

# **Critical Analysis of Literature about Hospital Emergency Rooms and Effective Protocols for Victims of Domestic Violence**

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## **Abstract**

Violence against intimate partners is a public health problem. Diseases can be diagnosed and then treated. Advances in epidemiology have sparked the prevention of many diseases. Thus, in the public health model, the prevention of violent acts can only be achieved through the diagnosis of particular dangerous environments where domestic violence is commonplace. In addition, high-risk groups can be identified and treated to prevent future rates of recidivism. Possible solutions to minimize risk factors of this public health problem are examined through statistics surrounding environments that continually produce violent domestic acts. Programs for detecting and reporting intentional injury can be constructed for use in Emergency Departments to alleviate this public health problem.

## **An Overview and Purpose**

Hospital emergency rooms are located in strategic areas throughout the country, and place thousands of health care workers in continuous contact with victims of violence. According to Justice Department estimates, "Emergency rooms at hospitals across the country are treating more than 1.3 million people a year for injuries caused by violent attacks, an increase of 250 percent over previous government estimates" (Lardner, 2003, p. 1). This critical analysis focuses on domestic violent injuries that represent a total loss of almost 8 million days of paid work per year in the United States. This translates into 32,000 full-time positions (Gerberding, Binder, Hammond & Arias, 2003). These statistics exemplify the enormous cost of domestic violent acts to American society. This incredible upsurge in violent injuries in the United States and the resulting costs have made it imperative that all healthcare workers receive proper training to recognize victims of violence upon contact. This may prevent future domestic violent injuries.

Men are the victims of violence more often than women according to the Justice Department. In fact, statistics showed that men represented 60% of violent injuries presenting at emergencies with women representing the remaining 40%. However, women are more likely to sustain violent injury in the home or in a familiar place by an intimate relation such as a husband, wife or significant other (Lardner, 2003, p. 1). Protocols for early detection and intervention in cases of domestic and external violence need to be incorporated into the operations of hospital emergency rooms to reduce the effects of intentional injury.

Direct questions can be routinely asked during patient interviews to encourage patients to reveal violent acts. It is important that health professionals maintain non-accusatory language in dealing with possible victims of violence. Health professionals have the ability to identify, assess, refer and report the intentional domestic injury. With training and commitment, it is possible to reduce the effects of this significant public health problem. The purpose of this review is to critically analyze theoretical and empirical literature about the effectiveness of hospital emergency rooms protocols for victims of domestic violence. This review will additionally identify and examine areas of future scholarly inquiry.

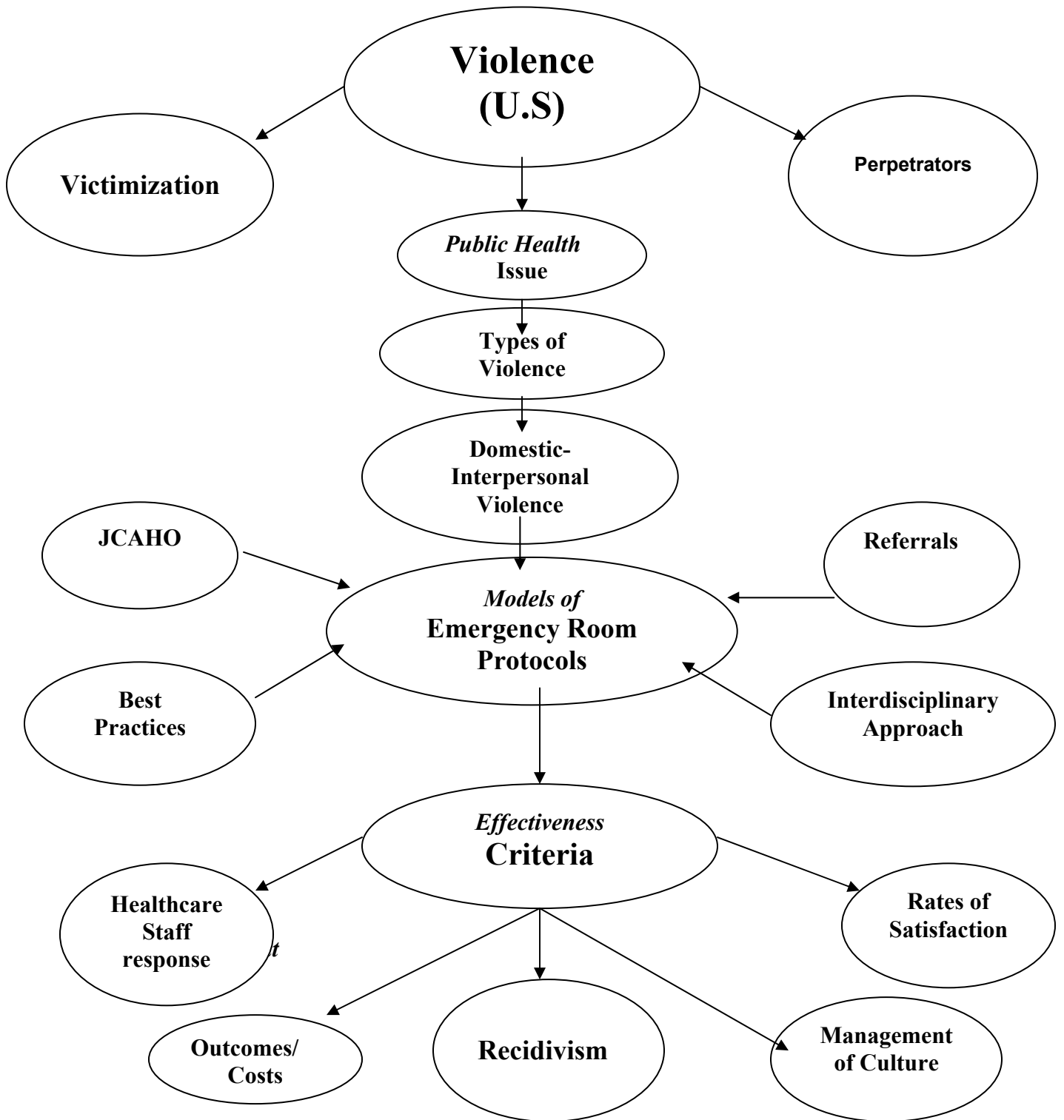
### **Organization of the Review**

The organizational approach of this review evolved from the various authors who have done research on this subject matter. A literature map has been constructed to visually define the key concepts and ideas as well as to show the relationships between the concepts of this review (See Figure 1). Concepts that are included in the literature map set the organization of the literature review section of this review. The literature map begins by introducing violence in the United States and distinguishes between the victim and the perpetrator. The literature map next presents the focus of the review on domestic violence specifically and then presents the models of emergency room protocols researched and finally effectiveness criteria of the protocols reviewed.

### **Significance and Rationale for the Critical Analysis**

According to Lardner, "Emergency rooms at hospitals across the country are treating more than 1.3 million people a year for injuries caused by violent attacks, an increase of 250% over previous government estimates"(Lardner, 2003, p. 1). Concurrently, in 75% of single offender violent attacks against women and 45% of violent attacks consisting of multiple attackers, the victim knew the perpetrator (Bachman & Saltzman, 1995). These statistics exemplify the current significance of interpersonal violence in the United States. This review focuses on the national problem that exists in the United States; however, this serious issue is not limited to the United States but can be expanded to encompass similar global issues. Critical analysis of literature regarding hospital emergency rooms and effective protocols for victims of domestic violence has become necessary due to the enormous increase in domestic violence attacks in the United States.

Figure 1 Literature Map



As the rates of domestic violent attacks continue to drastically rise and victims of attacks continue to present in the hospital emergency rooms for treatment, it is important to understand the impact on society such as healthcare workers, victims, perpetrators, costs to society and government agencies. This critical analysis of the literature concludes with a summary and interpretations of theoretical and empirical studies and provides conclusions and recommendations for future scholarly inquiry into effective protocols for victims of domestic violence.

## **Review of the Literature Regarding Effective Protocols for Victims of Violence**

### **Violence in the United States**

Violence in the United States is very pervasive and is able to change the quality of life in America. The empirical study from the Center for Disease Control utilizes statistics obtained for the year 1997 regarding various types of violent acts and in some cases resulting homicides to exemplify how significant the problem is. The report showed that on an average day in the United States, 53 persons die from homicide, 84 persons commit suicide, approximately 3,000 people attempt suicide and at least 18,000 people survive domestic assaults (CDC, 2003, p. 4).

### **Victimization and Perpetrators of Violence**

Statistics show that much of the violent crime that is committed in the United States today can be attributed to a very small percentage of people. According to the 1997 empirical study completed by the Centers for Disease Control, Healthy People 2010, victims of homicide are higher for African American and Hispanic youths. The homicide rates of African American males and females aged 15 to 24, in 1995, were twice the rate of Hispanics and 14 times the rate of white non-Hispanics (CDC, 2003).

Similarly, an empirical study completed in 1995 by Bachman and Saltzman, indicated that women (ages 12 and older) were victims of almost 5 million violent crimes in 1992 and 1993. The study completed in survey form by Bachman and Saltzman was entitled *National Crime Victimization Survey (NCVS)*. The NCVS obtains information about crimes reported to police as well as unreported crimes from a continuous national sample of household in the United States. The study interviewed approximately 50,000 households including 100,000 people over the age of 12. The survey had been redesigned, from the previous study, to include incidents of rape and sexual assault by intimates or family members. The NCVS study indicated that 75% of single offender violent attacks and 45% of attacks involving multiple offenders were at the hands of someone that the victim knew such as a husband or ex-boyfriend (Bachman & Saltzman, 1995). Victims of violent crime are included in statistical data that could be used to point out potential geographical areas of danger, activities of concern and groups at high risk of violence. Prevention of future violence can only be achieved after the violent act is brought to the attention of the health care provider.

The study by Bachman & Saltzman failed to discuss whether younger female trauma victims are more likely to be battered than older women. The study does suggest

that there are many reasons why women, in particular, choose not to report incidents of violence because of perceived societal stigmas (Bachman & Saltzman, 1995). By uncovering this theory of unreported victimization, the authors make it clear that many people are unaware that someone they know is likely to have been the victim of interpersonal violence. For this reason, one can conclude that all suspected domestic abuse must be identified and reported to the proper authorities.

### **Violent Acts as a Public Health Issue**

The Public Health approach domestic violence prevention requires that protocols for early detection and intervention in cases of domestic and external violence be incorporated into the operations of hospital emergency rooms to reduce the effects of intentional injury. Furthermore, the public health approach to domestic violence details the risk that all people in the United States have during their lives to suffer significant injuries at the hand of an intimate partner. The public health approach suggests that many domestic-related injuries are not accidents but are controllable, predictable, and thus preventable (CDC, 2003). If healthcare professionals in the United States are able to predict the risk factors involved in domestic injuries, the chance of preventing future violence is increased to a higher level.

### **Types of Violence**

There are various types of violence reported and unreported in the United States. Examples are homicide, rape/sexual assault, robbery, aggravated assault, simple assault and domestic interpersonal violence (Bachman & Saltzman, p. 2). The patterns of victimization are very different by sex of the victim. According to the NCVS study, Bachman and Saltzman cited that women annually report 500,000 rapes and sexual assaults, about 500,000 robberies and 3.8 millions assaults. Women were 10 times more likely to be victims of rape and sexual assaults according to the study. On the other hand, the rates of robbery and aggravated assault against men were double than those against women. These reports were made directly to NCVS interviewers in 1992 and 1993 (Bachman & Saltzman, p. 2).

A theoretical article on the identification, diagnosis and management of spouse abuse for physicians conducted by Brannen, Bradshaw, Hamlin, Fogarty and Colligan, in 1999, concentrates on implementation of measures to manage domestic violence in a military setting. This article suggests that since the physician is the first non-family member to come in contact with an abused woman, it is critical that the physicians are made aware of the severity of this problem. Physicians and healthcare personnel must be taught to intervene, provide information on referrals and become familiar with legal options for the victims of violence. This article takes a step further by introducing verbal and psychological abuse as significant forms of violence.

Physical violence is generally believed to consist of three subtypes of abuse: minor physical, severe physical and sexual abuse (Brannen, Bradshaw, Hamlin, Gogarty & Colligan, 1999, p. 2). Routine direct questioning regarding these three types of abuse in the hospital emergency room would significantly help to assess victims of violence.

Many women do not recognize themselves, as being abused and that there are alternatives for them to prevent further abuse.

### **Domestic-Interpersonal Violence**

The term domestic violence, or interpersonal violence, is a generic term used to refer to abusive or assaulting behavior between people who know each other. These people are intimates such as members of a family or current or former partners. By domestic, the violence may refer to various types of relationships in which violence occurs and it is useful because it separates the intimate nature of the violence from acts of violence from a stranger. C. Everett Koop, in 1992, declared domestic violence to be a national epidemic. Furthermore, 30 to 50% of female homicides are committed by current or past partners. The majority of victims of murder had either previously been treated by emergency room physicians or had reported the injuries to the local police (Clark, 2003). In the United States, the rate of violent injury has risen to the extent that the traditional law enforcement agencies are unable to overcome the problem. For this reason, it is very important that health care providers in hospital emergency rooms make a serious attempt to diagnose each case as they are admitted into the medical system.

Bell, Kpo and Rhodes initiated an empirical study of 50 hospital emergency rooms in 1994 to explore whether emergency rooms in a metropolitan county in the United States had proper standard procedures to offer service to patients who were victims of interpersonal violence. A questionnaire containing 55 questions was sent to hospitals specifically asking them about their procedures for handling victims of interpersonal violence. Although the survey determined that 75% of the hospitals had protocols set to handle abuse of the elderly, the hospitals most often responded only to victims in areas where they were mandated by law to respond. The areas that the hospitals had well developed procedures for handling violence in this study were child abuse and sexual assault. The study concluded that most emergency rooms do not have adequate systems for conducting epidemiologic surveillance of interpersonal violent acts. The conclusion made by this study was that protocols, services and referrals of victims of interpersonal violence must be all mandated by law or standards of treatment (Bell, Kpo & Rhodes, 1994).

This Bell, Jenkins, Kpo and Rhodes study sample was relatively small and should have included rural in addition to metropolitan hospital emergency rooms to get a better view of the services provided to victims of interpersonal violence across the United States. The Suggestions for utilizing the information retrieved from surveillance initiatives include the development of rape crisis centers, programs for children who experience domestic violence and batterer prevention programs. Programs such as these can be designed to decrease the incidence as well as the severity of violence that is perpetrated by individuals toward intimate partners.

### **Models of Emergency Room Protocols Joint Commission on the Accreditation of Healthcare Organizations (JCAHO)**

In 1991, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) mandated procedures for assessment of victims of domestic violence in all JCAHO accredited hospital emergency rooms in the United States (Schroeder & Weber, 1998). The problem is that not all hospitals are accredited by JCAHO and the hospitals that are often do not have the necessary protocols in place. Another issue that exists is that victims of interpersonal violence often do not volunteer information on the abuse. Although protocols required by JCAHO may technically be set up at the hospitals, healthcare professionals in the emergency rooms lack the knowledge and training to ask the appropriate questions to persuade them to divulge the domestic violence.

### **Best Practices**

Sacred Heart Medical Center in Spokane, WA, responded to the JCAHO mandate to develop comprehensive hospital protocols for assessment of victims of domestic violence, in 1991 by developing a comprehensive policy and training program. The protocol specifically addressed three areas of domestic violence: public education, medical professional education and patient care. Before this program was implemented, the hospital records indicated that only 4% of patients were identified as victims of domestic violence. In 1995, after over three years of enforcement and training, the percentage of victims of domestic violence raised to 35%, which earned the hospital the Catholic Health Association's Achievement Citation Award (Schroeder and Weber, 1998). This program is an example of "best practices" in healthcare in that it is a project that strives to improve the health of the people in the community.

Hospitals that initiate best practices not only implement programs that improve the health of the community, but also work toward developing bonds with the community at the same time. Some criteria for best practice models include programs that are universally accessible, available 24 hours per day and 7 days per week, divert victims from hospital admissions, provide appropriate screening and assessment, provide referrals and have evaluation tools in place (Central South Mental Health Implementation Task Force, 2001).

### **Outcome/Costs**

In regard to the costs of interpersonal violence other than emotional, Gerberding, Binder, Hammond and Arias calculated that victims lose a total of almost 8 million days of paid work in a year and \$4.1 billion in direct medical and mental health care (Gerberding, Binder, Hammond & Arias, 2003). The estimated number of emergency department visits for physical assaults against women was 241,103 in 1995. The total estimated cost per physical assault requiring emergency room care for these patients was \$658.79/case. This exemplifies the enormous cost of violent acts to American society. It is very important that law mandate social services referrals for these victims domestic violence.

## **Summary and Interpretations**

The literature reviewed established the importance of understanding the definition of domestic violence as a public health issue and of instituting training and education of domestic violence intervention techniques for all healthcare workers. The literature also maintained that training and educating staff regarding domestic violence, JCAHO requirements, best practices, referrals, and all areas of effectiveness criteria will help to prevent future acts of domestic violence and promote the health of the American population.

The research evidence consistently demonstrates that violence is one of the largest health problems faced in the United States at this time. Concurrently, the theoretical literature is that all employees of hospitals including non-clinical staff require training in the identification of domestic violence and appropriate response to the victims of the violence. Bachman and Saltzman contend that estimating rates of domestic and interpersonal violence is extremely difficult because of the many factors that inhibit victims from reporting the acts of violence (Bachman & Saltzman, 1995). Additional study into protocols for detecting domestic violence and effectiveness of current models of emergency room protocols is needed due to the inaccuracy of the data reported by victims of domestic violence.

## **Conclusions**

This review contends that it is the responsibility of health care providers to attend to the needs of victims of violence. The emergency room has the opportunity, unequaled by any other agency, to identify, intervene and treat victims of violence. Unfortunately, patients are often too ashamed or afraid to get help from social service agencies and therefore seek the anonymity of the impersonal hospital facilities. Healthcare professionals in the emergency room are vital to the timely identification and intervention of domestic violence. The recommendation of this review is to implement routine screening for patients who enter hospital emergency rooms to determine the possibility of interpersonal violence. To accomplish this task, all healthcare staff must be given in-depth training about domestic violence. In addition, each hospital must develop protocol for documentation and for making decisions on assessment and referrals to appropriate agencies.

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