

Guidelines for the Role of EMS Personnel in Domestic Violence

Excerpted from ACEP website

Introduction

Domestic violence is also known as partner abuse, spouse abuse and battering. It is part of a larger spectrum of family violence, which also includes sexual assault, child and elder abuse and neglect. It is estimated that 8-12 million women in the United States are at risk for abuse from a current or former partner.¹ The FBI estimates that a woman is battered every 5-15 seconds.² Although data is difficult to collect and interpret, studies have indicated that women seeking care in an emergency department for any reason are often victims of domestic violence.³ Consequently, prehospital providers may encounter these victims and must be aware of the unique problems inherent in these situations. Initial and continuing education programs for emergency medical services (EMS) personnel must incorporate information about domestic violence, including identification of victims, special aspects of care, scene safety and documentation requirements.

In 95% of domestic assaults the perpetrator is a man. However, it should be remembered that men can also be victims of domestic violence.

Recognition

Domestic violence crosses all boundaries, including those of age, race, education, socioeconomic class and sexual orientation. Frequently the victim will not admit to being abused, and this seems to be more true of middle class homes.⁴ Abuse should be suspected when the injuries sustained do not fit the history, and when patients seem ashamed or embarrassed about their injuries. Accidental injuries tend to involve the extremities and periphery of the body, whereas injuries from domestic violence tend to involve contusions and lacerations of the face, head, neck, breast and abdomen.⁵ The perpetrator is often unwilling to allow the victim to give a history or allow the victim to be alone with the EMS personnel.⁶ Excessive delays between injury and seeking treatment, repeated use of EMS services, injuries during pregnancy, substance abuse, and frequent suicide gestures are also hallmarks of domestic violence. Any of these conditions should lead EMS personnel to suspect abuse and respond accordingly.

Care of the Victim

Physical injuries need to be cared for according to standard practice protocols. However, special attention should be directed toward the emotional needs of the victim. Domestic violence stems from the abuse of power and control. It is characterized by a pattern of coercive behaviors that includes physical and sexual battering, verbal and psychological, abuse, economic control, and progressive social isolation, deprivation and intimidation.

Domestic Violence tends to follow a cycle of three phases. Phase one is comprised of arguing and verbal abuse, phase two progresses to physical and sexual abuse, and phase three consists of denial and apologies. The last phase is often referred to as a "honeymoon phase". Intervention is best accomplished in phase two or three. Without intervention the cycle repeats itself, usually increasing in frequency and severity.

EMS personnel must understand this cycle of violence in order to adequately assess the situation and care for the victim. They must understand that victims of abuse feel ashamed, humiliated and responsible for the violence. They must understand why victims stay in abusive relationships, and why they may eventually leave. Domestic violence tends to frustrate health care providers because of its recurrent and ongoing nature. EMS personnel need to see that by treating a victim in a respectful, sensitive and sympathetic manner, by confirming that the victim is not at fault and does not deserve to be abused, and by ensuring the victim safety, they will become agents of change in helping to give the support needed to eventually leave the abusive environment. If the patient elects not to be transported to an emergency department, prehospital providers should have a written list of community resources, including shelters

and hot-line numbers, that can be left with the victim.

Scene Safety

Police officers state that scenes of domestic violence are one of the most dangerous calls to which they respond. This is no less true for EMS personnel. If it is known from dispatch information that the scene is one of domestic violence, law enforcement should be summoned and EMS personnel should not enter the scene until it has been "secured" by the police. If domestic violence is not suspected until after arrival, the victim should be removed from the scene as quickly as possible. The victim and the perpetrator should be treated in a neutral and non-judgmental manner. No questions regarding possible violence, and no display of sympathy should be made until after the victim is in the ambulance and away from the perpetrator. Violence may be directed toward the EMS personnel, particularly if the perpetrator perceives that too much empathy is being directed toward the victim. It should be remembered that there is no safety in numbers, that no scene is ever "secure", and that removal of the victim is the surest way to provide safety for all.⁵

It has been suggested that EMS personnel do not have enough training in the management of violence. One study reported only 67% of providers surveyed had some training, and only 25% felt that they had any training in assessing the scene for potential violence.⁶ Such training is essential when dealing with domestic violence, and educational programs should include scene assessment, management of violence and, possibly, self-defense.

Some states have enacted "protective" legislation by establishing harsher penalties for an assault on health care providers. Support for such provisions is strongly encouraged.

Preservation of Evidence and Documentation

Domestic violence is a crime. Therefore, the scene must be treated as a crime scene, and standard precautions regarding preservation of evidence should be exercised. Training in these techniques by law enforcement personnel is beneficial.

Documentation should be comprehensive and exact. History obtained from the victim, alleged perpetrator and witnesses should be recorded. When possible, the victims own words should be used. If law enforcement officers are not initially on the scene, documentation of the scene itself should occur. A precise recording of injuries should be made, including type, number, size, location and explanations given a reported mechanism. Body diagrams are also helpful. Documentation of the behavior of the victim and the alleged perpetrator is beneficial. All of this is necessary should the case go to court. The names of law enforcement officers present should be noted on the prehospital report form.

Reporting

Most states do not have mandatory reporting requirements for domestic violence. In fact it is not clear if mandatory reporting ensures or diminishes the safety of adult victims. However, it is important for EMS personnel to inform the receiving hospital of their suspicions and observations. Such information should also be documented in their patient care report. EMS personnel should be familiar with state reporting requirements.

Conclusions

Domestic violence has reached epidemic proportions and EMS personnel will be called upon to evaluate and manage victims. EMS personnel must be educated in the cycle of domestic violence, special aspects of care, scene safety and documentation requirements. This should be part of initial and continuing educational programs.

References

- Filcraft A H, Hadley S M, et al; American Medical Association Diagnostic and Treatment Guidelines on Domestic Violence. Arch. Fa. Med 1992;1:39-47.

Crime in the United States. Washington, DC: FBI, 1986.

Randall T; *Hospital Wide Program Identifies Battered Women; Offers Assistance*. JAMA 1991;266:1177-1179.

Knowlden S M, Frith J F; *Domestic Violence and the General Practitioner*. Med J Aust 1993;158:402-406.

Randall T; Lawrence J M, et al; *Domestic Violence and Health Professionals*. Med J Aust 1993;158:86.

Roberts G L, Lawrence J M, et al; *Domestic Violence and Health Professionals*. Med J Aust 1993;158:86.

Bingham S; *Personal Safety and Nonviolent Crises Intervention*. Unpublished.

Tintinalli J E; *Violent Patients and the Prehospital Provider*. Ann Emerg Med 1993;22:1276-1279.