FIGHTING THE "SILENT EPIDEMIC"

Hospital Launches Comprehensive Program Against Domestic Violence

BY DEBORAH A. MARKIN, RN

Imagine yourself on a plane in the middle of the night. You are flying across the United States to be with your sister. Hours earlier you received a phone call from her as she lay in a hospital bed, a victim of domestic violence. Her marriage had seemed strong, normal. You wonder how this could have happened. But her call sounded desperate. She needs your help.

This was the experience, several years ago, of an emergency staff nurse at Sacred Heart Medical Center in Spokane, WA. She responded to her sister's call with initial confidence—after all, she had worked with victims of domestic violence for years. But once at her sister's bedside, the nurse's confidence was shaken. She found herself in a strange city, not knowing its resources. The hospital where her sister lay had no policies or procedures for dealing with the situation. And her brother-in-law had suddenly become a strange and menacing presence.

When the nurse returned to Spokane, she looked into her own hospital's policies for caring for victims of domestic violence. Unfortunately, like most other hospitals, Sacred Heart had no such policies. Nor did it have the tools necessary to educate either its own healthcare professionals or the general public on the subject. The nurse brought this fact to the attention of Sacred Heart's leaders, and they decided to remedy the problem.

Ms. Markin is co-chairperson, Domestic Violence Task Force, Sacred Heart Medical Center, Spokane, WA.

The Domestic Violence Task Force of Sacred Heart Medical Center, Spokane, WA, was a 1995 winner of the Catholic Health Association's Achievement Citation Award.

Launching the Task Force

In 1991 Sacred Heart formed its Domestic Violence Task Force. Among its 18 active members were representatives of those hospital departments that have the most experience with domestic violence victims: the emergency department, social services, the nursing service, women's services, maternity and pediatric services, psychiatry, and rehabilitation. The task force also included the hospital's ethicist and representatives of its medical staff, educational services, and public relations and security departments.

We began our work by contacting other U.S. hospitals to see if they had already developed poli-

Summary In 1991, when Sacred Heart Medical Center, Spokane, WA, launched its Domestic Violence Task Force, the group's members soon discovered that few U.S. hospitals had policies on domestic violence. So they created one.

They decided to address three interrelated areas: public education, professional education, and the care of patients who are domestic violence victims. First, the group wrote a booklet introducing the public to the battering phenomenon.

Second, to show medical professionals how to identify battering victims and intervene on their behalf, the group produced a video and organized conferences and training sessions. Third, the task force rewrote hospital policy to ensure appropriate treatment for patients who are victims of domestic violence.

Other organizations, including the U.S. Air Force, are using the task force's video. Sacred Heart has been given several awards for its work against battering. The task force is currently developing guidelines on domestic violence in the workplace.

cies and procedures for helping domestic violence victims. After spending three months calling some 200 institutions, we came up with about 20 written policies that addressed domestic violence. Most of these were written for the hospital's emergency department. Others addressed battering narrowly, under general abuse or sexual abuse policies. Some of the most complete policies dealt with battering from a law enforcement perspective. But none seemed to entirely fit our needs.

It became evident that our domestic violence policy should reflect the medical center's five key values:

- Care, compassion, and concern
- Respect for the dignity of the individual
- Quality of care for the whole person
- Care of the poor
- Teamwork

In addition, we realized early on that our policy must address the continuum of care within the hospital and tie it to a continuum of community resources.

The task force continued to study the literature on domestic violence and to share ideas. As we worked, we heard that the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) would soon require hospitals to develop their own domestic violence policies. Then, in 1992, the U.S. surgeon general issued a report urging the healthcare community to recognize the increase of domestic violence in this country (see **Box**). These developments encouraged the task force to press forward with our work.

We determined that we needed to address three interrelated areas:

- Public education
- Medical professional education
- Care of patients who are victims (or suspected victims) of domestic violence

Public Education

The more we studied domestic violence, the more we realized that most people know little about it. We therefore wrote *An Introduction to the Battering Syndrome*, an easy-to-understand booklet for Sacred Heart patients, which was first published in January 1992. An insert in the booklet gives battering victims tips on how to leave an abusive home; it also provides phone numbers for 19 local social service agencies.

At Sacred Heart, we advise a patient who we suspect is a battering victim to read the brochure but to leave it behind if she fears that the person who beat her might see it. On the other hand, we suggest that she hide the insert in her shoe because she may well need it later.

The booklet obviously filled a need. Within nine months of its publication, 5,000 copies were taken from Sacred Heart's waiting rooms, patient care areas, and medical clinics. The state's Department of Social and Health Services, our local Public Health Department, and Spokane Legal Services asked for large quantities. We also sent copies to area schools, physicians' offices, churches, and community centers. The booklet's success was a clear indication that we were on the right track.

> Our professionals needed training in handling domestic violence.

The task force also worked closely with Sacred Heart's public relations department to inform patients, physicians, staff, and the community about domestic violence. Articles on the topic have appeared in *Monday A.M.*, the hospital's weekly newsletter, and *Heartbeat*, its quarterly publication.

Medical Professional Education

Task force members realized that the hospital's professionals needed training in how to handle cases of domestic violence. Above all, we needed

THE "SILENT EPIDEMIC"

A 1992 report by the U.S. surgeon general estimated that violence against women by their intimate partners was responsible for more injuries than were car crashes, rapes, and muggings combined. It is estimated that one out of every four women will at some time be a victim of domestic abuse. Yet, the report said, most of these injuries go unreported.

Although most victims are women, men are also victims of domestic violence. The abuse of men is also underreported. Care givers at Sacred Heart Medical Center suspect that battered men are often too embarrassed to report it. In one situation, a male patient said he feared being labeled a "sissy"—even though wounds to his face and head required more than 60 stitches.

Of course, women also rationalize their failure to report being beaten. One woman may think she is the "only one" and be too humiliated to report it. Another may think that most women are abused, that it is somehow natural and expected in a relationship. Often such women have a childhood history of family abuse. Frequently, a battered woman will refuse to seek help because she believes—unrealistically—that if she were more careful or worked harder to please her partner, the abuse would end.

Domestic violence is a learned behavior. Of those who abuse, from 50 percent to 70 percent saw their mothers abused. About half were themselves abused as children, either physically or sexually. Abusers' actions are primarily based on the need to dominate and control. Domestic violence knows no socioeconomic, racial, or age boundaries. Most batterers appear to lead otherwise normal lives; about half are white-collar professionals.

Abuse can be physical, psychological/emotional, social, or sexual. Battering is a behavioral problem that cannot be alleviated through incarceration or a brief period of counseling. Some success for both batterers and victims has been seen as the result of batterer-and-victim treatment programs, which require months or even years of counseling.

to learn how to recognize cases of such violence in the first place. Victims had told us that, because it was so difficult to admit they had been beaten by spouses or friends, they really needed a physician or nurse to ask the right questions and elicit that information.

We began by organizing a conference on domestic violence for Sacred Heart's administrators, managers, supervisors, and educators. The conference inspired its participants to commit themselves to train staff members to identify battering victims and to make Sacred Heart a "lead organization" against domestic violence in the community.

Next we produced a videotape, *A Time of Opportunity: Helping Battered Women in the Health Care Setting*, designed to teach healthcare workers how to identify battering victims and how and when to intervene. In each hospital department, staff watched the video and then completed a written lesson on domestic violence. The video was shown separately to workers in social service, psychiatry, low-income clinics, pastoral service, medical records, rehabilitation, and personnel, and to medical residents and members of the board of directors and the board of development. Many staff members were so interested that we arranged for representatives of the local YMCA to come and present their "Alternatives to Domestic Violence" program. Networking with the YMCA and other local agencies has linked us to community resources that may be helpful to our patients.

We then arranged a second conference, at which Sacred Heart staff members discussed the ethical issues involved when one considers intervening in a domestic violence situation. Specifically, conference participants identified common hindrances that keep professionals from responding to victims of family violence. Participants compared the ethical foundations of professional responses to child abuse, elder abuse, and battering. Then they distinguished between one's duty to respect an adult's privacy and one's duty to prevent harm to an adult patient.

Indeed, the primary goal of all these training sessions has been to show staff members why they may be reluctant to ask questions of patients: embarrassment, fear of being sued, and fear of not knowing what to say, for instance. Most of us were raised with the belief that what goes on between a man and a women is a private matter, that what happens behind closed doors is none of our business. Once staff members were able to discuss these reservations and the related anxieties, they were more confident about addressing patient care situations.

Care of Patients Who Are Victims

Now imagine another scenario. You are a nurse working on a medical unit, caring for a middle-aged women who was admitted with a broken leg. Jokingly you ask her, "How are you doing? I'll bet that's the last time you kick the dog." Suddenly your patient bursts into tears. You apologize, but to no avail. You feel terribly guilty and confused. The patient finally recovers her composure and tells you, "No, no, it's not you. You see, it didn't happen the way my husband and I said it did." She then points to the fractured leg and says, "He pushed me from a balcony."

For too many years, healthcare workers have essentially wandered in the dark when trying to care for domestic violence victims. To end that state of affairs, the task force urged Sacred Heart to institute policies that would ensure appropriate treatment, intervention, and follow-up care for patients who are victims or suspected victims of battering. These policies were put into practice in the emergency department, nursing service, and social services.

Sacred Heart's existing administrative policy on abuse was rewritten to include all types, including abuse of children, the developmentally disabled, dependent adults, vulnerable adults, and elderly adults. These new guidelines not only meet, but in some cases—such as those involving comatose victims and children—exceed the guidelines issued by the American Medical Association and the JCAHO. Sacred Heart's domestic violence policies, similar in philosophy to a pastoral response released jointly by two committees of the National Conference of Catholic Bishops,[2] are based on the belief that violence in any form—physical, sexual, psychological, or verbal—is sinful, and often a crime as well.

> Our inpatient chart has been revised so that every patient is now asked, Are you ever concerned about your safety or violence at home?

The hospital's inpatient chart has been revised so that every patient is now asked, Are you ever concerned about your safety or violence at home? This is an important addition to the patient history information, especially since the admission may not be directly related to battering. (Sacred Heart has more than 25,000 admissions and 38,000 emergency patients a year.) For example, 25 percent to 45 percent of battered women are pregnant.[3] Adding this question to the patient history gives these women an opportunity to describe their fears and seek help.

Community Training

The task force has also assisted other local institutions, both medical and nonmedical, with employee training. We have arranged sessions for Group Health Northwest, the region's largest health maintenance organization; the Spokane Police Department; the Diocesan Council of Catholic Women, Seattle Province; and the Spokane Rotary Club, as well as many other state

and local organizations.

Last year we helped organize a conference called "Domestic Violence, Compassionate Care and Spiritual Guidance Training." The event was cosponsored by Sacred Heart, the Sisters of Providence, and the Spokane Police Department and its chaplains' program. More than 250 community counselors and spiritual leaders attended.

The task force has at times been overwhelmed by the number of requests for presentations. In the last three years, more than 2,000 persons have attended a presentation given by task force participants. Sacred Heart belongs to the Spokane Domestic Violence Consortium, a coalition of 70 agencies and organizations serving the community. On the national level, our video has been distributed to more than 250 hospitals and healthcare institutions, in 32 states and Canada. The U.S. Air Force is using the video to train family advocacy personnel in military hospitals around the world. And the Centers for Disease Control and Prevention have asked to include a description of the video in their resource list.

Impact on Patients and the Community

The new policies in place at Sacred Heart have positively affected the treatment and follow-up care of diagnosed or suspected victims of battering. Medical records from 1991 show that only 4 percent of assault cases were identified as representing domestic violence. Since the task force implemented its policies and training, the percentage has dramatically increased—to 28 percent of assaults in 1993, 33 percent in 1994, and 35 percent in 1995.

The booklet is now in its fourth printing, with more than 17,000 copies distributed, making it the region's most widely used pamphlet on this topic. Agencies in other parts of Washington and in Montana use our booklet, with an insert of local resources and phone numbers. In 1994 the task force received an award of recognition from the Spokane County Domestic Violence Consortium. Sacred Heart's training video received a first-place award at the American Society for Health Education and Training Media Festival. And, in 1995, the task force was given the Catholic Health Association's highest honor, its Achievement Citation Award.

Program's Financial Basis

Our success shows that it is possible to combat domestic violence without spending huge sums of money. The task force is financed entirely by Sacred Heart Medical Center. Our in-service training and community outreach education are conducted by the hospital's clinical nurse specialists, its staff ethicist, and others. The training video was produced by Sacred Heart's educational services department, which has its own studio and equipment, at a cost of $18,000. The hospital's public relations department developed and printed the booklet, which has cost approximately $5,400 to date.

Partly because Sacred Heart has recently seen a number of attacks on its employees by family members, we are now developing new guidelines on domestic violence in the workplace.

Outlook for the Future

At present, the task force is holding discussions with the leaders of the Spokane-based Providence Services system about setting up programs on domestic violence in its nine hospitals. Meanwhile, at Sacred Heart, we continue to teach new staff how to recognize and treat domestic violence victims.

Partly because Sacred Heart has recently seen a number of attacks on its employees by family members, the task force is developing new guidelines on domestic violence in the workplace. (We sponsored an all-day conference on the topic in February.) The guidelines will describe the responsibilities of both employer and employee in such situations. We intend to organize training sessions to show the hospital's department managers how to deal with violent persons. The Spokane Police Department has asked to share the guidelines with other city businesses worried about violence in the workplace.

Since 76 percent of Sacred Heart's work force is female, task force members have known from the beginning that simply raising the issue of domestic violence would cause reverberations among the hospital's staff. Recently, we began a weekly support group for employees who are (or fear they soon will be) victims of domestic violence. The group is offered free of charge and is led by two persons experienced in working with domestic violence victims. Thus, although the task force's first goal was to take care of others, in doing so we have come full circle, and are now focusing on the needs, welfare, and safety of our own employees. □

For more information, call Deborah Markin, RN, or Debra Portch, RN, at 509-455-4619 or 509-455-3131. To get copies of the task force's booklet and video, call Sr. Pam White, SP, at 509-455-3390.

NOTES

1. Men can also be victims of domestic violence. Experts estimate that 95 percent of battering victims are women and 5 percent are men.
2. "When I Call for Help: Domestic Violence against Women," *Origins*, November 5, 1992.
3. Anne Stewart Helton, *Protocol of Care for the Battered Woman*, March of Dimes Birth Defects Foundation, White Plains, NY, 1987, p. 3.