Intimate partner violence against women: To screen or not to screen in the emergency department?

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The Recommendation Statement from the Canadian Task Force on Preventive Health Care (CTFPHC) on the prevention of violence against women was published in the Sept. 16, 2003, issue of the *Canadian Medical Association Journal*.[1] It does not recommend for or against screening for intimate partner violence (IPV), due to insufficient evidence. Although this may seem like a blow to women's advocacy groups and health organizations, the CTFPHC recommendation gives emergency physicians and nurses some direction based on existing evidence; it suggests we should not expend limited emergency department (ED) resources on IPV screening until it is clear that such screening does more good than harm.

Partner violence is a serious heath and social problem but, for a variety of reasons, EDs deal with it less effectively than with other health problems. There are many IPV screening tools — some are even validated in ED settings — but like most screening tests, these have false-positives and false-negatives that may lead to adverse consequences.[2] In addition, studies have shown that universal screening for IPV is not universally accepted by women who present to the ED for treatment, nor universally applied by ED staff.[3–6] In settings where ED staff compliance with IPV screening has been high, this compliance has been short-lived.[4–7] There is also evidence that when patients provide information suggesting IPV it is not always acted upon by ED staff.[4] Most important is the fact that there is insufficient evidence of effective treatment for IPV victims.[8] Hence the CTFPHC recommendation.

The difference between screening, case finding and diagnosis must be understood. Screening is applied universally to a convenient population; for example, all adult women attending the ED. Case finding refers to the application of diagnostic tests to patients who belong to a high-risk group but present for (apparently) unrelated illness. To illustrate, an ED might "case-find" in patients with suspicious or high-risk presentations. Diagnosis involves identifying the cause of the problem that triggered the ED visit; so, although emergency staff should consider IPV in the differential diagnosis for any adult female patient who presents with evidence of assault, this would not be considered screening or case finding. Therefore, while the task force does not advocate "screening" all ED patients, their recommendations do not preclude "case finding" among patients with suspicious or high-risk presentations, or treating victims of IPV.

If there is insufficient evidence for or against IPV screening, why do leading medical organizations advocate for it? Most important, the prevalence of IPV in women attending EDs in the US is high, and the outcome is sometimes fatal.[3,9] Not screening might be construed as lack of concern about an important woman's health and emergency medicine issue. It is important, however, to consider the potential harm related to inaccurate or ineffective screening.[7] Patients whose screening results are false-negative may believe they do not meet some defined criteria and are ineligible for assistance. They may, therefore, remain at risk without further attempts to seek help. Similarly, false-positive results of screening might lead to conflict within the relationship or unnecessary separation. Furthermore, the time and resources spent on IPV screening are time and resources taken away from other investigations and treatment for which there is good evidence.

In short, IPV screening policies lack evidence of effec-

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tiveness and are not well supported by ED providers. If and when randomized controlled trials provide evidence that the ED is an appropriate site for IPV screening and that effective treatment exists, screening policies can be implemented with the necessary supporting resources. Until then the best and perhaps safest course of action is to recognize that IPV is a serious health problem with a measurable mortality rate, that many of these victims will present to the ED for help, and that health practitioners are obligated to provide the best available care for all identified IPV victims. This should generally include a social work consultation (if available), identification of children at risk, information about available community resources, and assistance in finding a safe shelter. In the interim, emergency physicians can serve IPV victims best by collectively lobbying for funding to support high quality, ED-based studies to discover the most accurate IPV screening methods and the most effective interventions.

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Editorial comment:

What do you do when a patient that you suspect has been assaulted gives an unbelievable history of injury? My own approach goes like this:

"You know, I've been working in ERs for a long time, and I've seen this kind of injury before. Most of the time this kind of injury occurs from someone being hurt by someone else. Is there something I could do to help prevent you from being hurt again?"

It's not surprising that this kind of open but non-confrontational approach brings out tears or further information. My only intention is to not be antagonistic. Many of these patients have already had to deal with too much hostility. Offer help kindly, and sometimes it will be accepted.

Do you think we should be spending time and resources trying to make a dent in this recalcitrant and often unmanageable problem? Send us your comments.

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