Editorial

Domestic violence in the emergency department: to screen or not to screen?
家庭暴力：应否在急症室筛查？

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In 1985, Mackay and Lo published the first study of 50 battered wives in the emergency department (ED) in Hong Kong.¹ The authors advocated a refuge for these battered wives who had nowhere to go. In fact, Harmony House introduced the first shelter in the same year. Since the 90s, more studies done in local EDs and antenatal clinics have demonstrated that domestic violence (DV) was not uncommon in the healthcare setting.²⁻⁴ In 2005, a territory-wide household survey reported that the prevalence of physical injury by a spouse ever and in the preceding 12 months were around 10% and 4.5% respectively.⁵

A more integrated approach to the management of DV emerged in the 90s. The Social Welfare Department promulgated the first "Multi-disciplinary Guidelines on the Handling of Battered Spouses Cases" in 1996 in an attempt to co-ordinate services provided by different agencies. Similar guidelines were published by the Accident and Emergency Service Coordinating Committee of the Hospital Authority for all EDs. The basic approach at the ED is to identify and treat survivors of abuse and then refer them to the social service. This approach does not address the important public health issue of prevention. Screening for DV in the healthcare setting has been advocated by many organisations e.g. the American College of Emergency Physicians, and scholars as a strategy to identify non-acute victims for early social intervention.⁶

There are, however, considerable controversies about the benefit of universal screening. Before we adopt this strategy in the ED, there are many questions we need to answer. What screening tool should we be using? Will this be acceptable to the patients and staff? What services are available to identified victims? Finally, will universal screening improve outcome in terms of decreased exposure to violence without inadvertently causing harm for some cases?

Many screening tools have been validated and some tested in the local population.⁷ In this issue, Chan et al confirmed the "Reliability and validity of the 'Extended - Hurt, Insult, Threaten, Scream' (E-HITS) screening tool in detecting intimate partner violence in hospital emergency departments in Hong Kong". A simple tool may facilitate screening in the busy ED. However, there are other barriers to screening e.g. lack of time and privacy in the ED. In an Australian ED study, the screening rate was only 10% despite training and a simple tool.⁸

Acceptability of screening was found to be quite variable for patients and low for staff in a systematic review.⁹ In four surveys, 43 85% of women respondents found screening acceptable and two surveys found that two-thirds of physicians and almost half of ED nurses were not in favour of screening. In a local study, 30% of patients refused to participate in

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an interview to find out the prevalence of DV. Privacy belief and traditional cultural values were found to be important factors affecting the doctors’ and nurses’ willingness to enquire about DV in their patients. Screening may increase referrals to the social services. However, there are not many studies on positive health outcome of screening. In a randomised control study performed in Canada, no outcome benefit e.g. reduced violence could be attributed to screening though no harm was identified. A systematic review of ED studies likewise did not find evidence for the efficacy of screening on DV-related mortality or morbidity. The U.S. Preventive Services Task Force has found insufficient evidence to recommend for or against routine screening of women for intimate partner violence.

In this era of evidence-based medicine, it is unlikely that many local EDs will adopt universal screening. Even if there is a small benefit, there is still the question of whether screening would be cost-effective given the many demands on our time. That does not mean we should adopt a nihilistic stance. Assessing abuse in women with risk factors may prove to be a more fruitful approach. Obviously, more studies need to be done to fill the gaps in our knowledge especially in the area of effectiveness of different interventions. Meanwhile, we should still collaborate with other parties to explore different ways to provide more comprehensive and timely service to the patients in need. The ED certainly has an important role to play in combating violence in the society.

References

5. Chan KL. Study on child abuse and spouse battering: report on findings of household survey. Hong Kong: Department of Social Work and Social Administration, the University of Hong Kong; 2005.