

Hospital-Based Responses to Woman Abuse

How Well Are We Doing?

ROBIN MASON

En 1989, Santé Canada a lancé des lignes directrices pour les politiques et procédures pour aider les femmes violentées. A ce jour, il n'y a pas eu de vérification systématique de ces recommandations auprès des hôpitaux sauf un sondage récent effectué dans les hôpitaux à la grandeur de l'Ontario. Ce papier en rapporte les résultats ainsi qu'une étude qualitative des professionnels de la santé.

Canadian prevalence data about woman abuse, also known as intimate partner violence (IPV), or wife assault, draws from two different national studies that defined violence as ranging from verbal threats to acts of physical violence. The 1993 *Violence Against Women Survey*, (Statistics Canada 1993) asked women about experiences of violence and the context of those experiences, and reported that 25 per cent had been exposed to abuse by their marital or common-law partner. Six years later, the 1999 *Canadian General Social Survey on Victimization* (Statistics Canada 1999) asked respondents to consider episodes of violence experienced either in the previous 12 months or five years. This survey estimated that in the five-year period prior to the survey, eight per cent of women and seven per cent of men experienced violence by their intimate partner. Although the number of episodes was approximately the

same for men and women, women reported more serious forms of violence and more serious consequences of the violence than did men. For example, women are more than twice as likely to have been beaten, five times more likely to have been choked, and almost twice as likely to have been threatened with or to have had a knife or gun used against them (Patterson). Women were also found three times more likely to be injured by their partners and five times more likely to require medical attention for their injuries, than were men (Statistics Canada 1999).

Earlier studies indicate that 43 per cent of women injured by their intimate partners required medical attention (Statistics Canada 1993) and that between one-fifth and one-third of all women treated in hospital emergency departments present with injuries caused by their partners (AMA; McLeer and Anwar). It is also known that abused women use health services at rates higher than do women who have not been abused and men who have been abused, including more physician visits, emergency room visits, hospitalizations, and report poorer overall health (Trainor 2002; Hotch, Grunfeld, Mackay and Cowan, 1996; Coker, Remsburg and McKeown; Kernic, Wolf and Holt; Moeller, Bachmann and Moeller).

In 1992, estimates of the annual cost for medical treatment of abused women in Canada ranged from \$CDN 408 million (Greaves, Hankivsky and Kingston-Riechers) to \$1.5 billion (Day 1995). Early identification and treatment of victims and potential victims have been suggested as strategies to reduce health care costs (Wisner *et al.*) and act as primary prevention (Hyman *et al.*). Yet, hospitals have been seen as slow to respond to the needs of victim/survivors (Bell and Mosher; Hanvey and Kinnon) and have been said to have shown “little or no leadership” on the issue (Hanvey and Kinnon). Although the federal government has funded initiatives to raise awareness of the issue within the health care community, there exist no national hospital guidelines or provincial accreditation standards relating to woman abuse.

Through the Federal Family Violence Initiative, in 1989 Health Canada released guidelines for policies, procedures, and protocols to help victims of woman abuse. To date, there has been no systematic review of the ways in which hospitals' have responded to these recommendations. This paper begins addressing this gap by presenting results of an Ontario-wide hospital survey of practices addressing woman abuse and key findings from

a qualitative study of health care professionals.

The Federal Family Violence Initiative

In 1988 Canada launched a four-year Family Violence Initiative (FVI) to address the health, social, and justice issues related to family violence, including woman abuse. The FVI, primarily considered woman abuse a criminal justice issue, yet explicitly noted the important potential role of health care providers in both treating acute injuries and providing a timely intervention during regular health visits.

Acknowledgement of the health care professionals' role in identifying, treating and referring the victims of woman abuse increased after the first FVI. Between 1991-1995, the second iteration of the FVI was mandated specifically to "increase the sensitivity and awareness of health professionals to family violence issues, and to encourage the development of resource and training materials to assist health service providers to respond effectively" (Hoff ix). Since 1996, the FVI has received ongoing funding to achieve its mandate of promoting public awareness, strengthening the ability of the criminal justice and housing systems to respond to the problem, and, supporting data collection, research and evaluation (National Clearinghouse on Family Violence). The extent to which the hospital sector has voluntarily responded to these initiatives is unknown.

The Study

Toronto is Canada's largest city, the capital of the country's most populous province. The Woman Abuse Council of Toronto (WACT) is mandated to develop for Toronto, a coordinated, inter-sectoral response to violence against women across justice, social service and

health sectors. In 2002, WACT received funding from the Ontario Ministry of Health and Long-term Care and the Ontario Women's Health Council for a project to begin promoting consistency and accountability regarding the ways in which hospitals, locally and across the province, respond to woman abuse. Partners in this project included Education Wife Assault, a grassroots agency dedicated to informing and educating the public about woman abuse and the Ontario Hospital Association, an organization of health care providers working toward the improvement of health services in Ontario, through leadership, advocacy, education, communications and service.

Method

In order to meet the objectives of consistency and accountability in hospital settings, knowledge of existing practices and standards was required. Thirty-six questions were designed to gather information about hospital practices, resources, education and training, and barriers encountered in implementing a hospital based response. The survey was piloted in five communities across the province, revised, and mailed out by the Ontario Hospital Association to the province's 157 hospitals in April 2002. Of the 157 hospitals that received the survey, 91 responded (55 per cent). All regions of the province were represented. The data were analyzed using SPSS software (version 10).¹

A subsequent study in one downtown Toronto hospital included semi-structured interviews with nine female health care professionals to examine their experiences in trying to integrate woman abuse sensitive care into daily practice. Interview questions were designed to learn more about role issues, education and training, challenges and strategies in shifting knowledge about woman abuse into practice.

Subjects were five nurses, two physicians, one occupational therapist and one physiotherapist, working in various service areas throughout the hospital including labour and delivery, the operating room, post surgery and family practice. Interview participants had been in practice between one and 30 years. All interviews were audiotaped and transcribed. QSR N6² software was used to manage qualitative data and generate reports. Coding of the transcripts was conducted collaboratively by members of the research team. Over successive readings of the transcripts, codes were consolidated into major themes.

What is Known: Results of the Survey Data

Policies and Protocols

In 2002, 35 of the 91 (38 per cent) hospitals had organizational policies in place; another 23 (25 per cent) hospitals claimed that policies were in development. Further, 46 (50 per cent) hospitals had procedures or protocols in place and 18 (20 per cent) other sites stated protocols were in development. Details were lacking about whether the described policies and protocols applied to the entire organization, or to specific departments.

Training and Education

Of the 91 hospitals that responded in 2002, 44 (48 per cent) provided training and staff education, and another 13 (14 per cent) hospitals were in the midst of developing staff training. Almost one third of the respondents, or 33 (36 per cent) hospitals, offered no training on issues of woman abuse. Of those hospitals providing training, nurses were most likely to be trained, followed by allied health professionals (e.g., social workers) and physicians.

Quality Assurance/Accountability

To assess accountability or quality assurance strategies followed in

2002, hospital respondents were asked to select from a list of eight possible mechanisms of accountability (internal committee, annual report, chart audit, leave to the regulated professions, risk management, department heads, or other). Some hospitals had more than one system in place, while 56 (62 per cent) hospitals had no formal monitoring of their response to woman abuse. Twenty-two (24 per cent) hospitals conducted chart audits or reviews to track the hospital response. Another eleven (12 per cent) hospitals had an internal committee regularly review hospital activities, while 24 (26 per cent) other sites claimed some other form of accountability. An annual report covering activities related to woman abuse was produced in eleven (12 per cent) hospitals. Risk management committees oversaw the activities of three (three per cent) hospitals.

When asked to evaluate their hospital's response to woman abuse on a scale of one to five, from fully implemented, to the issue is not dealt with at all, 33 (35 per cent) respondents declared their hospital was about midway in its development. Twelve (13 per cent) hospitals claimed they had a fully implemented response including organizational policies, protocols, staff education and training. Of these hospitals, eleven (91 per cent) were home to one of the provincially funded sexual assault and domestic violence treatment programs.

What is Done: Results of the Interview Data

It's Everyone's Business

Participants were clear in their belief that health care professionals need to know about woman abuse and should have the skills to respond appropriately to patients who experience violence or abuse. At least one person stated that everyone employed in a hospital, in-

cluding the cleaning staff, should have some basic knowledge of woman abuse and be able to direct a patient to sources of help. Yet there was also acknowledgement that some professionals, for example hospital social workers, have greater access to resources that would be useful to a woman who discloses woman abuse.

Influencing Factors

Although all participants believed that they should be aware of woman abuse, be able to ask about a woman's experience of abuse, and should know how to respond to disclosure, these beliefs did not readily translate into practice. There were several factors that influenced whether or not an intervention occurred. These were: a) personal life experiences; b) professional experience, particularly hearing "yes" in response to screening questions; c) fear and anxieties; d) peer support and organizational support; e) time; and, f) role ambiguity.

The first three are related to individuals while the subsequent three have to do with organizational and institutional structures and are considered below:

Support

Participants noted that the support of peers, managers, and administrators can facilitate inquiring about woman abuse. As one nurse noted:

We put it on our complete physical and I started asking and I remember how at first I was scared of what I was going to hear. But then when more people start talking about it, it makes it more comfortable, that, you know, you're not the only one dealing with it and other people feel the same way you feel.

Most participants thought that it was harder to ask about abuse in a hospital setting, than in a private

office, because the pace of work is more intense and it is more difficult to ensure privacy. However, two participants disagreed with this, saying: "You can always find a private space if you really need to do so. You could just walk down the hall with her away from other people." Not having clear direction from the organization about what happens post-disclosure was noted as lack of support and a potential barrier to asking about abuse:

We don't get a lot of training in terms of "Okay, if this is the issue this is who they should talk to, this is where they should go, this is what they should do." That unfortunately is a barrier for me. I can ask about it but then after I get a "Yes" answer then I'm like "Okay, now what?" Yeah, that's the hard part there.

Time

Related to the issue of organizational and peer support were comments on "time," including the lack of it. Most participants described the increased pressures and workload of hospital-based health care professionals as a potential barrier to intervention. Even those who routinely inquire about abuse described the "heart-sink" moment when a patient discloses, the "oh no," both because it slows down the day's schedule and exacts an emotional toll. As a family medicine resident described:

You know you're sitting in your busy clinic and someone comes in for their annual physical and you ask them a screening, that's what I ask anyway, a screening set of questions about abuse and violence and if they say yes then all of a sudden you've got something big to deal with. And so it's hard from a time management perspective and it's hard from a "wow this is an awful thing that's happening to this person" perspective and "what do I do about it now?"

Others noted that the nurse-patient relationship has been eroded and that nurses no longer have the opportunities to engage in activities, such as bed baths, that formerly created opportunities for a personal dialogue. Those who work on the post-partum floor, for example, said the move to shorter hospital stays following delivery and family-centered birthing practices have

from those who did not believe responding to woman abuse was a program priority. One nurse, for example, said that after she introduced routine inquiry into her practice she was reprimanded by the physician she worked with and told that woman abuse was not their concern, although there exists a hospital policy which clearly states it is everyone's responsibility.

abuse sensitive practices into routine care. Recent cuts in the transfer payments made by the province to hospitals have resulted in staff layoffs and reductions in services. The result, as articulated by our respondents, has been increased workloads for remaining staff, shorter hospital stays for patients, less individual and bedside attention, and a heightened sense of time

In the midst of the economic pressures and structural shifts, a supportive environment, including managers and peers who recognize the importance of woman abuse as a health issue, can make the difference in whether or not health care professionals decide to intervene.

made it challenging to find opportunities to speak with women apart from their partners.

Role Ambiguity

Some respondents noted that determining the extent and limits of their expertise, their professional role in relation to the patient, and the role of hospital social workers was confusing. "How involved should the nurse become with a patient who discloses?" "At what point should the patient be referred to a social worker?" "Who will cover my other patients while I deal with this patient?" were all questions nurses on the floor, for instance, struggled to answer. One nurse said:

Just knowing on a realistic base that if that were to happen (someone discloses) is someone else responsible to take over our other workload while we counsel this person? I don't know. And do we have the skills to counsel someone who just informed us that they're being abused? You know, we're nurses we know how to do things we're to do daily on this floor, but you know....

Others were more certain of their role but encountered opposition

Discussion

It is significant that close to 63 per cent of Ontario's hospitals had policies or protocols related to woman abuse in 2002. Another 46 hospitals had policies "in development." When approved, 78 per cent of the hospitals in Ontario will have policies or protocols related to woman abuse. Organizational commitment to the education of staff members is another indicator of the importance of the issue to the management and administrative team. In 2002, just over one-quarter of Ontario's hospitals were providing training and an additional 13 hospitals declared training and educational initiatives were "in development." When those hospitals have training in place, 57 of Ontario's 157 hospitals, or 36 per cent of all hospitals in the province will have staff trained in issues of woman abuse in place.

Yet, as important as policies or protocols and education and training are to developing a hospital response to woman abuse, on their own these may not translate into improved health care practices. Our qualitative study reveals significant barriers, some personal and some institutional, to integrating woman

as a valuable and disappearing commodity.

Those we interviewed indicated that in the midst of the economic pressures and structural shifts, a supportive environment, including managers and peers who recognize the importance of woman abuse as a health issue, can make the difference in whether or not health care professionals decide to intervene. The absence of accountability mechanisms and lack of consistency in existing measures makes it all too easy for hospitals to claim they have an integrated response when, in fact, there has been no translation of belief into action, of knowledge into practice.

Policy Implications

National and provincial initiatives in Canada and Ontario have successfully raised the profile of woman abuse within the hospital sector. However, financially stretched institutions and overburdened health care professionals require more in the way of tangible supports in order to implement sensitive practices into everyday care. Health care professionals with the knowledge to intervene have found themselves confronting bar-

riers arising from increased workloads, reduced time for individual patient care, lack of managerial and peer support and uncertainty about their role. While some of these may be resolved at the level of individual institutions, others require the concerted and directed attention of policy makers at the provincial and national level. The lack of hospital accreditation guidelines or standards addressing woman abuse has allowed individual institutions to decide whether or not they consider this a critical health care issue. Policy development and accountability to existing policies or protocols would be enhanced with the establishment of national hospital accreditation guidelines for responding to woman abuse.

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Robin Mason is a research scientist in the Violence and Health Research Program at the Centre for Research in Women's Health, Sunnybrook and Women's College Health Sciences Centre in Toronto, Ontario.

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FARIDEH DE BOSSET

A child and a working mother

While you are eating,
peeing
smiling
and playing
I know you are waiting
for one person, your mother.

The hours of the day
pass slowly, very slowly.
The sun sets.
You eat your supper,
try to play more
and she finally arrives.

You are both exhausted.
You hardly can smile
at each other now.
"No lovers quarrels",
Just resignation
of a child and a working
mother.

Farideh de Bosset is a poet who sees the storm in each soul and the seed of beauty in each cell and wants to share it with the world.