

Gender-based violence and mistreatment (and III). Practical guidelines for early detection and an integrated approach to emergency care

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Emergency rooms are among the most accessible places available to battered women seeking help, and large numbers of domestic violence cases are detected annually during treatment in these facilities. Victims of abuse come to emergency rooms for a variety of reasons and we must raise our awareness of the problem if cases are to be detected early. Key aspects of emergency care of victims of gender-based violence are early detection of cases in the course of taking a full medical history and the assessment of threat to the patient's life before discharge. A directed interview should be undertaken if there is any suspicion of physical abuse, and the caregiver should know the protocol for action in such cases. The patient should be informed of resources that are available and what procedures to follow in order to carry out whatever decision she takes. [Emergencias 2008;20:343-352]

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Introduction

Gender violence against a woman by her partner is a major public healthcare problem with epidemic proportions. This violence causes serious physical, psychological and social sequelae in these women and their families. They are manifested as continuous, weakening experience of abuse associated with a growing isolation from the exterior world and personal limitation and accessibility to resources¹. The main determinant factors of gender violence are the unequal relationship between men and women and the presence of a culture of violence to solve conflicts².

Together with primary care services, hospital emergency departments (HED) are one of the most accessible places which women who are victims of mistreatment can find to request help and high figures of domestic violence (DV) are detected among the users of these centres³.

In 1996, the WHO declared the eradication of violence against women to be a public healthcare priority⁴. The American College of Emergency Physicians (ACEP) defines DV as part of a behaviour pattern of coercion used to establish and maintain power and control over the person with

whom there is an intimate relationship or marriage. These behaviours include threats or physical of sexual mistreatment, psychological abuse, social isolation, privation or intimidation⁵.

This article aims to emphasise two important aspects of emergency care in gender violence: early detection with adequate anamnesis techniques and the evaluation of vital risk of a patient before discharge from our departments. In addition, we will demonstrate the high incidence and prevalence of mistreatment of our emergency patients and propose an algorithm for action in HED. The most serious cases of violence arrive at our HED and they must be treated in the most adequate manner possible. In the cases with lesser immediate severity, it is necessary to know the resources available which may be of greatest interest to the victim at this time without forgetting that the final decision lies in the hands of the patient.

Epidemiological data of domestic violence in emergency departments

In the report on the "Study of the measures and actions adopted by the members of the Euro-

pean Council" (2006) the European Council reported that 20-25% of the women in the European Union had undergone some type of physical violence during their life⁶. In Spain, the Macrosurvey of the Institute of the Woman carried out in 2006 (sample including 20,000 women of legal age) stated the number of mistreated women to be 9.6%⁷.

It is very difficult to measure the real prevalence since the data available usually underestimate its magnitude. If values from the HED are considered, most of the studies are performed in the United States. These studies estimate that 11.7%⁸ to 35%¹ of the women who attend these hospital departments are victims of DV (although this is not usually the reason for consultation), with an accumulated prevalence over life of 21 to 54.2%^{5,8,9}. In addition, these studies reported that 2% of acute injuries in women who arrive to the HED are attributed to DV⁹⁻¹³, 14% of the women seeking medical care in the HED have a history of having received physical or sexual abuse during the previous year^{10,11} and 25%¹ to 81%¹⁰ of the women who have attempted suicide have been the object of DV at some time in their life. Mistreated women also seek care in the Psychiatric Emergency Services and in Gynaecological and Obstetric Departments with values from the United States of 25% and 8 to 17%, respectively. Data from obstetric departments reveal that in 40% of the cases, the mistreatment begins during the first pregnancy¹⁰ which may lead to a depression resulting in miscarriage¹⁶. The incidence of gender violence in the HED in the United Kingdom is of 1.2% and the prevalence over life is 22.4%¹⁷, although posterior studies have raised this value to 34.8%¹⁸.

Data on the incidence or prevalence in the Spanish HED are unknown. Only some studies in primary care are available and these describe values similar to those of the Anglo-Saxon countries with a frequency of mistreatment (regardless of whether physical, emotional or sexual and were produced in the past or by the present partner) of 31.5% and with a clear association with worse psychic and self-perceived health¹⁹.

Barriers for the management of mistreatment in emergency departments

The healthcare sector has an important role in the early detection of this serious health problem to thereby reduce its consequences and the probability of more abuse^{12,20}. For many battered

women the HED is the first or only contact with healthcare professionals¹². Many consult for apparently banal or non urgent health problems but we should be alert and suspect possible mistreatment. The lack of diagnosis leads to an important increase in the morbidity of these patients with an increase in the frequentation of admissions to the HED and the use of out-patient healthcare resources or may even result in the more extreme or lethal consequences of gender violence such as homicide of the victim, her children or other innocent victims^{5,12,19,21}. Thus, battered women seek care in the emergency departments three-fold more often than other non mistreated women^{13,22}. There is strong evidence that the use of medical services increases with the severity of the physical assault¹³. These women may present in the medical services before seeking justice in social services, therefore, if the abuse is identified they can receive the adequate interventions to increase their safety and improve their health¹³.

The consequences, particularly psychological and social, of repeated abuse lead these women to have a very low self-esteem, feelings of blame and fear of the consequences of reporting the abuse. They therefore have very serious difficulties in confronting their problem. The family or social support provided is essential for their recuperation and the prognosis of the case. Other important reasons why the victims of abuse hide their problem is fear of losing their children, shame, tolerance to the violence, being unaware of being a victim, emotional, economic or social dependence on the aggressor, fear of social rejection, hope that the situation will change, cultural or religious ideas, etc.^{2,5,10}. All these reasons produce a delay in the detection of abuse and it has been calculated that from 5 to 10 years may go by before they report the crime^{21,23}.

On the other hand, emergency medicine professionals have serious barriers for the diagnosis of this type of health problem: high healthcare pressure, the lack of training, demoralisation, unawareness of the health problem, prejudices, fear of offending or invading the privacy of the victim and/or lack of knowledge of the resources and social help available²³⁻²⁵. American studies have indicated that 55% to 58% of the physicians never or rarely ask about DV⁵. Thus, it has been estimated that only 5-15% of the all the cases are diagnosed^{5,8,10,12}. In our country, in which the healthcare personnel may not be sensitised to this subjects, the values may be even lower^{24,26}.

The responsibility of the healthcare professional with respect to suspecting, detecting and noti-

fying aggression by mistreatment is of great importance. It should not be forgotten that it is a crime and according to article 262 of the Law of Criminal Indictment we are obliged to report gender violence to the prevailing authorities²⁴. At present, the Integral Law against Gender Violence states "the duty of healthcare personnel in the early detection and care to the victims as well as the application of healthcare protocols towards these aggressions". (Ley Orgánica de Medidas de Protección Integral Contra la Violencia de Género 2004). To do this it is very important to work in coordination with other professionals and institutions which are mentioned below.

In 2007 the "Common protocol for healthcare action to gender violence" was published by the Interterritorial Council of the National Healthcare System in which representatives of the autonomous communities and experts in the subject achieved a consensus for homogeneous action on behalf of the healthcare professionals with a specific section on emergency care².

Early detection of the cases of intimate partner violence in the emergency departments

As previously mentioned, the HED are one of the points of entrance in the healthcare system by victims of DV. This contact may be a crucial moment of early identification of DV¹⁸. The victims of DV arrive at the emergency department for several reasons and often do not manifest the real origin of their injuries. They sometimes arrive for injuries or health problems as a consequence of the violence itself (injuries, somatizations, anxiety attack or attempted suicide, among others), while other times the visit is a call for attention related to the need to request help. Thus, healthcare professionals require training and sensitisation towards this health problem to thereby take it into account when making the differential diagnosis in determined diseases^{24,26}.

When to suspect mistreatment

It is difficult to suspect the presence of mistreatment, although there are the so-called warning signs (Table 1) and the injuries associated with abuse (Table 2).

With respect to the latter, there are no characteristic DV injuries since they are similar to lesions produced by other mechanisms²⁷. Some guidelines include oriented typology of physical injuries of battered women¹. The range of behaviours in-

Table 1. Warning signs

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- The behaviour of the partner in the HED: attentive to the patient, sometimes answers for her, refuses to abandon the consultation or leave the patient alone with the professional. She continually looks to her partner "asking for approval".
 - Delay in the search for a solution to the problem for which she is being attended.
 - Refusal to allow examination beyond that of the injury.
 - Multiple previous visits (for traumatic processes or otherwise).
 - The story told by the patient or the partner does not coincide with the injuries observed: no concordance.
 - Depressive behaviour, anxiety, suicide attempts.
 - Traumatic lesions not related to traffic accidents which are blamed on domestic accidents or accidental falls at home.
 - Alcohol intoxication.
 - Recurrent chronic pains, leading the patient to be a "hyperfrequenter".
 - Pregnancy.
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HED: Hospital emergency department.

cluded in the physical lesions may go from simple shaking, pinching, slaps to unwanted sexual relations, rape and beating with severe and even mortal results (Table 2).

On suspicion of battery, in the clinical anamnesis the mechanism of the injury and even direct questions as to the possibility of gender violence should be insisted upon. Do not forget that physical aggression is often associated with sexual assault and therefore in the case of physical injuries it is important to ask about sexual violence. Other times women who are victims of mistreatment make frequent visits for ambiguous disorders with no data of organic disease, considered as psychosomatic causes. It is necessary to remain alert to panic crises, anxiety disorders and depression since they are frequent diseases in

Table 2. Injuries associated with mistreatment

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- Facial traumatismos.
 - Cuts on face and neck.
 - Mandibular fractures.
 - Ripping of the ear lobe.
 - Rupture of the eardrum.
 - Trunk traumatismos.
 - Abdominal traumatismos.
 - Ecchymoses in different stages of evolution.
 - Bruising, burns and cuts are described in relation to DV.
 - Follow a central and bilateral pattern with lesions in places suggestive of defensive postures (for example on the forearms).
 - Genital lesions.
 - Ambiguous disorders.
 - Suicide attempts.
 - Injuries in pregnant women:
 - Lesions on the breasts, genital area and abdomen.
 - Complications such as miscarriages, preterm birth or low weight newborns.
 - Punches produced by the aggressor on the abdomen may lead to premature detachment of the placenta (abruption traumatic) resulting in premature delivery, maternal death due to severe internal haemorrhage or uterine rupture.
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DV: domestic violence.

abused patients. Suicide attempts are one of the severe consequences of DV and are frequent in the HED. Different studies have indicated the great prevalence of gender violence in women who attempt to end their lives making it necessary to routinely ask about mistreatment in these cases.

Screening questionnaires

Performing a clinical history and routine physical examination may not be sufficient to diagnose DV. Thus, the question: Would an earlier and correct diagnosis be achieved by screening? If no unanimity has been achieved with respect to this question in primary care, the controversy in the HED is even greater. In different settings it has been suggested that screening is valid for all patients attending an HED due to the high incidence and prevalence²⁸ of DV. In the United States, screening is supported by entities such as the American Medical Association, American College of Emergency Physicians, American College of Obstetrics and Gynecologists, American Academy of Family Practice, American Academy of Nurse Practitioners and Emergency Nurses Association²⁹⁻³¹. Other associations such as the USPSTF (U.S. Preventive Services Task Force) do not include routine screening as a recommendation³². The Family Violence Preventing Fund organisation recommends routine screening of women over the age of 14 years who attend the emergency department³³.

Screening is accepted by most of the patients who attend an HED. Indeed, some studies have reported that 78% of the victims of DV are in favour of being asked about the problem since they often do not do mention it spontaneously^{5,34}. Nonetheless, it is less clear whether screening is accepted by the physicians and the nurses³⁵.

There is a wide variety of standards and tools possible for screening with no recommendations favouring any specific methods¹¹ and there is no valid test available in the Spanish language. At present, the questionnaires mentioned are being validated for Spanish-speakers. In addition, this questionnaire of detection should be accompanied by protocols of action with the aim of helping the victims of DV.

Because of the particular characteristics of the HED with a large influx of patients, short time, etc., short questionnaires which make direct questions related to two aspects are interesting: DV and the safety of the patient (we cannot forget that the patient arrives in an "acute" state). Among the present protocols for screening we be-

lieve that the most adequate for the HED are those which are made up of only a few questions so that the questionnaire is rapid and effective. The following three are of note.

A. The Partner Violence Screen (PVS): has 3 simple questions^{3,5}.

1. Have you been hit, kicked or punched or received any other injury by anyone during the last year? If so, by whom?

2. Do you feel safe in your present relationship?

3. Do you currently feel threatened by a previous relationship?

A yes to any of the above questions is considered positive of DV. With these 3 simple questions the principal aspects of the discovery of mistreatment are covered: the diagnosis of mistreatment in itself (question 1) and on the other hand, the sensation of safety of the victim, which is very important to evaluate the risk of the victim (questions 2 and 3). The sensitivity of this test is of 65%-71% compared to larger more complete tests^{5,17}.

B. A more recent screening test along the same line of short questions as the StaT elaborated by Leibschutz and Paranjape³⁶ has a sensitivity of 97%⁵. This questionnaire also includes 3 questions:

1. Do you have any relationship in which your partner has hit or slapped you?

2. Do you have any relationship in which your partner has treated you with violence?

3. Do you have any relationship in which your partner has broken, destroyed or thrown things?

These 3 questions include both physical and emotional abuse and are adequate (for their simplicity and brevity) for use in a HED similar to the PVS. Although the StaT does not make any direct question related to sexual abuse, this test was found to be more sensitive than the direct questions, perhaps because of the high coexistence of physical-sexual abuse⁵.

C. In a study published in 2001 carried out in a HED in New York³⁷ a 2-question questionnaire adapted from the American Medical Association Guidelines¹ was used:

1. Have you ever been physically or emotionally abused by your partner or someone important to you?

2. Do you currently feel that your partner or someone important to you physically or emotionally abuses you?

These questions, however, have not been validated despite being adapted directly from the questionnaire mentioned.

How to do the clinical interview with a victim of mistreatment

In view of all of the above, there is no consensus as to the systematic use of standardised questionnaires for use in the HED, particularly questionnaires in the Spanish language. In our setting a interview carried out with the minimum suspicion of mistreatment is recommended.

The HED are characterised by high patient flow, lack of time and space and overall a lack of privacy in contrast to consultations with primary care physicians. However, this should not impede adequate anamnesis of these patients when a case of DV is suspected.

The interview should be directed towards the injury of the reason for consultation, and, in the case of suspicion, direct questions as to DV should be made. The physical examination should be meticulous in both form and depth to not allow possible associated lesions to remain unperceived. The emotional attitude will also provide information. We should assure the confidentiality of the patient and guarantee discretion and privacy. The patient should be believed and taken seriously. Questions should range from general questions to more specific: "How are things at home?", "Who do you live with?", "Do you have problems with your husband?", "With your children?", up to the direct question of "Do you feel mistreated?", "Do you feel safe at home?", "Are you afraid?", "Have you been physically or sexually assaulted?". On confirmation of abuse, it is important not to blame the woman, respect her decisions and inform her of the dangers involved and the means available as discussed below.

Integrated approach to cases of gender violence in the emergency departments

The situation of abuse may present directly with the victim attending the emergency department (referring or not mistreatment) or through a situation of mistreatment derived from another professional (primary care physician, extrahospital emergency physician).

The diagnosis of mistreatment may be difficult to achieve and elements for confirmation are often lacking. This should not discourage physicians from maintaining an expectant attitude.

Once the diagnosis of a situation of mistreatment has been achieved, a systematic and integrated physical examination should be made with a basic evaluation of the current psychological state (although this is only a first approach and

later an interconsultation to mental health will be made if necessary) and the social state (work activity, children, relatives and close friends who can be counted on, previous episodes of abuse, police reports,...)¹⁰.

The second step is evaluation of the situation of immediate vital risk (IVR) or extreme danger^{1,2,38} (Figure 1).

A. IMMEDIATE PHYSICAL VITAL RISK: Physical injuries which may be the cause of vital compromise to the patient. This requires an immediate diagnostic-therapeutic approach which is a priority to the diagnosis itself of mistreatment or other psychic and/or social vital risks. As in other injuries or diseases with vital risk, the following should be carried out:

- Clinical history and meticulous physical examination of the injuries.
- Stabilisation and initial therapeutic approach of the lesions: management of a polytrauma patient.
- Complementary diagnostic tests to confirm and determine the precise severity of the injuries: radiographic, CT, echography, analyses... according to diagnostic suspicion.
- Evaluation and request interconsultation(s) to other specialists: intensive care, traumatology, surgery, neurosurgery, maxillofacial surgery...

Ruling out the presence of immediate vital physical risk does not discard the need for hospital admission or having to leave the patient in an emergency observation room, that is, the lesions may not be vital but may be sufficiently serious to require observation of specialised treatment (fractures, mild-moderate cranioencephalic traumatism,...).

If the patient does not require admission or observation in the emergency department for the physical injuries, the vital psychic and later the social risks must be evaluated.

B. IMMEDIATE PSYCHIC VITAL RISK: This consists in evaluating the risk committing suicide. All the cases of abuse present psychological repercussions^{39,40}. An initial evaluation is made in all the cases as well as an evaluation of mental health on indications of immediate psychic vital risk or the cause of attending the HED was attempted suicide. The approach should be direct with simple questions:

- Have you at any time wanted to "throw in the towel" and disappear?
- Have you every thought that you would prefer to be dead to not have any problems?
- Have you ever thought about killing yourself? How often?

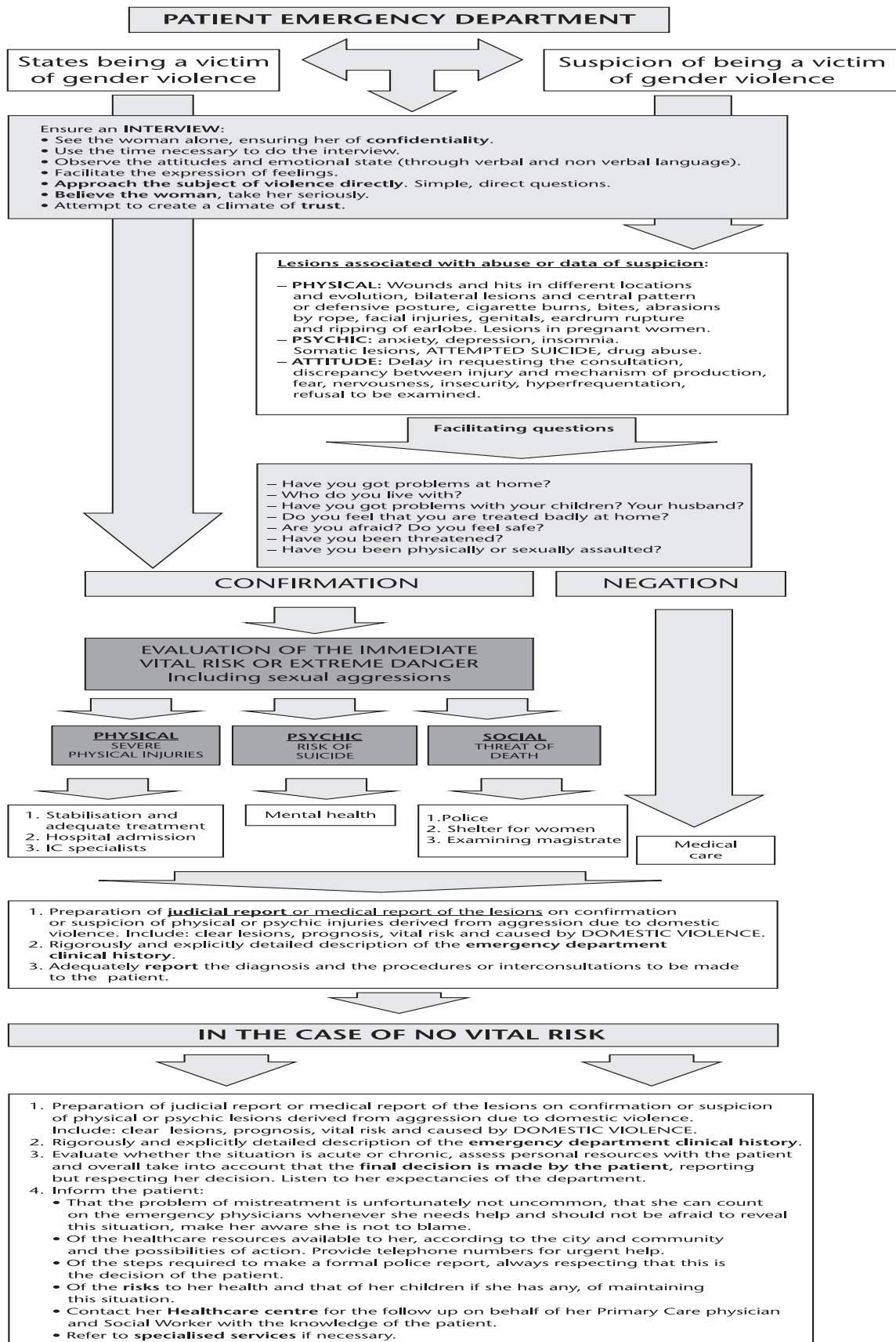


Figure 1. Protocol of action in the emergency department for situations of gender violence.

- Have you ever tried?
- Do you have any weapons at home? What floor do you live on? Are you taking any kind of medication?

The risk is high if the patient openly declares her intention, in case she had planned to do it or there are previous attempts. If there is not physical or psychic IVR, social risk should be evaluated.

C. IMMEDIATE SOCIAL VITAL RISK OR EXTREME DANGER²: This is present when there is the risk of the threat of death or a new serious assault even when the current injuries are not serious. This evaluation is difficult and conflict for healthcare personnel and is estimated through the sensation of safety of the victim herself:

- Are you afraid to go home? Do you feel safe? This evaluation is fundamental and the opportune measures must be adopted.
- Have you been threatened with a weapon or knife?
- Did you come to the emergency department because of injuries caused by your husband?

Factors of risk in the aggressor which might trigger an abrupt attack must be taken into account: alcoholism, drug addiction, psychopathological disorders. The risk is high if the aggressor has threatened to kill the patient or the children and thereafter commit suicide (extended suicide).

In the case of physical IVR the patient should be admitted to hospital following the same procedure for the case of psychic IVR (Mental Health Unit). In the case of indication of social risk or extreme danger the examining magistrate and the pertinent services should immediately be contacted. Specific women's care groups can be contacted as can the police force: Women's Aid Team (SAM) of the National Police Force or the Women and Minors Teams (EMUME) of the Civil Guard who will come to the emergency department and initiate protection measures, accompany the patient if legal action as in pressing charges is to be taken and they will report to the magistrate (integrated health service). Another option is to directly contact (option available to hospital emergency departments) the centres of emergency of the healthcare network of the woman under the General Direction of the Woman (each autonomous community has an emergency telephone number) who will assess the urgent needs and put the necessary resources into action: legal, psychological, assessment, shelter (including shelters if the woman should need to temporarily leave the family home), economic aid,... for the woman and minors in her charge under the age of 18 years (Table 3).

In exceptional cases in which no resource can be contacted, it is our obligation to keep the patient under observation in the HED and inform the examining magistrate in order to establish the opportune protection measures.

When there is no physical, psychic or social IVR, prior to discharge home the following should be carried out:

A. During the work time table contact the social worker for help and even try to contact the family physician to inform him/her of the situation in order to make the follow up.

B. Assess whether this is an acute or chronic situation, determine the personal resources of the patient and particularly take into account that the final decision is that of the patient, reporting but respecting her decision. Listen to her expectations.

C. Inform the patient:

- That the care given is continuous.
- Of the sociohealthcare resources available to her, according to the city and autonomous community and the possibilities of action (Table 3). Provide emergency telephone numbers.
- Of the steps required to press formal charges which are necessary for many of the resources existing.
- Of the possible risks to her health and that of her children if this situation continues.

Table 3. Sociohealthcare resources available to the victims of gender violence

1. URGENT CARE:	<ul style="list-style-type: none"> – Single telephone for emergencies: 112 24-hour care – Number of emergency against gender violence: 016 Information and assessment of the current rights and resources. <p>In each autonomous community the resources vary: some communities have legal and permanent psychologic assistance. We should know the resources available in our hospital centre.</p>
2. STATE POLICE FORCES	<ul style="list-style-type: none"> – Women's Aid Services (SAM) of the National Police Force. – Women and Minors Teams (EMUMES) of the Civil Guard. – Local and Autonomic Police Forces.
3. EMERGENCY CENTRES OF THE WOMEN'S AID NETWORK:	For admission of the woman and her children under the age of 18 to a women's shelter.
4. SOCIAL WORKERS OF THE HOSPITAL CENTRE:	This is of great importance for the coordination social resources and the follow up of the victim. The limitation is that this service is not available around the clock in some centres.
5. ASSOCIATIONS FOR MISTREATED WOMEN/WOMEN'S CENTRES:	These represent a useful resource in cases in which the woman has no immediate vital risk since assessment and psychological and legal assistance is provided. These may be a starting point for recognition of abuse on behalf of the patient.
6. OFFICES OF ASSISTANCE TO VICTIMS OF DOMESTIC VIOLENCE IN EACH AUTONOMOUS COMMUNITY.	

D. Refer the victim to specialised services if a psychological assessment and follow up is required by the mental health team or by teams of psychological support from victim's aid centres or associations.

E. Always register the events, with clear, precise description of the lesions, the diagnostic tests required, the final diagnosis and the therapeutic attitude and outcome of the patient in the clinical history.

F. Preparation of the judicial report (see next section).

G. Contact the Primary Care Team of the patient by the means chosen (telephone, fax, letter,...) since our intervention is limited on most occasions to punctual contact and it is the Primary Care physician who will be in charge of the patient.

How and when to make a report of the lesions or judicial report

In almost all Spanish HED there are the so-called lesions reports for cases of DV which are equivalent to a judicial report and the clinical history. The lesions report differs from the judicial report in that it has more specific section such as the assessment of the emotional state of the victim or an anatomical picture to facilitate the description of all the injuries. There are several copies: one for the medical history, another for the patient and another for the magistrate. In addition, this report clearly indicates that the cause of the lesions is DV and will therefore be taken through the court of domestic violence which is faster and, in some cases, specialised in this type of process. The making of a judicial report is controversial⁴¹ since in determined circumstances it could represent a risk for the safety of the woman. It is always necessary to inform the woman of its preparation and that the court will contact her to corroborate the data.

According to the Organic Law 1/2004 of Integrated Protection Measures against gender violence, it was established that healthcare action protocols must explicitly refer to the relations with the Administration of Justice in the case of confirmation or justifiable suspicion of physical or psychic injury caused by assault or abuse. On the other hand, as has already been mentioned, the Law of Criminal Indictment establishes the obligation of professionals to report (with injury report) if they are aware of a public offence.

In the common protocol for healthcare action towards gender violence² it is recommended that in cases in which the woman refuses to press charges and the healthcare personnel have well founded suspicion of the existence of physical or psychic abuse (no clear confirmation of the origin of the lesions to emit the corresponding lesion report) this situation should be reported to the District Attorney's Office as established in the legal precept. The District Attorney's Office will decide what legal process is the most adequate based on the circumstantial evidence provided.

If the patient is referred from another family physician, the judicial report should also be completed despite having previously been made. The duplicity of reports is preferable to the lack of a report.

The judicial or lesions report must be carefully drawn up with clear writing and expression and should describe the lesions and treatment administered precisely since this will be of great aid to the woman when pressing charges and requesting the necessary social resources.

Algorithm for the management of cases of gender violence in the emergency departments

Figure 1 depicts a scheme of the different steps of action, depending on the situations encountered to act when attending a victim of gender violence.

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Violencia y maltrato de género (y III). Nociones prácticas para su detección precoz y abordaje integral en urgencias

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Los servicios de urgencias son uno de los lugares más accesibles que pueden encontrar las mujeres víctimas de malos tratos para solicitar ayuda, por lo que se detectan cifras altas de violencia doméstica entre las usuarias de estos centros. Consultan por muy diversas causas, será importante estar sensibilizados con el problema para detectarlo precozmente. Los dos aspectos más importantes en la atención urgente a la violencia hacia las mujeres son la detección precoz con las técnicas de anamnesis adecuadas y la valoración del riesgo vital que tiene la paciente antes de ser dada de alta de urgencias. Se recomienda realizar una entrevista dirigida ante la sospecha de malos tratos, conocer y aplicar el protocolo de actuación ante estos casos e informaremos a la paciente de los recursos existentes y trámites a seguir existentes respetando la decisión que tome. [Emergencias 2008;20:343-352]

Palabras clave: Violencia doméstica. Servicios de Urgencia. Detección precoz. Riesgo vital.