Having this supportive environment would ease the transition for triage nurses as they screen for abuse and struggle with provider barriers when identifying abused women.

When routine screening is implemented, it usually entails a face-to-face approach rather than a self-administered questionnaire. As the literature and evidence suggests, there are trust, privacy, safety, and organizational reasons why face-to-face screening is

preferred over a paper questionnaire. During the clinical encounter many women need to establish a rapport and build trust in order to feel comfortable enough to disclose abuse.

An abused woman may be more likely to put inaccurate information on the questionnaire for a variety of reasons. For example, a woman's partner may be nearby to monitor her responses so the woman may write down inaccurate information. For the hospital, having yet another piece of paper at triage complicates the process further and there is a potential to lose the paperwork in an environment filled with forms.

The 3 screening questions used at the hospital were described and suggest how the Ontario government is more concerned with identification than with interventions for woman abuse. In terms of the ER environment, the screening questions must be concise and clear, and fit into the pre-existing health care setting. As well, key issues such as definitional consensus, validity and reasons to screen, hostility towards implementing a screening tool without being consulted, and lack of knowledge flow between staff and between staff and patients was explored.

Clearly nurses were not involved in the development of the tool, and some may have preferred to be involved or at least have been given the opportunity to state their opinion of the questions before they were implemented. The issue of asking about abuse affecting a nurse's credibility is key to training and must be addressed in the in-services so nurses can feel confident and comfortable asking abuse questions. Moreover, nurses provided many important and critical insights regarding the format and content of the questions.

Study findings suggest that nurses are experiencing a lack of knowledge flow between the sexual assault nurses and themselves in relation to the application of the screening tool. Findings revealed that the sexual assault nurses who are implementing the screening program must clarify the definition of abuse, who the target population is,

and the reasons for this decision. This would help eliminate confusion and misinformation about who gets screened and who doesn't.

Results also revealed that although there are many different styles and techniques used when triaging, these approaches followed a woman-centered perspective when triaging abused women. When triage nurses refused to screen, a host of reasons surfaced. Those nurses reluctant to screen cited concern that the questions would affect their credibility; the questions were deemed useless, inadequate or were not asked in the proper context. Other nurses did not agree with abuse screening in principle, did not identify enough abused women, or felt the questions were worthless. With a few exceptions, physicians in general aligned with the medical model and preferred to screen upon suspicion.

When providers were questioned about the most important thing to say and not to say, the focus was on offering help, ensuring safety, not victim-blaming, telling the woman no one deserves to be abused, and it's not her fault. Overall, findings reveal that nurses may encounter difficulty initially asking the screening questions in an appropriate manner, but after identification has been made nurses show sympathy and reassure abused women in a non-judgmental manner.

From observation and interviews, this study shows how the ER is no longer a site restrictive to medical emergencies. The ER is a place where health-promoting activities take place, and where statistics are collected. Throughout this organizational shift, health care staff and administrator are continuing to apply a clinical model while also embracing a health promotion approach in the delivery of care. This connection is within the boundaries of emergency medicine, supported and recommended by the government policies.

The findings suggest that since the inception of the screening tool at triage, identification of abuse has increased from 0.11% to 5%. Although only 26% of women were screened, identification will increase as more women are screened. Providers also expressed concern about juxtaposing routine screening with clinical practice. Ideally, routine screening would be asked of all women. However, due to several factors, routine screening cannot always occur. The debates uncovered in this chapter are further developed and discussed in the next chapter, which presents provider barriers to screening for abuse.

Chapter Seven

Barriers preventing abuse screening and protocol usage in the Emergency Department

By using issues and debates uncovered with the screening tool in Chapter 6, this chapter outlines key factors which may prevent a health care provider from using the screening tool and protocol. As well, the third theme of provider barriers is examined in addition to unanticipated insights into the organizational structure of the ER are explored.

Although many factors explain physicians' response to abuse, the underlying reasons are multifaceted, none of which account for it fully (Jecker, 1993). Provider barriers are shown with almost any screening tool and under any theoretical framework. Provider barriers identified in this study are attributed to the screening tool, the topic of abuse, and theoretical screening approaches, namely the medical model and a woman-centered approach.

The development of a screening protocol can affect the attitudes and behaviours of health care providers at the structural, professional, and at the personal level. For this chapter, provider barriers are divided into three typologies, structural, professional, and personal, with further sub-categories. This research indicates that privacy and time constraints were the most common provider barriers to screening. Findings in this chapter have several implications regarding how health care providers could appropriately respond to abused women, and for the development of a screening tool.

Provider barriers at the structural level

This section examines provider barriers with the screening tool and protocol at the structural level in the hospital and in the community. The structural barriers in the hospital include privacy and hospital hierarchy. The sociology of professions is explored

in relation to the lack of knowledge flow between staff. Structural barriers with the protocol include a lack of institutional support and a lack of social services in the community.

Many ERs are designed in such a way that it is difficult to incorporate privacy into the flow of patient care. The first structural barrier is the lack of privacy at triage, which prevents many women from disclosing abuse. Currently, there is only a pane of glass between triage and the Psychiatry Department. All nurses commented on the traffic near their station: volunteers, registration clerks, ambulance attendants, and patients in the waiting room:

"No, it's not effective because we find that it's just not a good environment to ask people the questions. In the triage area there can be an ambulance crew, the registration clerk, the nurse, another patient and maybe a relative. The relative stands beside them and then they [relative] gets upset and says, "Why are you getting rid of me? What's so personal that you can't say it in front of me?" So no, it's not a very good environment" (Participant 14, nurse).

As the next triage nurse describes, some nurses refuse to ask the questions because the perpetrator, family member, or friend may be standing next to them at the triage desk:

"Well there's no privacy. There's definitely no privacy. Our triage set-up is not private at all, and there's people around you everywhere. I mean triaging patients, I'm sitting beside a person here that's 2 inches from me and there's another person standing here 3 inches from me and talking who's not even a staff member. There's no privacy and that becomes the big issue, because I won't even ask that question if there's people around. I don't feel I should put anybody in that position" (Participant 8, nurse).

Next, one informed physician comments on the importance of privacy when asking personal questions such as abuse:

“As for the way it's done, the problem isn't with the screening tool it's with the environment, because it's not a private area at triage and some patients are reluctant to disclose at triage and as with most screening tools, it will miss patients who will be reluctant to disclose” (Participant 13, physician).

This particular physician has held training sessions on abuse. He understands having a private triage area is vital in allowing an abused woman to feel comfortable in such an unfamiliar setting. Nevertheless, health care providers understand that even having a private triage will not automatically encourage an abused woman to disclose abuse if she is not ready. However, having a private location can increase a patient's comfort level and increase upon disclosure rates:

“I think it depends upon where they're put. If they're in a room where the door is closed I think they're more willing to talk, whereas if they're behind a curtain and sometimes there are two people behind a curtain then they're not going to talk and I don't expect them to talk about that [abuse]” (Participant 16, physician).

Initially, the social workers, sexual assault and domestic violence nurses requested patients be triaged privately. However, due to providing a ‘family friendly’ environment, screening in private cannot always occur:

“I've asked that every patient be triaged on their own and the educators from emerg preferred not to, although the nurses said that they'd prefer that. But the educators and the managers preferred that we don't do that because we want to show that we're open to family and that we're not pushing people away” (Participant 14, nurse).

Despite promoting a family-friendly environment, staff and hospital administration recognize the lack of privacy in the ER, and according to one social worker, future ER renovations will make the triage more private:

“In the new emerg we’ve asked that the area is more private, so there will be at least that, that you won’t have the social workers, clerks or ambulance attendants standing right behind the triage nurse. So it’s going to be a little more private” (Participant 19, focus group-social worker).

The second barrier is the hospital hierarchy, which is an unexpected theme discovered during interviews and observations. Due to the organizational structure of the hospital and the caste-like system within nursing and medicine, hospital hierarchy is both a structural and professional barrier. As was shown in the previous chapter, health care providers did not know whom or how to screen for abuse. This thesis suggests that the hierarchical organizational structure of the ER and the professional social distancing between health care providers contributes to a lack of knowledge flow.

When considering a screening tool in the ER, many help-seeking activities, tasks, and skills tend to be separate, establishing responsibility boundaries between physicians, nurses, and social workers. Under the current hospital structure, emergency physicians diagnose and treat, attend to the clinical side of medical care; emergency nurses provide triage by managing patient care – both the clinical and the psychosocial elements; and emergency social workers, having only a basic background in health problems, are primarily concerned with promotion of social functioning.

Drawing from the sociology of professions, research findings reveal a division of space for work and leisure in the ER between nurses and physicians. Due to different responsibilities and status, physicians and nurses have their own separate and distinct roles and responsibilities. Although the research is dated, Shapiro (1978) calls this the “hospital hierarchy” and suggests health care providers are enmeshed in a pre-existing, well-defined system of hierarchical work relations. Shapiro states that physicians are the

most powerful members, while nurses and support staff occupy lower positions in the hierarchy. However, nurses do rank above ancillary workers. Yet compared to physicians, their authority and decision-making power are trivial, regardless of their experience.

Shapiro (1978) found not only does this hierarchy define matters of authority and power, but also provides a limitation of contact between the different levels of health care staff. Similar to Shapiro's work, a widely-cited study examining communication by health care providers in a hospital setting found "an almost caste-like set of patterns" (Wessen, 1966). The patterns of job requirements limit the interaction between hospital staff of different ranks. Wessen (1966) suggests the more "social distance" existing between occupational groups, the less likely interaction would take place. He concluded there is a universal tendency for those of high social rank to be freed from the obligations to interact with those of lower degree except on their own terms. Despite the research being over three decades old, when examining the stratified nature of the hospital and the structured nature of the relationships between the health care staff, there apparently has been little change in the organizational structure of the hospital.

A hospital is an agency where the organizational structure and the professionals therein operate under a defined set of policies and practices. According to Weber, bureaucracy is an ideal type, a form of organization in which everything is done according to rules, where everyone has a strict position, and where there is a clear chain of command (Collins, 1986). Arguably, a hospital is an example of a bureaucratic ideal type because policies and practices must be upheld and followed. Health care staff also have their own roles and responsibilities which are quite different and separate from one

another; department chiefs and hospital administration clearly set mandates, goals, objectives, policies, and practices to follow.

While there are limitations with Weber's concept of ideal types, in that most organizations never completely fit this model, a hospital organization represents a bureaucratic hierarchy. This hierarchy fosters social distancing, a caste-like system and a lack of knowledge flow between hospital staff. Filling specific roles and performing tasks limit contact and communication between all staff, whereby clinical practice can become inefficient and ineffective.

The structure and organization of the hospital greatly illustrates the attitudes and priorities of the planners. Grand Rounds⁵² increase physicians' training and knowledge in a certain medical area, while nurses hold in-services which provide continuing nursing training. Nurses also had their own social areas which were separate and distinct from the physicians. Nurses and physicians took breaks at different times and had their own eating areas. Nurses had a lunchroom which was equipped with a microwave, radio, refrigerator and table and chairs. Staff physicians had a private room which was always locked and had a couch, some furniture, computer, telephone, medical texts, mail boxes, and posted schedules of all physicians and residents for that month. Each group of health care staff had its own changing area, however lounges for physicians were more luxurious compared to the lounges for nurses. These aspects of hospital design reflect the assumption there are classes of people who should not be treated alike (Shapiro, 1978). Having such separate and distinct work and leisure spaces contributes to a lack of knowledge flow for managing the health of abused women in the ER.

⁵² Grand rounds are training sessions for physicians, residents and medical students organized by the Chief of Staff. These sessions occur frequently and review, assess, and educate physicians about current clinical practices, procedures, and conditions.

To address structural barriers with the protocol, health care providers require institutional support and guidance from the hospital administration and from the abuse task force. The hospital's task force on abuse was established with the goal of devising a screening tool and implementing it in the field. Since implementing the screening tool, the task force has disbanded leaving little or no institutional support for health care providers nor for the evaluation of the tool. As one physician states:

"It [the task force] was created to implement this screening protocol and to develop this domestic violence response team" (Participant 13, physician).

A task force goal was to evaluate the tool over specified time periods. Since the task force has not undertaken an evaluation, various physicians have assigned evaluations to medical students as year-end projects. One physician remarks:

"I still think that most people don't think it's [the task force] an important issue. And second of all, people are quite busy and have very limited time and resources to devote to something like this" (Participant 25, physician).

As a result, different segments of the hospital staff are engaging in activities ascribed under the auspices of the task force. According to Heinzer & Krimm (2002), the goals of an abuse task force are to increase awareness of domestic violence among health care providers; develop a protocol for screening, assessment, and referral; and educate staff in the use of the protocol through the network. Members of the task force are responsible for reviewing and revising hospital policies and procedures for the management of victims of domestic violence.

Insofar as health care providers are concerned, a lack of community resources was cited as a structural barrier. Nurses expressed frustration and anger over the fact they are

willing to ask and offer assistance to abused women but when referring to services, the resources are not always available. Health care providers require not only access to appropriate hospital resources but various kinds of support to feel comfortable when working with abused women (Henderson & Erickson, 1994). One of these supports is access to community resources such as women's shelters and advocacy groups. The Ontario Hospital Women Abuse Report (2003) found that 31% of hospital respondents cite insufficient community resources as a barrier to developing effective responses. Community resources are rapidly diminishing despite the establishment of the domestic violence and sexual assault programs.

In this next quote, a social worker states how staff are having a difficult time referring abused women to shelters and social services:

*"Well, shelter beds are in short supply, regardless.
So if we can get them into a shelter then that's fine.
For counseling and group services it goes up and down,
sometimes there're waiting lists, sometimes there isn't"*
(Participant 19, focus group- social worker).

As social workers agree, an effective intervention relies not only on the sessions with the client but also on the ability to refer to services within the community. If there are waiting lists for women's shelters and transition houses then social workers are left to find other alternatives, which limits the time they can spend counseling these women.

Provider barriers at the professional level

This second section explores provider barriers at the professional level. Physicians and nurses fail to adopt routine abuse screening owing to a multitude of professional factors. These barriers include lack of evidence, time constraints, forgetting to ask about abuse, and a lack of training. Professional barriers specific for nurses

included a lack of access to hospital resources. For physicians, legal implications and being professionally marginalized were cited as potential professional barriers when discussing abuse screening. However, legal implications and professional marginalization were not barriers that directly affected physicians interviewed.

A common reason cited by physicians for not engaging in routine abuse screening is the lack of sufficient evidence:

“The evidence right now from what I’ve read in the medical literature recently, doesn’t support screening. It doesn’t provide strong evidence to screen abuse, based upon the lack of evidence for clinical outcomes improved by screening” (Participant 21, physician).

Physicians who have not seen the evidence for screening are unsure of the benefits, or whether identification has increased, and whether clinical outcomes have improved due to screening:

So, I haven’t gotten into the habit of screening and I guess I’m not opposed to it, I would just have to change my ways and perhaps have somebody present some good evidence that universal screening is actually effective” (Participant 23, physician).

This next physician is unsure of the benefits and whether identification has increased since the screening tool was implemented:

“I wish I had some evidence other than anecdotal. I mean I think we’ve picked up some cases, whereby the patient has presented with that [abuse] and they have been given the opportunity to address the problem. At least they were asked about the problem and that gave them some glimmer of hope to come forth with their problem. But has that tool been instrumental in increasing the discovery of abuse? I don’t have that data so I’m not sure” (Participant 24, physician).

For this physician, clinical outcomes may not translate into the same qualitative outcomes abused women would deem important in helping them move to a more

protective lifestyle. Medicine as an ideology and hospitals as agencies are structured to look at evidence-based measures, diagnostic categories, clinical indicators and outcomes, and quality assurance measures (Stark and Flitcraft, 1996). Woman abuse victims and survivors look at the patient-physician relationship and rely on qualitative measures.

One of the most common provider barriers was time constraint. Time constraint is both a structural and professional barrier. Time constraint is a professional barrier because according to the medical model, the nature of the job requires physicians to see multiple patients and complete multiple tasks under time constraints. Work requirements do not allow physicians to spend a great amount of time with each patient. Time constraint is also a structural barrier as the ER is not organized to allow health care providers a great amount of time with each patient.

One physician notes while medical students and junior residents can spend the time with patients, staff physicians cannot afford to spend more than 10 minutes per patient in the ER. Consequently, many times it is the medical students and residents who have the time to screen for abuse as they have less responsibilities and a lighter patient load compared with staff physicians:

".. I'm a resident and I'm still spending quite a bit of time with my patients, but when you're staff and you've got 6-hour waiting times, you've got to see patients fast. I mean I can spend 15 minutes with a patient, while staff can spend 5 or 10 minutes, they can get a good idea of the problems to treat. But I think that sexual assault and physical abuse can be pretty subtle and can easily escape your mind when you have a couple minutes to diagnose and treat the patient" (Participant 18, physician).

The ER is organized whereby staff physicians must assess the urgency of medical conditions, be constantly up-dated on a case-by-case basis, must try to maintain a flow of

seeing patients, and are ultimately responsible for the patient. Another physician explains how the ER setting is not structurally organized to spend more than 7 minutes with a patient:

“ I don't think that I'm overly-effective at asking. You're busy and you're preoccupied with 8 other patients at the same time. Yeah, I think I'm better when things are slower and I have a little more time to screen, but on a busy day where I have 3 minutes to spend with a patient, I can't do it. So I think the biggest barrier is time pressure” (Participant 25, physician).

Another physician states:

“You have 3 to 5 minutes. Depends on how busy it is. If there's only one patient in the department you have all day, but normally there's 7 ambulances waiting outside to come in and we don't have any room to put people, so that's a big barrier. I'm just pulling numbers out of my head, but that's a typical day where you have tons of people” (Participant 22, physician).

The following quote illustrates how physicians already feel time-pressured in the clinical encounter and asking about abuse is not a high priority:

“We don't think of abuse first thing when we assess a patient, we try to rule out any dangerous causes, like heart attack, pneumothorax [collapsed lung], and abdominal pains, pathologies and we don't think of trauma. So I think there's more and more abuse so I think we should ask every woman who comes in with abdominal pain how things are going at home, except that we have such a short period of time for a person. I find there's a time constraint most of the time. That's the problem” (Participant 18, physician).

Three triage nurses resented asking women due to the time pressure of the job:

“I think you'll get less compliance if you ask more questions. I think there's so much pressure. If you take more than 3 minutes with a patient you're criticized for your triaging and stopped by the team leaders” (Participant 9, nurse).

These results are consistent with literature citing time constraints being major barriers physicians and nurses cite when screening for abuse (Lucey,2003; Ontario Hospital Woman Abuse Report,2003; Lyon & Reeve,1999). Another triage nurse remarks that screening slows the flow down at triage and suggests that nurses are not even asking about abuse anymore:

"In the beginning we talked about it and it was just an added stressor to the triage nurse asking one more question and slowing the flow down more and trying to get people through in 2 minutes sort of thing. By now, to tell you the truth, I don't think nurses are asking" (Participant 2, nurse).

At present, most triages are set up to disallow nurses asking about chronicity, frequency, severity, type and safety issues of abuse; the nurse only has 2 to 4 minutes to assess a patient. During those 2 to 4 minutes, a nurse has multiple tasks: asking about the main complaint, taking a medical history, enquiring about medication, taking vital signs, screening for abuse, and – time permitting – probing further if stories are inconsistent with the injuries. However, with the establishment of the physical and sexual assault treatment programs, nurses and social workers who are trained in domestic abuse are able to spend time with the woman and ask more in-depth questions.

In contrast, like many nurses who were interviewed, this triage nurse did not feel as though routine screening added time to the patient encounter at triage:

"..All I say is, 'Is there any reason why you have to feel unsafe in your home?' That doesn't take that long, 'cause most of the time you get no and if you do get yes then it's just you coming back telling them we're got counselors to help them. So I don't think that should be a factor. It probably takes longer asking them if they have any allergies, because the list of allergies people have can be quite long. It shouldn't be a time issue" (Participant 5, nurse).

Interestingly, physicians did not believe that asking three more questions at triage was time-consuming, but when asked if *they* were to routinely screen, time constraint was identified as a potential barrier:

“I mean every study that comes out says you can add two more questions at triage. So you know, I think there's a perception that it adds more time but in reality I think in the end it really doesn't add more time. It adds time if the answer is yes and I think that's the problem. If there's no system in place what do I do with a yes question. I think people are less likely to ask the question” (Participant 11, physician).

The third provider barrier both physicians and nurses mentioned was forgetting to ask about abuse in the patient encounter. For many nurses, documenting the complaint, taking vital signs, taking a medical history, and asking about medication use all occur within a matter of minutes. These tasks can occupy the nurses as they forget to ask about abuse. Although the screening questions are on the flow sheet, many nurses forget to ask because they do not have training reinforced on a regular basis. As one triage nurse explains:

“I don't think it takes that much more time to ask the question. I think people just forget about it” (Participant 2, nurse).

Another triage nurse admits that once in-services are conducted, this promotes a heightened awareness and knowledge of the screening tool which most nurses eventually incorporate into their triaging technique:

“Pretty much, I was forgetting a lot at the beginning but now it's routine” (Participant 6, nurse).

The fourth and closely-related barrier to routine screening is the health care provider's lack of training about abuse. Findings revealed the abuse training participants received in school depended on when they graduated. While nursing and medical

education 20 to 30 years ago may have touched upon elder or child abuse in a day session, other forms of abuse were not covered. For example, nurses practicing for the past two decades gained most of their abuse training through experience. Nursing graduates today receive training on abuse through core courses or through specialty courses:

"I would say that I've had no training until I took the ER course and program at Algonquin College. One day the sexual assault nurse came in and talked about domestic violence and the protocol for sexual assault" (Participant 10, nurse).

Similarly, one physician describes that 10 or 20 years ago medical schools did not include abuse training:

"I probably had some abuse training in my residency, one or two lectures. But I think it was focused more on child abuse, so I'd have probably had some training in that. You also have to remember that medical schools have revolutionarily changed, so my training from 1975 to 1979 in med school would have been different than it is today" (Participant 24, physician).

A senior resident indicates that during medical school three years ago, abuse training was offered by student groups:

"Yes I had abuse education, but not organized by the faculty or part of the curriculum. We actually had a student group which I chaired. We supplemented our curriculum and did workshops on issues such as this and we offered workshops on abuse, child abuse, sexual and physical abuse and that kind of thing" (Participant 15, physician).

All recent medical graduates interviewed had training about abuse in medical school or during their residency. A few residents had training in both medical school and residency:

"There were a couple half-day sessions during our residency. In med school it was a combined workshop with nurses and other health care practitioners and during residency we did have I think at least two sessions where that was the topic of the day. It was abuse in the ER" (Participant 16, physician).

Despite attempts to incorporate abuse training into medical curriculum, Jecker (1993) observed that 53% of North American medical schools do not offer any such instruction about woman abuse to medical students. Studies report that health professionals who receive intensive training about abuse maintain stronger beliefs that abused women should be helped and attribute less personal responsibility and blame to abused persons (Jecker, 1993).

When physicians were asked about the quality and quantity of abuse training, one physician describes her experience in attending a presentation on abuse which left an obvious impression:

"It was very practical and it was very simplified to give you concrete ways to deal with the patients and things to say to help them immediately. I think because it's a complicated problem and there are so many issues involved and so many barriers, it's helpful to know that you can do something in the short-term. They used four quick questions that you could use for everyone and a mnemonic for it. Then there was just practical advice to give to a woman who may not be ready to disclose. So just quick practical pointers, it was a long workshop but it came down to very simple things" (Participant 21, physician).

Although this physician recently graduated and was able to recall in great detail her abuse training, the fact such a course can have such an impact is encouraging and

demonstrates that abuse training has indeed a place within nursing and medical school education.

Although partner abuse is a common cause of patients' problems, this is only now beginning to receive sufficient attention in the hospital (Alpert, 1995). According to the Ontario Hospital Woman Abuse Report, produced by the Woman Abuse Council of Toronto (2003), 44% of Ontario hospitals reported their institution has not developed any training materials or educational resources; forty-eight percent of hospitals provide training and staff education on woman abuse, whereas 36% do not. Moreover, the survey found that the barrier most frequently encountered by hospital respondents were "unmet training needs" (53%).

When participants were asked if abuse should be a core component in nursing and medical education, all agreed. However, devoting an entire course to abuse was not a popular suggestion. Rather, nurses agreed that the topic should be raised as a component in the curriculum as opposed to being offered as a separate course:

"I think it could be looked at more. I don't think we need a whole course guided towards it. But there's a lot we could know about it" (Participant 4, nurse).

When nurses and physicians trained 20 to 30 years ago were asked whether abuse training should be included in today's health care education, all pointed out the benefits of providing staff with this information. One triage nurse states:

"Yes, I think it should be included in our training. I mean I got my experience after I became a nurse and whatever training I had many years ago I'm sure is inadequate. But yes, I think it should be because it's so prevalent in our society" (Participant 3, nurse).

In terms of continuing education, many nurses wanted to revisit how to deal with abuse situations, types of questions to ask, increase their comfort level, attend more in-services on abuse to reinforce their knowledge and practices, improve their communication skills, address patterns of injury, and find out whether identification has increased. One triage nurse explains:

“Communication skills, how to interview, appropriate questions that would be helpful, and patterns of injury are all things to review. For a lot of people it would be helpful to make them more aware” (Participant 1, nurse).

Another triage nurse states she would want to know the general characteristics of a perpetrator:

“I want to know about the kind of people that abuse. I find that interesting. It would make you more alert. And the kinds of abuse, and how to identify someone or how to draw it out of someone that they've been abused” (Participant 5, nurse).

This next triage nurse suggests that informing nurses that identification has increased would provide evidence screening at triage is beneficial and worthwhile for nurses:

“I would just be curious of how many we've actually picked up. Maybe if we knew we were doing some good, maybe we would be more likely to ask the question more” (Participant 7, nurse).

Similarly, physicians wanted to know more about the following issues: epidemiology (clinical cues, prevalence and risk factors); identification strategies; effective management and resources; how to become more comfortable with asking questions; how to adequately convey the message that they are there to provide support as

required; how to deal with difficult situations; and strategies for making sure that the person is interviewed alone.

One resident remarked that identification differs from knowing what to do afterwards. This resident would like to see a lecture on how to equip physicians with management strategies when encountering an abused woman:

“For me personally, I’m not as interested in the epidemiology because we know that it exists. So it’s more a question, what are strategies to identify and effectively manage and not only that but how it relates to the ER. So, are there simple things we can do to identify? I think some studies have already shown simple questions work. I think identification is fine, but then what do you do with that afterwards? Docs require simple directives, easy stuff that we can do in the ER, as this would be the most important thing, because again we’re just opening Pandora’s Box. You identify all these cases and all these emotions come to the surface and then we sort of wash our hands of them and what do you do? I think that’s not fair to anybody – to us or the patient, because here we’re kind of stuck and I think that’s the most important thing”
(Participant 11, physician).

In terms of physicians’ opinions regarding abuse training, Reid & Glasser (1997) conducted a study in the United States and found that almost 96% of the physicians believed more should be done to educate physicians about abuse, and 94% agreed abuse should be included in a doctor’s training. Yet nearly half said they would not participate in a domestic violence forum.

Similar to Reid & Glasser’s (1997) study, a Canadian study found while physicians were interested in being informed about abuse, 72% of physicians reported they did not know of any continuing medical education (CME) courses or workshops regarding woman abuse being offered in their province in the last 2 years; 87% believed

more courses are needed (Ferris,1994). However, while there is a need for more courses, it is unknown if these sessions would be CME courses. If courses are not certified or promoted by the hospital or professional associations, then attendance may remain low.

The professional barriers most frequently experienced by hospital respondents in the Ontario Hospital survey by the Woman Abuse Council of Toronto (2003) were unmet training needs (53%) and competing hospital priorities (53%). Other pressing barriers included lack of funding (47%), lack of time (45%), and lack of a physical area for screening (36%). As well, Waalen and Associates (2000) found lack of effective interventions and lack of provider education were the most commonly-mentioned barriers in both open-ended interviews and written surveys.

In order for continuing education to be successful among nurses and physicians the most important factor was to provide regular in-services and/or Grand Rounds to reinforce and refresh the knowledge gained. However, devising a system of reaching all nurses and physicians is challenging due to the organizational structure of the hospital:

“Maybe we need a Grand Rounds extending a special invitation for all nurses to join us. The problem with rounds is because we all work shifts, there's never more than half the doctors at a teaching session and usually just a handful of the nurses out of the hundred that come. So it takes repeat sessions to get everybody, so it's not easy to do it. That's always a problem with in-servicing, so you need the nurse educator who has a system of getting new information to the nurses” (Participant 17, physician).

In terms of barriers that were specific to nurses and physicians, nurses cited a lack of access to appropriate hospital resources. They expressed if they're going to ask about abuse, they need to make sure there are social workers, sexual assault and domestic violence nurses working to intervene for referrals and follow-ups otherwise screening may not occur and if it does it may follow the medical model:

".. if were going to identify people, we definitely have to have the resources right there" (Participant 14, nurse).

The next passage describes one triage nurse's frustration with the limited access to social workers in the evening and night shifts:

"There needs to be some kind of domestic violence follow-up. You can't ask the question and then not have a nurse that's going to be able to come in and see the patient or social work that's not going to be able to do something. I mean if you're asking the question at 8:00 at night, we have no social work coverage until the next morning. You know for that patient that's not necessarily an answer" (Participant 9, nurse).

Depending upon the nature of the violence, (physical or sexual) and who the perpetrator was (an intimate partner versus a stranger), the patient may not have an opportunity to see the sexual assault nurse during evening and night shifts. Nurses stated even when they wanted to make a referral to the sexual assault nurse, no one was available during the evening hours:

R- "Everybody has been very receptive to the asking, the biggest challenge I've heard is they have identified that they are being abused and trying to reach the sexual assault nurse that night.

K- Isn't one always on call?

R They're supposed to be, but they don't come in and they say they'll see the person tomorrow, things like that. Tomorrow the patient may decide no, I'm not going to see the social worker, I'm afraid.

K- So they lose the opportunity?

R- Right, and I've had several people say when it first came out that they identified but there was no one to come in or they had to leave a message or something like that.

K- So in that case would they also call a social worker if they couldn't get a sexual assault nurse?

R- I don't think so. Our social workers go home at 9:00pm, so I think that having the resources available would certainly help. Sure we're going to do it, but if we're going to

do it, when we identify somebody who is going to take it from there? And I think that is a big problem” (Participant 7, nurse).

Previously there were four ER social workers, but now due to funding cuts there are only two. They work a 9 a.m to 9 p.m schedule, so women coming in at night may not see a social worker until the following day. This limited access to social work raises concerns which has implications for the effectiveness of interventions in the ER. For example, the chart review revealed 8% of abused women sought medical assistance in the ER during daytime hours; more abused women (16%) are coming to the ER in the evening. As suggested in Chapter 4, discovering that half the time social work was alerted raises questions about whether social workers are accessible to assist nurses and physicians in responding to abused women.

A physically or sexually abused woman who visits the ER during the evening hours will be referred to the domestic violence or sexual assault nurse that night. However, those women who have been the victims of abuse by a stranger will be treated and referred to the ER social worker, but will not be referred to the SATP or the DVTP. This is because the mandate of the programs does not allow the sexual assault nurses or the domestic violence nurses to see victims of stranger violence or ‘simple assault.’ As the co-ordinator of the programs states:

“The Criminal Code doesn’t apply to simple assault such as violence committed by a stranger or non-intimate partner. The law related to intimate partner abuse is straightforward. The law related to simple assault is something else and so we haven’t been trained in anything related to simple assault and we don’t know whether they have the same options. It’s just not been part of our training” (Participant 12, sexual assault nurse).

Therefore, women abused by an intimate partner are referred to the specialized programs, while victims of non-intimate assaults are seen by the ER social worker and do not qualify for the programs.

Legal issues and professional marginalization by colleagues were cited as potential barriers for some physicians. In the following quotation, one physician comments upon the legal issues:

“...Any sort of cases which have a high medical/legal risk we're always very wary of. It's a concern, but then on the other hand I don't think that identifying someone who has been abused is medically and legally arduous. I think that it would be nice to see it the other way around, like if you didn't identify it, it would be medically/legally arduous. If we flip it to child abuse, if you don't report a suspected case then you're the one who's in trouble. You're legally responsible to report a suspect case. So it would be interesting if that were flipped around. So, obviously adults are different” (Participant 11, physician).

While this resident makes the point of identification not being medically or legally difficult, he is confusing two separate issues – identification and reporting. Comparing reporting child abuse and reporting woman abuse is a poor analogy. As the literature shows, mandatory reporting of woman abuse can jeopardize a woman's safety and expose her to more harm. Based upon the assumption a woman knows her situation best, mandatory reporting practices may cause her more harm and even put her life in jeopardy rather than ensuring her safety. Children under 16 years of age in Ontario (provinces have different age requirements) are not considered ‘adults’ and require community advocates. As the physician mentions, there are major differences between reporting laws for child abuse and woman abuse. As this physician suggests, while abuse has a high medical/legal component, once trained physicians would be better prepared to

manage the care of patients with medical, legal or social issues associated with some abuse situations.

Another aspect is how health care professionals are viewed by colleagues for advocating routine screening for abuse. Study findings suggest while the topic of abuse may not be as 'sexy' or 'provocative' as publishing about heart attacks in a medical journal, publishing about abuse is within the realm of emergency medicine and physicians:

"I wouldn't think that physicians are marginalized for publishing about domestic violence. I mean, I know several ER docs who have published on that kind of thing and it's within their own emergency community. I don't think that would be a perception at all. See, most of the ER docs don't publish anything"
(Participant 17, physician).

While another physician mentioned the value of publishing, he also indicates it depends on the medical specialty and the public's perception as to how well abuse research will be received within the specific medical fields:

"Oh sure, physicians are marginalized. Domestic violence is not as sexy as having a heart attack, publishing in Thrombolitics and saving lives. And unfortunately, that's the public's perception too as to what's going to have the bigger impact. We spend millions and millions in cardiac research for a very small benefit and research-wise, we all know that. That's where you can spend a lot more money, and drug companies too make a lot more money on drugs versus screening tools and social work. So where's the benefit to the drug companies?! So I think it comes down to money as well and public perception. But if you go back to a medical student's choice of careers, people sort of self-select. So in ER medicine, generally anything sort of goes from the psychological to the heart attacks and everything in between, whereas the psychiatry people love this stuff and will probably get recognized more for their contribution to those kinds of journals. As a cardiologist, we're not going to get as much recognition for abuse studies. So it depends on

what field you're in. From the ER physicians' perspective it probably is not any less, it's great to get published at all, but it's probably not as well-read as some of the big heart studies" (Participant 11, physician).

Cohen and Associates (1997) found attention to woman abuse within the health care system was driven by committed individuals. In all the cases studied, when the charismatic leader left the program there was little institutional commitment to continue the effort, and the screening program withered or disappeared completely. Cohen and colleagues (1997) found physicians, nurses, and other health care professionals who elected to work in any consistent way with victims of woman abuse describe being essentially marginalized by their colleagues and institutions, and report serious economic, social, and psychological, disincentives to providing care for this population.

Cohen and Associates (1997) found physicians stated that treating woman abuse victims was 'not respected' by their peers, was not 'the way to get ahead in the profession,' or was not the source of prestigious research grants and other support. These physicians felt that research into woman abuse as a public health problem may not be an apt way to obtain a grant from the Medical Research Council (MRC). Moreover, communicating effective screening interventions was not viewed as prestigious as publishing in the New England Journal of Medicine (Kaufert, 1988).

Contrary to the literature, physicians did not indicate that they felt marginalized by colleagues for advocating or publishing about abuse. Although medical specialties such as family medicine, emergency medicine, OB/GYN, and psychiatry may gain more recognition for publishing about abuse compared to a cardiologist, all ER physicians agreed that the most important thing was to publish regardless of the medical content.

Provider barriers at the personal level

As we have seen, there are many provider barriers to screening for woman abuse at the professional level. Now, we will focus on the physician and nursing barriers at the individual level. These barriers include cultural issues, comfort level, and embarrassment and shame. As well, the abuse screening questions encouraged patients to bring up unrelated events which prevent some providers from promptly identifying abused women and obtaining clinical details.

Research in this area indicates that some health care providers, in particular physicians, hold attitudes about abuse that prevent them from identifying abused women among their patients (Stark & Flitcraft, 1996). These attitudes include: loss of control and fear of offending the woman, since many feel uncomfortable addressing an area culturally defined as 'private'; denial of abuse by health care provider, many think their patients are not at risk; some hold negative patient stereotypes; health care providers see the patient and not themselves as being obstacles in the delivery of health care; and health care providers respond differently to the victims of physical abuse than to other accident victims (Waalén, et al 2000; McGrath et al. 1997; Stark & Flitcraft, 1996)

In the literature, several barriers to screening were not predictive of participants' screening practice patterns. As previously mentioned, this finding may be partially explained by the increased awareness and recognition of abuse as a health issue and abuse training. In this study, physicians reported cultural issues as a possible barrier. Personal barriers specific for nurses included comfort level, embarrassment and shame, and patients bringing up unrelated events during the triaging encounter.

An important barrier mentioned by a physician was the cultural aspect of asking about abuse. One physician, sharing a similar cultural background as some of his Asian

patients, suggests asking about abuse may appear provocative and is considered a personal question for such a public domain:

“There are also cultural issues as well. So working here we have an Asian population and a Chinese population. My perspective from exposure to the Chinese culture is that if you ask a question like that it's expected to be more inflammatory and if the primary problem is a medical reason you may not be able to assess them clinically, potentially as well. On the other hand it's part of an educational process to destigmatize that cultural learning but there are some cultural aspects” (Participant 11, physician).

Being culturally sensitive, respecting cultural diversity, and destigmatizing abuse as a private issue remains an ongoing barrier for health care providers. One possible response to a societal norm prohibiting interference in private areas is to recast abuse as a public event (Burge, 1989). Burge identifies ‘privacy ideology’ as an obstacle to emergency physicians’ involvement in woman abuse. Yet, rather than encouraging physicians to regard private relationships as susceptible to ethical scrutiny and medical intervention, Burge recommends they begin to view violence as “public or criminal behaviour,” which will evoke more open discussion with women. Thus, by screening in the ER this measure shows the public that health care providers take abuse seriously and abuse is wrong and ER staff can help.

Nurses responding to abused women disclosed their comfort level with these situations was a potential barrier in the ER encounter. According to one triage nurse:

R- “I think a lot of us are uncomfortable in asking them. I am.

K- And that's because of the privacy issues?

R- I don't think it's the privacy. I feel it's strange that I've never had to ask this question before. So it's something new” (Participant 5, nurse).

While many nurses did not fully explain why they felt uncomfortable asking about abuse, one triage nurse expresses that it may be the questions asked or because the staff could be in an abusive situation themselves:

“You know, maybe we feel uncomfortable asking the questions or maybe people have been in that situation themselves and don't want to go there. But really, I know there's no reason why we shouldn't [screen], but it's just not getting done” (Participant 10, nurse).

Research indicates many providers have personal experiences with partner abuse (Phelps, 2000). While this study did not examine providers' history of partner abuse, Rodriguez and colleagues (1999) did not find any association between physicians' personal experience with abuse and their experience with abuse and their screening practices.

When physicians were asked about their comfort level with screening for abuse, comfort level was rarely mentioned as being a barrier:

“From the physicians point of view I think physicians are comfortable asking about abuse. But I don't know enough about how the nurses feel” (Participant 24, physician).

Nurses also commented that fear of embarrassment or shame were barriers when screening for abuse:

“I think what people are going to think is- What the hell is the matter with her, what kind of question is that?” (Participant 9, nurse).

Another nurse suggests it's a reflection on you and most of the time women do not state they have been abused:

“Yeah, I feel as though it’s a reflection on me and I often feel embarrassed, because often they will just say no to abuse. I feel silly sometimes asking the question” (Participant 5, nurse).

According to Dechief (1999), nurses reported feeling more comfortable in asking women about abuse and in their ability to identify different forms of abuse after frequent workshops on domestic violence.

The last personal barrier cited by nurses was the screening tool encouraged patients to disclose unrelated events, making triaging difficult. Nurses described screening for abuse as opening the floodgates whereby patients make references to many events which appear unrelated to the ER visit: social, financial, spiritual, personal, family, and relationship issues:

“..I had one lady who started talking about it [abuse] and she came in for a sore foot and she went off on tangents of other things and she was really not making sense at all. I just wanted to know if she was abused and if she wanted something, we can deal with it. But she was going on and on and on and I had to sort of slow her down” (Participant 3, nurse).

Providers realize that asking about abuse and psychosocial issues opens up the clinical encounter whereby patients may embellish, elaborate, or describe all aspects of the incident(s). Under time constraints, maintaining a balance between obtaining relevant information and providing a woman-centered approach is difficult. This nurse felt that some patients take advantage of the situation and divulge personal histories and stories which make treatment challenging.

This chapter has provided information on provider barriers at the structural, professional, and personal levels. While negative provider barriers previously cited in the

literature were not found in participants interviewed, this may be due to an increased awareness of abuse as a health issue, the increased training providers received throughout their careers, and the use of a woman-centered approach. From its onset, the screening tool has influenced provider experiences. The development and implementation of the screening tool corresponds with a general move to incorporate a woman-centered approach, and a movement towards ensuring sufficient time and privacy in the triaging encounter.

Provider barriers at the structural level included lack of privacy, hospital hierarchy, and lack of social services in the community. Striking a balance between promoting a 'family friendly' environment and maintaining a private triage area is difficult in the ER. The ER policies may help patients feel more comfortable when accompanied with a family member or friend, however this environment is not conducive to asking questions of abuse. For this reason, physicians and nurses expressed a concern about the lack of privacy at triage. Providers also noted positive answers require further time and a private room may be difficult to obtain in an urgent care environment. Many ERs are designed in such a way as to preclude incorporation of this step into the flow of patient care. To remedy this situation, ER renovations should provide a more private area for screening.

Understanding the disparity and distinctions in work and leisure activities in the hospital setting is key when interpreting findings related to knowledge flow. This study suggests that part of the reason for the lack of communication and the lack of awareness between health care providers may be due to the organizational structure in nursing and medicine and the hospital. The hospital setting is organized around a hierarchical structure where social distancing and a caste-like system occur. As the results revealed,

confusion, rejection, or resentment surfaced when developing and implementing abuse screening tools.

Participating in future collaborations and combined nurse-physician training sessions on abuse protocols and tools may be useful. Clearly, abuse cannot be treated with a specific medical treatment but rather with social and cultural factors intersecting to influence and manage the abuse situation. Therefore, a teamwork approach to screening may clarify identities, roles and responsibilities, and foster an accepting attitude around screening. However, while steps must be taken to ensure frequent workshops are provided, there are also organizational barriers such as time, manpower, and resources.

Many triage nurses expressed frustration at not having community resources available when referring an abused women to a shelter or transition house. The disappearance of these social services is due to financial cutbacks and political issues. Therefore, when promoting routine screening, the government must be lobbied to increase community resources and social services for abused women.

As well, providers stressed the importance of having institutional support from the administration in order to successfully implement and evaluate screening tools. Study findings indicate re-instituting the abuse task force would provide this. The task force would be responsible for providing frequent workshops, increasing provider awareness and education about abuse, for conducting chart audits every six months to monitor the progress of the tool, and to discuss health care providers' experiences with screening. Professional barriers included: a lack of evidence-based research, time constraints, forgetting to ask about abuse, lack of training, limited access to hospital resources, legal implications, and potentially being professionally marginalized.

While many health care providers were familiar with the abuse literature and believed strong support existed therein for screening, some physicians demanded to see the evidence-based literature for screening. For these health care providers, they were unsure of the benefits, whether identification had increased, and whether clinical outcomes improved due to screening.

The time element was one of the most pervasive barriers. Health care providers stated the hospital structure and the job demands were not conducive to asking questions of abuse. Furthermore, many providers stated they forget to ask about abuse. Nurses have approximately 3 to 5 minutes to triage a patient, while physicians usually spend under 10 minutes per patient, and abuse is not always a priority in the clinical encounter. However, the findings suggest that residents can take 15 to 20 minutes per patient, thus are in an ideal position to screen for abuse.

Statements about problems which could be offensive or not have easy answers may not be delved into because of time constraints. Higher priority will be given to organic causes of diseases which can be dealt with expediently. Given the addressing of many illnesses do not fall within the allotted 7 to 10 minute physician-patient encounter, it may be necessary to re-examine the clinical time schedules.

Lack of abuse training for health care providers was another professional barrier. The effort to understand why physicians and nurses do not investigate abuse to the extent they should uncovers broad medical education issues (Venugopal, 2001). Questions are raised about how providers should be trained to deal with complex conditions intersecting medicine, society, law enforcement, and behavioural change where it is impossible to adhere to the medical model.

Continuing education of health care providers and commitment of staff in assessing victims are necessary to provide for the holistic care of individuals and improve the health of the community served by the hospital (Heinzer & Krimm, 2002). The consequences of inaction in this area are neglect of those most vulnerable in our communities, increased injuries and potential deaths of those victimized by violence, and failure to meet the health needs of women who have approached the health care facility.

Once abuse training in the hospital becomes more regular, the ER Chief of Staff and the nurse educator must support, encourage, and conduct these seminars to reach all nursing and medical staff. This will ensure staff keep abuse at the fore. Moreover, health care providers will also be better equipped to deal with any legal issues which arise, and professional marginalization can be kept to a minimum. Despite a lack of training, there are providers who are sensitive to the needs of the abused woman.

Limited access to hospital resources was another professional barrier nurses cited as a reason for not routinely screening for abuse. Many nurses expressed that they felt uncomfortable screening knowing there were no social workers during evening shifts. As the chart review revealed, more abused women seek assistance in the ER during the evening hours, therefore social work coverage is essential in the evening and night shifts. Unless the access to social workers was re-evaluated, a few nurses stated they would not screen for abuse.

While physicians cited being professionally marginalized and the legal implications as barriers, these were not barriers impacting the health care providers who were interviewed. While physicians may be wary of the social and cultural implications of abuse, these are not reasons to avoid or dismiss abused women who come to the ER.

Moreover, screening for abuse and publishing academic articles on abuse is within the realm of emergency medicine.

Barriers to screening at the provider level are multiple and multifaceted and result from both internal and external struggles (D'Avolio et al.2001). These included the cultural issues, comfort level, embarrassment and shame, and women bringing up unrelated events into the triaging encounter. Recognizing the implications abuse has on different cultures is important when considering interventions. The fear of offending certain cultures is embedded in the cultural construct of what is private (Sugg & Inui,1992). Not wanting to overstep the bounds of what is private yet acknowledging that abuse has medical consequences leaves the provider wary of how to approach the issue.

Two conclusions can be drawn from the comfort level of nurses and physicians. First, although physicians stated they were comfortable with asking about abuse, most screen sporadically. Therefore, because nurses are supposedly screening all women at triage, this situation can engender more uncomfortable situations compared to physicians screening on suspicion only. Second, physicians and nurses rarely communicate about the progress of the screening tool or share their feelings with asking about abuse. Since nurses attend in-services and physicians attend Grand Rounds, this separates the communication between the health care professionals.

Providing an ER setting where physicians and patients feel comfortable talking about abuse but also allowing staff an opportunity to discuss the screening tool amongst themselves is critical for eliminating provider barriers. Utilizing a woman-centered approach under these situations promotes open and free-flowing dialogue between nurses, physicians, and social workers.

In terms of comfort level, if physicians or nurses are experiencing abuse themselves, the impact of that experience may influence their ability to broach the issue with patients. A few nurses mentioned feeling embarrassed about asking abuse questions when abuse did not appear to be the cause of the injuries. However, through the training provided in workshops, nurses would better understand and appreciate the subtle signs of abuse. This training would enhance triaging skills so nurses would not feel as though their credibility is being compromised.

Screening for abuse and asking health promoting questions allows patients to elaborate and expand upon both related and unrelated events. The more questions asked at triage, the more time the encounter will take, and the more involved and longer the answers may be. When using a woman-centered approach providers must work towards allowing the abused woman to speak without dismissing her experiences, and make her aware of the programs available to her. This would all need to occur within the allotted time for each encounter, indicating a need to re-evaluate time allocations in this area. As more cases of abuse are seen in the ER, more institutions and professionals must reconsider the method and time-frame when managing the health of abused women.

Although personal attitudes can be a significant barrier for health care providers, an awareness of these cultural beliefs and attitudes and a movement to correct them exists. Some physicians and nurses suggest only a small portion of what happens in the physician-patient encounter is determined by individual health care professionals (Stark & Flitcraft, 1996). Rather, the encounter is shaped by its social and cultural context, the policies and resources of health care institutions, and the beliefs, values, and professional norms of the medical community (Stark & Flitcraft, 1996).

It is naïve to expect substantial changes in how victims and survivors of abuse are treated by individual health care providers unless there are changes made at all levels in hospitals and government. These include concurrent changes required at each of these levels-clinical practice, institutional resources, and professional norms-to link the prevention of woman abuse with appropriate care for these women. The next chapter will discuss how severe acute respiratory syndrome (SARS) impacted the ER and the consequences for abused women.

Chapter Eight

SARS and the abused woman

The fourth – and unexpected – issue identified from the semi-structured interviews reveals how severe acute respiratory syndrome (SARS) impacts abused women, with both positive and negative effects. This chapter shows that in situations where infection control policies and practices such as for SARS were implemented in the ER, the medical model is upheld and routine abuse screening is abandoned by health care professionals.

Due to the SARS outbreak, many health care providers felt a need to discuss how SARS was not only affecting their job performance but how it was impacting them on a personal level. Even though they knew I was researching the screening tool for abused women, many felt it was important to tell me about their frontline experiences dealing with the issue of SARS. Consequently, questions dealing with SARS were asked in the interviews, as everyone who entered the hospital was in one way or another impacted by SARS.⁵³ In keeping with the analogy of Pandora's Box, experiences with screening for woman abuse uncovered the concept of SARS which not only affects the ER environment and staff, but impacts the abused woman.

This chapter is divided into two sections. The first section explores SARS policies and practices in the ER which impact upon abused women. Here, abuse screening, the restriction of visitors and visiting hours in the ER, and masking and gowning procedures are explored. To examine the results, the sociology of nonverbal

⁵³ Participants in the first three interviews discussed the impact of SARS, and were asked how SARS impacted the ER and the abused woman. From these interviews, SARS questions were added to the interview guide.

communication is used. The second section discusses the hospital environment post-SARS.

SARS policies and practices impacting abused women

Abuse screening and SARS

SARS had an impact on the ER environment affecting health care providers, patients, and visitors. We are just beginning to realize and understand the magnitude SARS had on different segments of the patient population. For example, SARS changed hospital policies which affected abuse screening, visiting hours and the restriction of visitors, security measures, and infection control, all of which can potentially affect vulnerable patients such as abused patients, pregnant women, and immigrant women.

Immediately after abuse screening was implemented in February 2003, SARS gained worldwide attention making it the top medical priority from March to September 2003. During this time, hospitals in Canada implemented practices and policies which changed the flow of visitors to the hospital and changed health care practices.⁵⁴ As one physician indicates, SARS changed almost every aspect of care:

"How hasn't it affected the ER? I think it's affected it in every way, I can't even describe it. It's a totally different place. It's not as bad for us now, but it was pretty bad for us for a while. I don't know what to say, it's very different"
(Participant 23, physician).

Although the hospital did not report any confirmed cases of SARS, precautionary screening measures were established in ERs and abuse screening was temporarily put on

54 Background information on SARS including policy implications can be obtained from the Ontario Medical Association and the Health Canada web site.

http://www.health.gov.on.ca/english/public/updates/archives/hu_03/hu_sars.html,

<http://www.hc-sc.gc.ca/english/protection/warnings/sars/index.html>

hold, stressing instead clinical methods of screening. Workshops on and promotion of the screening tool were treated as low priority in the ER. Furthermore, due to the infection control practices and policies, physicians and nurses have limited time with abused women. According to one triage nurse:

“Abuse screening was high priority when it first came in, maybe six months ago when we’re doing the in-services, then SARS came and I think everything got put aside” (Participant 1, nurse).

Many nurses felt that abuse screening took low priority and was abandoned during March to August 2003. Consequently, all the work that went into training staff about the screening tool at triage was temporarily stopped so health care efforts could focus on the identification, containment and treatment of SARS (refer to Appendix H for the hospital’s SARS screening sheet). As one triage nurse states:

“I suppose it's gone lower down on the pecking order. They are more worried about the infectious cases and getting people sorted out if they present with certain symptoms. You're trying to get those people into the safest area and sexual assault is lower down on the priority list. I think the increased stress level of masking and gowning, the risk to yourself, has made us think more about me maybe and less about them” (Participant 15, nurse).

When sexual assault nurses were asked how SARS impacted upon abuse screening, most stated the triage nurses were too busy with SARS to remember to screen for abuse:

“I think people don't come [to the ER] as much, that's one issue. The other thing is that nurses may not be taking the time as much to be asking the questions, because they just have too much to deal with SARS [sic] and it's very busy out there. I think they're just overwhelmed and they've actually thanked me not to be pushing the

universal screening questions on them, because of the SARS issue” (Participant 19, focus group- sexual assault nurse).

When asked how SARS impacted abuse screening, physicians also stated that abuse screening became a low priority:

“It’s probably made everyone forget about that issue I bet you, because there’s so much hype about screening for SARS. They have this big form you have to fill out and sign and wear these masks. So I would guess that abuse screening has possibly, perhaps fallen off. I’m not sure about that, but that would be my guess” (Participant 24, physician).

Starting in Fall 2003, many sexual assault nurses and program co-ordinators want to make abuse screening a priority again and are planning in-services and Grand Rounds to this end. Further, having a ‘domestic violence’ field on the nursing flow sheet reminds nurses to ask the questions.

SARS also impacted meetings between the Woman Abuse Council of Toronto, senior managers from two hospitals in Toronto, and the Canadian Council on Health Services Accreditation (CCHSA). The purpose of the meetings was to integrate and amend the accreditation standards to reflect a health care response to woman abuse. Due to the SARS crisis, meetings between these two organizations were cancelled as the participants are all health care providers involved in their hospital’s response to the crisis. Thus, SARS impacted the process of integrating woman abuse policies and procedures in the hospital and ER setting.

Visitors and visiting hours

Findings revealed that during SARS, patients were allowed to have only one visitor in the waiting room, and the visitor was permitted to go into the cubicles with the patient for only 5 minutes every hour:

"..whoever is with them [the patient] is not allowed into the back area right now. Only for 5 minutes every hour. So they have ample opportunity if they wanted to screen for abuse" (Participant 6, nurse).

Previous to SARS, there were standard visiting hours (9:00a.m to 8:00p.m) without restrictions on the number of visitors to the hospital. For nurses, many acknowledged that the restricted visiting hours and the heightened security make it easier to perform tasks. The presence of security guards 24 hours a day in the ER discourages violent outbursts and cuts down on visitor disruptions in the waiting room.

Many nurses suggest the new visitor policies make it easier to get patients alone, benefiting victims of abuse. One triage nurse states:

"We started the program before SARS hit us and if anything, SARS has kept the relatives out. You can talk to the person alone, so there is a benefit to that" (Participant 4, nurse).

Policies limiting visitors also make it easier to request partners leave the examining room or cubicle. As one physician states:

"I think for the abused woman it's better in terms of less visitors, cause it's much easier to tell people to leave because we have a policy. Whereas typically when you have a male partner hanging around, he's very controlling and won't leave the room and it makes it more difficult to ask them to leave when there isn't a policy for everybody" (Participant 21, physician).

Thus, having a policy on restricted visitors to the ER makes it easier for physicians and nurses to isolate abused women as they are enforcing a policy and not making an excuse to see the woman alone:

“Again I think it [SARS policy] is better because we can enforce the partner or the abuser to leave the room because of hospital policy rather than just asking them to leave. If you say because of security measures and because of SARS, they might not be suspicious when they leave the room. There's probably a potential to pick up more cases” (Participant 14, nurse).

According to one triage nurse, restricting the number of visitors has been a positive step, as the number of people is dramatically reduced:

“Well, it's a lot easier for us in emerg and it's much easier apparently for the nurses in the wards because the relatives would be coming in at any hour, like 9 am 'til 9 pm. And there were constant relatives and sometimes you would go into a room and there would be 8 or 10 people with one person, especially the extended families” (Participant 7, nurse).

Another triage nurse remarks how the workload may have been cut by 80% when visitor restrictions were implemented in the ER:

“The immigrants and the large families - they all want to be there and the nurses couldn't get patient care done and they wouldn't get this and that. And then all of a sudden they would have this time on their hands and they could do things. And it's sort of the same in emerg. Especially in the cubicles or observation there would be 2 or 3 relatives with every patient and they would be coming to the desk asking you questions, ‘Oh, when am I going to be seen, and this, that and the other thing.’ ‘That lady over there needs something’ and you know that was cut like 80%” (Participant 2, nurse).

Although visitor restrictions has eased the workload for nurses, for others, stress levels increased:

"I think in general it's just added to our level of stress a little bit. The ER itself, because we have security here now, in some ways it's made our life a little easier because we don't have as many visitors sort of coming in and staying at the bedside. Although, then on the other hand we have to police that and that becomes a little more difficult. So, I don't know if it directly affects us asking the questions or I don't think it has much to do with it. But our stress levels in general is just a little bit higher" (Participant 9, nurse).

From another perspective, one physician indicated that the SARS screening makes it difficult to talk with family and friends about the condition of the patient. For family members and friends, SARS limited the access to information and contact with patients. From the hospitals and staff perspective, policies and practices were implemented which are meant to protect the hospital population from disease. However by doing this, contact between visitors and patient, and visitors and physician is limited:

"With the SARS outbreaks in Toronto, it was much harder to work here. We had to be gowned and masked more and it made accessibility of families more difficult. I actually don't like this. I think it's much more easier to have the families come in rather than go trying to find them in the waiting room and bring them in and talk to them all together. It's just easier on me, that's just my style. So I like to talk to the families all together and then I don't have to do it several times over" (Participant 24, physician).

While this physician found it difficult to locate family and friends in the waiting room, other physicians felt that having all these extra people in the cubicles impeded their work and the waiting room was the best place for visitors.

Masking and gowning

With policies and practices surrounding SARS, study findings revealed that masking and gowning impede effective patient communication. Health care providers stated that wearing masks makes it difficult to interpret nonverbal cues, which affect the physician/patient interaction:

"It's [SARS] made everything more difficult. We're doing the full gown and glove and protection gear. Every encounter took more time and you lost a lot of nonverbal cues from body language that you were getting from the patients and it's lost with the masks on. It took so much time both clinically and outside the department with all of the various directives that came down" [sic] (Participant 25, physician).

Individuals experience words and gestures as expressions of individuality.

Without social conventions and shared meaning, communication would be impossible (Griffith et al.2003). Research indicates that 55% to 70% of communication is nonverbal, while only 7% is actual words used (Damsey,2002). In the patient-physician encounter nonverbal communication is important information for providers. Patients are nonverbally expressive and this can give important clues about the patient's condition, as well as the likes, dislikes, needs, and desires. Communicating pain is often revealed with facial expressions⁵⁵, and many women in abusive situations will communicate pain, fear, and emotions in their facial expressions and body language. Patients wearing masks coming to the ER for sensitive issues such as abuse may verbally deny the medical problem but their nonverbal cues may be communicating otherwise.

⁵⁵ For further information on human communication, refer to the following web site:
<http://www.li.suu.edu/Library/Circulation/White/psy3650lwChapter13Spr03.pdf>

Another health care provider states how important nonverbal communication is within the triaging encounter:

"I found it difficult especially with the masks, because you can't see someone's face. So much communication is nonverbal and when you can only see someone's eyes it makes it a little difficult. So I'd say for me the greatest thing is not seeing the whole face. And also for them to me, because I try to be very aware of how I look to them - to smile, to be soft and kind and all of that stuff. So much of that is in your face and your body language, so I would say that just having your face covered has been the greatest trial for me" (Participant 7, nurse).

For physicians, nonverbal communication skills are associated with greater patient satisfaction (Griffith et al. 2003). Research indicates that nonverbal behaviours positively correlated with favourable patient outcomes include head nodding, forward lean, direct body orientation, uncrossed legs and arms, arm symmetry, and less mutual gaze (Beck et al. 2002). However, due to SARS' masking and gowning techniques, patients may experience difficulty interpreting a professional's nonverbal cues and may feel uncomfortable and report lower patient satisfaction.

In contrast, there are nurses who believed that the only difference SARS made was that everyone wore masks:

"I think it hasn't changed anything at all. Nothing's really changed except people wear masks" (Participant 5, nurse).

In terms of wearing masks for personal health, nurses have noticed they are getting less sick because they are wearing masks. One triage nurse suggests that:

"Since people have to wear masks, I've been getting less sick from people coughing on me" (Participant 8, nurse).

For providers, SARS policies and practices address infection control in the ER and have decreased the transmission of viruses between staff and patients. However, these policies also impacted upon the nonverbal communication between patients and providers.

What happens now?

With the threat of SARS having subsided as of August 2003, new directives have been issued by the Ministry of Health and Long-Term Care.⁵⁶ Screening every patient is no longer required at the hospital, however the hospital insists that everyone continue to monitor his or her own health. Currently, the hospital continues to have SARS screening sheets available at the front desk and bottles of disinfectant, however student nurses are no longer screening patients. Furthermore, for those who have access to the internet the hospital has posted a self-screening tool on its website which asks about SARS-related symptoms and exposure to infectious diseases to assist the public in determining their health status upon entering the hospital. At the bottom of the website are directives which advice individuals on the next steps if they answer 'Yes' to any of the previous questions. Furthermore, visiting hours have been restricted to between 3:00p.m and 8:00p.m daily.

This chapter examined how SARS changed the landscape in the ER, producing both positive and negative effects for the abused woman. Overall, SARS policies made for a safer environment for an abused woman and staff. This was evident with heightened security measures, restricting the number of visitors, and restricting visitors

⁵⁶ Ontario Ministry of Health and Long-Term Care (2004) *Health Update: SARS*
http://www.health.gov.on.ca/english/public/updates/archives/hu_03/hu_sars.html

which made the ER encounter more private. However, screening for SARS also revealed two negative, unanticipated consequences for staff and for abused women.

First, the medical model was upheld and routine abuse screening was abandoned and no longer enforced at triage. Although patients had more time alone with health care providers, abuse screening was not being conducted at triage on a regular basis. Second, although protective gear can stop the spread of the disease, one of the negative effects of wearing masks and gowns is making nonverbal communication and body language difficult for the health care provider to interpret. Since the health care encounter relies on verbal and nonverbal communication, not being able to assess facial expressions and body language made identification and probing for abuse difficult and was an unexpected negative outcome in terms of delivery of care.

Despite these negative outcomes, SARS protocols appeared to make for a safer environment for an abused woman, as policies were in place to allow for a more private examination.

Chapter Nine

Recommendations and future directions: Providers' experiences with screening for abuse in the ER

Violence against women is a social, political, economic, and cultural issue. The way in which a society defines, interprets, and responds to abuse can profoundly affect an individual's, family's, or community's experience of violence (Dekeseredy & MacLeod, 1997). Woman abuse as a social issue has forced people to review common-sense ideas of what defines a crime, how families live together, and how effective institutions are in finding solutions. In this respect, gender-sensitive policies and economic costs associated with woman abuse must not be forgotten.

Woman abuse is a serious health problem. The hospital Emergency Department has an important role in helping abused survivors. This dissertation examines health care providers' experiences in screening for woman abuse at one hospital's triage unit. Health care provider views on the utility of the Emergency Department's screening tool, resistance to, and barriers associated with applying the tool, and Emergency Department protocol are explored. The goal of the study is to describe issues around identification and screening practices from the nurses' and physicians' perspectives.

Using the analogy of Pandora's Box, analysis of the health care provider's experiences with screening for woman abuse revealed numerous difficulties with the design of the tool, its implementation, and related hospital protocol. Unanticipated insight was gained into the problematic organizational structure of the ER which negatively impacted the health care professional's screening practices for woman abuse in the triage unit. Strengths were uncovered with applying health promotion principles at triage. Four themes were identified in the research: patient characteristics as reported by the participants; health promotion in the ER; health care barriers in responding to woman

abuse (hospital hierarchy); and the issue of how SARS impacted the ER environment with implications for the abused woman.

The findings suggest that health care providers navigate between applying a woman-centered approach and the medical model when managing the care of abused women. Triage nurses routinely use a woman-centered approach when discussing psychosocial issues, inquiring into abuse with patients, and when asking health promoting questions in the emergency department. By contrast, physicians often referred to indicator-based methods for abuse screening and used clinical documentation styles, indicating that physicians tend to conform to the depersonalized medical model of treatment.

This dissertation provides both substantive and theoretical contributions to the current work in the fields of sociology, health and illness, family violence, social work, women's studies, and health care policy. On a substantive level, the primary research offers evidence of the experiences of health care professionals in establishing and implementing an abuse screening tool. Other sources of material on abuse screening at the hospital have not presented in-depth evidence of this nature, but rather focus on improving identification and statistics. This research places violence and health within a sociological context by examining the ideology of screening as well as roles and responsibilities during the patient encounter.

Using a sociological lens, the research demonstrates that health care providers formulate opinions about abuse based upon their professional identities, hospital hierarchy, personal barriers, and institutional mandates. Each health care profession creates its own community within the ER, and knowledge and professional practices evolve through definitions of the current situation, interpretations of previous training,

and anticipation of future directions. The theoretical framework draws from the medical model, a woman-centered approach, sociology of professions, health promotion, sociology of nonverbal communication and grounded theory.

Applying these theoretical frameworks allows the opportunity to explore the relations between health care providers and the delivery of health care for abused women as they occur in the ER. By drawing upon these different frameworks we are able to better understand the hospital hierarchy, why provider barriers exist, how health promotion strategies fit into the ER, and how SARS impacted the patient encounter.

The theoretical frameworks relate to the themes discussed and explore social relations in the formation of identity and hospital culture and structure. In the field of sociology, settings are acknowledged to be important for interaction, and many social interactions occur on a daily basis in the ER. The grounded theory approach facilitated the documentation of participants' experiences with the screening tool and an understanding of the influence of economic, political, professional, and social interference.

In terms of applied social research, the results of this will be useful for health care providers involved in organizing the existing DVTP and SATP at the hospital in addition to those planning other newly-established partner assault programs. Study findings will inform domestic violence programs at the hospital by providing insight into how health care professionals view their roles and identities, and how they interpret the screening tool for abuse and other health promotion strategies.

The grounded theory approach uncovered four themes, three of which were unanticipated: hospital hierarchy, SARS, and health promotion in the ER. The hospital hierarchy fostered social distancing between staff members, and the professional

organization of nursing and medicine has traditionally created a caste-like system which resulted in a lack of communication between social workers, nurses, and physicians.

The discovery of how SARS impacted upon the data collection and affected the hospital and the staff was unexpected but also added another layer to the data. SARS taught us that heightened security and policies restricting visitors increase patient privacy. Having such a hospital policy makes it easier for providers to ask partners and friends to leave the examination room.

The effects of SARS also show how even in the most ideal setting for screening under the best conditions, unexpected situations can arise which temporarily halt the screening process. This occurred at the hospital. Although part of the department was trained in triage abuse screening, an unexpected event such as SARS can disrupt this process and set the department back months in terms of planning and training. As a result, the sexual assault nurses and social workers must retrain all triage nurses, and the process to successfully implement the screening tool has begun again. Study findings also uncovered how important nonverbal cues are in the patient encounter. Wearing masks and gowns made nonverbal communication and body language difficult for health care providers to interpret cues from the abused woman.

Health promotion in the ER turned out to be another unexpected finding. The foundations for an infrastructure for health promoting strategies became apparent when I was able to step back and look at the 'whole' picture. Here, it was shown how the ER is not only a site of medical intervention, but also a site where health promoting screening questions are asked, statistics are collected, and brochures are available.

In Canada, the philosophy of health promotion is driving both federal and provincial health initiatives⁵⁷ (Lindsey & Hartrick,1996). There exists a tension between these contrasting paradigms as health care shifts to embrace a health promotion perspective. In order for health professionals to fully embrace health promotion, they must move away from the philosophy of the natural sciences and adopt a human science or patient-centered approach when delivering 'care.' Such a shift requires a radical transformation in the health sciences as nurses and physicians move away from a 'top-down' approach of the health sciences process and adopt a 'bottom-up' approach to health promotion in the ER (Lindsey & Hartrick,1996).

Demographic characteristics, clinical symptoms, and psychological conditions alone are not sufficient indicators of violence. Assessment for abuse therefore should be routine (McAllister,2000). This research offers a woman-centered approach whereby the goals of routine screening questions and asking about woman abuse be redefined so the initial contact with a health care provider (Gerbert et al.1999a), privacy, time, and the manner in which abuse is discussed, constitutes 'success'. The findings of this thesis suggest that routine inquiry is effective and can be successful when applied under appropriate conditions, such as tailoring the screening tool to the ER environment; when the woman does not have physical injuries requiring immediate medical treatment; if the provider can take the extra time with the patient; when privacy is assured; if the triage nurse has explained the term 'domestic violence;' and if providers are trained in abuse. However, to be effectively implemented into the ER, the most important elements of a woman-centered approach are privacy and time. While a woman-centered approach

⁵⁷ The 'Speech from the Throne' (2004) cites that the government must take the lead in establishing a strong and responsive public health system. Starting with health promotion, the government must help reduce the incidence of avoidable disease.

provides a value-free environment and non-judgmental staff, the approach cannot be successfully implemented without privacy and time. Although time and privacy are key elements in routine screening, these are also the most common barriers reported by providers when managing the care of abused women. For these reasons, a woman-centered approach may not be problematic in the ER setting.

Abused women also benefit from care that is focused on their strengths (Harris & Dewdney, 1994). Abused women are survivors of violent and controlling environments, and have resilience, coping skills, strengths, and specialized knowledge about violence in their lives. In using a woman-centered approach an abused woman's expertise is recognized by staff whereby women experiencing abuse are invited to work collaboratively with staff to address safety concerns and problem-solve. Providers who acknowledge abused women's expertise about their own situations will avoid giving advice. Under the medical model, professionals may advise a woman to disclose abuse, leave the abusive situation, press charges, or arrange for counseling. However, major changes may be dangerous or non-advantageous for women with abusive partners. Using a woman-centered approach, feminists assert that it is more effective to express concern and share information about resources available to abused women than to advise women to make choices. If women choose not to process or discuss an abusive situation, their wishes must be respected (DeFehr, 1997).

Summary

Chart review findings revealed that without abuse screening, 1% of abused women were being identified among the ER population. When routine screening was established at the hospital, identification increased to 5% (Lucey, 2003), and this figure is consistent with previous research (Grunfeld et al. 1994). Furthermore, routine screening does not mean that every woman is asked about abuse. With abuse screening protocols,

only 26% of women were being screened, similar to reports in the literature (Thompson et al.2000). To increase the rate of screening, health care providers should be aware of the criterion concerning when to and when not to screen under a routine screening policy.

The study highlights the difficulties associated with introducing a woman-centered approach to abuse screening within a busy ER. Difficulties include the problems of separating women from their partner in order to ask about abuse safely, lack of abuse training, and the problem of introducing another time-consuming task which has to compete alongside the multiple tasks demanded of ER staff. This thesis recommends routine screening under certain situations which take into account the ER environment, presenting complaint, provider barriers and the organizational structure of the ER. Routine inquiry should not be introduced without recognition of the increased burden on time and resources (Mezey et al.2003). Development of stronger partnerships with non-governmental organizations which have been working with abused women is likely to enhance the effect and sustainability of interventions.

For purposes of this study, participants were interviewed several months after the screening protocol was implemented and after most triage nurses had at least one training session on the tool. This was sufficient to heighten awareness of the abuse tool and to enable sporadic screening to take place, but was not sufficient to incorporate routine screening or many of the issues providers wanted to be informed about. Moreover, it was difficult to sustain training during this study due to SARS, staff shortages, staff rotation, and a high turnover rate among medical students.

The data gathered by qualitative interviews provide information on the dilemmas confronting providers, from within the providers' frame of reference and in the providers' language (Sugg & Inui,1992). This type of information is crucial in designing screening

tools and abuse workshops. This study recommends that while all health care providers attend frequent abuse workshops, these sessions must target residents and medical students as they are in the best position to spend time with patients. When examining the practicality of implementing workshops, findings suggested how the introduction of workshops can create social disruption and tension, but are also needed in order to heighten awareness and promote routine screening for abuse.

It is clear from this study that educating providers to intervene more effectively in domestic violence is not simply a matter of providing the evidence or of providing a field on the ER chart for abuse. As with all health issues that encompass elements of both medicine and social work, education and frequent workshops on abuse must include examining and reshaping barriers that may hinder providers' clinical skills. A combined workshop where both nurses and physicians discuss not only limitations and effective strategies with the tool, but how to establish effective communication between the two professions is needed. Here, workshops can also inform ER staff about the rates identified in the ER. As the results revealed, informing providers that identification has increasing may motivate physicians and nurses to continue routine screening.

Applying a woman-centered approach under these situations promotes open and free-flowing dialogue between staff whereby issues, ideas, and experiences are shared and discussed. Workshops would allow staff to bring more insight to the issue and to feel more comfortable screening for abuse. As well, workshops would be a forum to explore new ways to incorporate routine abuse screening in the triaging process.

Training health care professionals to screen for abuse should also include information about boundaries within the clinical interaction and strategies to assist these. Training needs to recognize and address the potential for setting unrealistic goals for

oneself in terms of what providers should be offering, and having too high expectations of what advice and information is likely to achieve (Mezey et al.2003). Counseling women who are experiencing abuse requires skill, experience, privacy, and can be time-consuming. Physicians cannot realistically be expected to always have time to provide such privacy, support, and counseling. However, it is important for all health care providers to understand that asking direct questions about abuse in a non-judgmental and compassionate manner is key. Critically, providers must be aware of, and must have access to supports and resources when referring women to social workers, abuse programs, and social services.

Future strategies for ensuring sustainability may include training more health care providers to become domestic violence nurses or trainers (Mezey et al.2003). Certainly, more training about abuse would alleviate pressures in finding a nurse who could spend the time with an abused patient, as most nurses would have this training and be prepared to work with victims of abuse. Ideally, domestic violence training should be mandatory in medical and nursing education, and continue with recognized refresher workshops throughout their careers. This would enable health care providers to develop the necessary skills to conduct sensitive screening and respond in an effective manner to women experiencing abuse.

A hospital should meet one or more of the following abuse criteria in order to be accredited: must have an abuse protocol; have a nurse trained in domestic violence always in-house; and offer frequent abuse workshops to all health care staff. This policy would apply to the ER and possibly any other department in the hospital, and ensure that issues of abuse are treated as priority.

For effective routine screening, privacy is required. Triage is usually the location where screening for abuse is conducted. However, privacy at triage is often limited. To help compensate for the rushed pace and exposed location of screening at triage, asking questions in other treatment areas (i.e., cubicles, resuscitation unit) may help improve overall conditions so disclosure of abuse can occur (Grunfeld et al. 1994). This thesis suggests that nurses, physicians, and social workers ask questions about abuse during the course of history-taking, assessment, or treatment. Grunfeld and colleagues' (1994) preliminary results indicated that routine screening protocols were carried out far more efficiently when all nurses and physicians shared ownership of the screening protocol.

DeFehr (1997) found that while staff should ensure unnecessary duplication of screening is avoided by checking patient documentation, it is important for each professional in the ER to be prepared to screen women about abuse in a direct and compassionate manner. The effectiveness of the hospital's screening tool at triage is unknown until further chart audits and workshops are held. However, the existing screening tool can be used at any point during a woman's visit to the ER in cases where they display injuries and in cases where abuse is not suspected.

When the pilot program ceases to exist and abuse screening is discontinued, it will fall to the domestic violence and sexual assault program as to whether or not abuse screening will continue at the hospital and be incorporated into hospital policy. Although awareness and knowledge of abuse has been heightened in the ER, screening must occur frequently in order to keep abuse a prominent consideration for providers. Following the conclusion of the pilot project, without the financial support and access to resources, screening for abuse may not survive. This would imply that knowledge and raised

awareness alone may not be sufficient to translate into clinical practice in the absence of additional resources and active organizational support.

For an abuse screening tool to be implemented and sustained, there needs to be active monitoring and auditing, support provided to deal with the distress that accompanies disclosure, and the time, abuse training, and confidential space to screen safely and effectively (Mezey et al.2003). For some women it may be enough to provide information that allows them to access help if needed, while in other cases the demands on the health care provider's time and emotions are more extensive. Consideration of these factors is necessary for routine screening to be safe and effective.

Study findings have identified several opportunities for implementing a screening program. Noting that screening for abuse is part of the standards of care alerts providers to their responsibility to screen. Consequently, providers screening on indicator-based methods may be more likely to routinely screen. Using a consistent tool for screening absolves the professional from creating random questions and makes screening part of the routine ER data collection.

Providers who believe assistance and resources from the hospital and community are available if they uncover abuse are more likely to screen. If nurses and physicians are confident they will be able to respond appropriately when a woman reveals abuse, they are much more likely to screen (D'Avolio et al.2001). Finally, offering clinical practice with a mentor may help increase implementation of an abuse screening tool.

To address woman abuse, this study recommends that the health care system take a long-term approach to the problem. Progress must be reinforced at every step and the screening tools must be constantly reassessed. This means evaluating screening questions for the appropriate health care setting, providing both quantitative and

qualitative measures for allocation of resources, and examining the availability of funding and staff compliance. Unless an institution is willing to commit long-term additional personnel and other resources to address the issue of woman abuse, it is essential that the ER protocols are designed to be incorporated into existing clinical practice (Waller et al.1996).

Future directions

Although the literature on screening practices in Canadian ERs is limited, there is literature to guide future research. The study of woman abuse is plagued with problems inherited from previous research in this area: definitions are controversial, outcome measures are problematic, and randomized control trials are logistically and ethically difficult. However, when examining the meanings and interpretations held by providers and patients, several questions can be addressed in future work using qualitative methodology. What factors cause or contribute to poor documentation of abuse in ER charts? Do health care settings use culturally-sensitive abuse screening tools and are translation services requested and easily accessed? Are supportive services such as social work and the DVTP and the SATP helpful in increasing identification and treatment of abuse in the department? Would more supportive services from community groups be helpful in increasing identification and treatment of abuse? How do social services and hospital resources impact upon abuse screening and protocols? Can abuse protocols survive without assistance from ER social workers? Lastly, how important is the task force in the implementation and sustainability of abuse protocols? Qualitative research focused on staff responses to these questions may be useful in the creation of conditions which encourage and support staff in their work with abuse. Thus, more qualitative

research is needed to explore providers' decision-making process for screening abused patients.

Practitioners, educators and policy-makers should examine the scientific rigor of information describing the barriers to screening for abuse (Chamberlain & Perham-Hester, 2002). Further studies are needed to evaluate the relationship between perceived barriers to screening and providers' actual screening practices in a variety of clinical settings that evaluate provider and patient characteristics.

Further research is needed to identify the best way to provide and maintain screening protocols in the Emergency Department in terms of structural and provider strategies. As alluded to in the section on structural barriers, more research into the broader political and economic context in which hospitals function is needed to understand the impact of institutional and governmental change on feminist research. While "government reports consider health care reform, they focus on greater efficiency and effectiveness defined primarily in market terms and based on a medical model" (Armstrong & Armstrong, 1996:51). It is worth inspecting government policies which complement or clash with advocacy groups and institutional mandates in a health care environment.

Ultimately, research on woman abuse protocols in the ER must examine not only provincial and federal government policies, but also the impact of government cutbacks on institutions and the women utilizing hospital services. Further, provincial and national screening practices and attitudes, and opinions about abuse screening questions and protocols in health care settings must be explored.

Qualitative research exploring the effectiveness of workshops and training sessions would be beneficial. Training strategies and content could be refined and

tailored for professionals. Providing case examples of how to incorporate woman abuse programs and policies throughout the hospital is recommended. Incorporating guidelines and discussions about the roles and responsibilities of health care providers under the Family and Child Services Act is needed. As well, workshops which emphasize communication strategies between different health care professionals and theoretical frameworks for screening can lead to a more comprehensive care and treatment program in the hospital for abused women. Information collected during these sessions could assist sexual assault co-ordinators in providing more complete and comprehensive information during training sessions. This information would also potentially aid other ER departments in developing and implementing their own screening tool. At the government level, this information could inform policy makers and gain endorsement by professional bodies such as the Registered Nurses Association of Ontario (RNAO).

Implementing workshops would also involve exploring how a woman-centered approach and health promotion strategies could be fully incorporated into the triage encounter. The literature indicates that implementing a woman-centered approach has the potential of being successfully integrated into already existing ER protocols. However, the strengths and weaknesses involved with incorporating a woman-centered approach in the ER must be documented. Exploring physicians' behaviours and how to change old habits is necessary by re-framing the way issues such as abuse are contextualized in medicine. Thus, screening should be routine and not rare.

Perhaps the most important research need on abuse screening in the ER is whether increased identification leads to improved patient outcomes (Zachary et al.2001). A paucity of evidence on the effectiveness of abuse interventions has led the CTFPHC and OMA to conclude there is insufficient information either to recommend or to oppose

routine screening. This thesis argues that screening may be justified for other reasons such as the high prevalence of unidentified domestic violence and the potential value to patient care. However, more research is needed into whether detection of abuse leads to improved patient outcomes which would contribute to the empirical evidence.

Few domestic violence referrals were made to social work before the screening protocol. It would be useful to conduct a chart review and see whether not only identification has increased and if social work consults and referrals to the domestic violence and sexual assault programs have increased since the inception of the screening tool. Incorporating subsequent chart reviews conducted by the hospital's Abuse Task Force is a means of evaluation and system/institutional accountability.

Conducting chart reviews will uncover the completeness of documentation, which is important for providing physicians with more empirical evidence-based studies. Moreover, while there is a substantial amount of literature examining the health effects of woman abuse, more studies are needed to examine the links between mental illness, alcohol and drug abuse, and woman abuse. The associations between chronic conditions such as psychiatric problems and asthma for the abused women would be important research.

Information regarding predictors of domestic abuse in the health care setting is helpful only in the context of enhanced service and research efforts (Zachary et al.2001). Further research is needed to determine the cost and effectiveness of interventions in medical settings and to assess the benefits to different groups of women who have been abused.

Initial studies suggest the prevalence of domestic violence among lesbians, gay, bisexual, and transgender individuals may be similar to that of domestic violence against

heterosexual women (Family Violence Prevention Fund, 1999). Before recommending routine screening practices, it is critical to conduct studies addressing the unique issues related to the delivery of quality health care for these individuals. In terms of continuing education, future research should explore whether relationships exist between a provider's formal training and his/her preparedness; beliefs about who, when, and how to screen; and outcome expectations when helping women suspected of being abused.

While still in the preliminary stages, future research must look at incorporating health promotion strategies in all types of health care settings. An examination of the format and context of health promotion questions is necessary to determine which settings are conducive and which are not conducive to asking. Here the goal is to make health promotion and public health activities consistent with a prevention framework, not just an intervention one.

More studies are needed which examine the impact of body language on the patient-physician/nurse encounter. SARS altered the behaviour of physicians and nurses. The staff realized the importance of privacy and nonverbal communication and body language in the patient-physician encounter. It is also worth investigating how hospital policies and practices affect abused women (privacy, confidentiality, masking and gowning, security and visitor restrictions) and other segments of the population.

SARS is not the first nor the last virus to impact policies and practices in a hospital setting. Consequently, we must document how these medical policies and practices affect vulnerable segments of the population. We need to ask ourselves how infectious disease control measures impact all patients, including abused women. Knowing this can foster and promote a more conducive atmosphere for delivering quality care and appropriate interventions.

There is also a need for qualitative studies exploring survivors' experiences with health care providers when seeking help, and with the screening tools. In-depth interviews can shed light on factors preventing abused women from disclosing abuse, or on factors which promote disclosure. Therefore, asking questions such as, "Is practice allowing women who are experiencing violence to feel safer, more supported and more able to trust staff?" and "Is the health and well-being of women being improved as a result of this program?" will contribute to the growing literature on abuse in Canada. Answering these questions will frame our ideologies and future directions for research and policy. Therefore, conducting quantitative and qualitative research in the field of violence and health is needed in Canada. These include chart reviews, prevalence studies, case-control studies, and interviews, all which answer different but important research questions.

When making future recommendations, it is important to remember who these interventions are for and what outcomes are desired. Some women who are victims of violence continue to find themselves judged, blamed, and in some cases, further violated by the 'helping' system. They have encountered a disjointed and often uninformed approach to care and assistance that often reverts to a medical response. Knowledge based on the experiences of women, health care providers, and informed by a woman-centered approach and a health promotion approach has the potential of becoming compatible within the clinical setting. With support from the medical profession, we need the government to be flexible in its distribution of financial incentive. Lastly, the role of the health sector in identifying men who abuse women and in developing interventions for them must be explored (Garcia-Moreno,2002).

This dissertation supports and broadens our understanding of health care providers and their perceptions of, and experiences with, policies and practices around abuse screening in the ER. As the discussion regarding the appropriate role of health care professionals in addressing woman abuse evolves, this information will inform our understanding of the patterns, justifications, and barriers to health care inquiry. These providers seek to be better-equipped to provide culturally-sensitive services for their female patients affected by abuse and who may have to deal with multiple issues.

In conclusion, a consensus is growing on the need to access and identify effective screening tools and protocols for health care providers and to inform both providers and policy-makers of the value of these interventions (Garcia-Moreno,2002). Although research on interventions is methodologically difficult and can be expensive, without a concerted effort in this direction we will not be able to move forward. Better recording and sharing of experiences across settings is needed since the medical model is not effective in all settings and does not address all conditions.

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Appendix A

Why survivors' voices are missing

The original intent to locate and interview a sample of abuse survivors through the examination of the medical charts was not feasible for several reasons. The hospital Ethics Review Board strictly enforces the policy that abused women can only be contacted by health care providers directly involved in their care. Thus, access to individuals as a result of their contact with health care professionals could not be negotiated through the hospital's Ethics Review Board. There are several methodological implications with this hospital policy which make it difficult and almost impossible to contact former patients.

Firstly, the ER is an urgent care environment where health care providers do not have time to contact former patients and briefly explain the study objective. Secondly, even if time can be allotted it must be the health care provider who managed her care in the ER in the first place who makes contact. Since there can be high staff turnover in the ER, locating a staff member involved in a former patient's care 1 to 2 years ago may be impossible. Many emergency physicians complete their residency and/or internships, leave, and complete their medical training in another department or at another hospital.

The Sexual Assault and Domestic Violence Treatment Program (SATP/DVTP) co-ordinator suggested a social work student doing a placement in the ER could possibly contact these former patients as a third-year project. This suggestion was rejected since the student did not manage the patient's care. The co-ordinator was also approached as a possible candidate to contact these patients, but not all patients were automatically

referred to the SATP/DVTP where the co-ordinator may have counseled them.

Furthermore, her duties at the hospital make it almost impossible for her to contact former patients. Alternatively, obtaining a sample through prospective methods in the ER was discussed, but gaining the co-operation of health care providers would be challenging and there would be serious ethical issues to address.

Considering the difficulties involved in collecting samples of abused women in a hospital setting, a women's shelter was deemed the best alternative. On November 6th 2002, I attended the Violence Against Women Coalition Group's meeting held at the Sandyhill Community Centre. This meeting attracts directors and co-ordinators of women's shelters, health organizations, frontline shelter workers, advocates, and representatives from the regional police department. I gave a brief presentation about my research objectives and tried to locate a shelter where I could conduct focus groups. Since I am looked upon as 'an outsider' in this tight network of women, my research proposal was not warmly received. Few questions were asked following my presentation, and I determined that the major concerns for these women were funding and staffing problems. Therefore, I was seen as 'another researcher' with noble intentions whose project would not take priority over their more fundamental issues.

To make the project more attractive to shelters, I offered to become a volunteer, to provide arrangements for day-care, and to compensate participants for transportation. Some shelter directors suggested conducting the focus groups during the regular support meetings the shelter already held, when the women were scheduled to meet anyway, thus obviating the necessity of starting completely new focus groups. However, shelters tend to be closed spaces, and workers are not likely to discuss the situations their clients were

in. Therefore, gaining entry seemed to be impossible for me as a researcher, student, or volunteer.

After many failed attempts to gain access to abused women through agencies, I abandoned the idea to instead pursue interviewing health care providers. As a result, my methodology dramatically changed from the original intent: this study interviews health care providers working in the ER at the hospital as opposed to conducting face-to-face interviews with abused women who have gone to the ER due to their injuries.

Consequently, I was able to explore the professionals' experiences in responding to the abused woman who presents in the ER. For a complete picture on the success of a screening tool, it is beneficial to consult both the targeted audience and the professionals conducting the screening; however, this study was unable to provide the experiences from both sides. Rather, this thesis explores health care provider experiences and their responses to the abused woman who presents in the ER, and thereby determines how best to identify and discuss issues of abuse.

I wanted to know if health care providers thought abuse was a health issue to be addressed in the ER, and whether screening for abuse had changed their ideology and practice of treating abused women. Having completed a review of the abuse literature for my Masters Degree, I was familiar with concepts related to the subject area. The initial research also enabled me to evaluate personal conceptions about the subject matter.

My Masters work (Moss, 2000) explored whether a woman-centered approach to abuse in the ER was feasible to implement. Findings from secondary analysis revealed this was possible, that there are organizational, professional, and personal barriers tied to economic and political incentives. Study findings also suggested that while there is no

‘right’ way for providing and/or maintaining a woman abuse screening protocol/program in an ER, all protocols should use a theoretical framework for understanding screening behaviours. Following this research, I wanted to interview health care providers to hear about their experiences with abused women, and with the recently-implemented screening tool for abuse. Throughout this research, I endeavoured to see how their experiences fit within the existing literature.

Appendix B

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EPIS/NACRS
RESPONSE TO REQUEST FOR STATISTICAL INFORMATION

TO: Kathleen Moss

FROM: Jane Banek, CCHRA(C)
National Ambulatory Care Reporting System/EPIS
Clinical Information and Records Service/Emergency Department
Ext. 13867

DATE: January 16, 2003

SUBJECT: Counts of Female Patients January 2000 - December 2001

		Female	Male	Total
	Jan-00	2250	2131	4381
	Feb-00	2227	1971	4198
	Mar-00	2347	2319	4666
	Apr-00	2347	2297	4644
	May-00	2418	2461	4879
	Jun-00	2504	2416	4920
	Jul-00	2580	2570	5150
	Aug-00	2544	2450	4994
	Sep-00	2314	2250	4564
	Oct-00	2507	2366	4873
	Nov-00	2327	2214	4541
	Dec-00	2305	2242	4547
Total 2000	Total	28670	27687	56357
	Jan-01	2536	2320	4856
	Feb-01	2245	2103	4348
	Mar-01	2545	2365	4910
	Apr-01	2320	2443	4763
	May-01	2577	2576	5153
	Jun-01	2526	2557	5083
Completed Months 00-01	Total	43419	42051	85470
	Jul-01	2582	2519	5101
	Aug-01	2586	2600	5186
	Sep-01	2504	2348	4852
	Oct-01	2584	2383	4967
	Nov-01	2310	2183	4493
	Dec-01	2556	2278	4834
Overall 2000-2001	Total	58541	56362	114903
Hospital Utilization by Sex		58541/114903=50.95%	56362/114903=49.05%	
Prevalance Rate/		64/58541=0.11%	4/56362= 0.01%	68/114903
No Screening		61/58541=0.10		0.05%
Monthly frequency		64/23= 2.78%	4/23= 0.17%	

EMERGENCY REPORT-RAPPORT DE L'URGENCE

DATE ya-mm-jj		PATIENT NO.		REGISTRATION-ENREGISTREMENT no hr-hre		health sec. no.-n° arch: r	
PATIENT COMPLAINT-SYMPÔME DU PATIENT						- Living Will-Testament	
FAMILY PHYSICIAN-MÉDECIN DE FAMILLE						CAMPUS	
PROV. CAT (province)		CLAIM NO.-RECLAMATION		ACCIDENT (date/time-heure)		street no.-n° de rue	
ACCIDENT SITE-LIEU DE L'ACCIDENT						city-ville prov. postal code-postal	
NAME OF EMPLOYER-NOM DE L'EMPLOYEUR						ins. prov. assure home tel.-tél. maison	
ADDRESS OF EMPLOYER-ADRESSE DE L'EMPLOYEUR						fax-fax	
IN CASE OF EMERGENCY NOTIFY EN CAS D'URGENCE AVISER (Relationship-Lien de parenté)						NOTIFIED-AVISÉ	
ACCOMPAINED BY-ACCOMPAGNE PAR						CODE (PPT)	
PATIENT'S ADDRESS (temporary work)-ADRESSE DU PATIENT (temporaire ou ancienne)						DATE (moved-déménagement)	
PREVIOUS VISITS-VISITES ANTERIEURES						Alert Code d'alerte	
ALLERGIES-ALLERGIES						MEDICATIONS-MÉDICAMENTS	
AGENCY PHYSICIAN-URGENTOLOGUE						TETANUS DETANUS	
IDENT						DIRECT	
PT REFERRED BY-PT REFERÉ PAR						TETANUS DETANUS	
HIRE						ORDERS-ORDONNANCES	
ENG RESULTS-RÉSULTATS IMAGERIE						REASSESS-RE-EVALUATION #1	
EVALUATION (Name-Nom)						REASSESS-RE-EVALUATION #2	
IL DIAGNOSIS-DIAGNOSTIC FINAL						INSTRUCTIONS ON DISCHARGE-INSTRUCTIONS AU CONGE	
WORK-TRAVAIL						FOLLOW-UP-SUM	
ISE-NFIRMIERE (signature)						INTERN/RESIDENT (signature)	
PHYSICIAN-MÉDECIN (signature)						Discharge-Congé	
D/T-CONGE/TRANSFERT						ADMISS	

Appendix C

TO (PLEASE CHECK (✓) USE ONE FORM PER DISCIPLINE)			
☐ AUDIOLOGIST	☐ PHYSIOTHERAPIST		
☐ CHAPLAIN	☐ PSYCHOLOGIST/PSYCHOMETRIST		
☐ CHIROPODIST	☒ SOCIAL WORKER		
☐ DIETITIAN	☐ SPEECH-LANGUAGE PATHOLOGIST		
☐ CNS* ☐ NURSE*	☐ RECREATION THERAPIST		
☐ OCCUPATIONAL THERAPIST	☐ RESPIRATORY THERAPIST		
☐ PHARMACIST	☐ OTHER (SPECIFY) _____		
☐ PHYSICIAN/SERVICE*			
* ATTENTION: _____			
TYPE OF ADMISSION:		PHYSICIAN PRIORITY	
☐ INFANT	☐ OUTPATIENT	☐ STAT	☐ ELECTIVE
☐ OTHER: _____	☐ EMERGENCY	☐ DAY PATIENT	☐ URGENT
REQUESTED BY (PLEASE PRINT)	SERVICE	TELEPHONE	DATE (YY-MM-DD) AND TIME REC
<i>[Signature]</i>			

Reason for consultation/Presenting problem:

43yo ♀ c. Assault by Partner, given into on Sh
but insisted to Return home c partner Police involve

Initial findings/Impressions:

Plan/Summary/Recommendations:

For further discipline specific documentation see: _____

SIGNATURE OF STUDENT/RESIDENT	PRINT NAME	DATE(YY-MM-DD)
SIGNATURE OF STAFF	PRINT NAME	DATE(YY-MM-DD)

Abused women visiting the ER by selected characteristics, Percentages

CONTACT	Female %	ACCOMPANIED BY	Female %
Family	51	Family	15
Friend	15	Friend	20
Counselor	2	Alone	57
Not Stated	33	Police/Social Worker	8
ARRIVE BY AMBULANCE		ER FORM COMPLETE	
Yes	39	Yes	66
No	61	No	34
TRIAGE FORM COMPLETE		SW FORM COMPLETE	
Yes	93	Yes	34
No	7	No	66
PSYCH FORM COMPLETE		AMBULANCE FORM COMPLETE	
Yes	2	Yes	36
No	98	No	5
		Not available	59
COMPLAINT		PREVIOUS ER VISITS	
Assault	80	Yes	44
Injury or laceration	15	No	54
Confused	2	Not Stated	2
Other	0		
missing	3	PERPETRATOR	
HIV +		Husband	16
Yes	2	Boyfriend/partner/common-law	62
No	98	Ex-partner	8
		Family, excluding intimate partner	5
AGE GROUP		Not Stated	5
<30 years	44	Self	2
31-< years	56	Missing	1
FUTURE VISITS		HEP B+/HEP C+	
Yes	38	Yes	3
No	57	No	97
Not Stated	5		
PAST HISTORY		WHAT'S INVOLVED	
History of abuse & alcohol	46	Perpetrator used alcohol & drugs	10
Perpetrator used drugs & alcohol	5	Patient used alcohol & drugs	20
Suicide/depression	7	Both used alcohol and drugs	10
Not Stated	41	History of abuse/ argument	10
Patient& perpetrator used alcohol	2	with boyfriend	
		Not Stated/ Other	51
PERPETRATOR ARRESTED		POLICE INVOLVEMENT	
Yes	8	Yes	53
No	92	No	46
		Children's Aid Society	2

Source: The EPIS database

Jan 2000-Dec 2001

N=61

Note: Due to rounding percentages may not add to 100%.

Abused women visiting the ER by selected characteristics, Percentages

INJURY LOCATION	Female %	SOCIAL WORKER ALERTED	Female %
Head, face, neck and/or eyes	49	Yes	51
Torso, stomach, back, shoulders arms, wrists and/or hands	31	No	49
Breasts, vagina and/or buttocks	7	PSYCH ALERTED	
Legs, knees, feet and/or ankles	10	Yes	2
Not Stated	2	No	98
MVA (Motor vehicle accident)	2		
FINAL DIAGNOSIS		NEUROLOGICAL STATUS	
Assault	53	Alert, oriented and cooperative	34
Injury or laceration	33	Alert and oriented	31
Other	3	Alert and cooperative	10
Not Stated	12	Alert	2
		Uncooperative and confused	2
		Not Stated	2
		Unconscious	2
MEDICAL HISTORY		EMOTIONAL STATUS	
Birth control pill and/or psychiatric drugs	15		
Acute conditions	2	Demanding	3
Chronic conditions	10	Calm and tearful	31
Asthma	8	Calm	20
Not Stated	7	Tearful	12
None	54	Anxious	31
Other	5	Not Stated	3
PREGNANT		CHILDREN AT HOME	
Yes	12	Yes	23
No	87	No	8
Not Stated	2	Not Stated	69
MEDICATIONS PRESCRIBED		INSTRUCTIONS	
Demerol, Gravel, Advil, Tylenol	34	F/U with shelter, police and/or GP	36
Ativan and/or Motrin		Rest/ Tylenol	12
Toxicity Screen	0	Sutures/ CT Scan/ X-Ray	8
Psychotropic drugs	3	Not Stated	41
Not Stated	46	Other Admit	3
STD/ HIV TESTING	5		
Can't read/ Other	12		
RELEASE OF MEDICAL INFO		SEVERITY	
Yes	21	Urgent	67
No	77	Less Urgent	28
NS	2	Non Urgent	2
		Not Stated	3

Source: The EPIS database

Jan 2000-Dec 2001

N=61

Note: Due to rounding percentages may not add to 100%.

Abused women visiting the ER by selected characteristics, Percentages

MARITAL STATUS	Female %	DIAGRAM/ BODY MAP	Female %
Marred	16	Yes	21
Single	18	No	79
Boyfriend	12		
Common-Law	2		
Not Stated	53		
TIME OF INJURY			
am	8		
pm	16		
1+ days ago	7		
Not Stated	69		

Source: The EPIS database

Jan 2000-Dec 2001

N=61

Note: Due to rounding percentages may not add to 100%.

Appendix E

Interview Guide- Health Provider

Introduction

Purpose of the study and discussion of participant's personal experiences with screening women in the emergency department
 Introduction and review of the consent form
 Confidentiality and anonymity
 Publication issues
 Study feedback
 Request permission to use a tape recorder

Note: The questions indicated will not be asked in any particular order. Some questions may not be asked at all if they are not appropriate for participants. Since the interview is guided by participants' desires to discuss various topics, many new questions will be formulated in the process. These questions do not appear below.

*Note

The questions below have been developed after a wide review of the literature, specifically examining the 1993 Violence Against Women's Survey, 1999 General Social Survey (victimization, cycle 13), 2003 Maternity Experiences Survey (not released), and population studies.

For purposes of the interview, "abuse/violence" is defined as "acts that result, or are likely to result, in physical, sexual, and psychological harm or suffering to a woman, including threats of such an act, coercion or arbitrary deprivation of liberty whether occurring in public or private life" (Women's Health Bureau, Violence Against Women fact sheet, Health Canada 2002).

General

Why should health care providers be concerned about abuse in their patient population?
 Do you see abuse as a major public health problem?
 Do you feel health care providers should ask about abuse?
 From your experience, is abuse a priority in your professional organization?
 From your experience, is abuse a problem in your patient population?
 What are the signs and symptoms that might alert a health care provider that a patient may be experiencing abuse?

Screening Questions

How effective and efficient are the hospital's questions on abuse?
 Are you aware or familiar with any screening tools on abuse in general?
 Current guidelines call to routinely screen and identify victims as a first step toward intervention, are you aware of and/or familiar with emergency department screening protocols here at the hospital?
 Do you think health professionals, especially in an emergency department should ask all women about a history of abuse? Why or why not?
 Do you think all health care providers are asking all women about a history of abuse?
 Do you always ask questions about abuse?

If not, what are some of the reasons you do not routinely screen for abuse (i.e., lack of time, lack of education and training, cultural barriers to communication or rapport, fear of offending the patient, frustration with lack of change in the patients' situation, or the patient's unresponsiveness to advice)?

Do you think it is important to universally screen all women?

Do you ask abuse questions in private, without a partner, family, or friend present?

Are you familiar/aware of other departments in the hospital that ask about or screen for abuse?

If abuse is suspected, is the patient's previous medical record always checked for suspicious injuries or injuries resulting from an undetermined origin? Have you ever done this?

Questions About Disclosure

When abuse survivors disclose abuse experiences to health care providers, how do you respond?

How do you feel health care providers manage the following aspects of care: identification, treatment, referral source, safety plan, and follow-up?

What's the best way to document the injuries?

Tell me how you go about identifying women whom you suspect have experienced abuse, but do not disclose it?

What are the difficulties you encounter when identifying patients? What do you find to be useful?

What do you think is the most important thing to say or to do in responding to patients whom you suspect might be victims of abuse?

What about *not* to do? Is there anything that a health care provider should *not* say?

Have there been cases in which you suspected a person might be a victim of abuse but you chose not to directly identify them as such?

Can you give me examples when this has happened?

Why did you choose not to directly identify the person?

Did you provide some kind of an intervention without directly identifying the women as a victim of abuse?

What did you do or say to help?

Are you aware of reasons why abused women do not disclose abuse?

From your experience, can you provide some examples where a patient might be indirectly disclosing abuse (i.e., for some women, side-stepping, minimizing, denying, or lying about the abuse are indirect forms of disclosure)?

How do you feel about women who are abused and do not disclose abuse to a health care provider?

What barriers do you think patients might have in seeking health care if they are in violent relationships?

Are you more comfortable with direct or indirect disclosure of abuse?

Have your identification rates of abuse been obtained through indirect or direct methods of disclosure?

Would you rather have a woman fill out a self-reported questionnaire on abuse, or ask directly?

Professional Training

What are your recommendations for the following areas of the SA program expansion?

- Knowledge and skill of the health care professionals
- Requirements of training
- Policies and procedures or protocols

- Requirements for integration into the violence against women and criminal justice service systems
- Requirements for accountability mechanisms
- Requirements for service delivery model

What would you like to gain from a workshop or training program on abuse?

Do you feel you have sufficient knowledge of issues around woman abuse in order to identify abused women?

Are you familiar with the legal requirements for reporting child abuse, sexual assault, violence against women, abuse of the disabled, and elder abuse to the police and/or Children's Aid Society (CAS)?

Did you receive any abuse training in school (i.e., medical school, nursing, social work training)?

If so, do you feel it is important to continue receiving training in issues related to abuse?

Do you feel abuse training should become a core component of course curriculum?

Are health care providers in the hospital offered any workshops or training sessions on how to identify woman abuse?

Do you think workshops and educational seminars would increase the awareness and knowledge of abuse for health care providers?

Would you participate in a workshop?

Do you feel abuse training where you work is a priority?

What method of instruction would you prefer (i.e., workshop, lunch time seminar, lecture, handbook, videotape, etc.)?

Have you attended any conferences in the area of the health care responses to abuse?

Are you aware of an organized Domestic Violence (DV) task force committee in the hospital?

Would you be willing to organize or participate in an abuse task force to establish screening protocols?

What are some of the barriers to establishing an abuse task force?

Awareness & Knowledge of Abuse

What kind of information would you like to know about abuse?

Are you aware of the reasons why women stay in abusive relationships?

Are you familiar with the abuse literature in the health care setting?

Have you read any articles about abuse in recent scientific journals?

Are you aware of the epidemiologic information of abuse (i.e., prevalence, incidence rate, patterns of abuse, risk factors, economic costs, and outcomes)?

Are you aware of possible risk factors and/or poor maternal and infant outcomes in abused women who are pregnant?

Do you know of any other research in the area of abuse going on at the hospital?

Social Change

What do you expect the benefits to be of routine screening in the ER?

How would you change the current reporting system of abuse?

Would you like to see the current ER in-take sheet have a field for DV?

How would you feel about implementing 5 extra standard questions (AAS) on the in-take sheet?

What are your concerns about the proposed SA program expansion?

Do you feel women who visit the emergency department have an opportunity to disclose psychosocial issues in private without the presence of a partner or family/friend?

Has there been any intervention that has changed your screening practices?
 Do you find your work more complicated and time-pressured when patients disclose?
 What are the challenges in giving care to victims of abuse?
 What are the most difficult parts for you personally and professionally?
 Can you tell me about the rewards or gratification you get from working with patients who are victims of abuse?
 A lot of physicians feel that "getting involved" means lots of time in court and possibly getting sued. Is this a concern of yours?
 Do you think that health care professionals who elect to work in any consistent way with victims of abuse would describe being marginalized by colleagues and institutions. Do you think they may report serious economic, social, and psychological disincentives to providing care for this population?
 What do you see happening to screening protocols in the future?

SARS

How has SARS changed the ER?
 How has SARS impacted the abused woman at triage?
 Do you feel as though SARS policies and practices are going to change the ER permanently?
 How do you perform your job differently with the threat of SARS?
 What are the pros and cons of implementing SARS policies and practices for patients and employees?

Demographic Characteristics

What is your age?
 What is your occupation?

Interview Closure

Do you have any questions?
 Would you like to meet again?
 Would you like to keep in contact?
 Would you like to have copies of the tape made from this interview?
 Do you know of anyone else who may be interested in being interviewed?
 Would you like me to send you a copy of my abstract?

Appendix F

Information Sheet & Consent Form

The purpose of this study is to find out about health care provider experiences' of abuse in the health care setting and to determine from you how best to identify and discuss issues of abuse/violence. This will involve being asked questions about screening practices for abuse. Your experiences with issues of abuse in the emergency department will be explored. It is important to hear from health care providers themselves if we are to understand the serious problem of violence against women. Understanding health care provider attitudes and experiences in screening practices through qualitative methods may provide guidance for clinical practice and research and surveillance with this population.

This consent form provides you with assurance that your identity will be protected. This interview is not intended to exploit you in any way.

Please read over the following carefully and sign at the bottom to indicate that you understand what you have read.

This interview will be used for Kathleen Moss's research towards her thesis at Carleton University.

This interview may be used for publications in the future.

In order to protect my identity and to respect my privacy, Kathleen Moss will use pseudonym (a false name) for my name in any reproduction of parts of this interview. All information which leaves the hospital will be coded and will not be identifiable by name. No records bearing my name will leave the Hospital.

I have a right to end the interview or to not answer all of the questions asked.

I have the right to withdraw from the study at any time without providing the investigator with a reason and this decision will not affect my work environment or employment the hospital at this time, or in the future.

If any new information about the study becomes available that might affect my willingness to participate in the study, Kathleen Moss will inform as soon as possible.

All results of the study will be kept confidential, unless I indicate that there is a risk or harm to an existing child.

I may be contacted for more than one interview.

If I want to contact Kathleen Moss to discuss the study at a future date I can.

If I have any questions about my rights as a research subject, I may contact the Chairperson of the Ottawa Hospital Research Ethics Board at (613) 761-4902.

To satisfy the Ethical Review Board at Carleton University, the interview tapes will be destroyed 6 months after the thesis has been successfully defended. If I want my personal tapes, I must alert Kathleen Moss before the thesis has been defended. All participants will be given notice of the date for the thesis defense.

I have read this Patient Information Sheet and/or Consent Form (or have had this document read to me), and have had an opportunity to ask the investigator any questions I had about the study.

My questions and/or concerns have been answered to my satisfaction and I agree to participate in this study. If I decide at a later stage in the study that I would like to withdraw my consent, I may do so at any time.

A copy of the Information Sheet and/or Consent Form will be provided to me should I want to review the information at a later date, if I need to contact someone about the study or my participation in the study, or simply for my records.

Signatures

Participant's Signature

Date

Participant's Name (printed)

The investigator acknowledges that this consent form has been read and understood.

Investigator/ Delegate's Signature

Investigator/ Delegate's Name (printed)

Study Contacts

Investigator:

Kathleen Moss

PhD Candidate

Department of Sociology

Carleton University

(613) 228-4199

Carleton University contact:

Steven Prus, PhD sociology

(613) 520-2600 ext. 3760

Ottawa General Hospital contact:

Civic Campus

Halina Siedlikowski, M.Nurs

Co-ordinator of the Regional Sexual

Assault Treatment Program &

Domestic Violence

Program

(613) 798-5555 ext.16555

Appendix G

NODE LISTING

Nodes in Set: All Nodes

Number of Nodes: 139

- 1 Demographics of SA & DV
- 2 More SA or DV
- 3 Patients being abusive towards staff
- 4 Sexual Health Clinic
- 5 Visit ER due to injuries, not just t
- 6 (1) /Physician training
- 7 (1 1) /Physician training/Educational training
- 8 (1 2) /Physician training/More training in
- 9 (1 3) /Physician training/medical hierarchy
- 10 (1 4) /Physician training/Awareness of community resources
- 11 (2) /Barriers-physicians
- 12 (2 1) /Barriers-physicians/why nurses may not ask the Q
- 13 (2 2) /Barriers-physicians/Cultural issues
- 14 (2 3) /Barriers-physicians/Time constraints
- 15 (2 4) /Barriers-physicians/Legal aspect
- 16 (2 5) /Barriers-physicians/Professionally marginalized
- 17 (2 6) /Barriers-physicians/Privacy
- 18 (2 7) /Barriers-physicians/Lack of training
- 19 (2 8) /Barriers-physicians/To establish a task force
- 20 (2 9) /Barriers-physicians/Age gradient
- 21 (2 10) /Barriers-physicians/Gender issue
- 22 (2 11) /Barriers-physicians/Comfort level
- 23 (3) /Barriers-nurses
- 24 (3 1) /Barriers-nurses/Privacy
- 25 (3 2) /Barriers-nurses/Time consuming-nurses
- 26 (3 3) /Barriers-nurses/Nursing comfort level
- 27 (3 4) /Barriers-nurses/Opening Pandora's box
- 28 (3 5) /Barriers-nurses/Forget to ask
- 29 (3 6) /Barriers-nurses/What questions to ask
- 30 (3 7) /Barriers-nurses/Embarrassment & shame
- 31 (3 8) /Barriers-nurses/Having resources available
- 32 (3 9) /Barriers-nurses/Age gradient
- 33 (3 10) /Barriers-nurses/Affects credibility
- 34 (4) /Addressing abuse in the ER
- 35 (4 1) /Addressing abuse in the ER/Abuse a health problem~
- 36 (4 2) /Addressing abuse in the ER/concern about abuse
- 37 (4 3) /Addressing abuse in the ER/Future Directions-nurses
- 38 (4 4) /Addressing abuse in the ER/Awareness with signs
- 39 (5) /Abuse Screening tool- nurses
- 40 (5 1) /Abuse Screening tool- nurses/Identification increased-nurses
- 41 (5 2) /Abuse Screening tool- nurses/Implementation of tool
- 42 (5 3) /Abuse Screening tool- nurses/Other tools
- 43 (5 4) /Abuse Screening tool- nurses/Question format
- 44 (5 5) /Abuse Screening tool- nurses/screen all women
- 45 (5 6) /Abuse Screening tool- nurses/Priority
- 46 (5 7) /Abuse Screening tool- nurses/Reasons some might not disclose
- 47 (5 8) /Abuse Screening tool- nurses/A professional tells story,

48 (5 9) /Abuse Screening tool- nurses/Ignorance
 49 (5 10) /Abuse Screening tool- nurses/Benefits of screening
 50 (6) /Patient demographics-Nurses
 51 (6 1) /Patient demographics-Nurses/Ethnicity
 52 (6 2) /Patient demographics-Nurses/SES
 53 (6 3) /Patient demographics-Nurses/Police
 54 (6 4) /Patient demographics-Nurses/Repeats
 55 (6 5) /Patient demographics-Nurses/Mental illness
 56 (6 6) /Patient demographics-Nurses/Patients reaction to screening Q
 57 (6 7) /Patient demographics-Nurses/Patients interpretations of abuse
 58 (7) /SARS
 59 (7 1) /SARS/nurses
 60 (7 2) /SARS/physicians
 61 (8) /Hospital structure
 62 (8 1) /Hospital structure/ER renovations
 63 (8 2) /Hospital structure/Funding
 64 (9) /Role of SA and ER SW- nurse~doc
 65 (10) /Nursing training
 66 (10 1) /Nursing training/Educational training
 67 (10 2) /Nursing training/More training in~
 68 (10 3) /Nursing training/Nursing hierarchy
 69 (11) /Hospital protocol
 70 (11 1) /Hospital protocol/ER process
 71 (11 2) /Hospital protocol/Nursing process
 72 (11 3) /Hospital protocol/Census
 73 (12) /Abuse screening tool-physicians
 74 (12 1) /Abuse screening tool-physicians/Screen all women
 75 (12 2) /Abuse screening tool-physicians/Implementation of tool
 76 (12 3) /Abuse screening tool-physicians/Identification increase
 77 (12 4) /Abuse screening tool-physicians/Priority
 78 (12 5) /Abuse screening tool-physicians/Benefits of screening
 79 (12 6) /Abuse screening tool-physicians/Reasons some may not
 disclose
 80 (12 7) /Abuse screening tool-physicians/Question format
 81 (12 8) /Abuse screening tool-physicians/More involvement in SA team
 82 (12 9) /Abuse screening tool-physicians/Individual cases of
 disclosure
 83 (12 10) /Abuse screening tool-physicians/Definition of abuse is
 vague
 84 (12 11) /Abuse screening tool-physicians/Implementation of SA centre
 85 (12 12) /Abuse screening tool-physicians/Methods to raise awareness
 86 (13) /Patient demographics-physician
 87 (13 1) /Patient demographics-physician/Ethnicity
 88 (13 2) /Patient demographics-physician/SES
 89 (13 3) /Patient demographics-physician/Police
 90 (13 4) /Patient demographics-physician/Repeats
 91 (13 5) /Patient demographics-physician/Mental illness
 92 (13 6) /Patient demographics-physician/Patient reaction to screening
 93 (13 7) /Patient demographics-physician/Patients interpretations of
 abuse
 94 (13 8) /Patient demographics-physician/Age of victims
 95 (14) /SATP and DVTP
 96 (14 1) /SATP and DVTP/coordinators role
 97 (14 1 1) /SATP and DVTP/coordinators role/Role of SA nurse
 98 (14 1 2) /SATP and DVTP/coordinators role/Are staff clear on the SA
 program~
 99 (14 1 4) /SATP and DVTP/coordinators role/SW working in the program

- 100 (14 2) /SATP and DVTP/Who qualifies for SA or DV program~
- 101 (14 3) /SATP and DVTP/Social supports in community
- 102 (14 4) /SATP and DVTP/Follow-up issues
- 103 (14 5) /SATP and DVTP/Format of screening Q
- 104 (14 5 1) /SATP and DVTP/Format of screening Q/Gov't mandate
- 105 (14 5 2) /SATP and DVTP/Format of screening Q/Implementation of tool
- 106 (14 5 3) /SATP and DVTP/Format of screening Q/Chart audit
- 107 (14 5 4) /SATP and DVTP/Format of screening Q/Identification
increased
- 108 (14 5 5) /SATP and DVTP/Format of screening Q/Follow-up training
sessions
- 109 (14 6) /SATP and DVTP/ER conducive to disclosure~
- 110 (14 7) /SATP and DVTP/Privacy issues
- 111 (14 8) /SATP and DVTP/Justifying screening
- 112 (14 9) /SATP and DVTP/Patient demographics- SW
- 113 (14 9 1) /SATP and DVTP/Patient demographics- SW/Ethnicity
- 114 (14 9 2) /SATP and DVTP/Patient demographics- SW/SES
- 115 (14 9 3) /SATP and DVTP/Patient demographics- SW/Police
- 116 (14 9 4) /SATP and DVTP/Patient demographics- SW/Repeats
- 117 (14 9 5) /SATP and DVTP/Patient demographics- SW/Mental illness
- 118 (14 10) /SATP and DVTP/Abuse~risk taking behaviours
- 119 (15) /Focus group
- 120 (15 1) /Focus group/Role of SA nurse or nurse practitioner
- 121 (15 2) /Focus group/Police involvement
- 122 (15 3) /Focus group/Increase in DV or SA
- 123 (15 4) /Focus group/Role of SW
- 124 (15 5) /Focus group/Format of screening Q
- 125 (15 6) /Focus group/Background on DV and SA centres
- 126 (15 7) /Focus group/SARS
- 127 (15 8) /Focus group/Barriers
- 128 (15 8 1) /Focus group/Barriers/Privacy
- 129 (15 9) /Focus group/Hospital structure
- 130 (15 9 1) /Focus group/Hospital structure/Restructuring
- 131 (15 10) /Focus group/Future training
- 132 (15 11) /Focus group/Criteria for program
- 133 (15 12) /Focus group/Patient demographics
- 134 (15 12 1) /Focus group/Patient demographics/Mental illness
- 135 (15 12 2) /Focus group/Patient demographics/Date rape drug
- 136 (15 12 3) /Focus group/Patient demographics/Age gradient SA theory
- 137 (15 13) /Focus group/Methods to raise awareness
- 138 (15 14) /Focus group/Benefits to screening
- 139 (15 15) /Focus group/Future direction of Q

Appendix H

HOSPITAL SARS SCREENING TOOL

Name:

Circle as appropriate: Patient ~~Visitor~~ Employee**SECTION A: Are any of the following true?**

Have you been to China, Hong Kong, Vietnam, Singapore or Taiwan in the last 10 days?

☐ Yes ☒ No

Have you been to any GTA hospital in the last 10 days?

☐ Yes ☒ No

Have you been to the Scarborough Grace/ York Central Hospitals in the last 10 days?

☐ Yes ☒ No

Have you had contact with a person with or under investigation for SARS in the last 10 days?

☐ Yes ☐ No**SECTION B: Are you experiencing any of the following symptoms?**

Fever

☒ Yes ☐ No

Myalgia (muscle aches)

☐ Yes ☒ No

Malaise (severe fatigue or unwell)

☐ Yes ☒ No

Severe headache (worse than usual)

☒ Yes ☐ No

Cough

☐ Yes ☐ No

Shortness of Breath

☐ Yes ☐ No**Disposition:**

- ☐ Go home and contact Occupational Health
- ☐ Go home and contact Public Health
- ☐ Go home and contact your family physician
- ☐ Employee sent to Occupational Health
- ☐ Go to Emergency for assessment
- ☐ Access to facility ☐ Yes

INTERVIEWER NAME:

Signature:

Date:

Appendix H

Health Questionnaire for ALL VISITORS and PATIENTS STAFF, STUDENTS AND VOLUNTEERS

UPON ENTERING HOSPITAL

Please answer the following questions and
follow the Directives

1. Do you have any of these symptoms?

• Severe muscle aches <u>OR</u>	☐ NO	☐ YES
• New / worse cough <u>OR</u>	☐ NO	☐ YES
• New / worse shortness of breath <u>OR</u>	☐ NO	☐ YES
• Severe tiredness or feeling unwell <u>OR</u>	☐ NO	☐ YES
• Feeling feverish, had shakes or chills in the last 24 hours <u>OR</u>	☐ NO	☐ YES
• Severe headache (worse than usual) <u>OR</u>	☐ NO	☐ YES
• Diarrhea	☐ NO	☐ YES

2. Have you been exposed to an infectious disease?

▪ Have you had contact with a person with an infectious disease in the last 10 days?	☐ NO	☐ YES
▪ Have you been in a healthcare facility closed due to problems with an infectious disease in the last 10 days?	☐ NO	☐ YES
▪ Has Public Health asked you to be on home quarantine or isolation in the last 10 days?	☐ NO	☐ YES

Directives

- If you are a visitor and have answered YES to any of the SYMPTOMS listed in question 1, please DO NOT VISIT!
- If you are a visitor, are symptom free but have answered yes to any of the items in question 2, please speak to a nurse on the unit prior to visiting.
- If you are a patient here for an appointment and have answered YES to any of the SYMPTOMS listed in question 1, proceed to your appointment and notify staff of your symptoms.
- If you are a staff member, student or volunteer and answer YES to any of the items listed in questions 1 or 2, please report to Occupational Health and Safety Services.

Thank you for helping us protect our patients and staff.

August 2003