

**Classifications of Intimate Partner Violence  
in Hospital-based Emergency Department Health Systems**

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## **DECLARATION**

I declare that this thesis is my own work and no part of it has been submitted for the award of a higher degree elsewhere.

**Philippa Olive**

**2<sup>nd</sup> September 2013**

# ABSTRACT

Violence against women is pandemic; globally 30% of women have experienced intimate partner violence. A review of literature indicated that even though intimate partner violence is a major public health issue, the health sector has been slow to respond, firstly by not identifying and responding to it in women's health consultations, and secondly by poor data collection. Emergency departments see a minority but important sector of women exposed to intimate partner violence: women most heavily abused by a partner. This thesis starts from a position, based on previous research in the field, that often when women attend an emergency department after an assault by their partner, their experience of intimate partner violence is 'missed'. Framed by the sociology of diagnosis, the focus of this thesis is the *(mis)classification* of intimate partner violence in hospital-based emergency department health systems.

This thesis was positioned ontologically and epistemologically through a synthesis of critical realism and complexity theory and employed a mixed-method research design involving interviews with women victim/survivors of intimate partner violence, health practitioners, and clinical coders; a review of emergency department attendance records; and a survey of administrative health data.

The claim made in this thesis is that, for hospital-based emergency department health systems, the best classification of intimate partner violence, in the form of physical assault, is 'assault by partner'. This claim is based on research findings presented in this thesis which indicated 'missed' intimate partner violence was a result of misclassification of 'intimate partner violence' into classifications that did not mobilize classification or intervention other than routine medical care. 'Assault by partner' was identified as best classification because there was no need for additional distinctions to be made: most patients in this study had experienced severe violence and suffered medium and high levels of injury. Furthermore, 'assault by partner' was proposed as best classification because of conceptual uncertainty and difficulty for health practitioners and clinical coders to classify 'domestic violence'. This thesis makes original contributions in the fields of sociology of violence against women, sociology of diagnosis, and health policy. From the research findings, recommendations for policy and practice to improve hospital-based emergency department system responses to intimate partner violence have been made.

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# LIST OF ACRONYMS

DALY	Disability Adjusted Life Year
CCFG	Clinical Coder Focus Group (used for interview data coding)
ED	Emergency Department
EDPD	Emergency Department Practitioner Doctor (used for interview data coding)
EDPN	Emergency Department Practitioner Nurse (used for interview data coding)
DH	Department of Health
DV	Domestic Violence
FCE	Finished Consultant Episode
HES	Hospital Episode Statistics
HPC	History of Presenting Complaint
ICD	International Classification of Diseases
IPV	Intimate Partner Violence
NHS	National Health Service
NHSREC	National Health Service Research Ethics Committee
PC	Presenting Complaint
SCREC	Social Care Research Ethics Committee
SU	Service User (used for interview data coding)
UK NSC	United Kingdom National Screening Committee
WHO	World Health Organisation
YLL	Years of Life Lost due to Disability

# GLOSSARY

Classification	Action of classifying; result of classifying.
Classify	Arrange in classes or categories; assign (a thing) to a class.
Complaint	The health concern that has caused a patient to access health services and in emergency departments it is also referred to as the ‘presenting complaint’.
Episode of Care	A bounded period of health service provision for a specified health problem.
Finished Consultant Episode:	An episode of admitted care under a hospital consultant. Patients may have more than one consultant managing their care during an admission so there could be duplication of cases in FCE data.
Health	<i>“A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”</i> (WHO 1948:Online).
Health Burden	The measure of disease using the disability-adjusted life year (DALY) over time of years of healthy life lost through premature death or disability (WHO 2013d).
Health Sector	A term to encompass Statutory Health Organisations (Department of Health and National Health Service Trusts), Non-statutory Health Organisations (units within an NHS Trust), and Health Professionals.

Intimate Partner Violence: *“Behaviour by an intimate partner that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours”* (WHO 2012:Online).

Letter of Access Confirmation of Higher Education Institute researchers granted access at an NHS institution to undertake research that has no direct bearing on provision of direct patient care (NIHR 2010).

Research Passport A system of NHS human resource security checks for Higher Education Institute researchers undertaking research in the NHS (NIHR 2010).

Screening Identifying a condition in people who may not display any indication of it but who may be at greater risk for it (UKNSC 2013).

System An arrangement of things, or set of relations of things with causal properties.

Violence against Women: *“...any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life”* (UN 1993:Online).

# CHAPTER ONE: INTRODUCTION

## Introduction

Violence against women is pandemic, occurring worldwide in epidemic proportions (WHO 2013c). Up to 70% of women report having experienced physical or sexual violence in their lifetime and many women live with the threat of violence in everyday life as violence against women is known to be perpetrated at home, at work, on public transport, and in public places (UN Women 2013). 'Violence against Women' has been defined by the United Nations General Assembly (1993) as meaning:

*"...any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life."* (1993:Online)

Violence against women affects women of all ages, takes many forms, and pervades every corner of the globe (UN Women 2013). The many forms of violence against women have been named as intimate partner violence, physical and sexual violence against sex workers, trafficking, exploitation, debt bondage, sex selective abortion, female infanticide, deliberate neglect of girls, rape in war (Watts and Zimmerman 2002), domestic violence (Walby 2009) rape, sexual assault, sexual harassment, so-called honour crimes, and harmful traditional practices, for example, early/child marriage, forced marriage, female genital cutting, dowry/bride price, suttee, and trokosi (Kelly et al 2006). Not only is violence against women a violation of women's human rights (UN General Assembly 1979; 1993; UN Women 1995), but it is also a major public health issue worldwide (UN Commission on the Status of Women 2013; WHO 2013c; IHME 2013a).

## **Structural Gender Inequality and Violence against Women**

Violence against women constrains women's liberty (Stark 2007) and full participation in public and private life (Heise and Garcia-Moreno 2002); it is recognized worldwide as rooted in structural gender inequality and is one of the most socially tolerated violations of human rights (UNFPA 2005).

This thesis is positioned from an understanding that violence against women occurs in a context of hegemonic masculinity (Connell 2009) and gender regimes (Walby 2009) in which the deployment, regulation and experience of violence is gendered. Theorizing violence through hegemony and gender makes visible the interconnections of multiple forms of violence against women worldwide and for which 'Violence against Women' (VAW) is the encompassing term. Connell and Messerschmidt's (2005) concept of hegemonic masculinity is a theory of gendered social order in which the socio-cultural 'ideal type' of masculinity subordinates 'others' in relation to race, ethnicity, class and gender constructions. Hegemonic masculinity is particularly helpful in comprehending the social power held by dominant male groups over women and other masculinities and through which gender inequality is constructed and violence perpetrated. As Kelly (1988) states,

*"Whilst certain groups of men have far more power than others by virtue of class and / or race privileges, they always have more power than their female counterparts".*

(1988:26)

## **The Extent of Violence against Women**

The extent of violence against women worldwide is uncertain because many of its forms, for example female genital cutting, and trafficking have not been widely measured (WHO



2103c). However, over the past two decades there have been important methodological advances to measure the extent of intimate partner violence in general populations (Walby and Myhill 2001, Walby 2005, Garcia–Moreno et al 2005; WHO 2013c). Intimate partner violence is the most commonly reported form of violence against women, affecting 30% of women globally (WHO 2013c), and in England, an estimated 900,000 women reported having experienced some form of abuse by their partner in 2010/11 (Britton 2012).

Intimate partner violence has been defined by the World Health Organization as:

*“Behaviour by an intimate partner that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours”* (WHO 2012:Online)

## **The Health Impact of Intimate Partner Violence**

The health impact from intimate partner violence is wide reaching (Campbell 2002; WHO 2013c). Women exposed to intimate partner violence suffer greater physical injury, sexual and reproductive health problems, mental health problems (WHO 2013c), and are at greater risk for long term conditions such as asthma and heart disease (Black et al 2011) than women not exposed. Intimate partner violence is a leading cause of disability and premature death for women worldwide (IHME 2013a, Jewkes 2013, WHO 2013c), and in 2010, was ranked 5<sup>th</sup> in the leading causes of years of life lost due to disability (Jewkes 2013).

## Health Sector Response to Intimate Partner Violence

The World Health Organisation has called for all health care providers to respond to intimate partner violence (Krug et al 2002; WHO 2010, 2013b). In England, the role of health service providers to respond to intimate partner violence has been formalized in Department of Health policy documents since 2000 (DH 2000, 2005, 2011). Responding to intimate partner violence in health consultations involves its identification and the mobilization of interventions in the form of medical help and help relating to the issue of intimate partner violence (DH 2005, THAVAW 2010, WHO 2013b).

Emergency departments have long been identified as a health service at which women seek medical attention for injuries caused by an intimate partner (Campbell et al 1994, Roberts et al 1996, Wright and Kariya 1997, Spedding et al 1999, Yam 2000, Sethi et al 2004, Feder et al 2009). Indeed, studies undertaken in England, Australia and the United States, identified that women attending emergency departments because of injuries caused by their partner, made up between 1% and 3.5% of total emergency department caseloads (Olive 2007). Findings from the British Crime Survey of England and Wales (Britton 2012) identified that only a small proportion of women who reported partner abuse to the survey attended an emergency department for treatment of injuries sustained through a partner assault. This finding from the British Crime Survey of England and Wales (*ibid*) is important, suggesting that, as sites of health intervention for intimate partner violence, emergency departments are an important section of the health sector response, because they likely see the most heavily abused women, i.e., women who have suffered injury from an assault by their partner and which warrants immediate medical intervention.

Despite its massive global health burden the health sector response to intimate partner violence has been reported as largely 'slow' (WHO 2013c, Taft et al 2013, Feder et al 2009), and it has been 'slow' in two important ways: firstly, in terms of often not identifying and responding to intimate partner violence in health consultations (Campbell et al 1994, Yam 2000, Hegarty and Taft 2001, Bradley et al 2002, Howard et al 2010, WNC 2010), and secondly, in terms of poor intimate partner violence data collection in administrative health data systems (WHO 2103c). Without identification during consultations women's experiences of intimate partner violence are not validated and interventions for it not mobilized. Identification in health consultations is also important for health sector data collection so that the health burden of intimate partner violence can be more accurately measured in public health monitoring systems. These two important interconnected and historically problematic issues of the classification of intimate partner violence: the identification of intimate partner violence in emergency department health consultations and its classification in hospital-based emergency department administrative health data are central to this thesis.

### **The Problems of Identification in Emergency Department Consultations**

Women find being asked about intimate partner violence during health consultations acceptable (Hurley et al 2005, WNC 2010) and desirable (Yam 2000, Hurley et al 2005, Feder et al 2009, WNC 2010), and sets of question have been validated for this purpose (Feder et al 2009). Yet, research has identified that women's experience of intimate partner violence was not always acknowledged or asked about during emergency department consultations for injuries caused by their partner (Campbell et al 1994, Yam 2000, WNC 2010). The reason

for this is uncertain; some health practitioners do not think that intimate partner violence is a problem for health services to respond to (Fitzpatrick 2006). Furthermore, the measurement of effectiveness of health service interventions for intimate partner violence and upon which identification policies for health services are determined is contested. Some researchers consider that routine screening, meaning asking all women about intimate partner violence, should not be undertaken in health consultations (Ramsay et al 2001, Ramsay et al 2002, Coulthard et al 2004, Nelson et al 2004, Taft et al 2013) whilst others propose that it should (Nelson et al 2012). The different positions on screening policy are based on measures of outcome; for those who reject routine screening, improvement in health and reduction of violence were necessary outcome measures, whilst for those who advocate routine screening, identification and increased rates of referral to specialist services were deemed sufficient measures of successful outcome.

Based on systematic reviews of 'evidence', the current policy recommendation for identification of intimate partner violence in health services in England is the method known as 'case finding' (THAVAW 2010). 'Case finding' is the identification of intimate partner violence by practitioners screening only those patients who present with conditions associated with it (WHO 2013b). Yet research has indicated that even when protocols for *routine screening* have been implemented, patients exposed to intimate partner violence were still missed (Ellis 1999, Yam 2000, Cann et al 2001, Ramsden and Bonner 2002, Dowd et al 2002, Häggblom et al 2005, Djikanovic 2010, Torres-Votolas et al 2010, Beynon et al 2012) indicating widespread and likely complex problems of 'identification' of intimate partner violence in health consultations. Thus it is likely that the case finding method

currently recommended will result in a larger number of peoples' exposure to intimate partner violence being missed.

### **Research to Increase Identification**

Health research aiming to increase the numbers of people identified during health consultations exposed to intimate partner violence has mostly been of two designs: developing predictive models and improving the health environment. Research has investigated the characteristics of patients exposed to intimate partner violence and their injuries for predictive 'markers' (Muelleman et al 1996, Spedding et al 1999, Halpern et al 2005, Boyle et al 2010, Wu et al 2010). The usefulness of predictive models for this population has been questioned for necessarily excluding a certain proportion of the population from its analysis and models (Barata 2011). Research in the field has examined interventions to improve the health environment to make it more conducive to identification (Hathaway et al 2002, Coben 2002), in terms of providing privacy (Ramsden and Bonner 2002, Ellis 1999, Davis and Harsh 2001), practitioner training (Bournsnel and Prosser 2010, Ramsden and Bonner 2002, Ellis 1999), and implementing protocols and prompts (Bournsnel and Prosser 2010, Olsen et al 1996, Fanslow et al 1998). One recent study (Rhodes et al 2011) identified that even when intimate partner violence was recorded on emergency department attendance records, often interventions for it were not. This previous research in the field indicates that identification has been an important but also very problematic issue, and further, that even when intimate partner violence was identified, intervention was not always recorded as mobilized.

## **Collecting Data for Public Health and Health Service Monitoring.**

There are systems of classification (Holder et al 2001; HSCIC 2009; WHO 2013) in operation worldwide and in England for the classification of intimate partner violence in administrative health systems. These systems of classification are used to classify episodes of health care for which intimate partner violence was the cause of the health problem. An 'episode of care' is the term used for a bounded period of health service provision for a specified health problem. In this thesis 'episode of care' is used to refer to an attendance at an emergency department or an admission to hospital. Recent research (Schafer et al 2008, Btoush et al 2008, Btoush et al 2009, Rhodes et al 2011) has illustrated the use of one of these classification systems in hospitals in the United States but little is known about the use of classification systems in hospitals in England for collecting administrative health data about intimate partner violence.

## **The Knowledge Gaps in the Field**

Some research in the field reporting on emergency department identification and response provide a project-framing definition of intimate partner violence (Bournnell and Prosser 2010, Klopstein et al 2010), but this was not always the case (Choo et al 2012, Rhodes et al 2011, Btoush and Campbell 2009, Schafer et al 2008). In all these studies (*ibid*), whether a definition was provided or not, the category of 'intimate partner violence' was taken as given and left untroubled. In terms of *identification* of 'intimate partner violence' in health consultations much of the research has relied on indicators or the validity of screening tools to identify *'it'* (Bournnell and Prosser 2010, Svavarsdottir and Orlygsdottir 2009) and the classification 'intimate partner violence' was left unpacked. Leppakoski et al (2010) and Yau

et al (2013) have importantly examined attributes of intimate partner violence in emergency department caseloads that alert emergency department practitioners. However, and most importantly for understanding 'missed cases', none of the research in the field to date has examined the construction of the classification 'intimate partner violence' in health consultations in terms of not only what was included in the classification 'intimate partner violence', but also what was excluded.

Some research (Choo et al 2012, Schafer et al 2008, Btoush et al 2008, Btoush et al 2009, Rhodes et al 2011) has used classifications of intimate partner violence applied in administrative systems to identify populations in health services whose episodes of health care were classified as 'intimate partner violence'. Similarly, in this research (*ibid*) the process of application of the classifications of 'intimate partner violence' to episodes of care was not examined. Of these studies, one (Schaffer et al 2008) identified that two classifications performed well to correctly identify a population exposed to 'intimate partner violence' in health service data systems, but the classification system's fitness in terms of sensitivity, i.e., incident data for the health population exposed to intimate partner violence and identified as such during their health consultations, has not been investigated.

This thesis research differs from other work in the field because it positions the *classification, and vicariously the misclassification, of intimate partner violence* as the most important issue for emergency department responses and the collection of data. From the knowledge gaps in the research of this field to date, the main research question that this thesis addresses is:

*‘How best can intimate partner violence, in the form of a physical assault, be classified to reduce misclassification, increase identification, mobilize intervention (according to patients’ stated preference) in emergency department consultations, and collect data about it in hospital-based emergency department administrative systems?’*

## **Theoretical Framework**

To address the problems of ‘identification’ this thesis draws on the sociology of diagnosis. It draws on Jutel’s sociology of diagnosis in which ‘identification’, or in other words, the diagnosis of a health problem, has in its ontology three interconnected classificatory dimensions: its classification; the process by which the health problem becomes classified; and, the meaning of the health problem’s classification in terms of its consequences (Jutel 2011). For Jutel (*ibid*) these three dimensions are collectively important for comprehending the application of a diagnostic classification for any given health problem. This thesis also draws on Brown’s (1990, 1995) conceptualization of the sociology of diagnosis, in which structural inequalities, i.e., the power of social institutions cannot be disentangled from the social construction of a ‘diagnosis’. This is important for this thesis which has positioned violence against women as a cause and consequence of structural gender inequality.

This thesis is interdisciplinary, drawing on knowledge from the fields of sociology of violence against women, sociology of diagnosis, health service research and health policy. From this interdisciplinary position, the aim of this thesis research is to establish the better forms of classification of intimate partner violence for improving hospital-based emergency



department responses to it in England. To address the thesis' aim and main research question, the research has been designed to:

- Identify the classifications applied during emergency department consultations for an attendance after an assault by partner.
- Establish the classificatory attributes of the different classifications that have been applied for an assault by partner during emergency department consultations.
- Identify the interventions initiated during emergency department consultations for an attendance after an assault by a partner.
- Identify relationships between the different classifications applied and interventions initiated for intimate partner violence during emergency department consultations for an attendance after an assault by a partner.
- Explain why intimate partner violence, in the form of physical assault by a partner, was classified in different ways during emergency department consultations.
- Identify the classifications applied in administrative health data systems in England for emergency department health consultations for an assault by partner.
- Establish across which classifications in administrative health data systems in England, were hospital-based emergency department and admitted patient episodes of care for an assault by a partner most likely distributed.
- Explain why cases of intimate partner violence, in the form of physical assault by a partner, were classified in different ways and distributed across different classifications in hospital-based emergency department administrative health data systems in England.

## **Ontology, Epistemology and Methodology**

The research for this thesis has been positioned ontologically and epistemologically by a synthesis of critical realism and complexity theory. This approach attends to ontological and epistemological depth in terms of dynamic, multi-modal, and multi-directional properties of social systems that lie behind patterns of events and experiences. A mixed-method research design was employed for this research and this involved three elements: interviews with women victim/survivors of intimate partner violence, emergency department practitioners, and clinical coders; a review of records of emergency department attendances that had been classified as an assault that had taken place in a home; and a survey of hospital-based emergency department administrative health data. The mixed-method research design was justified on philosophical grounds, and theoretically connected to the ontology and epistemology to produce explanatory accounts of patterns of events and experiences. Quantitative data were analysed for patterns of classifications of and responses to intimate partner violence at different levels of emergency department health systems (consultations and administrative health data systems). Where possible, quantitative data in the form of indicators of classificatory importance, were tested for their strength of association with classifications applied. Qualitative data were analyzed for items with explanatory properties for the patterns of classifications of and responses to intimate partner violence observed at different levels of health systems. The quantitative and qualitative research data were analysed and interpreted to produce explanatory accounts of the classification of intimate partner violence in hospital-based, emergency department health systems and to establish the better forms of classification for it.

## A Note on Terminology and Style

'Intimate Partner Violence' is the term used by the World Health Organisation (2012) for gender-based violence against women perpetrated by a current or former intimate partner.

However the term 'domestic violence' is also commonly used and is employed in England by the Department of Health (2005, 2010, and 2011), Home Office (2010, 2013) and civil society organisations (Women's Aid 2013, Refuge 2009). Intimate partner violence has greater specificity for violence perpetrated by partners whereas domestic violence is also used to refer to violence perpetrated by wider kin relations or acquaintances sharing the same residence. For this thesis I use both; I use the term 'intimate partner violence' more for my discussions, and the term 'domestic violence' to reflect the everyday terminology applied in health settings and wider society in England. The term 'partner' is used to mean the person's current or former partner with whom they have or had an intimate relationship. In this thesis, drawing on the work of Kelly, Burton, and Regan (1996), I use the term victim/survivor to acknowledge both the abuse that a person exposed to intimate partner violence has experienced and the person's agency and resistance against this abuse.

This thesis has been written following established academic writing stylistic conventions. As points of stylistic clarity, double quotation marks and italics are used for speech and direct quotes. Italics are also used in the text to stress a word or phrase to emphasize importance. Single quotation marks are used in this thesis principally to mark key and often contested concepts, for example 'domestic violence'; and to call attention to incongruity in language representations, for example 'domestic violence' used in reference to intimate partner violence, and 'low level violence' in patients attending an emergency department for injuries

sustained in an assault; and to denote titles of things, for example books and classification system categories. Single quotation marks have also been used to identify when language use or a concept is the subject under discussion, for example 'alleged assault' and 'serious harm' or 'risk of serious harm' respectively, and which may also hold contestation and incongruity.

## **Introduction to the Chapters**

In Chapter Two I review the relevant literature. In this chapter I position 'violence against women' and 'intimate partner violence' ontologically as a cause and consequence of wider structural gender inequality and do this to explicate typologies of violence which are important for how intimate partner violence is classified. I further explicate intimate partner violence as a major global public health issue in terms of its health burden for women worldwide and as a matter that health services should respond to. I establish emergency departments as a location that likely see the most heavily abused women who seek medical treatment after an assault by their partner. Following this contextualization I then introduce current policy frameworks for responding to intimate partner violence and discuss the evidence base underpinning it. I establish the scope of the knowledge base to date and identify gaps in the field in relation to 'identification' of intimate partner violence and mobilization of interventions during emergency department consultations. In the second half of Chapter Two, I present and discuss the systems of classifications in use in hospitals in England to classify episodes of care for the consequences of intimate partner violence. I identify the importance of understanding not only the classification of intimate partner violence but also its misclassifications for the two interconnected issues of classification of

intimate partner violence: the classification of intimate partner violence in emergency department health consultations and its classification in hospital-based emergency department administrative health data systems. In this chapter I establish the criticality of the classification(s) of intimate partner violence for the field and explicate the importance of the sociology of diagnosis for this thesis.

In Chapter Three I set out the ontological, epistemological, and methodological concerns for this thesis. An argument is made to position the research ontologically and epistemologically in a synthesis of critical realism and complexity theory for the ontological depth and multi-directional causal fluidity that this approach accommodates. A mixed-method research design is introduced and justified on philosophical grounds and theoretically connected to the ontology and epistemology to produce explanatory accounts of intelligible patterns of events and experiences. The three elements of the research design (interviews with service users, health practitioners, and clinical coders; a review of emergency department attendance records; and a survey of hospital-based administrative health data) are introduced and described. The empirical status of the data sources in relation to the mixed-method design are discussed to identify how these differ from monist-method research approaches. At the end of Chapter Three I present a table that maps the research questions to sources of data and to the chapters in which they are addressed.

This research had particular ethics and data access issues to contend with and these are identified and discussed in Chapter Four. In this chapter, I also question the governance of

research, and argue that ethics committees are not always best placed to advise on more nuanced aspects of research with particular complexities. In Chapter Four I also highlight the difficulties involved in accessing research feasibility information needed from NHS Trusts prior to undertaking data collection, and I identify and discuss the issues that affected access to data and to interview respondents. I conclude Chapter Four with an overview of the sources and types of data collected and the data chapters that follow.

Chapters Five through to Eight are the empirical data chapters and in these, the research findings are presented, discussed and interpreted. In Chapter Five I identify the different locations of patient/practitioner interaction during emergency department consultations at which classifications of intimate partner violence for patients attending after an assault by their partner are made. In this chapter, I principally report on the analysis of data from emergency department attendance records and which identified the classifications that were applied at the different locations of patient/practitioner interaction. I also report on and discuss the methods employed by emergency nurses and doctors to document classifications of intimate partner violence in patients' emergency department attendance records. The research findings reported in Chapter Five are important because they inform on the patterns of classificatory events found and signal sites of causal significance for the classification of intimate partner violence for an assault by a partner during emergency department consultations.

In Chapter Six I draw on interview and emergency department attendance record data to explain the construction of and meaning given to different classifications applied to intimate

partner violence in the form of a physical assault. In this chapter I explicate how practitioners construct distinctions of 'types' of intimate partner violence within the classification 'intimate partner violence'. I interpret the research findings to explain how practitioners construct different types of serious intimate partner violence and popularized versions of less serious intimate partner violence. I report on the implications that these different constructions of intimate partner violence have for how practitioners understand its volume and its intelligibility in their caseload, and I critique this. I present data about severity of force and severity of injury documented in records and which contests practitioners' held perceptions of which 'types' of intimate partner violence were of low and high volume in the emergency department caseload. In Chapter Six I examine the items recorded in patients' emergency department attendance records that indicate classificatory importance and test their significance for applications of the classification 'domestic violence'.

In Chapter Seven I draw on interview data to explicate different methods of identification of intimate partner violence during health consultations reported by service users and practitioners. In this analysis I identify multi-directional causal properties for the classification of intimate partner violence and the mobilization of interventions based on the method by which it is identified, and the perception of patients' desire for intervention. In Chapter Seven I present analyses of interview and emergency department attendance record data to establish the difference that classifications made for patients, in terms of interventions and referral routes mobilized. I identify the frequencies of classifications

applied and interventions and referral routes mobilized and I establish which interventions and referral routes were mobilized for which classifications.

In Chapter Eight I present, discuss and interpret data about the classifications of intimate partner violence in administrative health data and their rates of application. I first present and discuss routinely collected data from the perspective of providing information to health practitioners likely to provide ongoing follow-up services for patients after an emergency department attendance. I then examine routinely collected administrative data from the perspective of public health and health services monitoring of intimate partner violence. I examine the classification of intimate partner violence in emergency department and admitted patient administrative health data. I identify and discuss different vocabularies for 'intimate partner violence' used by practitioners in medical records and by administrative classification systems. Drawing on administrative health data detailing rates of applications of the different classifications and interviews with professional medical classifiers, called 'clinical coders', I establish the fitness of the classification systems in operation in hospitals in England for health monitoring of intimate partner violence in the form of a physical assault.

In Chapter Nine I draw the research findings from each of the data chapters together and further contextualize and interpret their meaning. In this chapter I first discuss the classifications of intimate partner violence that made a difference for mobilization of interventions and referral routes. I further interpret the classifications through the sociology of diagnosis in that I discuss the classifications' definitional attributes; the impact of the



process of identification for classifications, in terms of the method of reporting intimate partner violence; the classifications' consequences in terms of interventions and referrals mobilized; and, the classifications applied in administrative health data. I identify the current best indicators for intimate partner violence in emergency department and admitted patient care administrative health data. From my interpretations, I propose the best form of classification for intimate partner violence in the form of a physical assault in hospital-based emergency department health systems.

In Chapter Ten I present the important findings from this research and articulate the implications of them. From the key findings, I make twelve recommendations to improve classification and response to intimate partner violence in the form of a physical assault in hospital-based emergency department systems in England. I discuss the findings in the context of critical realism and complexity theory indicating why this approach was important, and I present a statement about the status of knowledge claims presented in this thesis. In Chapter Ten I also discuss power relations inherent in the classification of intimate partner violence during emergency department consultations, in the construction of national and international taxonomies to classify 'intimate partner violence', and in the determination of measures of effectiveness for interventions initiated in health systems for intimate partner violence. I provide an account of the classifications of intimate partner violence in the form of a physical assault in hospital-based emergency department systems. Finally, based on research presented in this thesis, I articulate the original contribution to knowledge that this thesis makes to the sociology of violence against women, the sociology of diagnosis, and health policy.

## CHAPTER TWO: 'MISSINGNESS', CLASSIFICATION OF INTIMATE PARTNER VIOLENCE IN HEALTH SYSTEMS

*"That which has no name, that for which we have no words or concepts, is rendered mute and invisible: powerless to inform or transform our consciousness of our experience, our understanding, our vision; powerless to claim its own existence." (Dubois 1983:108)*

*"Violence against women is a public health problem of epidemic proportions. It pervades all corners of the globe, puts women's health at risk, limits their participation in society and causes great harm and suffering." (WHO 2013c:35)*

## INTRODUCTION

The juxtaposition of these two quotes exemplifies the paradoxical yet longstanding reality of many women's experience of violence being simultaneously everywhere and nowhere. This chapter, in which I present the landscape for the classification of intimate partner violence in hospital-based emergency department health systems explicates the epidemic nature of violence against women, its health burden (albeit underestimated), and its simultaneous presence and absence. By this I mean its classification and misclassification in emergency department consultations and systems for monitoring public health.

Violence in intimate relationships cannot be separated from the social context in which it is enacted (Merry 2009) and this chapter will first set the context of violence in intimate relationships. This section argues that conceptualizations of violence and intimate partner violence are not fixed; different definitions co-exist at macro, micro and meso levels, and nor are they stable, shifting in response to social, political and cultural interpretation and this has implications for how intimate partner violence may be classified. This section will present the key debates in social theory and argue that intimate partner violence is an example of violence in society, the deployment of which is a consequence of gender inequalities constructed in gender regimes.

Health services are just one part of societal responses to assist victim/survivors and prevent violence against women. This chapter explicates intimate partner violence as a public health issue. Relocated through the lens of public health, the health burden of intimate partner violence and health systems responses to it are examined. The review of the literature that

is presented here illuminates paradoxes and perversities in health systems and competing interests and tensions involved in the classification of and response to intimate partner violence. In this chapter I draw attention to the areas where there are paradoxes and gaps in the current body of knowledge, and from which I raise questions for the classification of and response to intimate partner violence, in the form of a physical assault, in hospital-based emergency department systems.

### **Structural Gender Inequality and Violence against Women**

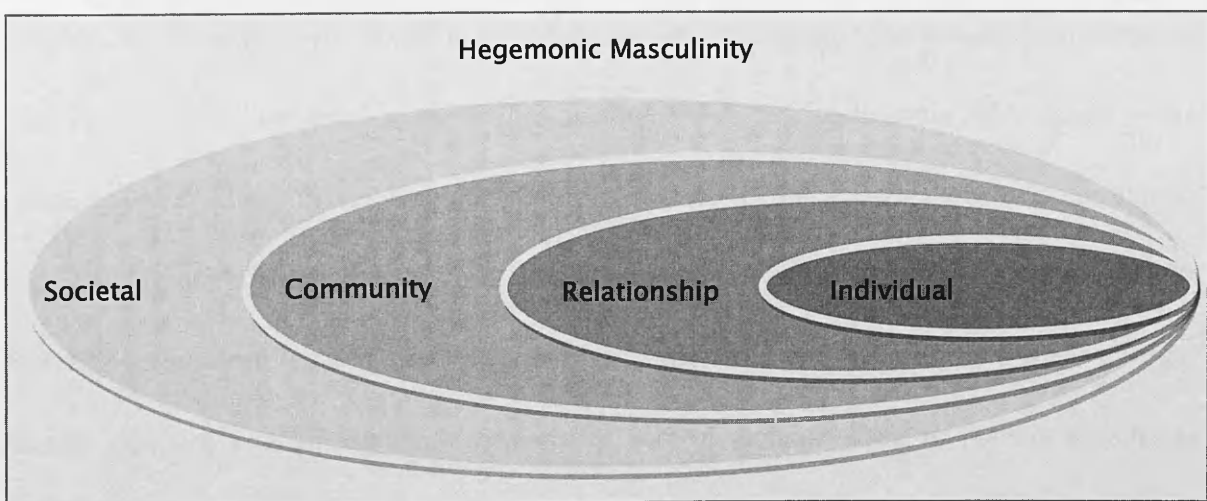
Walby (2009) differentiates four types of structural violence in societies: legitimate violence, irregular violence, coercive institutions and interpersonal violence. In Walby's (*ibid*) theory, social order is preserved through legitimate violence sanctioned by the state through the maintenance and deployment of its military and coercive institutions. Whilst not legitimate, irregular violence is condoned and widespread in coercive institutions of the state and in interpersonal violence (Walby 2009). Violence is both, constitutive of power and an instrument of power employed by the dominant in social practices of the state, institutions, social groups, and individual relations through which social order and its inequalities are preserved and human rights are violated (*Ibid* 2009).

The gradated subordination of 'others' in the theory of gender order and hegemonic masculinity (Connell and Messerschmidt 2005) offers explanatory comprehension of violence in all types of intimate and non-intimate relations as enacted to subordinate, oppress, and control, to maintain gendered power relations. Theories of hegemonic masculinity (*ibid*) and gender regimes (Walby 2009) developed from feminist critique of patriarchy. This feminist

critique articulated intimate partner violence as entrenched in patriarchal social ideology and structures in which men historically possess, exert power over, and control women (Dobash and Dobash 1979) through legitimated or condoned violence and gender inequalities (Walby 1990; 2009). Men's rights over women and male entitlement through the marriage contract were only withdrawn in full in England in 1991, until which point, rape within marriage was lawful (Mooney 2000). The criminalization of gender-based violence is however incomplete, and today, violence continues to be instrumental in the preservation of gendered social order and reproduction of gender inequality (Walby 2009) employed in privileging 'male entitlement' (Kelly 1988) at individual, state, and global levels of interaction.

This is not to say that the perpetration of violence against women is stable or fixed, by contextualizing the ecological model of violence (Dahlberg and Krug 2002) in hegemonic masculinity (Figure 2.1) a comprehension of forms of violence against women, changing and adapting across time and place is possible.

Figure 2.1 The Ecological Model of Violence (Dahlberg and Krug 2002) in Context of Hegemonic Masculinity



In the ecological model (Dahlberg and Krug 2002) of violence, interconnections between different sets of gendered social relations at different levels of social systems in complex causal pathways result in different forms and rates of violence against women in different times and places. The individual level involves socio-cultural-biological elements of humans, the relationship level is concerned with our proximal social relations, the community level involves our community social relations and local institutions, and the societal level involves cultural norms, socio-political context, and larger institutions (health, economy, education, and social policies) of society that reproduce intersecting inequalities that shape risk of exposure to violence.

### **Alternate Theories of Intimate Partner Violence**

The theory of intimate partner violence I have presented and drawn on to position this thesis is based on a body of feminist critique of patriarchal hegemony, but there are alternate positions most notably arising from Family Violence theorists and the construct of gender symmetry in the perpetration of acts of violence.

#### ***Gender Symmetry Theory***

Straus (2006) argues that traditional feminist views of female to male violence may cause women to perceive their violence as legitimate and proposes that through convergence theory, as women become more equal in society, they will also become more equal in the enactment of crime. In support of this view, Archer (2006) found a positive correlation between women's empowerment and female violence towards their partner, and an inverse correlation between women's empowerment and women's victimisation by a male partner. In this context, and employing a measure of acts of violence used to resolve conflict in

relationships (Conflict Tactics Scale, Straus 1996), it was found that men and women perpetrated and initiated roughly equal acts of violence towards their partners (Straus 1980, Archer 2000, Graham–Kevan, Archer 2008). Thus, it was argued that feminism had become inadequate for understanding the violent behaviours of men and women and alternate classificatory conceptualizations, or typologies have been proposed.

This research finding of gender symmetry in perpetration of violence (Straus 1980; Archer 2000, Graham–Kevan and Archer 2008) was in contrast to data from criminal justice systems, women’s refuges, and hospital emergency departments, in which the picture was considerably different, with men primarily perpetrators and women primarily victim/survivors (Johnson 2006, Kimmel 2002, Sethi et al 2004). In response to this contrasting data it has been proposed that in agency data, we are seeing the disproportionate *effects* of intimate partner violence on women that prompt calls for outside assistance (Johnson 2006, Stark 2010). However representative samples using better, more sensitive survey methods (Walby and Myhill 2001) have identified the disproportionality of intimate partner violence against women in England in terms of prevalence, frequency, and health impact (Walby and Allen 2004). Nevertheless, the question of direction of perpetration of violence in intimate relationships and its symmetry or asymmetry has resulted in the development of typologies of intimate partner violence (Dobash and Dobash 1979, Straus 1980, Archer 2000, Johnson 2006, Stark 2007, Anderson, 2009, Cook and Parrott 2009, Langhinrichsen–Rohling 2010), some of which as the later data chapters illustrate have popularised versions.

## Typologies of Intimate Partner Violence

Typologies can help in theorizing the concept of intimate partner violence through the analysis of attributes of phenomena. Table 2.1 provides a summary of some of the ways intimate partner violence has been differentiated and specified in typologies of intimate partner violence.

Table 2.1 Planes of Differentiation from Typologies of Intimate Partner Violence

Theorist(s)	Type of Violence		
	Controlling and / or violent assault	Low level violence	Direction of Violence
Dobash and Dobash (1979)	Violence against wives / wife-beating		Unidirectional
Straus (1980)	Marital Violence		Bidirectional
Johnson (2006)	Intimate Terrorism		Unidirectional
	Mutual Violent Control		Bidirectional
	Violent Resistance (self defence)		Bidirectional
		Situational Couple Violence	Bidirectional
Stark (2007)	Coercive Control		Unidirectional
	Partner Assault		Unidirectional
		Couple Fights	Bidirectional
Langhinrichsen-Rohling (2010)	Dyadic Dominance		Bidirectional
	Dyadic Disregulation		Bidirectional
		Dyadic Couple Violence	Bidirectional

Axes of differentiation have been made in relation to direction of violence, type and severity of violence. Direction of violence has been described in terms of whether one (unidirectional) or both (bidirectional) people in the relationship perpetrate acts of violence against the other. Severity and type of violence has been distinguished in terms of it being 'low level', 'violent assault', or 'controlling'. It has been proposed that it is exposure to the type of intimate partner violence that is controlling and of severe force that is most often



seen often in agency data (Johnson 2006, Stark 2007). Low-level violence has only been theorized in a bidirectional way and it is hypothesized that this population, couples deploying bidirectional, low-level violence, is likely unknown to agencies but is observed in victimisation surveys of representative samples (Johnson 2006, Stark 2007).

Most commentators (Straus 2006, Archer 2000, and Johnson 2006) agree that any violent act is morally wrong, yet whilst perpetration of acts of intimate partner violence is a crime in many countries (UN Women 2011), even in these, 'common couple violence' (bidirectional and low-level), for want of a better term, is often legitimated and condoned.

### ***Classificatory Boundary of an Act of Violence***

Qualitatively differentiating intimate partner violence broadly into two classifications based on severity of violence is problematic because of the classificatory boundary of an act of violence. Stark (2006) contends that much of the everyday acts of 'coercive control' are indeed 'low level' and often leave no injury. Stark's (2007) conceptualization of 'coercive control' defines intimate partner violence as incorporating micro-regulation (control) of women's lives with myriad tactics underpinned through regimes of gender inequality and violence. In Stark's (2006) conceptualisation, acts of violence are not necessarily severe; rather it is the combination of violence and tactics used to control that define intimate partner violence. However, such conceptual layering makes classification more difficult:

*"The fact that CC [coercive control] builds on normative stereotypes makes it hard to distinguish where sexist constraints end and personal regulation of domestic routines begins."*

(Stark 2006:1022)

My reading of Stark means that because low level violence takes place in gendered (unequal) intimate relations, such violence cannot be discounted from the classification 'intimate partner violence' thus a classificatory distinction of 'common couple violence', I argue is a misclassification. Furthermore, the experience of an act of violence goes beyond the actuality of a violent act and extends to then include perceived potentiality and threat of future violence.

## **PREVALENCE OF INTIMATE PARTNER VIOLENCE**

Although general population survey techniques have improved over time (Walby and Myhill 2001), still the social risks of reporting and the feasibility of getting truly representative samples (Walby 2005, Smith 2006) means that best estimates are likely conservative underestimates. Based on measures of acts of sexual violence, acts of physical violence, and threats of violence, the lifetime prevalence of intimate partner violence against women has been estimated to range from 23.2% in high income countries to between 24.6% to 36.6% in low and middle income countries. Globally, 30% of women reported that they had experienced physical and/or sexual violence by a current or former partner (WHO 2013c). In 2010, in England and Wales, women's reported lifetime prevalence of non-sexual partner abuse since the age of sixteen was 24% (Britton 2012).

## **THE HEALTH CONSEQUENCES OF INTIMATE PARTNER VIOLENCE**

The health impacts of intimate partner violence are huge, involving the experience of violence and regulation of life that limits full democratic participation in social life (Heise and Garcia-Moreno 2002). For this thesis, the focus is on the health consequences of

intimate partner violence defined as contributing to women's premature death and disability.

## **Premature Death**

From research undertaken in high income countries, such as the UK and the US, it has long been established that women's greatest risk of homicide was from an intimate partner. More recently, in a global review of prevalence of intimate partner homicide (Stöckl et al 2013), this significantly greater risk for women has now been confirmed across sixty-six countries. One of the issues raised by Stöckl et al (2013) in conducting the global review was the large proportion of data for which the victim/perpetrator relationship had not been recorded. In this same study, the proportion of women killed by a current or ex-partner was found to be six times higher than for men (Stöckl et al 2013). In England and Wales, ninety-three women were killed by their partner in 2010/11, and women were ten times more likely to be killed by their current or former intimate partner than men (Osborne 2012). However, many more women exposed to intimate partner violence commit suicide, and in a recent study women exposed to intimate partner violence were found to be 4½ times more likely to commit suicide than women who were not exposed (WHO 2013c).

## **Disability**

Homicide and suicide data, however, are only part of the picture and women experience disability and premature death as a result of physiological and psychological harms from intimate partner violence. Over the last decade since the first review of health consequences of intimate partner violence (Campbell 2002) was published in the Lancet, a growing body of research has further detailed the extent of health consequences of violence against women and which has been recently collated in a report by the World Health Organisation (2013c).

This report (*ibid*) hypothesizes likely causal pathways from biological and psychological stress responses to different forms of intimate partner violence that result in adverse physiological and psychological health outcomes. Although extensive, the research to date has mostly been cross-sectional rather than longitudinal, meaning that causality in terms of probabilities and casual direction are underdetermined. Notwithstanding, the evidence is sufficient for the World Health Organization to conclude that *“exposure to intimate partner violence is an important determinant of poor health for women”* (2013c:31).

The recent World Health Organization’s systematic review of intimate partner violence exposure and health outcomes (2013c) found that, although regional variations exist, overall, women exposed to intimate partner violence were more likely to experience poorer health outcomes in measures of sexual, reproductive and mental health, physical injury, and premature death. In a different study, women in the United States, with a history of intimate partner violence were found to be more likely ( $p < 0.001$ ) to experience nine out of ten long term conditions (asthma, irritable bowel syndrome, diabetes, high blood pressure, frequent headaches, chronic pain, difficulty sleeping, activity limitations, poor physical health, and poor mental health) than women with no reported exposure (Black et al 2011). Long term health consequences may result from the continued health burden of an injury, from employing coping strategies that pose health risks (Campbell 2002), or from physiological responses to stress, induced from exposure to intimate partner violence (Lokhmatkina et al 2013, Black et al 2011).

### *Health Burden of Intimate Partner Violence*

The cost or health burden of intimate partner violence is measured in health terms as years lived with disability (YLD), years of life lost (YLL) and/or years of healthy life lost (DALY) (WHO 2013d). The health burden from intimate partner violence is uncertain and underestimated because of lack of research evidencing causal relations and underestimations of prevalence in general population surveys and administrative data (WHO 2013c). That said, and although the data sources were unclear, the Global Burden of Disease Project has listed intimate partner violence in the top twenty-five of global risk factors for premature death and disability for 2010, measured in the number of healthy life years lost (IHME 2013a). And, in the UK, Murray et al (2013) reported that there were 68,000 (uncertainty interval 42,000 – 104,000) years of healthy life lost for women attributable to intimate partner violence (Murray et al 2013). The health burden of intimate partner violence, though still underestimated, is a major cause of premature death and disability from physical injury and chronic (physical and mental) ill-health.

### *Injury Burden of Intimate Partner Violence*

The direct health burden because of injuries suffered as a result of intimate partner physical violence is also uncertain because the data is not routinely disaggregated to the level of victim/perpetrator relationship. In 2009, death by violence was globally the tenth leading cause of premature death for women of reproductive age (WHO 2009), and in 2010 intimate partner violence against women ranked fifth worldwide in the leading causes of years of life lost due to disability (Jewkes 2013). In the United Kingdom, interpersonal violence was the 29<sup>th</sup> leading cause of death in terms of years of life lost (YLL) for men and women aged between twenty and fifty-four years old, down 30% and from 20<sup>th</sup> position in 1990 (Murray

et al 2013). Interpersonal violence reportedly accounted for 0.12% of the total number of healthy years lost (DALY) for women in 2010 in the UK (IHME 2013b).

This latest review by the World Health Organisation (WHO) (2013c) reports that despite injury being an important health outcome measure of intimate partner violence they found administrative data was limited and identified gaps in population data about injuries, and the extent and forms of them in different settings. The WHO's (*ibid*) interest for research on injury and intimate partner violence is not so much for the relative risk of injury for women exposed to intimate partner violence but rather, for understanding the health effects from injury attributable to intimate partner violence. In the latest global survey 42% of women who had experienced intimate partner violence had suffered an injury (WHO 2013c). In this report (*ibid*), it was proposed that general population surveys were better than hospital or clinic data because of the report of injuries for which treatment was and was not sought and suggest that hospital-based data is insufficient because women often "do not seek health care for injuries caused by partner violence", "may be reluctant to disclose", and furthermore, when women do present, most hospitals do not collect victim/perpetrator relationship information (2013c:26). However, if the World Health Organisation is interested in burden rather than risk then hospital-based data can strengthen the body of knowledge about the short and longer term health burden of injuries directly attributed to partner violence even though it may be incomplete. In addition, if classifications systems were more robust, then administrative health data employing them could also be used to monitor rates of report of intimate partner violence to health services over time.

### *Intimate Partner Violence in Emergency Department Populations of England<sup>1</sup>*

In a review of prevalence of intimate partner violence in clinical populations in the UK, Feder et al (2009) concluded that the prevalence rates of intimate partner violence in clinical populations appeared to be greatest in Emergency Departments, however this finding was likely skewed by the inclusion of a study (Wright and Kariya 1999) that only sampled women attending an emergency department after an assault of which 46% reported intimate partner violence in the last two months. Three more recent epidemiological studies in the UK illustrated that at least one percent of patients attending an emergency department were doing so for injuries directly related to an episode of intimate partner violence (Spedding et al 1999, Boyle and Todd 2003, Sethi et al 2004).

According to the self-completion module of the British Crime Survey of England and Wales (Britton 2012), in 2010/11, an estimated 900,000 women experienced 'partner abuse'. The category 'partner abuse' included non-physical abuse, threats, acts of minor force, acts of severe force, less serious sexual assault, serious sexual assault, and stalking. Of the 900,000 women reporting partner abuse, an estimated 27%, equating to 243,000 women suffered some form of injury, and 28% of whom or 68,040 women sought medical attention (Britton 2012). Of the estimated 68,040 women that received medical attention, 18% or 12,247 women did so from an emergency department (*ibid* 2012). This means that approximately, only 1.4% of women reporting 'partner abuse' to the British Crime Survey of England and Wales (Britton 2012) attend an emergency department for treatment of their

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<sup>1</sup> It is recognised that women exposed to intimate partner violence attend emergency departments for a range of health problems most notably for associated mental health sequelae. Data about these other related health consequences are not included because the focus of this thesis is on intimate partner violence in the form of a physical assault.

injuries suffered in an assault by their partner. Importantly, this suggests that although emergency departments are seeing a minority of women abused by their partner, it is likely that they are seeing the most severely physically injured and highly abused.

## **HEALTH SERVICE RESPONSE FOR INTIMATE PARTNER VIOLENCE**

Although women attend health services for the consequences of intimate partner violence, the health sector response to it has been reported as slow worldwide (WHO 2013c, Taft et al 2013, Feder et al 2009). There is a complex mix of mobilization and resistance to intimate partner violence as a health issue for health care practitioners to respond to; its legitimacy as a matter for medical consultations has been questioned by women victim/survivors and health practitioners alike (Lavis et al 2005, Feder et al 2006).

Women victim/survivors of intimate partner violence have supposed that health care professionals were disinterested in social problems and that even if they were interested women were concerned that health care professionals *“would reframe the situation as a medical problem”* (Feder et al 2006:34). Women have questioned the usefulness of health intervention that focuses on symptoms and medicine, and not the cause of the health problem (Rose et al 2011). Conversely, medicalisation has been reported as a vehicle for health practitioners to act (Duxbury et al 2006), to better understand patients’ health problems, and to make more accurate diagnoses and better management plans (Barata 2011). There is evidently a tension, from both victim/survivors and health care practitioners, for the boundary of the sphere of legitimacy for health sector intervention.



## CURRENT HEALTH SERVICE POLICY

Despite these debates, the mobilization of health policy advocating health services as sites of intimate partner violence intervention is well established worldwide (WHO 2010, 2013b) and England has had national guidance for health practitioners on how to respond since 2000 (DH 2000). The health response to intimate partner violence is charged with 'advocating violence prevention' and 'providing services for women' (García-Moreno et al 2005) 'in collaboration with other organisations' (DH 2010). 'Prevention' for health settings means identifying abuse early, providing necessary medical treatment, and referring women to appropriate care (DH 2010, THAVAW 2010).

The World Health Organisation (2013b), based on systematic review of the literature, has recently published clinical and policy guidelines for health care providers responding to intimate partner violence. The recommendations most relevant for practitioners responding to intimate partner violence in emergency department consultations are grouped under the following headings:

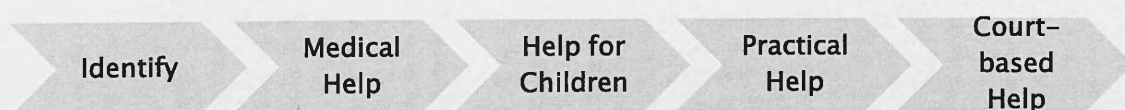
- Women-centred care
- Identification of intimate partner violence
- Care for survivors of intimate partner violence
- Reporting.

Women-centred care involves ensuring privacy and confidentiality while communicating limits of confidentiality, being non-judgmental, validating what the woman is saying, providing practical care and support, not being intrusive, asking about the woman's experience of partner violence but not pressuring to talk, helping access information about

resources available, assisting the woman to increase safety for herself and her children, and mobilizing social support (2013b).

The UK's Taskforce on the Health Aspects of Violence against Women Domestic Violence Subgroup (THAVAW 2010) identified a number of 'care pathways' through health care services that patients suffering health consequences from intimate partner violence may take, and the emergency department was named as one of the locations. However, there are mixed messages in policy documents about the role of emergency departments. The emergency department is not named as a health service site besides those of primary care, maternity care, genito-urinary medicine, and mental health services that particularly should 'identify' and have 'pathways' for women 'victims' of violence to get to ongoing care (DH 2010c), but in others it is named as a site where women exposed to violence attend for health services (DH 2010, Bellis et al 2012). Given that women suffer direct injury and that emergency departments provide services for trauma, it seems curious that it is not consistently identified as a site for intervention. Nevertheless, the 'care pathway' for current or historic intimate partner violence is illustrated by the Taskforce (THAVAW 2010) as:

Figure 2.2 Care Pathway for Intimate Partner Violence (THAVAW 2010)



From the Department of Health's (2005) guidance for health practitioners in responding to 'domestic violence', 'Identify' is concerned with issues of screening, enquiry and facilitating disclosure; 'Medical Help', beyond usual treatment for a patient's injury, is concerned with

recording the event, recording injury using body maps, forensic evidence collection such as taking photographs of injuries, health assessments, and providing information about 'domestic violence'; 'Help for children' involves assessing children's risk from violence and referring to children's safeguarding services, and health visitor or school nurse for ongoing care; and 'Practical help' involves patients' immediate safety and/or risk assessments, referral to specialist and advocacy services, and arrangements for distancing from perpetrator if desired/required. 'Court-based help' is not directly relevant to emergency department services but good record keeping with injury body maps and photographs will support patients' cases in court. These health service interventions are summarised in Table 2.2.

Table 2.2 Emergency Department Interventions (from DH 2005, DH 2010, THAVAW 2010)

Domain	Interventions
Identify	'Domestic violence' aware service
	Attention to domestic violence risk indicators**
	Screening /Enquiry
	Supportive facilitation of disclosure
Medical Help	Physical health assessment
	Mental health assessment
	Alcohol / drug use assessment
	Provision of information about domestic violence
	Referral to general practitioner
	Referral to mental health services
	Referral to specialty consultant
Record Keeping	Descriptive recording of event
	Forensic evidence collection
	Body map injury recording
	Photographic injury recording
	Recording of interventions
Practical Help	Safety and/or Risk assessment
	Referral to nearest domestic and sexual violence services
	Referral to health visitor
	Homicide or danger assessment
	Safety strategy including safety plan
	Referral to social services and/or housing services
	Distancing from perpetrator
	Refuge or protective hospitalization
	Risk of Serious Harm referral
Referral to police services	
Help for Children	Referral to safeguarding team, and health visitor or school nurse
	Referral to child and adolescent mental health team

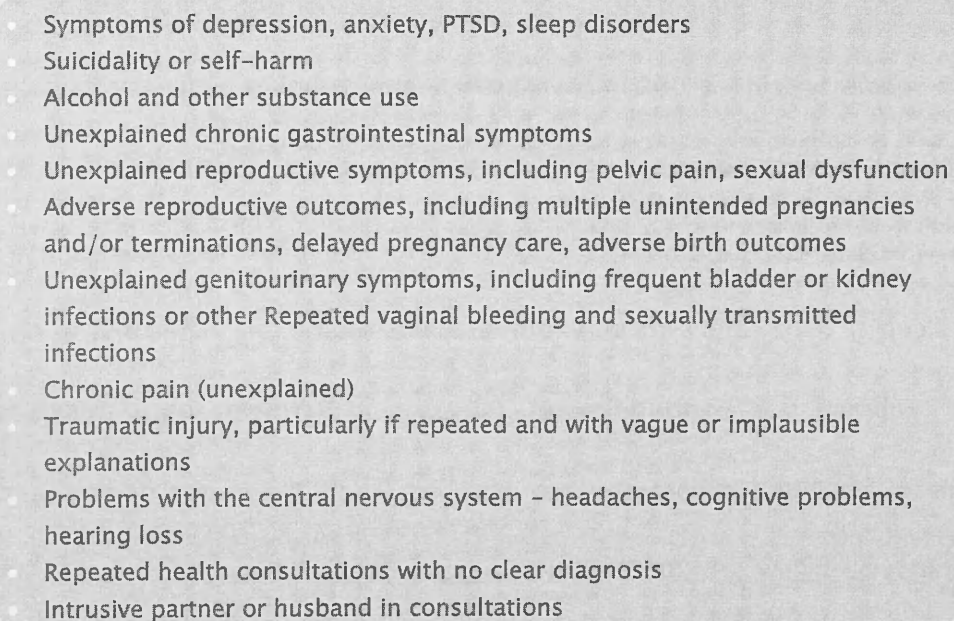
\*\*Risk Indicators: Frequent appointments for vague symptoms, Injuries inconsistent with explanation of cause, Woman tries to hide injuries or minimize their extent, Partner always attends unnecessarily, Woman is reluctant to speak in front of partner, Woman is submissive or afraid to speak in front of her partner, Suicide attempts – particularly with Asian women, History of repeated miscarriages, terminations, still births or pre-term labour, Repeat presentation with depression, anxiety, self-harm or psychosomatic symptoms, Non-compliance with treatment, Frequent missed appointments, Multiple injuries at different stages of healing, Patient appears frightened, overly anxious or depressed, Partner is aggressive or dominant, talks for a woman or refuses to leave the room, Poor attendance at antenatal clinics, Injuries to the breasts or abdomen, Recurring sexually transmitted infections or urinary tract infections, Early self discharge from hospital (DH 2005).

## Identification

Methods of identification of intimate partner violence by practitioners in health consultations has been discussed in terms of 'screening' or 'case-finding' (Ramsay et al

2002, Taket et al 2003, Feder et al 2006, WHO 2013b). 'Screening' means identifying a condition in people who may not display any indication of it but who may be at greater risk for it (UK NSC 2013), and has also been referred to as 'routine enquiry' (Taket et al 2003). For intimate partner violence, this would mean asking all women in health consultations about their exposure to intimate partner violence because of women's greater risk. 'Case-finding' means asking only those people who have conditions associated with intimate partner violence (WHO 2013b). The World Health Organization has listed 'conditions associated' with intimate partner violence (see Figure 2.3).

Figure 2.3 Conditions Associated with Intimate Partner Violence (WHO 2013b)

- 
- Symptoms of depression, anxiety, PTSD, sleep disorders
  - Suicidality or self-harm
  - Alcohol and other substance use
  - Unexplained chronic gastrointestinal symptoms
  - Unexplained reproductive symptoms, including pelvic pain, sexual dysfunction
  - Adverse reproductive outcomes, including multiple unintended pregnancies and/or terminations, delayed pregnancy care, adverse birth outcomes
  - Unexplained genitourinary symptoms, including frequent bladder or kidney infections or other Repeated vaginal bleeding and sexually transmitted infections
  - Chronic pain (unexplained)
  - Traumatic injury, particularly if repeated and with vague or implausible explanations
  - Problems with the central nervous system - headaches, cognitive problems, hearing loss
  - Repeated health consultations with no clear diagnosis
  - Intrusive partner or husband in consultations

The items in this list (Figure 2.3) and the risk indicators for intimate partner violence identified in Table 2.2 refer to vague and/or unexplained problems, and traumatic injury is considered more if associated with repeat or vague or implausible explanations. In terms of

emergency departments responding to intimate partner violence in the form of a physical assault, it seems strange that 'assault' is not listed given that 42% of women globally suffer injuries from intimate partner violence (WHO 2013c). Many of the intimate partner violence associated conditions listed are termed in ways that suggest they would have had a long duration, and case-finding by virtue of its requirement for these conditions associated with it, is less likely to identify people early on in their exposure to intimate partner violence.

The UK National Screening Committee current policy position is that screening for intimate partner violence in health consultations is not recommended (UK NSC 2006) (this policy is currently under review but is unlikely to change (Spiby 2013)). The UK National Screening Committee's (2006) policy position was based upon a systematic review that found no evidence of the effectiveness of interventions (Ramsay et al 2001). This systematic review of effectiveness of interventions (*ibid*) found that screening increased rates of identification, referral to, and uptake of specialist domestic violence services. However, these were deemed the wrong set of outcomes, and not an adequate proxy for measures such as quality of life and mental health status (Ramsay et al 2001). However, there is a paradox, because although there was no new or additional evidence, current practice guidelines for antenatal services in England recommend 'routine enquiry' (NICE 2010). So, whilst screening of all women entering hospital antenatal services in England has become policy, the method known as 'case finding' is the current modus operandi for all other NHS Health Services.

## Missingness: The Paradox of 'Being Seen' and 'Not Being Seen'

However, it seems that 'case finding' as a method to identify is problematic; a number of studies indicate that health care professionals miss opportunities to ask women about intimate partner violence (Hegarty and Taft 2001, Bradley et al 2002, Howard et al 2010, WNC 2010). In research undertaken by the Women's National Commission (2010), women articulated instances of 'being seen' for the consequences of intimate partner violence yet the *intimate partner violence* was 'not seen', as this account illustrates.

*"My daughter (...) not very long ago had her two front teeth knocked out by her partner who head-butted her. She was taken to A&E, and was treated really carelessly by the medical staff there, it was all very rushed, they were brusque and didn't ask her about domestic violence at all. They referred her to a dentist, who didn't ask her about the domestic violence either (...) She had a long course of dental treatment because of the damage he'd caused, and still no one asked her about the domestic violence, how it happened, let alone referred her to anywhere that could help her. It was all very perfunctory, they were treating this injury, responding to the fact she needed new teeth; that was all. (...) I believe that if health had addressed it early on, she might have been able to get out of the relationship a lot earlier, and the impact on her and her child, which has been dreadful, would have been less."*

(FG B, WNC 2010:41)

The Women's National Commission (2010) report has, unfortunately, a number of similar accounts, in which women report inattention to the problem of intimate partner violence in health consultations.

The second paradox about screening is that most women find routine enquiry for intimate partner violence in health settings acceptable (Hurley et al 2005, Feder et al 2009), indeed most wanted health professionals to raise the issue and ask them about it (Yam 2000, WNC 2010). Furthermore, simple direct questioning has been shown to be effective in facilitating disclosure of intimate partner violence (McFarlane et al 1995, Feldhaus et al 1997, Morrison et al 2000, Feder et al 2009, Taft et al 2013, Spiby 2013). Research has repeatedly shown that when emergency department patients are routinely asked about intimate partner violence detection rates significantly increase (Olsen et al 1996, Morrison et al 2000, Larkin et al 1999, Larkin et al 2000, Feder et al 2009, Taft et al 2013).

Nonetheless, further systematic reviews have concluded that screening in all health care consultations is not recommended because there was no evidence of its effectiveness for reducing further violence or improving women's quality of life or health outcomes (Coulthard et al 2004, Nelson et al 2004, Taft et al 2013, WHO 2013b). The health burden of intimate partner violence against women is sufficient to name it as a major public health issue but the effectiveness of interventions for particular sets of health outcomes were deemed insufficient to warrant routine screening.

Jewkes (2013) in her article '*The end of routine screening*' proposes that, after three randomized control trials in Australia (Hegarty et al 2013), USA (Klevens et al 2012), and Canada (MacMillan et al 2009) reporting no difference in health measures between intervention and control groups after screening of 'asymptomatic' women and a standard intervention (providing information, discussing safety and referral to specialist services



and/or counselling), it is indeed time to reappraise 'identification' and 'intervention'. However, screening still has its advocates, and indeed the US Preventative Services Task Force (2013) recommends that clinicians screen all women of child bearing age irrespective of whether they have signs of exposure to abuse or not. Support for the recommendation is founded upon research evidencing that screening increases identification and referral to support services which could improve health outcomes and reduce violence, and because it is welcomed by women, and also not known to have negative health effect in terms of reduced quality of life or reprisal violence (Nelson et al 2012).

The different positions on screening policy are based on measures of outcome; those who reject routine screening only considered improvement in health and reduction of violence for its outcome measures, whilst for those who advocate routine screening, identification and increased referral to specialist services were deemed adequate measures of successful outcome. Yet, screening success was also viewed differently by service users and health practitioners (Feder et al 2006). For service users, their report in response to enquiry was not necessary for a successful outcome; women placed value on knowing that the health practitioner was a source of future support (Feder et al 2006). Conversely, health practitioners placed value on patients' report of intimate partner violence in response to enquiry (Feder et al 2009). This section of the review has identified that there are competing theories for what counts as a measure of successful outcome from screening for intimate partner violence among health professionals and service users. Still, the sector advocating health sector defined measures of outcomes and rejecting screening is most dominant.

Opponents of routine screening do not negate the value of enquiry for female patients, but rather advocate the case finding method during health consultations for health problems either directly associated with intimate partner violence or in which intimate partner violence may be a less direct causal factor, such as mental health problems (Ramsay et al 2002, Taket et al 2003, Feder et al 2006, Jewkes 2013, WHO 2013b). From the perspective of case-finding, the question then for emergency department practitioners is for which patients enquiry about intimate partner violence should be undertaken.

### **Markers of Intimate Partner Violence**

A body of work (Muelleman et al 1996, Spedding et al 1999, Halpern et al 2005, Boyle et al 2010) has examined characteristics of injuries in cases of reported intimate partner violence in comparison with non-partner assault control groups to establish whether injury-based markers of intimate partner violence exist and which could help practitioners in the process of identification. In a systematic review and meta-analyses of this work, Wu et al (2010) found that head, neck, facial injuries and multiple injuries were significant markers of intimate partner violence in women attending emergency departments with injuries. However, Barata (2011) suggests that whilst predictors of intimate partner violence may prompt health practitioners to ask about intimate partner violence, his concern is that predictive models necessarily exclude populations from being asked. Barata (2011) also contends that given under reporting and under recording of intimate partner violence in health settings, predictors are likely to be based on populations who were 'ready' to report in response to violence escalation and may not be representative of the population who do not wish to disclose or whose experiences are missed by health practitioners. Thus it would

seem that the case-finding method of screening based on known risk or markers is, by its nature, not only inherently biased, but also likely to exclude exposed populations.

## **Improving the Health Environment**

Earlier studies have reported women's dissatisfaction with lack of privacy and lack of empathy from staff during emergency department consultations (Campbell et al 1994, Yam 2000), and emergency practitioners' reported discomfort and lack of knowledge in dealing with women's exposure to intimate partner violence (Ramsden and Bonner 2002, Ellis 1999, Davis and Harsh 2001). Since then, much research has been undertaken to improve the health environment (Hathaway et al 2002, Coben 2002) to increase practitioners knowledge and skill (Cann et al 2001, Dowd et al 2002, Häggblom et al 2005, Bournsnel and Prosser 2010, Djikanovic 2010, Torres-Votolas et al 2010, Beynon et al 2012), and mode of enquiry (McFarlane et al 1995, Feldhaus et al 1997, Morrison et al 2000, Olsen et al 1996, Larkin et al 1999, Larkin et al 2000, Feder et al 2009).

There have been differing views from practitioners about their experiences of responding to intimate partner violence in emergency department consultations. In one study in the US, emergency department practitioner respondents reported feeling positive about time spent talking with women and reported understanding that women's choices at that time may be constrained (Robinson 2010). However, in the same study (*ibid*), some emergency department practitioner respondents reported that they didn't respond to a report of intimate partner violence or didn't ask about it because of the subsequent work and/or time involved with dealing with it, and because of the frustration that some women didn't act to

end violence. In this latter scenario, there was a deliberate misclassification of intimate partner violence by practitioners during emergency consultations. Robinson (2010) also found that even though screening policies were in place in departments not all nurses knew about them. In a further study it was found that rather than policies, an intervention checklist was associated with more frequent emergency department diagnosis of intimate partner violence (Choo et al 2012) suggesting that prompts on how to respond also increased identification. Lam (2002) describes four types of organizational knowledge: 'embrained', 'embodied', 'encoded' and 'embedded'. Embrained knowledge is based on the individual's learned knowledge; embodied knowledge is tacit, developed from contextualised practices; encoded knowledge is the knowledge distributed in organisational policies and protocols; and embedded knowledge is tacit organisational knowledge developed from norms and routine (Lam 2002). It is likely that interventions aimed at improving the health environment will be more effective if these four types of organisational knowledge are addressed.

### **Reporting Intimate Partner Violence**

The processes of reporting intimate partner violence are complex. Factors indicated as likely to impact whether women report intimate partner violence or not have been identified as: the severity of violence (Kelly 1998, Walby and Allen 2004), concern for children (Yam 2000, Coy and Kelly 2011, WNC 2010), women's personal perceptions of 'domestic violence' (Kelly 1988, Walby and Allen 2004), and the accessibility of services (WNC 2010, Coy and Kelly 2010). Help seeking by women in Norway suggests that women are active about which agencies to contact based on *"different interactional consequences of intimate partner*

*violence*" (Vatnar and Bjørkly 2009:239). Women were more likely to contact police if they felt their lives were at risk and more likely to contact health professionals when they had suffered severe injury (Vatnar and Bjørkly 2009). In other work in England, Boyle et al (2005) compared two confidential lists of 'domestic assault' (an assault by a partner) during 2001; the first list comprised of 158 domestic assault cases identified in an emergency department (n=91 female and n=67 male) and the second of 263 cases of domestic assault reported to the local police service (n=201 female and n=62 male). Only fourteen cases, eleven women and three men were on both lists (Boyle et al 2005). These studies suggest that women mobilize different sets of help-seeking practices in response to domestic assault and which are likely contingent on a variety of considerations and circumstances.

In a recent study, undertaking a grounded theory analysis of disclosure stories from women attending emergency departments in Canada, Catallo et al (2013) report that non-disclosure was a process of weighing up the benefits of seeking care against the intrusion in life that report could bring. The concept of intrusion was in relation to having to repeatedly narrate events, pressure to undergo forensic evidence collection, and involvement of child protection or police services. Women were fearful of being found out and of losing control of the time and place of disclosure (Catallo et al 2013). Positive outcomes were associated with self-initiated disclosure rather than from forced disclosure; forced disclosure involved police, transportation to the hospital against their wishes, the invasion of privacy from having photographs taken, long term child protection and partner betrayal. Self-initiated disclosure was associated with significant life 'turning points' such as fear for life, fear for their foetus, and needing medical care. In this study, there were two other categories of

non-disclosure that women reported, avoiding care to achieve normalcy, and failed disclosure because of the inability to establish trust with a practitioner during the consultation (Catallo et al 2013). This research is particularly interesting because it identifies four classes of report of intimate partner violence, i) avoidance of care to maintain normalcy, ii) self-initiated report attributed to significant life or health event, iii) forced-disclosure from involvement of the police, and iv) failed disclosure because of inability to establish trust. It would seem that this fourth class of report, failed-disclosure, were misclassifications of the patients' health consultation.

## **Help for Children**

'Child protection' is one of the policy interventions for intimate partner violence (WHO 2013b, THAVAW 2010). However, in the UK, fear of social services because of the perceived threat of losing children has been reported by service users in mental health services (Rose et al 2011) and general practice (Feder et al 2006). Peckover (2013) suggests that it was the increasing profiling of domestic violence as a child protection issue during the 1990's that led to section 120 of the Adoption and Children Act (UK Parliament 2002). This section of the Adoption and Children Act (*ibid*) clarified the definition of 'significant harm' for children to include the harm a child may be at risk of suffering from witnessing (seeing or hearing) the ill-treatment of another person, such as domestic violence, meaning that children living in a household in which intimate partner violence is perpetrated are deemed 'at risk of significant harm'. This change in the law creates perverse effects, because in terms of emergency department services responding to an adult, the threshold of risk on which practitioners are duty bound to intervene is lower for the patients' children or pregnancy

from 'witnessing' than for the adult victim/survivor, for whom statutory duty to intervene is based on 'serious harm' meaning life-threat.

Whilst not discounting a concern for children exposed to their parent's experience of violence, the impact on children from *witnessing* is contested; a number of studies report that 'impact' is likely variable and dependent upon children's resilience (Hester et al, 2006, Mullender et al 2002). In addition, the consequential increase in referral to children's services because of 'witnessing' has meant that social worker teams have become inundated, the risk from which is that serious cases may inadvertently be overlooked (Stanley et al 2011). Whilst the law was likely conceived with good intention, its perversity is multi-faceted; for not only has it been reported as stressful for women when accessing services (Rose et al 2011, Feder et al 2006) but it has also been reported as potentially problematic for children, as mothers in greater need may be underserved because of stretched resources (Stanley et al 2011).

## **Practical Help**

Earlier in this chapter under the section heading 'Identification', I reported on the large body of screening implementation research, there has been much less research into routine care in terms of identification, practical help, good record keeping, and help for children. One such study in the United States (Rhodes et al 2011), examining the documentation of routine care in medical records of women attending an emergency department after an assault, found that 82% of records had 'legally useful' information of the event and injury recorded, 45% of women reporting intimate partner violence were referred to a social

worker, 33% had documentation of safety assessment, 25% had documentation of referral to specialist services, and 50% had communication with police services recorded. The sample for Rhodes et al's (2011) study was identified from police records of charges for intimate partner violence during a one year period. The emergency departments from which records were examined for this study (*ibid*) had a response pathway that involved screening for intimate partner violence on the department's intake form, reporting of assault-related injury to police, documentation of the assault, safety planning, social work evaluation, and referral to community specialist services. It is curious that even with clearly defined screening identification, intervention and referral pathways protocols in place that of the 70% of women who reported intimate partner violence after an assault, only a small proportion (11%) completed the response pathway.

The important finding from Rhodes et al's (2011) study was that the report of intimate partner violence did not always mobilize intervention, and in particular that the intervention of referral to specialist services was the least recorded. As a review of records with no contextual data such as interviews with service users or practitioners, Rhodes et al (2011) offers little explanation, and it could be that women declined the intervention or that details about interventions were just not documented.

## **CLASSIFICATION AND HEALTH MONITORING**

Classification of intimate partner violence is important. In the last section, classification was identified as important for mobilizing clinical classification and intervention. Earlier in the chapter, I used data from classification systems illustrating their importance for systems of



public health monitoring and which also attribute causal risk factors for death and disability in populations. I also identified gaps in health systems knowledge about the health impacts of violence against women. I claimed that the health impacts of violence against women were obscured, firstly because of lack of research evidencing causal relationships for long term outcomes, and secondly, that short term impacts such as those from injuries after physical assault were not sophisticated enough to explicate the health burden for women from intimate partner violence. In this section I discuss the classification systems in operation in hospital-based health systems in England for classifying episodes of care in which intimate partner violence was identified.

## **HOSPITAL-BASED CLASSIFICATION SYSTEMS**

There are two classification systems in operation in hospitals in the NHS in England, the Accident and Emergency Data Dictionary Coding Tables (HSCIC 2009), and the International Classification of Diseases of Health and Related Problems (ICD) (WHO 2013a). The Accident and Emergency Data Dictionary Coding Tables classification system is maintained by the NHS Information Standards Board and the Health and Social Care Information Centre (HSCIC 2013). The International Classification of Diseases of Health and Related Problems (ICD) is maintained by the World Health Organization (2013a). In England, the International Classification of Diseases is mandated for classifying inpatient episodes of care in NHS hospitals, but its use for emergency department episodes of care is optional; emergency departments are mandated to provide health information using the 'Accident and Emergency Data Dictionary Coding Tables'. Because patients attending an emergency department for

health services after an incident of intimate partner violence may be admitted to hospital, both of these health information systems are of relevance for this thesis.

These classification systems are important because the patient level data produced by them are used by government, commissioners, and practitioners in England to understand individual, local, and national population health needs and to facilitate quality monitoring (Fitzpatrick and Jacobsen 2003, HSCIC 2012, 2013a, 2013b, and 2013c). NHS Service providers are required by the Department of Health in England to record specified health information using these classification systems for each episode of patient care to produce a standard set of health information, known as Commissioning Data Sets, for clinical groups of patients (HSCIC 2013a). Hospital Episode Statistics (HES) are created from the classification of patient level health information submitted by NHS Acute Trusts to the Secondary Uses Service managed by the NHS Information Centre Core Data Warehouse (NHS IC 2010). The emergency department patient level information is classified at the point of care by staff that directly input information into patients' electronic records. For patients admitted to hospital, patient level information documented on inpatient medical records is classified and coded by a team of clinical coders after patients' discharge.

### **Emergency Department Hospital Episode Statistics**

The Accident and Emergency Coding Tables list the classifications for the Accident and Emergency Department Commissioning Data Set for emergency department patient level data. The Accident and Emergency Coding Tables are a more limited taxonomy, the data items and classificatory options for each item are listed in the Accident and Emergency Data

Dictionary (HSCIC 2009). Although limited, the coding tables are still extensive, and thus only the classifications relevant to diagnosis, interventions, and referral will be discussed. For classifying intimate partner violence in the form of an assault by a partner, the Accident and Emergency Department Commissioning Data Set and hence the emergency department electronically recorded patient information have data items similar to those of the World Health Organization's (WHO) (Holder et al 2001) 'Injury Surveillance Guidance'. This document (*Ibid* 2001) advocates the collection of data for injury surveillance to assess change over time regionally and cross-country, and to support the design and evaluation of interventions for the prevention of violence against women. To achieve this goal, the World Health Organization's Injury Surveillance Guidance (*Ibid* 2001) proposes a core minimum data set (core MDS), a core optional data set (core ODS) and a supplementary minimum data set (supplementary MDS). For assaults the classifications for each of these data sets are as follows (see Table 2.3):

- The core minimum data set comprises: a case identifier, age, sex, intent (assault), location, activity at the time, mechanism of injury, and physical nature of injury.
- The optional data set includes: race/ethnicity, external causes (ICD-10, if in use), date of injury, time of injury, injured person's residence, alcohol use, other psychoactive drug use, severity of injury, disposition, and a free text field for incident summary.
- The supplementary optional data set for assaults and homicides contains: context, victim/perpetrator relationship, and object used.

Table 2.3 Comparison of ‘Injury Surveillance’ Data Collection

WHO Injury Surveillance Classifications	Accident and Emergency Commissioning Dataset
<b>Core Minimum Data Set</b>	
Case Identifier (anonymised)	M/M
Age	M/M
Sex	R/R
Intent: assault	M/R
Place	M/R
Activity at time of event	
Mechanism of injury	
Physical nature of injury	R/M
<b>Core Optional Data Set</b>	
Race/Ethnicity	R/R
ICD-10 external cause of injury	O/M
Date of Injury	
Time of Injury	
Injured person’s residence	M/R
Alcohol Use	
Other psychoactive substance use	
Severity of Injury	
Disposition	M/R
<b>Supplementary Optional Data Set: (assaults &amp; homicides)</b>	
Context	
Perpetrator relationship	
Object used	

Key: M:Mandatory; R:Required; O:Optional

In this table, the first column lists the item classifications recommended by the World Health Organization’s Injury Surveillance Guidance. The second column shows the input status of these item classifications in NHS England’s Accident and Emergency Commissioning Data Set whether mandatory (M), required (R), or optional (O). In essence, a ‘mandatory’ status means that these data are necessary, a ‘required’ status means that its supply is required to meet NHS standards and should be supplied if available, and ‘optional’ status means that these data items are optional and may be omitted. Data items in the Accident and Emergency Commissioning Dataset are grouped, and the data group holds the primary input

status over items in the group, meaning that if a group is optional (O) and the organisation chooses to populate it then the data entry status for each item should be adhered to. The first letter indicates the data group status, and the second letter indicates the data item status.

Data recording of case identifier and age are presently the only data fields deemed necessary in the Accident and Emergency Commissioning Data Set. As mandatory/required, required/mandatory, or required/required statuses, it is likely that increasingly NHS Trusts in England collect and supply information about sex, intent (assault), location of assault, injuries incurred, race/ethnicity, injured person's residence, and disposition in terms of whether the patient was admitted, transferred, or discharged. The collection of this data means that for this research, data about the classification of assaults against women at institutional system level and patient level can be accessed.

The data items of classificatory interest for this emergency department section of the chapter are 'Patient Group', 'Clinical Diagnosis', 'Attendance Disposition', and 'Location', and these correspond with the World Health Organization's Injury Surveillance Guidance data items: 'Intent: Assault', 'Physical Injury', 'Disposition', and 'Place', respectively. These items are of interest for two reasons. First because they are used to inform patients' general practitioners about the health problem a patient attended the emergency department with, and secondly, because they form the most relevant characteristics of emergency department consultations for an assault by a partner that are system measurable and which could be used to system monitor standards for emergency department service responses for intimate

partner violence, in the form of an assault by partner. These data items and their classificatory options frame the classification of emergency department consultations for an assault by a partner in terms of 'Identification of cases' (patient group), 'the patient's ongoing health problem' (clinical diagnosis), and 'referral routes' (attendance disposition).

In parallel with international and UK reports of decreases of interpersonal violence over time, there has been a corresponding reported year on year decrease in the numbers of men and women treated at emergency departments after being injured from interpersonal violence in England and Wales (Bellis et al 2012, Sivarajasingam et al, 2012). The reduction in emergency department attendances for interpersonal violence has been attributed to the success of community safety partnerships which involve targeted intervention at late night, urban hotspots of violence identified through information sharing about incidents of violence between partner organizations (Florence et al 2011). Whether this decrease is the same for intimate partner violence is unknown and furthermore, it is not possible to know precisely because victim/perpetrator relationship information is not routinely collected by administrative systems in the National Health Service of England.

Information about the location of an assault, for example whether the incident took place in a home or public place is data that can be collected and it is likely that incidents of intimate partner violence are more commonly perpetrated in home locations. One study (Rooney 2012) reported on the rate of change of emergency department attendances in Lancashire after a 'domestic assault' (i.e. an assault in a home) and this too found a year on year decrease, however the data had not been disaggregated to assess if this was the same for

men and women. The literature indicates that the numbers of emergency department attendances for interpersonal violence are steadily decreasing but changes in the rates of forms of violence that disproportionately affect women are obscured by the way that data on interpersonal violence are classified, collected and analysed. Classification of intimate partner violence in health systems is important so that health data can be analysed for the rates and consequences of the forms of violence that disproportionately affect women. The questions for the emergency department hospital episode statistics data are how is intimate partner violence classified in hospital-based emergency health systems; if there is not a classification for it then where is it distributed; and what is the better form of classification for intimate partner violence for analyzing rates of change over time.

### **Admitted Patient Care Hospital Episode Statistics**

In England, the diagnoses of patients admitted to hospital are classified using the International Classification of Diseases of Health and Related Problems (ICD). The use of the ICD classification systems to generate samples of records of patients attending hospital for medical treatment after an assault by a partner has been reported in the health research literature (see for example Schafer et al 2008, Btoush et al 2008, and Btoush et al 2009) from the United States. In this body of work (*ibid*) a clinically modified version of the Ninth edition of the International Classification of Diseases known as ICD-CM9 has been used, but as with all editions of the International Classification of Diseases, version ten (ICD-10), as used in the UK, maps onto previous editions. The International Classification of Diseases (ICD) version 10 (ICD-10), lists 12,420 health related, diagnostic categories (WHO 2013e); ICD-9 had 6,969. The fourth-character place of incident occurrence codes in Chapter XX

(External Causes of Morbidity and Mortality) means that the ICD-10 now holds 14,199 classifications (WHO 2013e).

## Intimate Partner Violence and ICD Classifications

To discuss the classificatory boundaries of International Classification of Disease classifications for intimate partner violence I first want to discuss the classificatory attributes of four definitions of intimate partner violence from a range of policy stakeholders. The four definitions chosen (see Table 2.3) were from:

1. Women's Aid
2. The World Health Organization
3. The Cross Government definition
4. THAVAW – Taskforce on the Health Aspects of Violence Against Women

Table 2.4 Definitions of 'Intimate Partner Violence'

Organisation	Definition
Women's Aid (2013)	'Domestic violence' is physical, sexual, psychological or financial <b>violence</b> that takes place within an <b>intimate</b> or <b>family-type</b> relationship and that forms a <b>pattern</b> of <b>coercive</b> and <b>controlling</b> behaviour.
WHO (2012)	<b>Intimate partner violence</b> (under the rubric of gender-based violence) refers to <b>behaviour</b> by an intimate partner that causes physical, sexual or psychological <b>harm</b> , including physical <b>aggression</b> , sexual <b>coercion</b> , psychological <b>abuse</b> and <b>controlling</b> behaviours.
Cross Government (England) (HO 2013)	The Government defines 'domestic violence' as <b>any incident</b> or <b>pattern</b> of incidents of <b>controlling</b> , <b>coercive</b> , <b>threatening behaviour</b> , <b>violence</b> or <b>abuse</b> between those <b>aged 16</b> or over who are, or have been, <b>intimate partners</b> or <b>family members regardless</b> of gender or sexuality. The abuse can encompass, but is not limited to: psychological, physical, sexual, financial, emotional.
THAVAW DV Subgroup (2010)	THAVAW defines 'domestic violence' as, 'a <b>pattern of coercive</b> and <b>controlling</b> behaviour' that includes 'physical, sexual, psychological, and economic <b>violence</b> within <b>intimate</b> partner relationships, whether between, married and cohabiting adults, ex-partners, or people in non-cohabiting relationships including <b>teenagers</b> .



Whilst many similarities across the definitions are evident in relation to the forms of violence experienced, one notable field of difference is the definitional framing by ‘any incident’ versus a ‘pattern of acts or behaviours’ (See Table 2.4).

Table 2.5 Comparison of Definitions of Intimate Partner Violence by Form, Type, and Frequency of Violence and Perpetrator relationship.

Organization	Form	Type	Perpetrator	Frequency
Women's Aid (2013)	Physical Sexual Psychological Financial	Violence Coercion Controlling behaviours	Intimate / family-type	Pattern
WHO IPV (2012)	Physical Sexual Psychological	Aggression Coercion Abuse Controlling behaviours	Intimate	Any Incident
Cross Government (2013)	Physical Sexual Psychological Financial Emotional	Coercion Threatening behaviour Controlling behaviours Violence Abuse	Intimate family members (age > 15years)	Any incident or Pattern
THAVAW (2010)	Physical Sexual Psychological Economic	Coercion Controlling behaviours	Intimate (includes young women of teenage years)	Pattern

Definitions incorporating pattern distinguish ‘intimate partner violence’ from a single, isolated incident. The issue behind this distinction concerns some women’s experience of multiple acts of multiple forms of violence over a period of time. Nevertheless, violence is a form of power, and all violence, even if only perpetrated once, is coercive (Walby 2009). The threat of violence evoked by the experience of an isolated, so-called ‘one-off’ act, has long term consequences and thus is itself a long term coercive and controlling act. From this perspective, history of acts, one-off or otherwise, remain significant in women’s lives.

The common criteria across the definitions were:

- Violence perpetrated by someone with whom the person has had intimate relations.
- Multiple forms of violence which at the minimum incorporates physical, sexual and psychological violence.
- Multiple types of violence for which direct physical violence is not a necessary requirement.

### ***ICD Classifications for Intimate Partner Violence***

International Classification of Disease (ICD) classifications are assigned a unique alphanumeric code. With reference to the multiple forms of intimate partner violence identified in the four definitions, ten ICD classifications appear to be more specific for intimate partner violence than other classifications framed solely as an ‘assault’, and the first six were (in ICD vocabulary):

T74.0	Neglect or abandonment
T74.1	Physical abuse (Includes: Battered baby or child syndrome and spouse syndrome (Not Otherwise Specified))
T74.2	Sexual abuse
T74.3	Psychological abuse
T74.8	Other maltreatment syndromes (Includes: Mixed forms)
T74.9	Maltreatment syndrome, unspecified (Includes: effects of abuse of adult and child abuse (Not Otherwise Specified))

These first six categories can be found in Chapter XIX ‘Injury, poisoning and certain other consequences of external causes (codes S00–T98)’ listed under T74 ‘Maltreatment syndromes’. The next three can be found in Chapter XX ‘External causes of morbidity and mortality’ (V01–Y98) and listed under the primary rubric of ‘Assault’ (X85–Y09).

- Y05.0 Sexual Assault by bodily force (Includes: rape (attempted) and sodomy (attempted) by location 'Home')
- Y06.0 Neglect and Abandonment by spouse or partner. Includes: Mental cruelty, physical abuse, sexual abuse, torture. Excludes: neglect and abandonment (Y06) sexual assault by bodily force (Y05).
- Y07.0 Maltreatment by spouse or partner: Other problems related to primary support group Excludes: maltreatment syndromes (T74)

And the last one, Z63.0 is located in Chapter XXI 'Factors influencing health status and contact with health services' (Z00–Z99) in which Z63 is for 'other problems related to primary support group, including family circumstances'.

- Z63.0 Problems in relationship **with spouse or partner**. Discord between partners resulting in severe or prolonged loss of control, in generalization of hostile or critical feelings or in a persisting atmosphere of severe interpersonal violence (hitting or striking).

The difference in classification between ICD–10 Chapters XIX, XX and XXI is important because it determines whether a code can be used as a *primary* diagnosis. From this list, only T74 classifications can be used as a primary diagnosis and the others by nature of being external causes or factors of a primary problem may only be imputed as a *secondary* diagnosis. An overview comparing the attributes of these ten ICD codes is presented in Table 2.5 and this is followed by more detailed explanation.

Table 2.6 Summary of Characteristics of ICD-10 Classifications for Intimate Partner Violence

ICD Code	Form of Violence	Type of Violence	By Partner	By Location	Frequency	1 <sup>st</sup> Dx*	2 <sup>nd</sup> Dx*
T74.0	Neglect or abandonment	Maltreatment				✓	✓
T74.1	Physical Abuse (inc child abuse)	Maltreatment	✓		? Pattern	✓	✓
T74.2	Sexual Abuse	Maltreatment				✓	✓
T74.3	Psychological abuse	Maltreatment				✓	✓
T74.8	Other	Maltreatment				✓	✓
T74.9	Unspecified	Maltreatment				✓	✓
Y05.0	Sexual Assault	Bodily force		✓			✓
Y06.0	Neglect and abandonment	Maltreatment	✓				✓
Y07.0	Mental cruelty, physical abuse, sexual abuse, torture	Maltreatment	✓				✓
Z63.0	Control, hostility, criticism, physical violence	Persisting atmosphere of interpersonal violence	✓		Pattern over time		✓

Legend: \*1<sup>st</sup> Dx denotes possibility for application for primary diagnosis and 2<sup>nd</sup> Dx denotes possibility for application for secondary diagnosis

### *T74 Maltreatment*

ICD-10 classification codes are made up of four characters. The first three denote the main classification and the fourth character, the sub-classifications of that category. So, T74 is the classification code for 'Maltreatment Syndromes', in this category the fourth character after the '.' (point) denotes a specific form of maltreatment experienced. So T74.0 signifies neglect or abandonment, T74.1 Physical abuse – 'Battered baby, child or spouse syndrome',

T74.2 sexual abuse, T74.3 Psychological Abuse, T74.8 Other maltreatment syndromes and mixed forms, T74.9 Maltreatment Syndrome Unspecified – effects of: abuse of adult NOS or child abuse NOS. T74 classifications can be applied to adults and children so that even at the maximum fourth character level, health data will conflate child maltreatment with adult maltreatment unless the data is disaggregated by age.

T74.1 specifies ‘battered spouse syndrome’ under the rubric of ‘physical abuse’. The origins of the sub-classification ‘battered spouse syndrome’ are not specified in ICD documents but it first appeared in ICD version 9 and is likely derived from the classificatory architecture of Lenore Walker’s (1979) theory of ‘battered women syndrome’. Walker (*ibid*), from her work as a psychologist, developed her theory of battered woman syndrome as a collective term describing a cluster of psychological symptoms, experiences and behaviours reported by women victim/survivors of male partner violence. Walker’s theory has been employed in clinical and legal contexts, facilitating women’s access to psychological therapy (Walker 2009) and as mitigating legal defence for women accused of killing their abusive male partners (Walker 2009; Dutton, Ostoff and Dichter, 2011). However, in response to developing knowledge in the field, the construct ‘battered woman syndrome’ has been much critiqued in terms that no universalizing theory profiling ‘battered women’ can adequately accommodate the range of women’s experiences and is considered to be a ‘flawed model’ (Dutton, Ostoff and Dichter, 2011). Notwithstanding, the classification ‘battered spouse syndrome’ remains extant in ICD-10. As a ‘syndrome’, the classification conveys meaning of multiple and different events experienced over time rather than a one-off incident of ‘battering’ yet its classification is framed solely by one form of violence – physical abuse. In

this T74 category the ICD has capacity for 'other' and 'unspecified forms' of maltreatment and the empty categories between .3 and .8 provide space for the future addition of categories. The classification T74.1 'physical abuse / battered spouse' is the T74 subcategory most specific for partner perpetrated violence.

### *Y External Cause Codes*

Y codes are classified as 'external causes of morbidity and mortality'. Y05 is the ICD-10 code for 'sexual assault by bodily force' and includes rape (attempted) and sodomy (attempted). The fourth character for this code is not a classification by type of sexual assault or by victim/perpetrator relation but rather by location. So .0 for Y05 signifies that the sexual assault took place in a home as opposed to other location sub-classifications named as a school, sports area, industrial area etc. 'Home', however is not necessarily the person's own home. 'Home' in the context of the ICD rather appears to indicate a private residential property. It is of note that victim/perpetrator options are absent from this classification which is perhaps indicative of the category more aligned to stranger rather than acquaintance or kin perpetrated sexual assault.

Y06 is the classification for 'neglect and abandonment'. Conversely, for this category the fourth character here solely differentiates victim/perpetrator relations, .0 is by spouse or partner, .1 by parent .2 by acquaintance or friend, and so forth. Y07 in the ICD-10 taxonomy is defined as 'other maltreatment syndromes'; mental cruelty, physical abuse, sexual abuse and torture are included in the category but Y06 neglect and abandonment and Y05 sexual assault by bodily force are excluded. For Y07, the fourth character also

differentiates sub-classifications by victim/perpetrator relationship, so that Y07.0 represents other maltreatment syndromes by spouse or partner. The Y code classificatory options 'by perpetrator' only denote spouse, partner or parent as the familial perpetrator options and does not allow for the designation of other family relations as perpetrators. The classification Y07.0 by holding multiple forms of violence – mental, physical, and sexual, and a range of types of violence – cruelty and abuse, and specifying spouse or partner as perpetrator shares many of the attributes found across definitions of 'domestic violence' discussed earlier. The classification threshold does not itself expressly differentiate between the number of incidents experienced, although again as a 'syndrome' implies multiple forms of events and impacts over time. The most notable feature of these ICD-10 classifications is that there is no uniformity to Y sub-classifications of 'maltreatment' and 'sexual assault'; some are sub-classified by victim/perpetrator relationship (Y06; Y07) and some by location (Y05).

### *Z63 Factor Codes*

Z codes are *factors* influencing health status and contact with health services, 'Z63' classifications denote 'Other problems related to primary support group' and Z63.0 signifies 'problems in relationship with spouse or partner'. The definition of Z63.0 is:

*'discord resulting in loss of control, hostility, critical feelings in a persisting atmosphere of 'severe' interpersonal violence which it defines as hitting or striking'*

(ICD-10 2007)

This definition is closely aligned with definitions of intimate partner violence as a pattern of behaviour and exempting 'one-off' incident experiences and low-level violence.

There are noticeable differences in strength of causal relationship expressed in the language of classifications. Y codes are more categorical in their statement of 'external cause' causal relationship, whereas for Z codes, as factors, the causal relationship is less direct. From this analysis, the codes Y07.0 and Z63.0 appear to be the ICD codes most closely aligned with the commonalities of definitions of intimate partner violence. Conversely, T74.1, whilst still relevant, is limited to physical abuse and seemingly constructed as a medical condition, a syndrome in its own right rather than a causal factor of other health problems or injuries.

In a study of the predictive value of International Classification Disease codes for cases of intimate partner violence, Schafer et al (2008) found that the codes yielding the most specificity were the ICD-CM9 equivalent codes of Y07.0 (yield 98% positive), T74.1 (yield 89% positive) and T74.9 (yield 72% positive). The collective specificity of these three codes for intimate partner violence was 95%, but specificity reduced to 50% for an 'assault' code. However, when compared to the state-wide telephone survey of intimate partner violence, the number of emergency department records coded with one of the three classifications in this study (Schafer et al 2008) represented approximately 25% of the number of women who reported seeking medical attention after an assault. The implications from this study, is that when applied, three International Classification Disease codes had strong predictive value for intimate partner violence, meaning that they could be useful as a sampling frame, but its representativeness is unknown and likely biased. Furthermore, in terms of public health surveillance of the health burden of intimate partner violence, it remains unreported as to whether low rates of application of these codes is widespread and why they are low. It is



also unknown whether these codes are applied in England, nor is it known in which classifications of admitted patient care hospital episode statistics is intimate partner violence distributed in England and why.

## THE KNOWLEDGE GAP

This literature review has identified a large body of research for the identification and response to intimate partner violence in emergency department consultations, however very little has been undertaken in England or the United Kingdom. To improve identification, there has been a significant body of research undertaken and this has focused on examining indicators of intimate partner violence in the emergency department caseload (Yau et al 2013, Muelleman et al 1996, Spedding et al 1999, Halpern et al 2005, Boyle et al 2010, Wu et al 2010), ways to make the environment more conducive to identification (Hathaway et al 2002, Coben 2002, Cann et al 2001, Dowd et al 2002, Häggblom et al 2005, Bournsnel and Prosser 2010, Djikanovic 2010, Torres-Votolas et al 2010, and Beynon et al 2012), and improving screening tools (McFarlane et al 1995, Feldhaus et al 1997, Morrison et al 2000, Olsen et al 1996, Morrison et al 2000, Larkin et al 1999, and Larkin et al 2000, Feder et al 2009). One of the principal concerns underpinning this body of research has been *missed cases*.

Missed cases are important in relation to the research highlighting women's agency in mobilizing routes of intervention (Vatnar and Bjørkly 2009, Boyle et al 2005); this research (*ibid*) indicates that women are active about which agencies were contacted and when, foregrounding the importance of agencies to classify and intervene. Yet to date, missed

cases or misclassifications have not been central in research, in terms of examining not only what was included in the classification of 'intimate partner violence', but also what was excluded. Some of the research in the field provided a definition of intimate partner violence to frame the research (see for example Bournell and Prosser 2010, Klopstein et al 2010) but not all did (see for example Choo et al 2012, Rhodes et al 2011, Btoush et al 2009, Schafer et al 2008). None of the studies that I have examined for this review unpack the concept 'intimate partner violence'; rather 'intimate partner violence' was taken as given and its shared meaning assumed. Research in the field has also identified that even when identified, interventions were not necessarily mobilised (Rhodes et al 2011, Robinson 2010), and this raises questions about the connectedness of interventions to the classification of 'intimate partner violence'.

Similarly, in research using classifications of intimate partner violence from technical classifications, i.e., the International Classification of Disease to identify populations exposed to 'intimate partner violence' in health data (Choo et al 2012, Schafer et al 2008, Btoush et al 2008, and Btoush et al 2009, Rhodes et al 2011), classificatory exclusions have not been examined and nor has the process, in terms of examining the cases to which classifications were or were not applied.

This thesis research differs from other work in the field because it positions the *classification, and vicariously the misclassification, of intimate partner violence* itself as the most important issue for emergency department responses and the collection of data. From

the knowledge gaps in this research field to date, the main research question that this thesis addresses was formulated as:

*‘How best can intimate partner violence, in the form of a physical assault, be classified to reduce misclassification, increase identification, mobilize intervention (according to patients’ stated preference) in emergency department consultations, and collect data about it in hospital-based emergency department administrative systems?’*

## **SOCIOLOGY OF DIAGNOSIS**

Brown (1995), the originator of the term ‘sociology of diagnosis’, located ‘sociology of diagnosis’ in the social construction of diagnosis and illness, and positioned it between the social construction of illness and the social construction of medical knowledge. At this interface Brown (1995) suggests that

*“Rather than a given biomedical fact, we have a set of understandings, relationships, and actions that are shaped by diverse kinds of knowledge, experience, and power relations, and that are constantly in flux’.* (1995:37)

From Brown’s account (*ibid*) the sociology of diagnosis, understands a diagnosis, or in other words a classification, as socially constructed, involving complex sets of causal relations. Understood in this way, the sociology of diagnosis is likely a useful conceptual framework for investigating the classification of intimate partner violence, and the mobilization of interventions during emergency department consultations after an assault by a partner.

Brown (1995) drew on Latour and Woolgar's (1979) sociology of science and argued that their concept of 'science in action' was useful for medical sociology to study disciplinary production of knowledge and technical developments but that it was less valuable for medical sociology of patient/professional interactions. However, in later work, Latour (1983) made the boundary of laboratory (inside) and the real world (outside) indistinct. Latour (*ibid*) examined the social life of science in the making, if one was to extend Latour's concept to formulate 'diagnosis in action' - the social life of diagnosis in the making becomes open to sociological inquiry.

The sociology of diagnosis has recently been reworked, most notably by Annemarie Jutel (2011). Drawing on the work of Blaxter (1979) and Brown (1995), Jutel's (2011) sociology of diagnosis conceptualizes 'diagnosis' in terms of its category, its processes and its consequences. In this conceptual layering, Jutel (*ibid*) proposes that the social elements of a 'diagnosis', its classification, diagnostic process, and diagnostic consequence are entangled, each necessarily involved in its production. In this way 'diagnosis' or as termed here 'classification', can be viewed as the social interconnections of multiple systems of diagnoses/classifications, systems of diagnostic/classificatory processes, and systems of diagnostic/classificatory intervention.

Importantly for this thesis, Brown (1995) diverged from Latour and Woolgar's (1979) flat sociology of science in an important way. Brown (1995) troubled the exclusion of structural power relations inherent in social institutions and socially powerful groups from social research. Power and structural inequality were central to Brown's (1995) sociology of

diagnosis; he believed that contested medical diagnoses were windows into power relations in medical experiences. This thesis, in the context of violence against women as a cause and consequence of gendered structural inequality, draws on the Sociology of Diagnosis to examine the classification of intimate partner violence at different levels of emergency department health systems each with their own gendered power structures.

## CONCLUSION

Violence against women blights the health and well being of women worldwide and intimate partner violence is a major contributor to women's premature death and disability. However, the health burden from intimate partner violence is uncertain and underdetermined as health systems often fail to record intimate partner violence as a causal factor of women's ill health. The literature evidences that women seek services of emergency departments after incidents of intimate partner violence from which they have suffered injuries, and that emergency departments likely see the most heavily abused women. Health services have been cited as slow to respond to intimate partner violence, a situation that is paradoxical given its health consequences.

'Missingness' of intimate partner violence occurs at many levels of hospital-based emergency department health systems. In emergency departments, current case-finding screening practices may miss cases and thus intimate partner violence can be misclassified during emergency department consultations for an assault by a partner. Furthermore the report of intimate partner violence did not always mobilize interventions. The statutory risk threshold for intervention is lower for victim/survivors' children than for the patient

attending for treatment. What counts as 'effectiveness' for screening and intervention is contested, as women, practitioners, institutions, and policy makers have competing interests.

In the latter section of this literature review I argued that the classification of intimate partner violence was also important for systems of public health monitoring and that the health consequences of intimate partner violence were obscured, first by the data collected and secondly by the analysis undertaken on it. I identified that there were two different systems for classifying emergency department episodes of care, and whilst there has been some research using the International Classification of Disease from the United States and the Accident and Emergency Department Data Coding Tables from England, it is limited.

The research to date positions the classification of intimate partner violence as given and stable, yet my reading of the literature through the lens of diagnosis as classification, process, and consequence evidences the potential for misclassifications within each of these dimensions. The gap in the knowledge base centres on the classification and misclassification of intimate partner violence during emergency department consultations and in hospital-based emergency department health systems.

In this chapter I have explicated both the paradoxes and perversities of the classification of intimate partner violence co-existing at multiple locations and levels of health systems in both emergency department consultations and in the systems for monitoring them. I have identified its classification and potential for misclassification, raising uncertainty about into

which classifications intimate partner violence is distributed in hospital-based emergency department health systems. Central to this concern however, is women's reported experiences of intimate partner violence being 'missed'. The sociology of diagnosis was introduced and identified as a useful analytical framework to understand the social and structural entanglements of classifications and their consequences.

# CHAPTER THREE: ONTOLOGY, EPISTEMOLOGY AND METHODOLOGY

*"In science we always deal with limited and approximate definitions of reality. This may sound frustrating, but for systems thinkers the fact that we can obtain approximate knowledge about an infinite web of interconnected patterns is a source of confidence and strength." (Capra 1996:42)*



## **INTRODUCTION**

In this chapter the research aim and the research questions to address the aim are set out. The ontological and epistemological assumptions and foundations for the project (critical realism and complexity theory) are discussed and justified, and the overall research design (mixed-method research) for the project is then introduced. The ontological and epistemological issues inherent to mixed-method research design are explicated before discussing the status of quantitative and qualitative data for the research, and, the status of claims that can be made from the research findings. The chapter is brought to a close by a description of the three elements of research methods chosen for the project. The three elements are: interviews with service users and stakeholders, medical record review (the review and abstraction of data from medical records) of emergency department attendances, and a survey of routinely collected administrative health data (hospital episode statistics). An overview mapping the research methods to the research questions along with which chapter each question is addressed is presented in Table 3.2 on the last page of this chapter.

## **RESEARCH AIM**

The aim of the research is to establish the better forms of classification of intimate partner violence for improving hospital-based, emergency department responses to it in England. By ‘improve responses’ I mean: to reduce misclassification, increase identification, mobilize intervention (according to patients’ stated preference) in emergency department consultations, and collect data about it in hospital-based emergency department administrative systems.

## RESEARCH QUESTIONS

The principal research question to address the aim was formulated as:

How best can intimate partner violence, in the form of a physical assault, be classified to reduce misclassification, increase identification, mobilize intervention (according to patients' stated preference) in emergency department consultations, and collect data about it in hospital-based emergency department administrative systems?

The following eight supplementary questions were developed to guide enquiry to address the aim and principal question.

1. Which classifications for intimate partner violence are applied during emergency department consultations for an attendance after an assault by a partner?
2. What are the classificatory attributes involved in the construction of different classifications of intimate partner violence applied during emergency department consultations for an attendance after an assault by a partner?
3. Why is intimate partner violence, in the form of physical assault by a partner, classified in different ways during emergency department consultations?
4. What interventions and referral routes for intimate partner violence are initiated during emergency department consultations for an attendance after an assault by a partner?
5. What are the relationships between the different classifications applied and interventions and referral routes initiated for intimate partner violence during emergency department consultations for an attendance after an assault by a partner?
6. What are the rates of applications of classifications for intimate partner violence, in the form of physical assault by a partner, in a sample of Emergency Department Hospital Episode Statistics and Admitted Patient Care Hospital Episode Statistics?

7. In which Emergency Department Hospital Episode Statistics and Admitted Patient Care Hospital Episode Statistics classifications are cases of intimate partner violence, in the form of physical assault by a partner, most likely distributed?
8. Why are cases of intimate partner violence, in the form of physical assault by a partner, classified in different ways and distributed across different classifications in Emergency Department Hospital Episode Statistics and Admitted Patient Care Hospital Episode Statistics?

## ONTOLOGY AND EPISTEMOLOGY

The research is positioned ontologically in critical realism, and epistemologically in a constructionist-inspired version of complexity theory.

### Ontology: Introducing Realism

Ontological perspectives range from Realism to Idealism (Murphy et al 1998). Although conceived in opposition, these 'polar' philosophical positions have much in common; they both reject the possibility of objective knowledge and singular truth understanding about the world, accept the constructed and socially produced nature of our knowledge of the world, and question the intelligibility of 'reality'. The distinction between these positions is most keenly apprehended in the conception of reality. Realist theory assumes that phenomena exist independently of human observation (Blaikie 2007), a conception that idealists reject. Idealist theory supposes that '*the external world consists merely of representations and is a creation of the mind*' (Murphy et al 1998:64). The key issue arising from an idealist position is that there are as many realities as there are people (Smith 1984).

Maxwell (2012), a self-defined realist, contends that realism has been a dominant philosophical worldview in the contemporary era yet one that is often unacknowledged, and this is the starting point for justifying critical realism as the ontological position for this research.

Realism is defined as:

*"The view that entities exist independently of being perceived or independently of our theories about them"* (Philipp 1987:205).

The position of comprehending phenomena as existing independently of our perception of them is perhaps more easily regarded in simple reference to innate physical objects but becomes more complex when referring to human constructions of natural and social phenomena. To consider realism in relation to social life I draw on Schwandt's (2007) 'sense-making' realist idea of everyday life:

*"(...) on a daily basis, most of us probably behave as garden-variety empirical realists – that is, we act as if the objects in the world (things, events, structures, people, meanings, etc.) exist as independent in some way from our experience with them. We also regard society, institutions, feelings, intelligence, poverty, disability, and so on as being just as real as the toes on our feet and the sun in the sky. (2007:256)*

The premise for this project emerged from previous research intimating that sometimes intimate partner violence was not named during emergency department health consultations for injuries sustained from an assault by a partner, and that women's expectations of the service, in terms of responding to the experience of intimate partner violence, were not met.

Lying behind these research findings are assumptions about a mind-independent 'real' world of everyday emergency department health services, namely that:

- i) Intimate partner violence exists and that there is an understanding of its defining attributes.
- ii) Health institutions providing emergency department services, doctors and nurses to consult with, people experiencing intimate partner violence, and systems for intimate partner violence identification and intervention exist.

A realist ontological position is consistent with how people report they experience and act in the world and imagine things existing independently. Furthermore, much social science is necessarily ontologically and epistemologically dualist in that it presumes an independent existence of some 'thing' (programme, service, policy) (Heap 1995).

### **Ontology: Critical Realism**

Critical Realism, also referred to as Depth Realism, emerged from Roy Bhaskar's (1978) project to develop a systematic realist account of science and a philosophy *for* science rather than of science and by default of 'knowledge'. Whilst conceived in epistemological terms, Bhaskar's realist philosophy of science holds three distinct but overlapping ontological domains: the empirical domain, the actual domain, and the real domain. The three domains, as illustrated in Table 3.1 are populated by different epistemic ways of knowing about things in terms of events, experiences, and mechanisms.

Table 3.1 Domains of Realist Ontology & their Constituents (Reproduced from Table 1.1, Bhaskar 1978:56)

	Domain of Real	Domain of Actual	Domain of Empirical
Mechanisms	✓		
Events	✓	✓	
Experiences	✓	✓	✓

In Bhaskar's (1978) model, these ways of knowing about things hold significance for attribution of causality to phenomena. For Bhaskar (*ibid*), patterns of events and experiences are insufficient for causal explanation because they are dependent on some form of human observation for their existence and because correlations between events or experiences are not equivalent to causation. In terms of causal explanation: 'the tendency of a thing to act in a particular way', (1978:50), Bhaskar positioned 'mechanisms', defined as 'causal structures' and 'generative mechanisms', as having the potential for causal explanation (1978:51). The ontological significance of Bhaskar's work is that 'mechanisms' lie behind patterns of events and experiences and as such add ontological depth to phenomena. Bhaskar's (1978) project focused on the conception of a philosophy for natural science, nevertheless critical realism and the concept of causal mechanisms is embedded in much realist social science<sup>2</sup>.

The conversion of critical realist theory to social science is however not straight forward. Sayer (2010) argues that for 'regularities', meaning uniform empirical observations of causal mechanisms, to be observed, two conditions must be present. The first condition is that:

*"There must be no change or qualitative variation in the object (...) possessing causal*

<sup>2</sup> See for example Sayer (2010); Walby (2009); Pawson and Tilley (1997); Byrne (1998); Elder-Vass (2010).

*powers if mechanisms are to operate consistently*” and the second *“the relationship between the causal mechanism and those of its external conditions which make some difference to its operation and effects must be constant if the outcome is to be regular”* (Sayer 2010:122). For Sayer (*ibid*) systems holding these conditions are ‘closed systems’ because there is no mutual interaction between the system’s causal mechanism(s) and its environment for if there was, the external condition for system closure could alter, and secondly, the internal condition for closure (the object possessing causal power) could, through its interaction with external conditions, become qualitatively different. Sayer (2010) suggests that social systems are open systems because human action modifies extrinsic conditions, and human learning modifies internal conditions. Conceiving social systems as open systems is not to suggest the notion of unpredictability, Sayer (2010) explains that a dominant mechanism within a system can be observable in patterns of outcomes, and names such observable patterns from dominant mechanisms as arising from ‘quasi-closed systems’.

### ***Critical Realism and the Social Construction of Knowledge***

For Bhaskar’s (1978) philosophy of (natural) science, knowledge is ‘of’ things – things that do not depend on human activity. He calls these ‘things’ ‘intransitive objects of knowledge’, and these ‘intransitive objects of knowledge’ are distinguished from ‘transitive objects of knowledge’. Transitive objects of knowledge are human constructs, the *“established facts and theories, paradigms and models, methods and techniques of inquiry”* of the day (1978:23). For Bhaskar, both intransitive and transitive objects of knowledge are necessary and states a philosophy of science must be able to hold the social character of science and the independence from science of the objects of scientific thought (Bhaskar 1978:24). My

reading of Bhaskar (1978) means that for critical realism, the socially constructed nature of knowledge cannot be disentangled from science; the conjoining of ontological realism and epistemological constructionism is the foundation of critical realism (Maxwell 2012).

### **Epistemology: Introducing Constructionism**

This research is positioned epistemologically in Constructionism. Constructionism holds the view that 'things' are not discovered as in Objectivism, nor do they reside solely in the mind of the observer as in Subjectivism, but rather are constructed (Blaikie 2007). Constructionism holds that the meaning of 'things' are constructed in the mind of the observer in co-existence with constructed understanding of things that already exist (Blaikie 2007). The social construction of knowledge and its concomitant fallibility of knowledge are embedded in critical realist epistemology (Sayer 2010).

### **Epistemology: Complexity Theory**

Sylvia Walby (2003) describes complexity theory in epistemological terms as a suite of trans-disciplinary conceptual tools that can help produce explanatory accounts of the social world. The tools of complexity theory that I draw on to explain the social world are 'feedback', 'open-systems', 'self-reproduction', 'self-organisation', 'co-evolution', 'complex adaptive systems', 'emergence', and 'path dependency'. In describing these concepts I present both an ontological and epistemological standpoint for the social world and by stating its ontological position I also state what is intelligible about it.



## Feedback

Complexity theory has its origins in the disciplines of cybernetics and general systems theory that emerged from the interdisciplinary Macy Conferences on Cybernetics 1946 – 1953 (Ramage and Shipp 2009). Early cyberneticist Norbert Wiener coined the term ‘cybernetics’ for theorizing the concept of *feedback* in closed systems. ‘Feedback’ was characterised by its catalytic properties to maintain the function and stability of closed systems in engineering such as a central heating thermostat (Ramage and Shipp 2009). For Wiener, the coupling of communication *and* control, the message *and* action, in the form of a self-regulating feedback loop was central to cybernetics, where initial condition A “propagates around the links of the loop, so that each element has an effect on the next until the last “feeds-back” the effect into the first element of the cycle (A)” (Capra 1996:56).

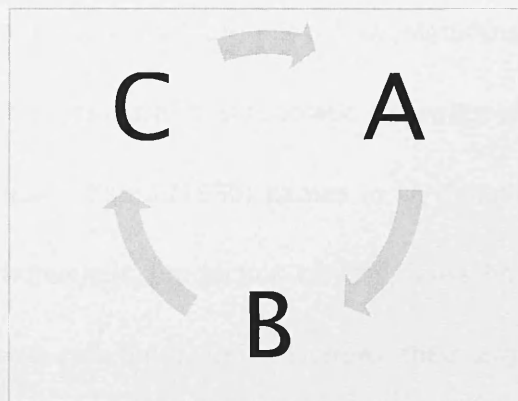


Figure 3.1 Causal Feedback Loop (from Capra 1996:56)

Feedback loops are not literally ‘circular’ but rather “*abstract patterns of relationships embedded in physical structures or activities of living organisms*” (Capra 1996:64). The significance of feedback is that, just as in critical realist depth ontology, patterns of relationships of a system can be distinguished from its structures. Similarly as Sayer (2000)

explains, the domain of the 'real' in critical realist theory refers to the causal powers (mechanisms) of social structures, thus 'mechanisms' from critical realist theory and 'feedback' from complexity theory are both similarly distinguished by their causal or catalytic properties.

### ***Open Systems, Self-Reproduction and Self-Organisation***

Ludwig von Bertalanffy advanced systems theory through the concepts of 'open systems' and 'dynamic equilibrium'. Through his work on organisms, Bertalanffy described an *open system*, as having a distinct boundary with its environment but through which both matter and energy can pass (Ramage and Shipp 2009). The continual exchanges between an open system and its environment means that it is constantly changing yet retains its form, a state Bertalanffy coined 'dynamic equilibrium' (Ramage and Shipp 2009). This retention of form or 'self-reproduction' is referred to as 'autopoiesis' by Maturana and Varela (Capra 1996); Maturana and Varela (1980) explicated autopoietic networks within a biological cell from which it can reproduce itself. Capra (1996) names in lay functional terms elements within cells' autopoietic network (nucleus, production centres, powerhouses, recycling centre, solar station, storage sacs, and cell fluid) and describes their organizing relations for self-reproduction. System autopoiesis holds two key system defining concepts, self-reproduction and self-organisation (Walby 2003). The elements within cells' autopoietic network are themselves open systems too, meaning that there are systems within systems and multiple modalities of interconnections between systems. Relations between systems can be conceived as being nested and non-nested and as having varying degrees of proximity to each other. The concept of systems within systems adds ontological depth in

the form of linked levels of phenomena. Complexity theory with its epistemological structuring of ontological depth in systems is thus congruent with critical realist depth ontology.

### ***Co-evolution and Complex Adaptive Systems***

Though nested, Capra (1996) suggests that the relationships between systems are not hierarchical. Rather than conceiving interconnections of systems within systems as in some way subordinate, Walby (2003) explains that in complexity theory, elements within systems are conceptualized as separate systems and as such have all other systems as their environment. Furthermore, the constant flow of energy and matter through systems means that rather than a state of dynamic equilibrium, open systems operate far from equilibrium (Capra, 1996). Rather than notions of rigid, hierarchical relationships and interconnections in causal pathways, complexity theory forwards a *'more fluid conception of the mutual impact of systems'* (Walby 2003:7). The interaction between a system and its environment entails *co-evolution* as a system adapts to changes in its environment; that each system has internal systems, co-evolving adaptation is likely to be very complex (Walby 2003). The significance of 'co-evolution' and 'complex adaptive systems' for research are the non-linear interactions of elements and corresponding complex, multi-directional causal pathways.

### ***Emergence and Path Dependency***

In terms of social systems, Walby (2003) gives the examples *'that individuals living together constitute a household; that individuals working together constitute an organisation; that*

*many citizens constitute a nation'* (2003:10) as social systems within social systems, these linked yet different levels of a system also provide examples of 'emergence'. The concept of emergence in complexity theory can be understood as arising from a collection of system changes. In complexity theory new structures can emerge from the interactions of system elements between a system and its environment, and correspondingly new structures means that new properties of the system may emerge (Gatrell 2005). A question remains as to what constitutes emergence? Is it a pattern of behaviour or multiple, fragmented, indeterminate events?

The hybridization of critical realism and complexity theory means that emergence may be considered in more or less relation to critical realism and complexity theory. For example in critical realist leaning complexity theory, emergence is seen more in terms of observable patterns of behaviour of phenomena (statistical probability) as seen in the work of Prigogine and Stengers (1997) and Byrne (1998), whereas in postmodern leaning complexity theory emergence is seen as the heterogeneous relational properties of systems (Cilliers 1998). The approach for this project is positioned on the boundary between the two; critical realist, recognising the measurable relations and causal properties and yet 'postmodern', drawing on the fluidity of sets of relations from postmodern theorists such Bauman (2000) and Foucault (1991) [1978]. I understand my position in terms that Best and Kellner (1991) describe as a synthesis that recognizes the theoretical developments of the 'postmodern' period but one that does not reject fully those that predate it.

Walby (2003) proposes that 'emergence', by recognizing linked yet different levels of a system, captures their co-existence and the relationship between them. Epistemologically this makes imaginable concomitant multi-level systems research, through which greater approximations of knowledge about sets of relations within systems can advance explanatory accounts of phenomena. For this project the significance of Walby's definition means that for social science 'emergence' can be understood as more than new structures and new properties of new structures, stretching the concept to encompass new sets of relations between systems and between different levels of systems and their distributed patterns of behaviour.

'Emergence' extends notions of seemingly linear paths of determination implied in self-organizing, self-reproducing systems. In social systems Walby (2003) suggests that the path dependency of systems is shaped by social and political institutions which can 'lock-in' particular relations of power, opportunity and knowledge between systems. From this perspective it is possible to comprehend unyielding and self-sustaining social systems, however, changes, even small changes in the power, opportunity, and knowledge relations between complex adaptive social systems can result in the emergence of new systems, and which may be a bifurcation or total disruption of other systems. Hence it is possible to conject that path dependency of social systems may have variable degrees of stability over time and place contingent upon power, opportunity and knowledge relations.

Sayer's (2010) critical realist theory of social science can be mapped onto concepts within complexity theory. For example path dependency and emergence can be seen to be related

quasi-closed systems, the 'regularity' or 'path dependency' of which depends on the strength of dominant causal mechanisms. In co-evolving environments, once dominant mechanisms may weaken, and new systems with new properties can emerge. Sayer's (2010) work advances the project of critical realist theory for social science through the ideas of open, closed, and quasi-open systems but does not stretch into the domain of complexity theory. Complexity theory further advances critical realist theory for social science by attending to additional layers of ontological and epistemological depth enabling greater fluidity for understanding the dynamic, multi-modal, and multi-directional properties of social systems and their uncertain, unpredictable qualities.

### **Defining the Systems of the Classification and Response to 'Domestic Violence' in Emergency Department Consultations**

Complexity theory provides conceptual tools to provide a systems-based explanatory account of phenomena. However the complexity of potentially infinite multi-modal interconnections of co-evolving systems can prove challenging when attempting to define the system(s) under study. The existence and boundaries of systems may be obscure; for example, is there a system for classifying intimate partner violence in emergency department consultations?, if so, what is the system's boundary?, which systems at different levels is it interlinked with?, which systems on the same level is it interconnected with?, and furthermore is it possible to know whether a component of health service systems is a complex adaptive system?

Paley and Eva (2011) suggest that to designate something as a complex adaptive system may only be intelligible as a finding of research; they propose that “*even the term ‘system’ is a hindsight concept*” (2011:271). Cilliers (1998) also contends that the border of a complex system may not be perceptible and as such knowing what belongs to a system and what does not, may not be evident. So whilst Capra (1996) describes a system as an “*(...) an integrated whole whose essential properties arise from the relationships between its parts*” (1996:27), it is perhaps more helpful in the first instance to think of a system as a set of relations. Paley and Eva (2011) advocate caution in claiming that any aspect of health service delivery is a ‘complex system’ suggesting that any phenomena which involves a group of people will likely tick the boxes of ‘complex adaptive system attributes’ but does not necessarily mean that it is one.

Missing from accounts of complex adaptive systems in health care, Paley and Eva (2011) suggest, are the pattern(s) to be explained and explanations, and as such the ‘complexity theory’ in the form of “*global structures explained by the specification of rules governing local behaviour*” is missing too. This uncertainty of systems and system boundaries, according to Paley and Eva,

*“justifies taking a conceptual ‘slice’ through a vast tangle of structures and processes, isolating a fuzzy set of interacting elements, and describing the abstracted network thus identified as a CAS” [Complex Adaptive System] (2011:271).*

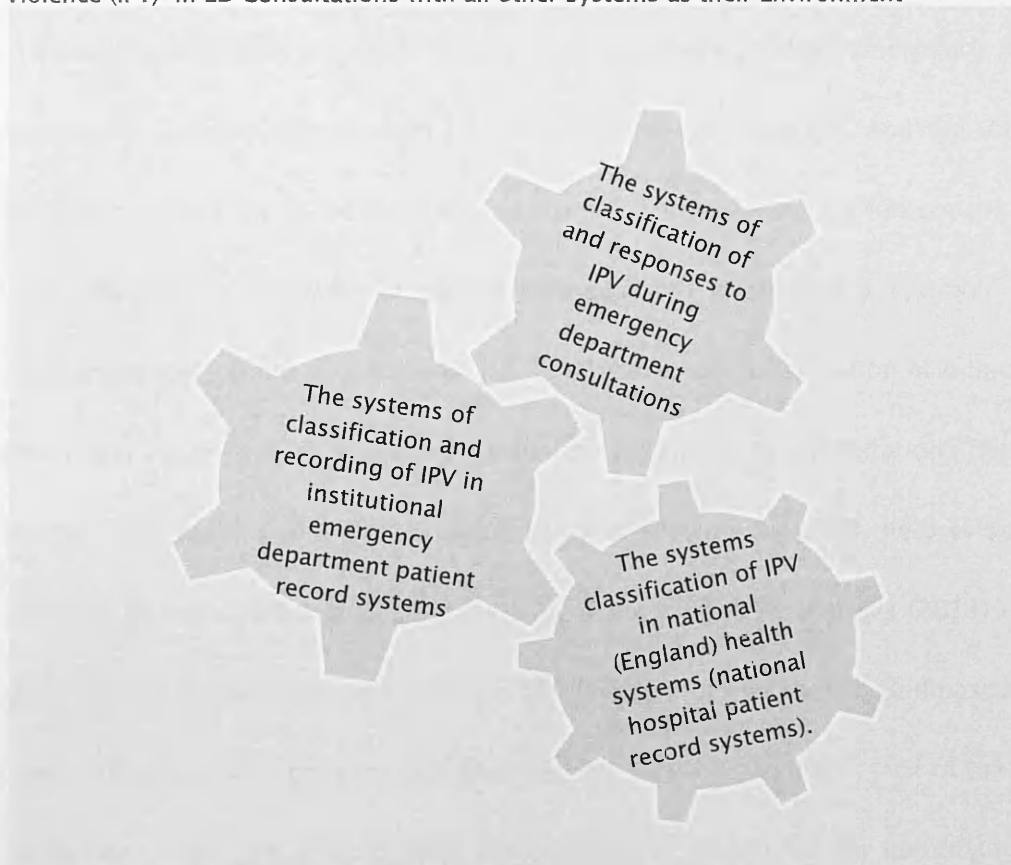
However, the entanglements mean that ‘taking a conceptual slice’ is not straightforward. The available data and access to data meant that for this research the metaphorical ‘conceptual slice’ was not so much clean-cut, but rather was itself, fuzzy. In taking a

conceptual slice I identified three interlinked systems for the classification and response to intimate partner violence in emergency department consultations:

- The systems of classification of and responses to intimate partner violence during emergency department consultations.
- The systems of classification and recording of intimate partner violence in institutional emergency department patient record systems.
- The systems of classification of intimate partner violence in national (England) institutional health systems (national hospital patient record systems).

The three interlinked systems are illustrated in Figure 3.2 below, and whilst this is a rather flat version, its positioning in terms of ontological depth will depend from where it is first viewed.

Figure 3.2 Complexity Theory Systems of the Classifications and Response to Intimate Partner Violence (IPV) in ED Consultations with all other Systems as their Environment





These systems are autopoietic, and taking all other systems as their environment, have relationships with all other systems; each 'system' is an interlinked system of systems that include: emergency department patients, doctors, nurses, clinical coders, data managers, professions, emergency departments, hospitals, information systems, classification systems, commissioning datasets, institutional policies, safeguarding adult and children protocols, cultural attitudes towards intimate partner violence, services for intimate partner violence, professional codes of conduct, and statutory duties. Furthermore, as each system takes all other systems as its environment means that interconnections are infinite, but some systems will likely exert greater causal properties than others.

## **RESEARCH DESIGN: OVERALL STRATEGY**

Previous research had indicated a seemingly ad hoc, almost random quality to the classification of intimate partner violence and responses to it in emergency department consultations. Similar findings stem from the UK, Ireland, Australia, and the United States suggesting that this isn't a local matter concerning the dynamics of a few consultations that did not complete in the way the patient intended, but is perhaps a systemic problem. I imagined that there could be myriad elements affecting the classification of intimate partner violence and responses to it during health consultations at consultation, departmental, institutional, regional, national, and global levels of systems. Much of the previous research in the field, as highlighted in Chapter Two, is of the kind Paley and Eva (2011) describe as 'factor-delineating qualitative research', in other words 'barrier theory' findings that identify possible influences on process or outcome such as lack of knowledge, lack of time, and lack of resources. This type of qualitative research can be invaluable for identifying elements

with potential causal significance for outcomes but cannot indicate their causal significance or how they interact with other elements. However, qualitative research is more likely to focus at the level of the consultation and in approaching this study I considered that further qualitative research of this genre was unlikely to contribute anything significantly new and more importantly could not produce explanatory accounts to directly influence wider policy. Additionally as a nurse, I imagined that emergency department practitioners would likely be weary of research that identified problems but didn't offer solutions. 'Systems thinking', defined as "*the understanding of phenomenon within the context of a larger whole*" (Capra 1996:27) was the starting point for the research design to move beyond the level of the emergency department consultation to interlinked systems at different levels of the system.

The research design for this project was mixed-method research (an overview of the design is presented later in Figure 3.3). Mixed-method research design is defined as:

*"a combination of at least one qualitative and one quantitative component in a single research design, aiming to include the benefits of each method by combining them"*  
(Baban 2008:338).

In this project of quantitative/qualitative mixed-method research, quantitative methods have been applied to survey health data from different system levels to look for patterns of classification and responses to intimate partner violence and associations between them, and qualitative methods have been used to collect service user and professional stakeholder perspectives to provide experiential witness accounts of systems and to explicate the patterns found in the quantitative data analysis. It is the application of critical realism, complexity theory and mixed-methods research to move beyond the level of consultation

system that differentiates this from other research in the field and gives the project methodological originality.

In the model of mixed-method research employed for this project, quantitative and qualitative data are used independently and collectively to describe and explain phenomena and to describe and explain relations between phenomena. For this research, the overall weighting of epistemic privilege is given to statistical inference combined with qualitative explanatory accounts. In such an approach 'data-mixing' is concerned with connecting the data, which for this study means creating explanatory accounts for the interlinked systems from different levels. Each method adds 'analytic density' (Fielding 2008) in theory development to explain rather than describe the classification of and responses to intimate partner violence in emergency department consultations. Of central concern for research designs and the methods employed are the constraints on claims that the findings can make, for this project there are two dilemmas to explicate: mixed-method research and the quantitative/qualitative divide, and the status of quantitative and qualitative data.

### **Mixed-Method Research and the Quantitative/Qualitative Divide**

A principal tension for epistemologically justifying mixed-method research design stems from, what I consider to be, an artificial divide between 'quantitative' and 'qualitative' research methods. My argument here is to claim that quantitative and qualitative research methods are not ontologically antithetical as has been claimed (Murphy et al 1998). The quantitative/qualitative divide stems from binary dichotomisation of methodological approaches principally constructed through critical defences based on the wrongs or

limitations of the other (Hammersley 2008). 'Paradigm war' debates arose from the premise that quantitative research methods are essentially realist and qualitative methods fundamentally idealist and as such are incompatible (Murphy et al 2008). Nonetheless, social scientists have long successfully combined quantitative and qualitative methods in practice (Bergman 2008), yet the quantitative/qualitative paradigm war and incompatibility thesis posed epistemic difficulty for social scientists employing 'mixed-method' research. To justify the deployment of mixed-method research for this project I contend that the quantitative/qualitative divide in these terms is a falsehood and secondly, connect the epistemological basis for this mixed-method research with Critical Realism and Complexity Theory rather than Pragmatism.

### ***The artificial quantitative/qualitative divide***

The quantitative/qualitative divide of research method is a convenient dualism for the ontological and epistemological continuums positioned dichotomously in either realist or idealist terms. Many texts posit a notion of monist research approaches that fit neatly with these ontological and epistemological paradigms (see for example Crotty 1998) yet methods do not by their nature have paradigmatic membership (Symonds and Gorard 2010). Heap (1995), using the example of Guba and Lincoln's (1989) Fourth Generation Evaluation which lays claim to a relativist ontology and that multiple socially constructed realities exist, contends 'monist' research approaches are often dualist in practice. Heap (*ibid*) suggests that Guba and Lincoln's relativist ontology is based on 'monist cognitive constructionism' which fails to account for "social dimensions and sources of 'cognitive states'" (1995:53). For Heap (*ibid*) cognitive constructionism and social constructionism are necessarily

entangled, and furthermore argues that dualist realist practice is evident in Guba and Lincoln's treatment of interview data in that "*linguistic constructions' are collected and analysed and treated as stable, determinate, intersubjective phenomena, that is objective*" (1995:57). Indeed, Hammersley (1992) also argues that much qualitative research quantifies its data both explicitly (content analysis) and more subtly (thematic analysis). Similarly, the social construction of knowledge, as famously reported in Latour and Woolgar's (1979) book *Laboratory Life: The Social Construction of Scientific Facts*, cannot be disentangled from quantitative methods.

### ***The ontological/epistemological basis for mixed-method research***

Having established the erroneous and contested nature of the quantitative/qualitative divide leaves the debate about how mixed-method research should be ontologically and epistemologically positioned somewhat mute. That said, it is still worth pursuing because ontological and epistemological justification is frequently missing from many mixed-method research texts and if referred to is oftentimes deferred to notions of 'triangulation', 'complementariness', and 'pragmatism' and I want to position my work in rejection of these epistemological concepts.

Symonds and Gorard (2008) contend that the paradigm wars culminating in the 1980's with an incommensurability thesis for quantitative and qualitative methods left researchers combining methods with an epistemological crisis, and to defend mixed-method approaches alternate modes of justification were proposed. One such notion was 'triangulation', a method of increasing the validity of research results through convergence

of findings from different data sources and which surpasses truth claims from monist methods alone (Bergman 2008). Inherent in this concept of triangulation is the notion of 'complementariness', a pretext of mixed-method research solving the methodological limitations of quantitative and qualitative methods. Yet such an approach reinforces methodological dualism, but perhaps of more concern is the potential for 'god-eye' type claims to truth rather than cautious approximations of knowledge.

Conceived as a research design that ameliorates the biases and limitations of monist methods, the justification for mixed-method research through triangulation paved the way for myriad configurations of mixed-method research (Bergman 2008). Indeed configurations of mixed-method research and the corresponding questions of how they are integrated, combined, or blended is often the central feature of mixed-method research methods texts. Myriad configurations of mixed-method research pose challenges for positioning a philosophical basis for mixed-method research under the current configuration of normatively constructed, dichotomous paradigms. Perhaps to accommodate such wide epistemological variation, Tashakkori and Teddlie (2003), Johnson and Gray (2010) and Biesta (2010) align mixed-method research with 'pragmatism', the philosophy of free choice.

Pragmatism is a challenging notion to contest particularly when it is formulated, as Geyer and Rihani have done, as choosing the best method for the research under question.

*"There is no hierarchy of knowledge or methods in the social sciences. However certain methods are more appropriate for some phenomena than others. (...)*

*Recognising the strengths and weaknesses of quantitative/qualitative methodological strategies and possibly combining them is the primary methodological strategy.” (Geyer and Rihani 2010:31)*

However, I contend that best intentioned pragmatic choices are being made in all research projects irrespective of the methods employed whether overtly dualist or monist. The focus of my rejection of Pragmatism as a philosophy for science is not a rejection of pragmatic decision-making but rather of Pragmatism as a principal *philosophical* foundation for research.

Mixed-method research is often positioned for its potential to deconstruct the notion ‘paradigm’ (Bergman 2008) yet mixed-method research, conceived as the ‘the third paradigm’ by some mixed-method researchers (Jonson and Onwuegbuzie 2004) further reinforces epistemological paradigms (Symonds and Gorard 2008). I draw on the work of Bergman, (2008), and Symonds and Gorard (*ibid*) who argue that the divide between quantitative and qualitative methods is misplaced.

*“Mixing methods is wrong, (...) not because methods should be kept separate but because they should not have been divided at the outset”*

(Gorard 2007:1)

Having contested the quantitative/qualitative paradigmatic divide and rejected the notion of Pragmatism as an epistemological foundation, the principal philosophical basis for the methods employed in this project is founded on critical realism and complexity theory which accommodate ontological and epistemological depth and help to produce explanatory accounts of phenomena.

## The Status of Quantitative Data

The quantitative data collected and analysed for this project are items that can be abstracted from systems into a quantitative form. I previously acknowledged the difficulties of knowing the principal systems for the classification of, and responses to, intimate partner violence. I had ideas from the literature review of some of the elements (or systems) that were likely important. Byrne (1998) suggests that quantitative data are attributes of open complex systems meaning that data quantitatively abstracted from systems and measured are indicative of the patterns of events lying behind which are causal mechanisms. So if, as Byrne (*ibid*) suggests, quantitative data are indicative of open complex systems, by collecting and analyzing quantitative data, the characteristics of the system(s) of classification of and responses to 'domestic violence' are being described and the relations between elements of the system(s) are tested even though we may not know the boundary of the system(s) we are studying.

The research was designed to obtain information about attributes of the system(s) in the form of quantitative variable measures of the applications of classifications of and responses to intimate partner violence in different levels of health system in England. The different levels of health systems from which quantitative data was abstracted was: local institutional in the form the medical records of emergency department attendances (Element 2 medical record review) and in the form of local institutional and national hospital episode statistics from routinely collected health data (Element 3 survey of hospital episode statistics).



### ***Quantitative Data from Retrospective Medical Record review***

Medical records are the formal record of an episode of care for an ‘illness experience’ and can provide ‘patient oriented’ and ‘practice-oriented’ data (Badcock et al 2005:453). One appeal of medical record review is that it provides information about patients’ experiences during ordinary medical care and uses routinely collected, existing data to conduct practice-based, clinically relevant research. Medical record review is the method of choice in approximately 25% of all articles of original research published in emergency medicine journals (Gilbert et al 1995, Worster et al 2005). Data in Chapter Two suggests that intimate partner violence is under-reported and under-recorded and seemingly low-volume, hence direct observation was not a preferred method option. In addition, direct observation was not considered appropriate for this research as it would likely affect the setting and data collected. Shah (2010) found that clinical records tended to under report care provided, indeed, medical record review studies are frequently criticized on grounds of the potential for data degradation at data transfer interfaces (Nagurney et al 2005), as Badcock et al state:

*“In truth, they [medical records] are interpretations of clinical scenarios recorded by different observers who choose to record what they think is relevant or important”*  
(2005:446).

Whilst direct observation methods in Shah et al’s (2010) study were most accurate, medical record review studies are able to prefix their findings with the quantifier ‘at least’.

### ***Quantitative Data from Hospital Episode Statistics***

The survey of Hospital Episode Statistics provides numerical counts of pre-constructed categories of aggregated and disaggregated classifications most specific for intimate

partner violence. The data are in the form of rates of applications of classifications for intimate partner violence in hospital-based emergency department and inpatient health information systems.

In addition to describing the attributes of the system, quantitative analyses in the form of frequencies of occurrence of attributes and tests of association, though not inferring causation can, through statistical significance, indicate the strength of relations between elements of a system. The statistical analyses of quantitative data, though these are also constructions, can be also analysed further with the qualitative data from interviews to produce, non-linear, multi-directional, socially constructed, explanatory accounts of the system(s) of classifications of and responses to intimate partner violence in hospital-based emergency departments in England.

### **The Status of Qualitative Data**

Debate on the status of qualitative interview data pivots around interviews being understood as direct access to respondents' perspectives on the world, versus social interactions in which respondents present accounts of themselves through which they can be deemed favourable, competent and moral (Murphy et al 1998). Earlier phenomenological qualitative inquiry advocated depth interviews as a means of accessing respondent perspectives and understandings of phenomena, the importance of which was to find out about things, feelings, thought or intentions, that cannot be observed, or about things that took place at an earlier point in time, or about events at which an observer could not be present (Murphy et al 1998). Conversely, interviews as social interaction, from a strong social constructionist

perspective, are conceived as performatively constituting the social world and as such 'interview data' can be used for research but only in so much as a topic of analysis itself concerning what went on in the interview in terms of discourse or conversational analysis (Murphy et al 1998). Both these perspectives acknowledge the social construction of interview data but differ with respect to what the data can be used for.

The rejection that interviews can access respondent perspectives about external realities outwith the interview itself is based on four premises (Hammersley and Gomm 2008):

1. Discursive psychology: that what people say does not represent what goes on inside their heads.
2. Epistemological scepticism: accounts themselves are constitutive of 'reality' rather than offering intelligibility about external events independent of the interview.
3. Methodological caution: that observation methods offer less threat to validity than interview methods.
4. Reactivity: the contamination of interview data throughout the interview process.

Hammersley and Gomm (2008) welcome the critique of qualitative interview data in relation to naïve utilization of interview data which they define as '*treating what people say as obvious in its meaning and implication*' (2008:93), and they reject the outright dismissal of interview data for these purposes. Whilst rejecting that people have complete knowledge of their own thoughts and feelings and that they are able to express them, Hammersley and Gomm propose that this:

*"...does not require us to deny that people have unique personal experiences that they can talk about, or that they have distinctive sources of information that may not be immediately accessible to others". (2008:95)*

Hammersley and Gomm (2008) reject the notion that respondent's accounts of and dispositions to events external to the interview situation are invalid but advise researchers to proceed with methodological caution, to recognise the imperfect intelligibility of reality, and the context dependant nature of the interview data.

Drawing on Hammersley (1992), I treat respondents' accounts as *"indicators of cultural perspectives held by the people producing them"* (Hammersley 1992:53) through which I analyse the data for respondents' classificatory constructions of intimate partner violence. Secondly, I treat respondents' accounts *"as a source of information about the phenomena to which they refer"* (Hammersley 1992:53). Here I am relying on respondents' 'witness accounts' of emergency department consultations for intimate partner violence for information about the construction of 'intimate partner violence' and interactions that took place. Respondents' 'cultural constructions' of classifications and 'witness accounts' of emergency department consultations for intimate partner violence are also used to frame qualitative analysis of quantitative data from the medical record review. Respondents 'cultural perspective' and 'witness accounts' are held together in tension, the intention here is not for triangulation of methods but rather plausible, yet still fallible explanatory accounts.

For interview data understood as *"indicators of cultural perspectives held by the people producing them"* (Hammersley 1992:53), questions about the truthfulness or falsity of respondent accounts are not especially relevant because the aim is to document respondents' constructs. However as 'witness accounts' contributing to explanatory accounts of phenomenon, the matter of truth and falsity becomes more important. Notwithstanding the social construction of respondents' accounts it is anticipated shared experiences of everyday realism of the classification of and response to intimate partner violence will corroborate individual respondent's accounts. In this research qualitative data are analysed alongside quantitative to data produce, non-linear, multi-directional, socially constructed, explanatory accounts of the system(s) of classifications of and responses to intimate partner violence in hospital-based emergency departments in England. For elements of systems for which no quantitative data was able to be abstracted but qualitative data addresses, qualitative data analysis will be used to suppose hypotheses about the element.

### **The Status of Explanatory Accounts**

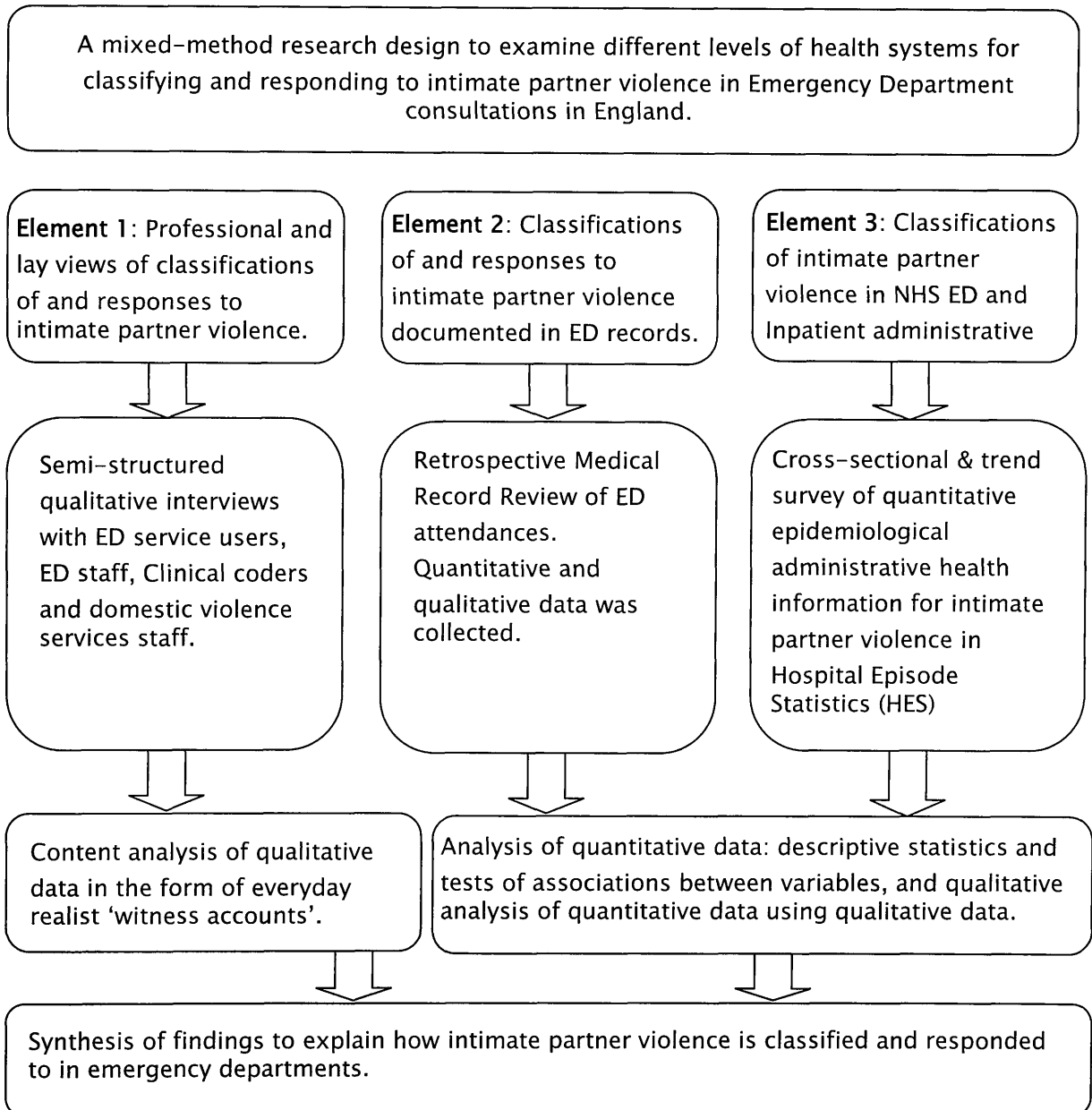
The explanatory accounts constructed are understood in the critical realist position as not necessarily true, rather that they are credible yet concomitantly fallible.

## **RESEARCH DESIGN AND RESEARCH METHODS**

In the previous sections, during the course of establishing and justifying the ontological and epistemological assumptions for the project, I introduced mixed-method research design and the philosophical and epistemological concerns of employing such an approach. In this

section I explicate the methodology and methods to answer the research questions presented earlier more explicitly. An overview of the research design and methods is illustrated in Figure 3.3 below.

Figure 3.3 Overview of Research Design and Methods



The research design is mixed-method and comprises three method-based elements. The methods were selected so as to obtain data from different levels of the system which through the critical realism/complexity theory, mixed-method approach offered explanatory accounts of interconnected micro and macro level systems. The three method elements were chosen because of the availability of classificatory and service response data in health systems. Available data were abstractions from medical records, professional and lay accounts of classifications and/or consultations, and routinely collected administrative NHS health data.

The three method-based elements in the research design (Figure 3.3) have been mapped onto the three levels of systems for classifying intimate partner violence in emergency department (ED) consultations illustrated in Figure 3.2.

- Element one employs semi-structured interviews with service users and health practitioners for qualitative accounts of classifications of and responses to intimate partner violence from experiences of emergency department consultations and this data was analysed by qualitative thematic content analysis.
- Element two, a medical record review of emergency department attendances, converts qualitative data about the classifying and recording of intimate partner violence from institutional emergency department patient record systems into quantitative data. The quantitative data has been analysed using statistical methods of analysis (descriptive statistics and tests of association of variables). The quantitative data findings were also analysed with reference to qualitative data from service user and health practitioner interviews.

- Element three, a cross-sectional and trend survey of quantitative epidemiological administrative health information for intimate partner violence in Emergency Department Hospital Episode Statistics (HES) and Admitted Patient Care Hospital Episode Statistics (HES) provided quantitative information about the classifications for intimate partner violence in regional (Lancashire) and national (England) hospital episode statistics. The quantitative data (applications of classifications of intimate partner violence) was analysed using descriptive statistics and with reference to qualitative findings from element three (qualitative interviews with clinical coders).
- Element one (semi-structured interviews with health practitioners) also obtained qualitative information about the classifying and recording of intimate partner violence in institutional emergency department and inpatient patient record systems and this data was analysed by qualitative thematic content analysis.

## **RESEARCH METHODS**

An overview mapping the methods to the research questions along with which chapter each question is addressed is presented in Table 3.2 at the end of the chapter. A description of each method element following the general format of: objective; method; sample; data collection; and data analysis, now follows. In this methods section the data collected for each element is identified (the non-collection of data from some research sites and stakeholder groups is discussed in the next chapter).



## **Element 1: Professional and lay views on classifications of and responses to intimate partner violence**

### ***Objectives***

Interviews with service users and professional stakeholders were undertaken to obtain accounts of classification of and responses to intimate partner violence during emergency department consultations.

Interviews with data managers and clinical coders were undertaken to obtain their accounts of classifying and coding episodes of care with classifications of intimate partner violence from the ICD-10.

### ***Method***

Semi-structured, in-depth interviews with service users and professional stakeholders.

### ***Sample Design: Service User Interviews***

Four community-based domestic violence services were approached to be research sites for the recruitment and interview of service user participants. There were three key criteria for service user participants: to be female, to have personal experience of intimate partner violence, and to have attended or considered attending an emergency department during their experience of intimate partner violence.

### ***Sample Diversity***

To maximize the breadth of experiential data collected and diversity within the sample, a criterion-based purposive sampling method (Ritchie et al 2003) for service user participants was developed to guide participant recruitment. Six diversity factors likely to impact women's health experiences, utilisation, and perceptions of emergency department services

for intimate partner violence were identified from the literature and a plan to broaden access routes to participation was conceived. The six diversity factors were: the form, frequency, and severity of violence experienced, age, ethnicity, friends and family network, perceptions of personal safety, and personal socioeconomic resources. The sample design was conceived as a tool to guide targeted recruitment meaning that whilst attempting to widen participation, no-one coming forward to participate in an interview would have been declined. However, as detailed in Chapter Four, access to participants was complex and often difficult, and in total eight service users participated in the research and diversity of the respondent group was accordingly limited.

### ***Sample Design: Professional Stakeholders***

Key professional stakeholders were emergency department practitioners (nurses and doctors) and wider professional stakeholders were NHS Acute Trust Domestic Violence Leads, NHS Acute Trust Hospital-based Social Workers, NHS Acute Trust Data Managers and Clinical Coders, Specialist Domestic Violence Service Staff, Sexual Assault Referral Centre Staff, and General Practitioners). A professional stakeholder sample matrix was developed for highlighting the stakeholder participant populations and potential number of participants for issues of research feasibility. Clinical Coders had not been in the original research design, their importance as a key group was highlighted once the analysis of the International Classification of Disease and Admitted Patient Care Hospital Episode Statistics was commenced.

Four community-based domestic violence services were approached to be research sites for the recruitment and interview of domestic violence service staff participants.

Four Acute NHS Trusts were approached to be research sites for the recruitment and interview of hospital-based practitioner participants.

Four primary care practices were approached to be research sites for the recruitment and interview of general practitioner participants.

### ***Participant Recruitment Protocol: Service User and Stakeholder***

Once ethical approval and site permissions had been obtained<sup>3</sup> community domestic violence service managers and stakeholder group managers were contacted by letter to introduce the research project taking place. In situations where the potential participant was a named individual working more independently the letter was sent directly to them. The letter introduced the research and aspiration for participant recruitment. Copies of the research information materials (A4 poster, flyer, and participant information sheet) for potential participants were enclosed and the manager was asked to distribute the research materials at the site so that they were accessible to potential participants. Participant information and consent materials were developed with specific reference to the NHS Patient Safety Agency and National Research Ethics Service (2011) guidance. The letter of introduction also offered researcher attendance at staff / service user group meetings to explain the research to potential participants. Recruitment was on an opt-in basis and potential participants were asked to contact the researcher via a project designated research

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<sup>3</sup> Issues of research ethics and access to research sites, participants and data are presented and discussed in Chapter Four.

email and mobile telephone number. If there was no response from the manager or potential participants at a site after two weeks follow up was done twice at fortnightly intervals via telephone call and/or email. Non-response was enquired about where possible so that support for the research to go ahead could be implemented but if this was not possible no further requests were made.

*Participant Recruitment: Service User Interviews*

Three domestic violence service sites supported the project and eight service users from across two sites participated in an interview.

*Participant Recruitment: Emergency Department Practitioners*

Three Acute NHS Trust sites supported the project and nine emergency department practitioners service users from across two sites participated in an interview.

*Participant Recruitment: Clinical Coders.*

Three Acute NHS Trust sites supported the project and six clinical coders from one site participated in an interview

*Participant Recruitment: Domestic Violence Service Staff Members.*

Three domestic violence service sites supported the project and ten domestic violence service staff from across two sites participated in an interview

*Participant Recruitment: Hospital-based Social Workers*

No hospital-based social workers came forward to participate in an interview.

*Participant Recruitment: General Practitioners*

No general practitioners came forward to participate in an interview.

*Interview Protocol: Service User and Stakeholder Interviews*

An interview protocol attending to participants' rights, privacy, comfort, safety and well-being was developed and followed, and arrangements for participant expenses, interpreter

services, and child care had also been made. The interviews were conducted as detailed in the research protocol approved by the Social Care Research Ethics Committee<sup>4</sup>.

### ***Data Collection: Service User and Stakeholder Interviews***

Interviews were undertaken as detailed in the interview protocol. Interview guides were developed (see Appendix One) based on the topics raised in the literature review, stakeholder consultations and the research aim and objectives. Interviews were semi-structured to be responsive to participants' priorities and direction. Interviews lasted from between thirty minutes to an hour. Participants were aware they could stop at anytime and also retract participation up until the final research report was written. Participants could opt-out of interview audio-recording, and one participant did so; for this interview notes were made during the interview. All other participants agreed to interview audio-recording; audio records were transcribed by a secure transcription service and anonymised. The anonymised interview transcripts were checked for accuracy and entered into NVivo9 software programme, a computer assisted qualitative data analysis system (CAQDAS), for data management and analysis.

### ***Qualitative Data Analysis Service User and Stakeholder Interviews***

The qualitative data analysis (QDA) employed a 'tight' rather than 'loose' design (Miles and Huberman 1994) meaning that much pre-data analysis structuring took place in terms of the formulation of research questions, hypothesis generation and interview topic guides

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<sup>4</sup> The research protocol (a 47-page document) and further documents approved by the ethics committee are not included due to the limitations on thesis size but are available on request.

based on what was already known from earlier research about intimate partner violence and health consultations. Using Ritchie et al's (2003b) 'Framework' method I developed a network of nodes (thematic categories of information) based on the research questions in NVivo9 CAQDAS software with which to tag and code data from interview transcripts. In a process of transcript readings and familiarization, further nodes were added and I wrote abridged accounts of each participant's interview noting items interpreted as of importance and significance for the respondent. I had originally proposed to follow Ritchie et al's (2003b) 'Framework' method of qualitative data analysis, however, on applying the 'Framework' method in practice found it more closely aligned to grounded theory, theory generating methods and which did not fit with the theoretical framework for this research. A revised coding schema was developed using Miles and Huberman's (1994) framework for realist qualitative data analysis which also included coding for descriptions of constructs, themes, patterns, explanations, and relationships. The qualitative interview data was analysed for respondents' constructions of phenomena and for explanatory witness accounts of events. The qualitative accounts were also used to qualitatively analyse the patterns of univariate and bivariate statistics from the quantitative data to propose explanatory accounts for patterns identified. I grouped together shared perspectives found in the qualitative data and quantified them to strengthen explanatory accounts.

## **Element 2: Classifications of and responses to intimate partner violence documented in emergency department attendance records**

### ***Objective***

To collect information about the classifications of and responses to intimate partner violence recorded in emergency department attendance records.

### ***Method***

Retrospective Medical Record Review of Emergency Department Attendance Records.

### ***Sampling Design: Retrospective Medical Record Review***

As no specific sampling frame of intimate partner violence exists in the A&E Data Dictionary Coding Tables the Electronic Patient Record System was electronically screened by a member NHS Trust staff to produce a sampling frame of all the Emergency Department attendances in 2010 that had been coded with the A&E Data Dictionary data fields i) incident type: 'assault', ii) incident location: 'home' or 'home other', iii) age on arrival: sixteen years or older. This electronic filtering means that the sample comprises of people aged sixteen years or older attending the emergency department who reported experiencing an assault in their home ('home') or in a residential location ('home other').

Four Acute NHS Trusts were approached to be research sites for the retrospective medical review, three sites supported the project, however for reasons of feasibility as detailed in the section on 'Access' in Chapter Four, a medical record review of emergency department attendances was only undertaken at one site (Site Three). The reason for undertaking the

emergency department attendance record review at Site Three was because emergency department hard copy records at this site were scanned and thus electronically available precluding the need for manual retrieval.

### *Sample*

Two months in 2010, a spring/summer month and an autumn/winter month, were selected as the sample periods. The Christmas and New Year period was avoided as rates of intimate partner violence are reportedly higher at this time of year and thus this exclusion was to avoid potential skewing of rates of cases of partner violence in the overall caseload. The rates of emergency department attendance for the sample months are not presented so that the research sites cannot be identified. Every record that met the criteria (n=90) was included in the review.

### *Sample groups*

Two sample groups were identified for data analysis from the sampling frame:

1. All cases of assault by location 'home'
2. A sub-group of cases of assault by location 'home' in which the patient's partner was identified as the perpetrator.

### *Data Collection*

A protocol for the Retrospective Medical Record Review data collection was developed and the data collection was conducted as detailed in the research protocol and approved by the Social Care Research Ethics Committee and the Health Research Authority (formerly National Information Governance Board) Ethics Committee. The Retrospective Emergency Department Medical Record Review collected non-confidential and non-identifiable data from all the records of emergency department attendances in the two month sample period.



Recorded data about the classifications used by ambulance personnel, emergency department receptionists, triage practitioners, and nurse/medical practitioners were collected along with information about modes of attendance, the form and severity of violence and injury, and interventions and referral routes were collected. The locations, actors, and modes of recording data in emergency department records is explicated in detail at the beginning of Chapter Five it is located there to explain the variation in sample sizes for the data findings from the different locations of the emergency department consultation.

Data about the forms of violence recorded (course of conduct violence, sexual violence, psychological violence, physical violence and surveillance); frequency of violence or whether it was recorded as a first incident; severity of violence based upon differentiations in the Revised Conflict Tactics Scale (Straus 1996); injurious impact of violence based upon the Counting Rules for Recorded Crime (Home Office 2010b, 2010c); the classifications of violence used; age; sex; and the recording of patients' pregnancy or presence of children in the household were collected. Data collected about responses in terms of interventions for intimate partner violence were: descriptive recording of event; forensic evidence collection; body map injury recording; photographic recording of injury; risk assessment; high risk of homicide assessment; distancing from perpetrator; safety strategy; child protection; mental health assessment; alcohol or drug use assessment; and protective hospitalization or refuge. Data collected about responses in terms of intimate partner violence referral were: referral to specialist domestic or sexual violence services or refuge; police pre-involvement or referral; referral to social services, referral to children's services; referral to mental health services, referral to health visitor / school nurse or general practitioner. It was not possible

to collect data about employment status or ethnicity as these fields were often not completed.

The *electronic* record review included data that would not be available in a *hard copy* review. The additional data visible to the reviewer was electronic field information about the source of patient referral to the emergency department and the location of where the incident took place. This additional electronic information entered into the electronic patient record during emergency department patient registration by administrative reception staff does not appear on the hard copy attendance record that practitioners are provided with to document the consultation. That the location and source of referral is not made visible to practitioners is significant and will be referred back to later in the chapter.

To collect the data I was granted access to the Electronic Patient Record (EPR) system at an NHS Trust. Whilst collecting the data onsite I was covered by a Research Passport<sup>5</sup>, and Letter of Access<sup>6</sup>, and worked under supervision and guarantee of the onsite collaborators. Records were viewed and data collected in a private area in the Research and Development Department at the Trust. The data extracted from records was directly entered onsite into pre-prepared IBM SPSS<sup>®</sup> (Statistical Package for the Social Sciences) data file on a laptop computer which was protected by screensavers and password protected whole drive

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<sup>5</sup> A Research Passport is a uniform system of NHS human resource security checks for Higher Education Institute researchers undertaking research in the NHS (NIHR 2010).

<sup>6</sup> A Letter of Access details HEI researchers granted access at an NHS institution to undertake research that has no direct bearing on quality of care (NIHR 2010).

encryption. No personal data was collected and no identifying data of the NHS site was stored in the SPSS® file.

### ***Quantitative Data Analysis: Retrospective Medical Record Review***

The data was checked for accuracy and inconsistencies, six cases were removed from the sample because they were not 'assaults' or related to a recent assault. Three other cases that appeared not to be assault related were left in the sample as I could not be certain that they were not also assaults. Two of these cases were males that incurred injury whilst perpetrating violence on home property, in one case the person punched a wall and in the other the person was throwing and breaking objects. The third case was a female who sustained a laceration. The final sample for analysis was made up of 84 cases.

The data was analysed using statistical tools within SPSS® to produce univariate and bivariate analyses. The Lancaster University Department of Mathematics and Statistics were consulted to provide advice on statistics. Univariate analyses of data produced distributions of data in the form of variable prevalence rates and frequency tables of classifications and responses recorded. Bivariate and multivariate analyses were conducted using comparative data analyses in the form of cross tabulations and tests of association (chi-squared) between variables. Where possible tests of association tested the significance of variables for classifications deployed and interventions initiated. Qualitative data from the service user and stakeholder interviews were used to further analyse the patterns of univariate and bivariate statistics from the quantitative data. In sum, the quantitative data were used to

identify patterns and associations in the data and qualitative data were used to propose explanatory accounts of patterns identified.

### ***Handling Missing Data (Retrospective Medical Record Review)***

Missing data in this research may come from non-coverage, total non-response, partial non-response, or item non-response.

#### ***Non-coverage***

Non-coverage is recognized in the sample design through the employment of pre-screening filters (Accident & Emergency Clinical Data Codes: incident type: 'assault' and location type: 'home') from which to identify a sample of cases of intimate partner violence. This design introduces an element of bias as there may be a population experiencing intimate partner violence who do not attend emergency departments as a result of an incident of violence but attend for other health consequences, for example mental health problems. The use of ICD-10 clinical codes for a second sample frame was an attempt to ameliorate this bias, however, the data from Hospital Episode Statistics indicates that ICD-10 codes are infrequently applied and this frame may also have elements of inherent bias. This is recognized as a limitation of the study but as no sampling frame exists, this sample design is most likely to produce a sample populated by cases of intimate partner violence.

#### ***Total Non-Response***

Total non-response was limited as once records are selected for participation, total non-response was only because of an irretrievability of records. For the purpose of data analyses, these cases were considered to be missing completely at random. The number of total non-response has been accounted for in the research reports.

### *Partial non-response*

Some patient records were partially completed, for example individuals attended the emergency department and registered to be seen but subsequently left without being seen (LWBS) or left before treatment (LBT). These cases of partial non-response are an important subset of emergency department attendances for intimate partner violence and have not been excluded from the study. As a consequence the total population counts in the analyses vary.

### *Item non-response*

In this research, item non-response arose from the data item not being applicable to that case, from illegibility of handwritten data, or from non-recording of the item. These three types of missing data item non-response (not applicable, illegible, unrecorded) were differentiated in SPSS® coding. Item non-response due to items not being recorded are of interest in this research and were coded as a legitimate response as assumptions about why the data is missing cannot be made. The data set was built to code items of non-response as a field of interest for analysis as follows.

- 999 Missing data (in the traditional sense)
- 998 Not mentioned in record
- 997 Not applicable to this case or this variable.
- 996 Unknown
- 995 Record unavailable
- 994 Left before being seen
- 993 Not seen in the emergency department – referred to another provider.
- 992 Uncertain or unclear information
- 991 Patient was seen but left before treatment completion
- 888 Incorrect coding or case irrelevant to the study.

In handling missing data the focus has been on methods of data collection and data set construction that will minimize the amount of 'missing data'. Methods for handling missing data for example weighting and imputation are not appropriate for this data set in which data missing completely at random or missing at random cannot be assumed. Missing data in these forms have been accounted for in research analyses and the potential limitations and meanings of missing data are discussed in the relevant sections of the research findings chapters.

### **Element 3: Classifications of intimate partner violence in NHS hospitals administrative health data (Hospital Episode Statistics)**

#### ***Objectives***

To establish the rates of applications of the classifications most likely used for intimate partner violence in Emergency Department Hospital Episode Statistics (HES) and Admitted Patient Care Hospital Episode Statistics (HES).

To establish in which Emergency Department Hospital Episode Statistics (HES) and Admitted Patient Care Hospital Episode Statistics (HES) classifications episodes of care for 'intimate partner violence were most likely distributed.

#### ***Method One***

Cross-sectional and trend survey of quantitative epidemiological administrative health information for classifications of intimate partner violence in Emergency Department Hospital Episode Statistics (HES) and Admitted Patient Care Hospital Episode Statistics (HES)

### *Method One Sample of Emergency Department Hospital Episode Statistics*

A data request was made to the North West Public Health Observatory (NWPHO) in September 2010 for the numbers of emergency department attendances in Lancashire for assault disaggregated by age, gender and location for years 2007, 2008, 2009.

### *Method One Sample of Admitted Patient Care Hospital Episode Statistics*

1. Admitted Patient Care Hospital Episode Statistics available online.

The Admitted Patient Care Hospital Episode Statistics 4-character primary diagnosis tables were viewed online and data about the number of FCE's (Finished Consultant Episodes) and Admission spells for men and women aged fifteen years<sup>7</sup> or older coded with one of the ICD 10 classifications for intimate partner violence for years 2006 to 2011 were collected.

2. Admitted Patient Care Hospital Episode Statistics dataset obtained by request from the North West Public Health Observatory.

A data request was made to the Northwest Public Health Observatory for the numbers of people aged sixteen years or older admitted to hospital in England from 2006 - 2011 and whose admission was coded with one of the ten ICD-10 codes disaggregated by rank diagnostic classification (primary or secondary), sex, mode of admission (emergency, elective or other), and service provider (NHS Trust). The categories of data are slightly different to the online data. The web site produces data by finished consultant episode and admission spell whereas the data produced in response to the bespoke request is by number of patients.

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<sup>7</sup> The age categories online were fixed and therefore it was not possible to identify a sample of people aged sixteen years or older from this source.

### *Quantitative Data Analysis: Hospital Episode Statistics*

The quantitative data was received from NPHO in Excel format. Univariate analyses were performed to produce frequency tables and descriptive statistics. Analysis of the quantitative data using qualitative data from interviews was also undertaken.

### **Method Two**

A survey of a sample of central (admitted patient care) medical records that had been coded with one of the International Classification of Disease Codes T74.1; T74.2; T74.3; T74.8; T74.9; Y05.0; Y06.0; Y07.0; and Z63.0 as a primary or secondary diagnosis between 2006 and 2010 for patients aged sixteen years or older at the time of coding.

#### *Method Two: Sample*

All the central records medical records that had been coded with one of the International Classification of Disease Codes T74.1; T74.2; T74.3; T74.8; T74.9; Y05.0; Y06.0; Y07.0; and Z63.0 as a primary or secondary diagnosis between 2006 and 2010 for patients aged sixteen years or older' at the time of coding were identified electronically by a Data Manager at NHS Trust Site 2. Purposeful sampling of these central medical records was undertaken to obtain, where possible, a number of records of male and female patients for each of the classifications. Hospital numbers were used by Trust staff to retrieve the sample of records.

#### *Method Two: Data Collection*

Records were viewed and data collected onsite, in a private area, in the Research and Development Department at the Trust for which I was covered by a Research Passport, and Letter of Access, and worked under supervision and guarantee of the onsite collaborators. The data extracted from records was directly entered into a data file on a laptop computer which was protected by screensavers and password protected whole drive encryption. Data



about the characteristics of the health problem requiring admission that was coded with one of the ICD-10 codes were collected. No personal data was collected and no identifying data of the NHS site was stored in the file.

### *Method Two Data Analysis*

The data was analysed for the descriptive accounts of admission to understand the use of International Classification of Disease classifications for forms of intimate partner violence and the types of health problems resulting from intimate partner violence that they were used for.

## **SUMMARY**

In summary the ontological and epistemological foundations for the study are critical realism and complexity theory. A mixed-method research design was employed to combine quantitative and qualitative research methods to produce explanatory accounts of the classification of, and responses to intimate partner violence, in emergency department consultations. The quantitative data were analysed for patterns of classifications of, and responses to intimate partner violence, at different levels of systems, and for associations between quantitative variable indicators of interconnecting systems. Qualitative data were analyzed for explanatory mechanisms for the patterns of classifications of and responses to intimate partner violence at different levels of systems to explain how intimate partner violence is classified and responded to in emergency departments and to identify the better forms of intimate partner violence classification for improving hospital-based, emergency department responses to intimate partner violence in the form of physical assault.

Table 3.2 Overview of Research Questions and Methods

Research Questions <i>(Chapter in which principally addressed)</i>		Research Methods		
		Element 1	Element 2	Element 3
		Interviews with service users and stakeholders	Medical Record Review of ED Attendances	Survey of Hospital Episode Statistics
P R Q	How best can intimate partner violence, in the form of a physical assault, be classified to reduce misclassification, increase identification, mobilize intervention (according to patients' stated preference) in emergency department consultations, and collect data about it in hospital-based emergency department administrative systems? <i>Chapter 9/10</i>	X	X	X
S1	Which classifications for intimate partner violence are applied during emergency department consultations for an attendance after an assault by a partner? <i>Chapter 5</i>		X	
S2	Which classificatory attributes are involved in the construction of different classifications of intimate partner violence applied during emergency department consultations for an attendance after an assault by a partner? <i>Chapters 5 and 6</i>	X		
S3	Why is intimate partner violence, in the form of physical assault by a partner, classified in different ways during emergency department consultations? <i>Chapter 6 and 7</i>	X	X	
S4	What interventions and referral routes for intimate partner violence are initiated during emergency department consultations for an attendance after an assault by a partner? <i>Chapters 7 and 8</i>	X	X	
S5	What are the relationships between the different classifications applied and interventions and referral routes initiated for intimate partner violence during emergency department consultations for an attendance after an assault by a partner? <i>Chapters 7 and 8</i>	X	X	
S6	What are the rates of applications of classifications for intimate partner violence, in the form of physical assault by a partner, in a sample of Emergency Department Hospital Episode Statistics and Admitted Patient Care Hospital Episode Statistics? <i>Chapter 8</i>			X
S7	In which Emergency Department Hospital Episode Statistics and Admitted Patient Care Hospital Episode Statistics classifications are cases of intimate partner violence, in the form of physical assault by a partner, most likely distributed? <i>Chapter 8</i>	X	X	X
S8	Why are cases of intimate partner violence, in the form of physical assault by a partner, classified in different ways and distributed across different classifications in Emergency Department Hospital Episode Statistics and Admitted Patient Care Hospital Episode Statistics? <i>Chapter 8</i>	X	X	

## CHAPTER FOUR: RESEARCH ETHICS, ACCESS, AND DATA

## **INTRODUCTION**

Chapter Four begins with the detailing of the ethical concerns initially identified for this research project. Four further points raised by the ethics committee and which placed additional technical constraints on research processes are also explicated in terms of their meaning for the project. The tensions between researcher self-governance and the ethical authority granted to ethics committees are discussed. Following this critique of 'prospective research governance', issues for the project relating to access to research sites, participants, and data, as introduced in Chapter Three are discussed in terms of the lessons learned and the meaning that the difficulties of access had for the research data collected and for researching health systems responses for intimate partner violence. This research is primarily concerned with intimate partner violence against women and the inclusion and exclusion criteria for the different sources of data in terms of gender and sexuality are stated. The strengths and limitations of the quantitative and qualitative data collected for the overall constraints on the claims that can be made are discussed and established. The chapter concludes with an introduction to the data chapters that follow explaining how systems thinking and the sociology of diagnosis have informed the presentation of data. An overview of the sources of data, the methodological work that was done with them, and the chapters that the data appear in can be found on the last page.

## **RESEARCH ETHICS**

The research was conducted in accordance with the Research Governance Framework for Health and Social Care (Department of Health 2005b), and the Ethical and Research Governance Framework of Lancaster University Research Ethics Committee. I submitted the

project to the Social Care Research Ethics Committee (SC REC) for ethical review rather than the National Health Service Research Ethics Committee (NHS REC) because some elements of the research were conducted in organisations outside the NHS that did not have formalized research governance or ethical review processes.

Hammersley (2009) questions the claim to ethical authority placed upon research ethics committees above that of the researcher. Yet whilst I concede Hammersley's (*ibid*) argument that a researcher, as expert, likely has greater knowledge and insight of the ethical dimensions in their field of study, I welcomed ethical review. Firstly, because the research could be considered 'sensitive', and secondly, as a novice researcher, appreciated having the project reviewed by a diverse and experienced committee<sup>8</sup>. Lee defines sensitive research as '*research which potentially poses a substantial threat to those who are or have been involved in it*' (1993:4). In this project 'threat' could arise from intrusion into aspects of participants' private life, risk of sanction in response to disclosures of risk of harm to self or others, and risk of emotional distress from recall of experiences of intimate partner violence.

The ethics review application required information detailing: scientific justification for and value of the research; research methods for sampling, data collection, analysis and dissemination; potential harms and benefits for participants; informed consent; data protection; and data security. In total more than 130 final documents were produced

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<sup>8</sup> The ethics committee had sixteen members comprising academics in health, social care, and ethics, professionals from statutory (social, police, and health) services, and lay representation.

accounting for the research protocol in meticulous detail. The ethical and governance issues and arrangements made for the project were in relation to:

- Non-consented access to medical records
- Access to non-anonymised patient records
- Safety and well-being of participants
- Process to record consent to participate in the study
- Potential emotional impact for interview participants
- Disclosure of risk of harm to self or others
- Researcher well-being.
- Data protection and data storage
  - Data protection: Anonymity and confidentiality
  - Data protection: Storage and physical security
  - Research methods data protection protocol
  - Security of data with identifiable information
  - Service user and stakeholder interviews
  - Participant identifiable information
  - Interview data
    - Interview transcription
    - Interview transcripts
  - Quantitative data
    - Retrospective medical record review
- Access to research data
- Retention of research data
- Dissemination of research findings
- Consumer and stakeholder involvement
- Diversity and criteria for participants for the study
- How the research will be used
- Dissemination
- Secondary data analysis after the study
- Participant expenses

The SC REC expressed concerns on a further four issues:

- Given that domestic violence is associated with a greater risk for mental health problems how would mental capacity to consent to participate in the research be assessed?
- Given the potential for disclosures of risk of harm to themselves or others, how would participants be informed about the possible requirement of the researcher to breach confidentiality?
- Service users participating in an interview should be able to opt out of the hospital-based medical record review and to have their records excluded from the sample search.
- Interview participants should be able to opt-out of interview audio-recording.

## **Mental Capacity**

Originally the project design started from a position of assumed capacity in those 'opting-in' to take part. However the ethics committee considered that this was not sufficient to prevent the inadvertent inclusion of people lacking capacity to consent to participate. The assumption of capacity is positioned as the starting point in the Mental Health Act (UK Parliament 2005) and Mental Health Capacity Act 2005 Code of Practice (DCA 2007). However, ensuring the inadvertent inclusion of someone lacking capacity in effect means that all participants' capacity had to be assessed. A protocol for assessment of mental capacity was formulated from the Mental Health Capacity Act (UK Parliament 2005) and Mental Health Capacity Act 2005 Code of Practice (DCA 2007). I evidenced my competence to assess capacity for the SC REC on my past experience of facilitating informed consent as a Registered Nurse in the NHS and on having undertaken the NHS 'Good Clinical Practice' research course. The process of researching information about mental capacity to develop the consent protocol improved my knowledge and understanding and as a result I probably conducted the consent process in a more exact, detailed and consistent manner, and more

likely than not, ensured that people lacking capacity were not inadvertently included in the study.

## Disclosures of Risk of Harm to Self or Others

The research ethics committee advised that a limited confidentiality statement be incorporated into the participant information sheet stating:

‘Everything you say/report is confidential unless you tell us something that indicates that you or someone else is at risk of harm. We would discuss this with you before telling anyone else’.

Whilst not obligated by law (NSPCC 2011<sup>9</sup>), I understand that I have a professional (RCN 2004, NMC 2008, DfES<sup>10</sup>) and citizenly duty (NSPCC 2011<sup>11</sup>) placed upon me to act on becoming aware of risk of significant harm to children but rather understood that adults (with capacity) are assumed to be able to make judgments about their own risk of harm and how to respond to that risk irrespective of whether anyone else disagrees with their decision or considers the decision not to be in their best interests. In situations of intimate partner violence the risk of harm to the *self* and to *others*, particularly the person’s children, are

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<sup>9</sup> NSPCC (2011) ‘Whilst local authorities have a mandatory duty to investigate if they are informed a child may be at risk, there are no specific mandatory child abuse reporting laws in the UK that require professionals to report their suspicions to the authorities’ (2011:3).

<sup>10</sup> Royal College of Nursing: ‘any nurse, who has direct or indirect contact with children, must be able to identify children and young people who are vulnerable, at risk of harm or abuse, and act accordingly’ (RCN 2004:5).

Nursing and Midwifery Council: “*You must disclose information if you believe someone may be at risk of harm, in line with the law of the country in which you are practising*” (NMC 2008:3).

Department for Education and Skills: “All those who come into contact with children and families in their everyday work, including practitioners who do not have a specific role in relation to safeguarding children, have a duty to safeguard and promote the welfare of children” (DfES 2006:10).

<sup>11</sup> National Society for the Prevention of Cruelty to Children: “If you’re worried about a child you should contact the NSPCC Helpline to discuss your concerns with one of our qualified advisers” (NSPCC website 2011)



entangled, first, I discuss the issue of disclosure of risk of harm to the adult participant with capacity, and then consider risk in relation to participants' children.

### ***Risk of Harm to Self***

In the context of intimate partner violence, the issue of 'risk to the self' is profoundly complex. On one hand, placing greater emphasis on the self and agency, it is argued that women should be acknowledged as experts of their situation and their decisions about what to do should be respected (Mullender and Hague 2001). However, in situations of intimate partner violence, women's 'space for action' is narrowed as a result of coercive controlling behaviours of the perpetrator (Kelly 2007). Understanding women as having a limited space for action can be interpreted and responded to in two ways. First, from a feminist perspective, women should be supported by appropriately skilled people to make their own decision in a way that simultaneously increases 'space for action' through empowerment (Kelly and Humphreys 2001, Coy and Kelly 2011). Conversely, limited space for action could be interpreted as justification for contesting an individual's capacity to make decisions to transfer decision making to authorities and to sanction intervention. Indeed, in the United States some States have introduced mandatory reporting<sup>12</sup> (Durborow et al 2010) for disclosures of intimate partner violence in health settings, an intervention understood as reallocating the burden of reporting to authorities from service users to health practitioners.

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<sup>12</sup> 'Mandatory reporting' refers to laws enacted by State Statute that require health professionals to report suspected domestic violence to police services irrespective of the victims wishes (Durborow et al 2010).

The effect of mandatory reporting laws on women's disclosure practices is problematic and controversial. In one attitudinal survey (Houry et al 1999) 15% of women reported that they would be more likely to disclose intimate partner violence if the health practitioners were mandated by law to report to other agencies. Yet in another (Hayden et al 1997), 39% of women indicated that they would not disclose intimate partner violence to health practitioners if mandatory reporting practices were in place. Mandatory reporting practices are often found in conjunction with mandatory arrest<sup>13</sup> and no-drop prosecution<sup>14</sup> practices. In San Diego, where Hayden's (*ibid*) research was undertaken, agencies reported success: 50% decrease in intimate partner homicide and a doubling of police intimate partner violence investigations in the seven years since mandatory reporting was introduced. Yet, others argue that mandatory arrest and non-drop prosecution policies in the United States have been found counterproductive (Davis et al 2004). Whilst households in States with mandatory response practices report lower rates of intimate partner violence in National Victimization Surveys, incidents of intimate partner violence in these states are less likely to become known to police (Dugan 2003). The purpose here is not to provide a comprehensive review of mandatory reporting practices but rather to illustrate the tensions of such policies in situations of intimate partner violence that deny victim/survivors' autonomy and right to confidentiality.

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<sup>13</sup> 'Mandatory arrest' policies require the police to make an arrest if there is probable cause to suspect domestic violence irrespective of the victim's wishes (Han 2003).

<sup>14</sup> 'No-drop prosecution' requires prosecution of the perpetrator of domestic violence irrespective of the victim's wishes (Han 2003).

In England non-consented reporting by health practitioners to police services under Data Protection Act (UK Parliament 1998) exemptions is possible if there is a risk of 'serious harm'. Derived from the Data Protection Act (1998), the General Medical Council (GMC) (2009) and Nursing and Midwifery Council (NMC) (2008) indicate that disclosure to a third party about risk of 'serious harm' must be justifiable and in the 'public interest' to protect the person or others from risk of death or 'serious harm' and in such an eventuality, confidentiality may be breached with or without consent. Disclosure to a third party is contingent on and proportionate to harm from non-disclosure weighed against harm from disclosure.

The General Medical Council gives 'serious crime' as one example of risk of 'serious harm'; the Department of Health (DH) (2010b) states that:

*"'Serious crime' is not clearly defined in law but will include crimes that cause serious physical or psychological harm to individuals. This will certainly include murder, manslaughter, rape, treason, kidnapping, and child abuse or neglect causing significant harm and will likely include other crimes which carry a five-year minimum prison sentence but may also include other acts that have a high impact on the victim"* (DH 2010b:9).

The boundaries of justifiable third party disclosure are complex, for example rape is not necessarily a crime warranting breach of confidentiality reporting to police. The right of victim/survivors' not to report rape to police is a feature of services provided by Sexual Assault Referral Centres and Rape Crisis Centres.

For adults with capacity there is a greater concern for the risk of harm to *others* than to the person to whom the information relates supporting the notion that adults with capacity are responsible for their own decisions about themselves. Indeed, section 9 (DH 2010b) indicates that:

*“An individual’s best interests are not sufficient to justify disclosure of confidential information where he/she has the capacity to decide for him/herself. There has to be an additional public interest justification, which may or may not be in the patient’s best interests.”*

That the research ethics committee suggested that a blanket breaching confidentiality statement be incorporated into the participant information sheet seems somewhat at odds with this Department of Health guidance for disclosure of information for *adults with capacity*. So, despite a limited professional duty to disclose and one that is not legally required unless it is in the wider public interest, a confidentiality statement was placed on the research project. The parameters of what constitutes serious harm are undetermined in policy documents questioning whether this is an effective addition to the project or an interventionist risk averse paradigm that Foucault (1991) [1978] imagined as the ‘apparatus of security’.

### ***Risk of Harm to Participant’s Children***

Central to the Children Act (UK Parliament 1989) is the ‘paramountcy principle’ – that a child’s best interest and welfare is paramount (NSPCC 2011) and hence in England, the rights of adults are overruled if there is a risk of ‘significant harm’ to children (GMC 2007, NMC 2008, DH 2010, UK Parliament 1989, 2002, 2004). ‘Significant harm’ is a term

introduced in the 1989 Children Act as a “*threshold that justifies compulsory intervention in family life in the best interests of the children*” (DfES 2006:8). Whilst the Family Law Act (UK Parliament 1996) provided *women* with protection from perpetrators of ‘domestic violence’, more recently, the Adoption and Children Act (2002) clarified and stretched the definition of ‘significant harm’ to children to include the *witnessing* (seeing or hearing) of ill-treatment to another. This positioning of legal threshold of ‘risk of harm’ for children to include *witnessing* means that the threshold of statutory duty bound intervention is lower for the child(ren) of an adult victim/survivor of intimate partner violence than for the adult victim/survivor.

Whilst ‘risk of significant harm’ from witnessing the ill-treatment of another is placed on all children living in households where domestic violence is perpetrated, children’s resilience varies and ‘harm(s)’ are not automatic nor indeed universal (Mullender and Hague 2001, Worrall et al 2008). This is not to minimize the problem of ‘domestic violence’ for children but rather to expose the potential problematic of laws that relegate the standing of the direct adult victim/survivor. Abrams (1995) argues that under gender-based oppression, women’s agency is necessarily constrained yet women continue to act in self-determined albeit constrained ways. From Abrams’ (*ibid*) perspective child protection from ‘domestic violence’ may become the lever of power to force women to act for fear of the consequences of being identified as ‘failing to protect’ her children. These downward (state) and upward (self) regulatory mechanisms for Foucault (1991) [1978] ensure the goals of government. Thus power is not exclusively oppressive; it is concurrently productive in that new behaviours emerge through resistance to power (Foucault 1991 [1978]).

Though new ways of acting in resistance to power can be understood as productive, missing from Foucault's account is an analysis of the operations of practices of resistance. From a lens of inequality, acts of resistance may not restructure power relations and moreover may further constrain people's practices in ways that reproduce or even widen relational power differentials. For example, mandatory referral practices may cause women to limit the amount of information they disclose about violence they experience to professional agencies and which may reduce the allocation of resources to them. For Foucault (1991) [1977] power is not 'possessed' rather it is enacted dispersed in day to day relations between people and between people and institutions. I contend that enactments of dispersed power are not equally positioned: inequality in terms of disadvantage and privilege permit 'power over' one by the other and hence I reject Foucault's proposition that power cannot be possessed. Partial agency (Abrams 1995) and narrowed space for action (Kelly 2007) whilst helpful in communicating the reality for women living with domestic violence are simultaneously problematic for their potential to be misused by coercive institutions of the state in order to justify disregard for women's autonomy in ways that further constrain and subordinate. The duty of citizens and professionals to report children at risk of harm whilst not mandated by statute is well-established in policy and professional guidance, alongside which there is an increased sense of culpability for women's (*perceived*) inaction which may not be sufficiently nuanced. My concern is the extent to which the context of constrained confidentiality in the form of child protection from witnessing intimate partner violence is problematic for women's democratic participation in everyday life, such as participation in research.

### *Constraint of Confidentiality Clause*

My original intention was not to have explicit reference to breaching confidentiality in the participant information preferring to advise the participant of the possibility of third party disclosure of information should they begin to say something that may lead to a disclosure of harm. The rationale for this stemmed from a discussion with a director of domestic violence services during the stakeholder consultation who intimated that service user participants would be already very aware of limits of confidentiality and accordingly guarded in their responses. In retrospect, this approach may have been difficult in practice; a disclosure of harm could have occurred before there was time for me to give limit of confidentiality advice and which could have impacted participant / researcher relations. However, the service user participants in this study were known to services and therefore it would be unlikely that third party disclosure could have been justified unless it was a new, materially different situation. We know that women make decisions about disclosure based on fears of involvement of authorities and state agencies, but from a research perspective it is important that women can speak without fear of consequence. Thus as a researcher, I believe that there is a case for justifying non-breaching of confidentiality even in cases of risk of serious harm to self and of child witnessing of intimate partner violence although this may be viewed by some as ethically unsound. To conform to the recommendations of the Social Care Research Ethics Committee the limit of confidentiality statement was incorporated in participant information.

## Opt-out Option for the Medical Record Review

The mixed-method research design involves qualitative interviews with service users and stakeholders, and a non-consented, non-anonymised retrospective medical record review<sup>15</sup> of a sample of records more likely to be populated by women experiencing intimate partner violence. My *knowledge* of interviewees' medical records was raised as an ethical concern at the Social Care Research Ethics Committee meeting (September 9<sup>th</sup> 2011) at which I was present. Specifically, the problem was conceived as being that if the interviews were conducted after the medical record review it could be possible for me to make a connection between a medical record that I had seen and the person in front of me taking part in an interview, and the interviewee would not know that I had that level of intimate knowledge about them. However, in this project the interviews were to be conducted prior to the medical record review, so the hypothetical situation described would not happen. Even so, the Research Ethics Committee decided to advise that the service users interviewed should be able to opt-out of the sampling frame for the medical record review. Paradoxically, medical record review opt-out was not made a condition for non-service user interview participants yet it would be reasonable to expect that a similar ethical dilemma could exist for potential stakeholder participants too.

This opt-out required more personal data to be obtained (full name, date of birth, and address) so that a person's NHS number can be excluded from sample frames. This was not my preferred option as it meant reducing the degree of anonymity offered to potential

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<sup>15</sup> The non-consented non-anonymised retrospective medical record review warranted ethical review by and was granted favourable opinion to be undertaken by the Health Research Authority, formerly the National Information Governance Board Ethics Committee.



participants. Indeed, three of the ethics committee recommendations (audio-recording consent, medical record review opt-out, and research report distribution) required participants to provide greater personal information than originally requested despite research-based justification in the protocol for maximizing anonymity when conducting research with this population as recommended by Abrahams et al (2004). In response to the ethical committee's advice the service user consent form was amended to include an opt-out option.

### *'Opt-out' Option for Interview Audio-Recording*

The ethics committee also suggested that participants should be able to take part in an interview but be able to opt-out of having the interview audio recorded, and the consent form was amended accordingly.

## **HEALTH RESEARCH AUTHORITY ETHICS APPROVAL**

An application was made under Section 251 of the NHS Act 2006 (UK Parliament 2006) to the Health Research Authority (formerly the National Information Governance Board) Ethics Committee (HRA EC) for the non-consented access to non-anonymised medical records. The Health Research Authority Ethics Committee granted the application on condition of receipt of favourable Social Care Research Ethics Committee opinion and written confirmation from each research site's Caldicott Guardian<sup>16</sup> affirming the security of patient information and data in accordance with NHS standards. Once the Health Research Authority received security confirmation from each NHS Trust a site specific approval letter was supplied. The

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<sup>16</sup> A Caldicott Guardian is a senior person appointed in each NHS Trust responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing.

final site approval was received seven months after the Health Research Authority Ethics Committee approval in principal.

## **Discussion: Ethics Review as Prospective Governmentality**

The Social Care Research Ethics Committee recommended revisions to my work that seem bound in deontological ethics – of universal duties and rights, good and bad acts rather than on the consequences of the revision. In this section about ethics review as ‘prospective governmentality’, I consider the policy of ethical review of research through Foucault’s (1991) [1978] ideas of downwards and upwards continuities of pedagogies of government to meet ‘convenient ends’ and Hammersley’s critique of the ability of ethics committees to predetermine “*what ought to be done (...) from abstract principles*” (2009:214).

For Hammersley (2009) rather than being predetermined, “*ethical principles come out of and are secondary to ‘ethical practice’*” (2009:215). The process of ethical review has without doubt mobilised me to think more deeply about potential impacts for participants and consumers of the research. Still, Hammersley (2009) contends that it is not possible or practical to try to pre-anticipate all that could happen. Of significance to Hammersley’s argument is the ‘*unavoidable role of relatively autonomous, situated decision making by researchers’* (2009:215), and perhaps this is exactly the point – ‘self-government’ is only one element of ‘governmentality’ and often seen to be insufficient to protect the interests of the public. Hammersley (*ibid*) doubts that ethics committees would be sufficiently knowledgeable in method and methodology. Indeed, during this project’s ethical review the committee member raising the issue of the researcher having sight of interview participants’

medical record review was not familiar with the complexities of matching people to their medical records. In extending this argument Hammersley (*ibid*) questions the notion of discrete 'ethical decisions' proposing that feasibility, methodology and ethics are entangled in 'research decisions' and considers methodology and feasibility to be 'contextual knowledge' that a research ethics committee would have insufficient knowledge of to better the researcher's decisions.

Of particular relevance for this project is Hammersley's (2009) concern with 'ethical enthusiasts' who, especially in relation to social science, have lowered the threshold of what constitutes serious harm. For Hammersley (*ibid*), ethics committees display the strongest form of regulation, that of *prospective* regulation of action and argues that there are no grounds for this approach and is concerned that overregulation and lower thresholds of potential harm may result in constraining research activities so that difficult groups, topics, and methods are avoided. This resonates with my concerns that statements about mental capacity and limits of confidentiality in a population with greater prevalence of mental health problems and sometimes difficult relations with authorities could limit the range of participants' experiences represented in the study.

The 'problematic of government' concerns how to be ruled, how strictly, by whom, to what end, by what methods' (Foucault 1991:88), and it would seem that in this project the Social Care Research Ethics Committee took its stance from codes of professional conduct for health and social care. The crucial question then is whether research practice should be governed by the same general rules applied to people working in the field being researched?

In addressing this question one must consider the often mutually exclusive ends of research practice and ends of professional practice. The goals and decisions of professional practitioners' day to day work are founded on the knowledge base to date – from past research. Conversely, research practice aims to generate new knowledge and in this project this is knowledge about what becomes classified as 'intimate partner violence' and what does not, and the difference that classification makes to intervention. If it is possible that the limit placed on confidentiality serves to constrain what people report and thus limit the data obtained, then the research bound by such a rule could be considered unethical. From this position research ethics committees should recentre their object of concern from the convenient ends of current government policies to the ends of the research. This is not to justify unethical interventions and harms to people, but the space to speak without fear of threat of government intervention. For the current system of governance, downward regulatory mechanisms are seemingly necessary as a means of security in addition self-governance. However, as Hammersley (2009) proposes, there is a case for research 'governance' by a small circle of knowledgeable people close to the field and 'surveillance' by ethics committees sufficient to minimize broad potential 'harms' to social science participants.

## **ACCESS TO RESEARCH SITES, PARTICIPANTS AND DATA**

To develop the research proposal, design and methods I made contact with key NHS and Third Sector stakeholders to introduce the research project, to consult about research design, research methods, feasibility, any site specific practical issues for the study at that location, and to make further contacts with other departments. At the NHS research sites I

consulted with Emergency Department Clinical Directors, Research and Development Managers, Information Managers, Electronic Patient Record and Medical Record Managers, Data Managers, and Emergency Department Domestic Violence and NHS Trust Safeguarding Leads. At the service user recruitment sites (Third Sector, community based domestic violence services) I consulted with Service Directors, Service Users, and Staff Members.

The original research proposal was an ambitious design that aimed to compare emergency department classifications of and responses to intimate partner violence across Lancashire and which involved four geographical areas each with an Acute NHS Trust, Primary Care Trust, and Specialist Domestic Violence Service. The intention was to compare the data about emergency department responses to intimate partner violence across the four areas to be able to make claims about classification of and response to it in different contexts based on the configuration of emergency department, hospital and community services for intimate partner violence in each area. The scope of the research as originally imagined was not possible for myriad reasons which are detailed in brief below; an overview of the type and range of data collected from each area is illustrated later in Figure 4.1.

### **Access to Acute NHS Trusts**

There were variable levels of support for the project from the NHS Trusts and their respective Research and Development (R&D) Offices. Each Trust is organised differently and it was difficult to identify people with the required level of responsibility. I was aware that some staff I contacted may not have had previous experience of dealing with a researcher from outside the NHS so I ensured that they had been pre-alerted to my contact either by

the Research and Development office or another senior NHS colleague. Each Research Site was contacted in accordance with the protocol set out in the Social Care Research Ethics Committee approved research proposal. I provided each contact with an overview of the project and tried to arrange a meeting yet remain appreciative that for some email or telephone contact may be preferred.

### *NHS Trust Site Area 1*

The clinical director was supportive of the project and identified that the emergency department did not have facility for electronic identification of a sample of emergency department records but that a manual sample search was possible. The Research and Development office at this site was initially quite distant despite attempts to engage with them during the setting up phase and it was difficult to obtain information from information and medical record managers about Trust record retrieval processes and systems. Once Ethics Committee and NHS Research and Development applications were mobilized in summer 2011 the Research and Development office became much more helpful. Final site permission was obtained in January 2012. A senior emergency department medical staff member was designated to support the recruitment of staff members and four emergency department staff volunteered to participate. Contact was made with the hospital social work team but no participants came forward. A research nurse was designated to support the project and help with the manual retrieval of emergency department records. The decision was made not to retrieve medical data at this site in May 2012 due to the growing unfeasibility of comparison of similar data across areas. Site approval had just been

obtained for Site 3 at which electronic viewing of a filtered sample was possible and a central record sample had been obtained at Site 2.

### ***NHS Trust Site Area 2***

The clinical director and emergency department manager were supportive of the project and the emergency department manager arranged a joint meeting with the emergency department Domestic Violence Lead and Trust Safeguarding Lead. The emergency department manager also arranged for me to speak at a staff meeting about the project. Five emergency department staff members volunteered and participated in an interview. Further contacts with the Domestic Violence and Safeguarding leads for interview participants were not responded to. The Research and Development office was very helpful and facilitated meetings with emergency department, central record, and information managers. A central record sample using the International Classification of Disease sampling frame was obtained at this site and 29 central records were reviewed in March 2012. I arranged to interview the Trust's clinical coding manger, and when I arrived the meeting was with six clinical coders and was then a group interview. Contact was made with the hospital social work team but no participants came forward.

The emergency department record manager at site 2 failed to attend a number of meetings and was consistently unresponsive to contact by myself and the Research and Development office. During this time the practicalities of emergency department record sample retrieval remained unknown. At the end of April 2012 I received information from Trust Research and Development office that the emergency department records for the time frame were stored

off-site and that it would be too costly and time consuming to retrieve a screening-criteria filtered sample but a years' worth of records (twenty large boxes) could be delivered which could then be manually hand searched on site by myself for the sample. Due to the impending time constraints and the receipt of final approval at Site 3 where electronic retrieval and viewing was possible I decided not to proceed with the emergency department record review at Site 2.

### ***NHS Trust Site Area 3***

The clinical director and emergency department manager were supportive of the project and provided direct access to the emergency department record manager. This site has been using electronic patient record systems for over five years. A limited amount of patient data is electronically entered at the point of registration, triage and discharge at all the sites, but at this site the complete hardcopy patient record is scanned and can be electronically retrieved and viewed. This site was the only site at which the emergency department record review was feasible as originally proposed. Contact with central record managers was more difficult, and in respect of the feasibility issues limiting cross site comparison and the findings from reviewing central records at site two I decided that a further review would add little to the project and did not review central records at this site. No emergency department or social work staff members came forward to participate in an interview at this site. I asked the emergency department clinical director for feedback about the interview non-response, for which a general lack of engagement with the research process among staff was offered; research was not conceived as part of their everyday work being done by others.



### ***NHS Site Area 4***

Contact was made with the NHS Trust emergency departments' clinical director and after consultation with the emergency department management team I was informed that they could not support the project because of pressures on their department integrating a new electronic patient record system.

### ***GP Participants***

General practitioner participants were invited to participate in an interview after random selection of a general practice from three Primary Care Trusts in research area. (The Primary Care Trust in area 4 was not sampled as the Acute NHS Trust in this area had declined to participate.) The general practices within each of the Primary Care Trusts were identified from NHS online General Practitioner Lists. The General Practitioner practices were approached as detailed in the Participant Recruitment protocol; no General Practitioner participants came forward to participate in an interview.

### **Access to Service Users and Domestic Violence Service Staff**

Each Research Site was contacted in accordance with the protocol set out in the Social Care Research Ethics Committee approved research proposal. I provided each domestic violence service director with information about the project and arranged a meeting with them where possible. The data from interviews with specialist domestic violence workers is not included in this thesis because the material obtained did not directly relate to classification in health systems.

### ***Domestic Violence Services Area 1***

The domestic violence service in Area 1 was in a period of organisational flux. The service manager had a series of sickness absences and no-one else had the authority to sanction the services' participation. After a period of time the manager from services in Area 4 took over managerial responsibility for Area 1 and service users and staff were recruited from the domestic violence service in Area 4.

### ***Domestic Violence Services Area 2***

I met with the manager at the domestic violence service in Area 2 and was granted permission to attend a service user coffee morning to get service users' views about the research project and its methodological appropriateness. The service had arranged a private room and at the coffee morning I spoke to four women about the research and asked specifically about their views on non-consented access to non-anonymised health records for research. The general consensus from the service users was that they did not think that non-consented access to non-anonymised health records for research was problematic if the outcome of the research could improve services. Once the research had been granted favourable ethical opinion I attended one of the Freedom Programme sessions and staff member meetings to introduce the research project to service users and staff. At this site six service users and six staff members participated in an interview.

### ***Domestic Violence Services Area 3***

The director at the domestic violence service in Area 3 was supportive of the project. At this site an article about the research was placed in the service's news letter and the director

asked staff members to distribute the research flyers and information sheets to service users. No service users or staff members came forward to participate in an interview at this site.

### ***Domestic Violence Services Area 4***

Once the Acute NHS Trust in area 4 had declined to participate I had decided not to pursue a domestic violence service or general practitioner practice in area 4. However, the domestic violence service manager from Area 4 took over the service in Area 1 on a temporary basis and was keenly interested and supportive of the project. The manager did not feel that it would be feasible to go forward in Area 1 given the current flux of the organisation. It was also becoming increasingly apparent that it was not going to be possible to undertake the research as originally intended, i.e., comparing across areas, and with no responses from Area 1 and 3, and I welcomed the possibility of participants from Area 4. After meeting with the domestic violence service staff in Area 4 two service users and four staff members came forward to participate at this site.

### **Access: Lessons Learned**

A possible critique of the design of the project was that it was too ambitious and that I took on too much work. Some of which I would concur with, for example arguably social worker and general practitioners views were not key for the project. That said, another perspective is always illuminating and their absence constrains the research findings in terms of emergency department responses to intimate partner violence from the perspective of patients' often long term key health and social care providers. The matter that no general

practitioners or social workers responded is worthy of note as is the Acute NHS Trust in area four's decision not to engage with the project at all, also of note is that no staff members from Acute NHS Trust site 3 responded either. There has historically been a culture in the NHS in which social research was not considered core business and a legacy of this may remain for some despite the establishment of the UK Clinical Research Collaboration (UKCRC) in 2004 to strengthen and facilitate research in the NHS. It is possible that for some practitioners, research is generally not a high priority, and for some research about health service responses to intimate partner violence which has often shed unfavourable light on statutory service responses may also be off-putting. I understand staff members' guardedness, particularly social workers, who often face criticism in situations that are highly complex and challenging. Participant recruitment was best at sites that I had met with staff members and service users or who had designated a staff member to encourage staff participation. I had offered group and one-to-one meetings at all sites; some sites readily took up this offer whereas others did not. On reflection, in future research I may be able to use this experience to more readily recognize conducive contexts more likely to engage with research and recruit. That said, everyone should have the opportunity to take part in research and self-selecting sites more likely to participate could add additional biases.

Conducting NHS research as an 'outsider', i.e., not part of a clinical team invokes additional ethics and governance requirements in the NHS and rightly so. The research had National Institute of Health Research (NIHR) funding and as such qualified for support from the Coordinated System for gaining NHS Permission (NIHR CSP) through the Comprehensive Local Research Network (CLRN). This support was invaluable in that the cost of medical

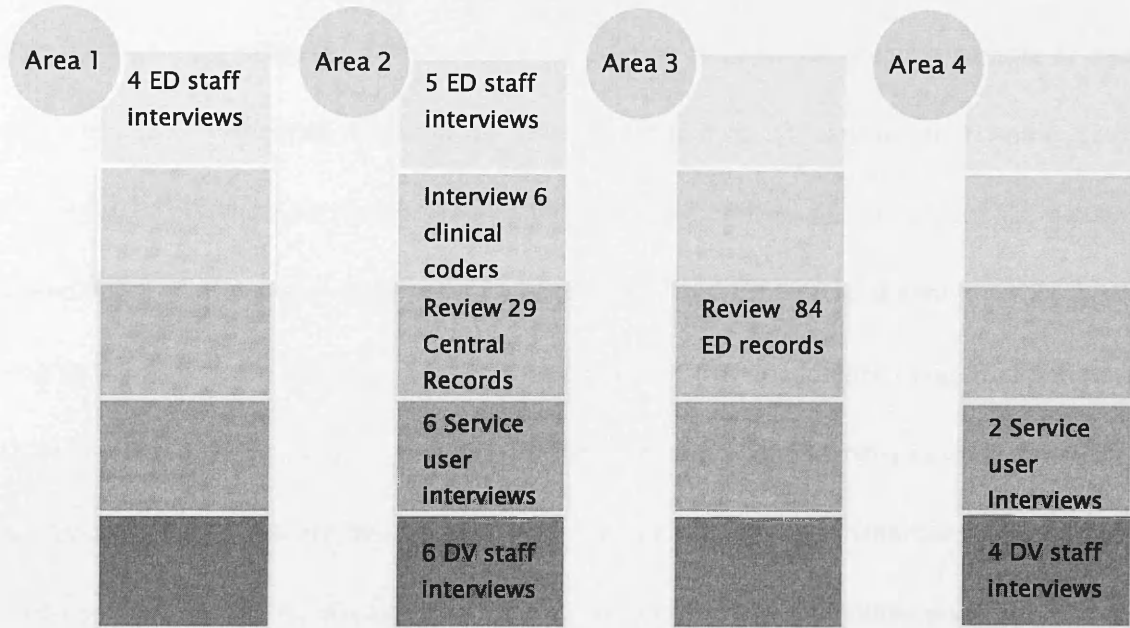
record retrieval was covered and the Research and Development offices were more duty bound to assist, although gaining access to people still proved difficult a times. Having knowledge of working inside NHS health systems was also helpful, but not sufficient. An insider researcher is likely to be more knowledgeable of and have greater access to research site systems.

I went to great lengths to contact, talk, and meet with the appropriate responsible parties to try and identify the systems and processes so that the feasibility issues for the medical record review could be properly assessed, and this was very time consuming. The review of emergency department attendance records was most feasible at Site Three because the records were electronically scanned. I don't necessarily think that a pilot would have helped tremendously in that I had meticulously developed the medical record review data variables, and each site, as indicated above, had very different systems and which posed very different problems. Still, as the data chapters will further illustrate, this process in itself is as much a part of the research findings. Attempting to undertake this research has clearly identified the lack of systems in place to conduct research about service responses for intimate partner violence in NHS hospital-based health systems and that anonymised intimate partner violence research is currently not feasible due to the lack of means in many Acute NHS Trusts administrative data systems to identify a sample for intimate partner violence research without manual search.

# DATA COLLECTED

The final configuration of data collected, is outlined in Figure 4.1, and although it did not follow the original plan, it was more than sufficient to undertake the research.

Figure 4.1 Overview of Data Collected



## Introduction to Data Collected

As indicated in Chapter Three there were three research method elements. Each of the research methods was a source of information from a different level of the health system(s) for classifying and responding to intimate partner violence in emergency department consultations for an attendance after an assault by a partner. In each geographical area and in each element of the research methods the data collected was not as originally imagined. The non-participation of research sites, non-response of groups of practitioners, less than intended recruitment of participants and sampling of medical records placed constraints

on the analysis that can be undertaken and in turn the overall findings. Nonetheless, the data and findings have strengths as well as limitations and these are summarised below.

### **Limitations and Strengths: Quantitative Data Collected**

The sample for the medical record review was dependent on emergency department administrative staff coding incidents and it is likely that some cases were misclassified in their inclusion or exclusion. Still, it is the best means available to obtain a sample of people attending the emergency department after experiencing an assault in a home setting. According to Worster and Heines (2004) medical record reviews are not useful for measuring phenomena that are not commonly documented. This project is the first in England to employ medical record review to abstract data about the documented classification of and responses to intimate partner violence during emergency department consultations for an attendance after an assault by a partner, so it was unknown as to whether intimate partner violence was commonly documented or not, although my supposition was that it wasn't. That said, for this project, what is not recorded is as much of interest as what is recorded. It was also recognised that there was likely missing data from records, nevertheless, missing data is significant for an analysis of the better forms of classification to improve hospital-based, emergency department responses to intimate partner violence in England.

The quantitative data in the form of numerical counts of applications of classification for intimate partner violence in local and national hospital episode statistics are of pre-constructed categories in operation in health systems which alone produce descriptive accounts. Yet when analysed alongside clinical coder and emergency department

practitioner accounts and medical record recordings, the data contributes to the explanatory account of classifications and better forms of classification of intimate partner violence, in the form of physical assault, in hospital-based emergency department systems.

### **Limitations and Strengths: Qualitative Data Collected**

The concern raised in Chapter Three about the performative nature of interviews is a valid one. Indeed, one of the participants early on in an interview said: *"I don't know what you want me to say"*, possibly illustrating an approach to the interview in terms of what the interviewer wants to hear, but could also be in relation to the respondent's uncertainty in a novel situation. Overall, most participants seemed to be candid in the way they spoke of past events and the nature of health service responses, and I think that this was assisted by the context of the interview. For service users the interview took place at a community domestic violence service and not a health service, and they were recalling past events so it was less likely that they would feel obliged to speak positively for fear of reduced service. For professionals, all interviews were at their place of work (although alternate arrangements could have been made) and it must be recognised that professional constraints were likely placed on what was said. However, with a background of working as an emergency nurse, and as such an 'insider' it could be argued that a shared understanding of the 'context' of emergency department consultations between the researcher and health professional respondent was probably helpful in terms of what respondents chose to say and how they talked about things. It is also of note that the health practitioner participants were concerned about the population of women experiencing intimate partner violence attending their service and spoke candidly about limits of services,



their understanding of the intimate partner violence, and their awareness of emergency department initiated intervention. However as a simultaneous outsider (not a member of the health organisation that the nurses and doctors worked for, or of the domestic violence services) respondents' accounts could have been both more and less constrained. The interview respondents were all self-selecting, although local collaborators directed local recruitment of participants albeit in different ways. The limitation of qualitative data is acknowledged, yet as articulated in Chapter Three, qualitative data are considered culturally constructed witness accounts and as such are considered to produce credible explanatory accounts for the patterns and relations of classifications of and responses to intimate partner violence identified in the quantitative data.

## **Gender and Sexuality**

NHS domestic violence policy is an example of gender mainstreaming. The policy does not exclude men and acknowledges that men may experience 'domestic violence' yet it expressly recognises the increased risk and rates of violence perpetrated against women by a male intimate partner. It could be argued that this is a heteronormative assumption, but it is one that takes account of the greater reported rates and disproportionality of consequence of intimate partner violence against *women* (Hester 2009). With reference to the disproportionality of violence perpetrated against women I am principally concerned with violence against *women* and the research materials and information sheets indicated this. However to permit a gendered analysis of classification and responses to intimate partner violence in health systems, data from Hospital Episode Statistics included both men and women as too did the medical record review. I did not seek to recruit male participants

for the interviews as it was unlikely that I would obtain sufficient numbers of respondents to do an adequate gendered analysis of qualitative data and was concerned about inappropriate conflation of phenomena as men's experience of intimate partner violence is likely different (Hester 2009). It was not possible to disaggregate by sexuality in the medical record review, partners were often referred to in gendered terms in the medical records but not consistently so. There were therefore no subgroups in the hospital episode statistics or medical record review based on sexuality, and there were no inclusion / exclusion criteria for interviews based on sexuality. One of the service user respondents had experienced intimate partner violence from a same-sex partner. The study makes claims about the systems of classifications of and response to intimate partner violence against women.

### **Limitations and Strengths: Research Findings and Data Synthesis**

The analysis of the multiple forms of data from multiple levels of health systems is constructed to produce, non-linear, multi-directional, socially constructed, explanatory accounts of the system(s) of classifications of, and responses to, intimate partner violence against women in hospital-based emergency departments in England. For elements of systems for which no quantitative data was able to be abstracted but qualitative data addressed, qualitative data analysis alone was used to premise explanatory assertions. Whilst offering an explanatory account to address the research and research aims, I remain cognisant that science can never produce comprehensive understanding, returning to Capra:

*"In the new paradigm [post-Cartesian science] it is recognised that all scientific concepts and theories are limited and approximate. Science can never provide any complete and definitive understanding."* (Capra 1996:41)

The point that Capra (1996) makes here, and as discussed in the last chapter referring to the systems embedded in a ‘conceptual slice’ of a phenomenon, is that the systems involved in phenomena are part of an interlinked network in which all systems take all other systems as their environment, the connections between which are highly elaborate and complex. This means that it is implausible to consider that a complete account of phenomena is possible, yet nevertheless, greater approximations of knowledge of phenomena are possible and thus the claims in this project are credible, greater approximations of knowledge of the better forms of classification for intimate partner violence in the form of a physical assault for improving hospital-based, emergency department responses to it in England.

## **INTRODUCTION TO DATA CHAPTERS**

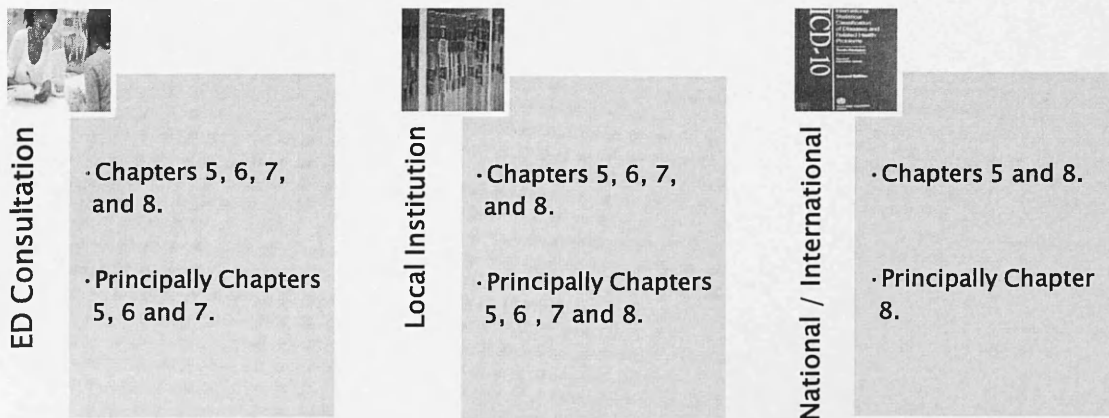
An overview of the sources of data and how data are utilised in each of the four research findings chapters (chapters five to eight) is presented in Figure 4.3 on the last page of this chapter. Two frameworks are drawn on for the presentation of research findings. The first is in relation to complexity theory and the different levels of systems for the classification and response to intimate partner violence in hospital-based emergency department health systems, and the second draws on the sociology of diagnosis.

### **Complexity Theory Systems Approach to the Data Chapters**

Three different levels of system were identified in Chapter Three from which it was possible to obtain data. The three levels of systems were: emergency department consultation, local institutional, and national and international institutional. Findings relating to the emergency department level systems are drawn on for Chapters Five, Six, Seven and Eight. Findings

relating to the local institutional level are included in Chapters Five, Six, Seven and Eight. Findings relating to the national and international institutional levels are included in Chapters Five, Seven and Eight (see Figure 4.2). That these systems cannot be separated is indicative of their mutuality and interconnectedness and supports the claim that this project moves beyond the level of the consultation to make claims about micro and macro level systems for the better forms of classification for intimate partner violence in the form of a physical assault for improving hospital-based, emergency department responses to it in England.

Figure 4.2 Overview of Different System Levels and Corresponding Data Chapters



### Sociology of Diagnosis Approach to the Data Chapters

Drawing on the sociology of diagnosis framework of diagnosis as classification, process and consequences, the data chapters follow classification journeys through hospital-based emergency department systems: from the emergency department to administrative health data.

## CONCLUSION

In Chapter Four the ethical concerns for the research have been discussed. The issues of research governance and the technical constraints of undertaking the research have been discussed and reflected on. From this reflection, lessons learned for future projects were outlined. Based on the constraints of the research data collected, an analysis of strength and limitations of the research data was presented. In conclusion, the data chapters that follow were introduced and the connections between the presentation of data and the theoretical frameworks underpinning the thesis were explained.

<p><b>Chapter Five:</b> <b>'Diagnoses':</b></p> <p><b>Classifications of intimate partner violence applied during emergency department (ED) consultations</b></p>	<ul style="list-style-type: none"> <li>• Data from ED Medical Record Review and interviews with ED service users and ED practitioners (nurses and doctors).</li> <li>• In this chapter the analysis of data entered into the medical record at different times by different practitioners in different locations during the ED consultation are used to explicate how intimate partner violence, in the form of physical assault by a partner, is classified during emergency department attendances, and which classifications are used when and by whom. Data from interviews with health practitioners explicates their recording practices.</li> </ul>
<p><b>Chapter Six:</b> <b>'Distinctions':</b></p> <p><b>Constructions of distinctions of classifications for intimate partner violence in emergency department (ED) consultations</b></p>	<ul style="list-style-type: none"> <li>• Data from ED Medical Record Review and interviews with ED service users and ED practitioners (nurses and doctors).</li> <li>• In this chapter the analysis of qualitative data from nurse and doctor interviews and quantitative data from the medical record review are presented to explicate the construction of distinctions of classifications for intimate partner violence in hospital-based, emergency department health care consultations.</li> </ul>
<p><b>Chapter Seven:</b> <b>'Difference':</b></p> <p><b>Interventions and Referral Routes for classifications of intimate partner violence in emergency department (ED) consultations</b></p>	<ul style="list-style-type: none"> <li>• Data from ED Medical Record Review and interviews with ED service users and ED practitioners (nurses and doctors), and specialist victim service providers.</li> <li>• In this chapter descriptive statistics of interventions initiated, and tests of association between interventions and classifications previously presented, and qualitative data from service user, nurse, doctor and specialist victim service providers interviews are presented to examine the difference that classifications of intimate partner violence makes to patients' case management.</li> </ul>
<p><b>Chapter Eight:</b> <b>'Data':</b></p> <p><b>Classifications of intimate partner violence in Hospital Episode Statistics</b></p>	<ul style="list-style-type: none"> <li>• Data from ED and Admitted Patient Care Hospital Episode Statistics (HES) and interviews with practitioners (nurses and doctors), and clinical coders.</li> <li>• In this chapter the analysis of qualitative data from nurse, doctor, and clinical coder interviews is presented to explicate the classifications and the construction of classifications for intimate partner violence in hospital-based administrative health information systems.</li> </ul>

**CHAPTER FIVE: 'DIAGNOSES', CLASSIFICATIONS OF  
INTIMATE PARTNER VIOLENCE APPLIED DURING EMERGENCY  
DEPARTMENT CONSULTATIONS**

## INTRODUCTION

In this chapter I identify the classifications of intimate partner violence that were applied during emergency department consultations for an attendance after an assault by a partner and begin to explicate the classificatory importance for the construction of the different classifications and the sets of relations between them. Principally, data from the emergency department attendance records are presented although some data from nurse and doctor interviews are also drawn on.

The emergency department attendance record data is complex being constituted by different actors (ambulance crew, administrators, nurses, doctors) in different locations (sites of patient/services interaction), and because this is the chapter where this data is first introduced, its constituents are first explained. After introducing the locations and actors of emergency department medical records, findings from the data analysis about classifications applied by different actors in different locations for intimate partner violence in the form of an assault by partner are presented. Data from interviews with health practitioners is introduced to explicate practitioners' classificatory recording practices.

In this chapter I argue that whilst there was disparate use of different classifications of violence by different actors across different locations, each had preferred systems of classifications and these and their frequency of application are discussed. I claim that there was concomitant and seemingly paradoxical destabilizing and stabilizing of classifications across the locations and that stability and flux of classifications for intimate partner violence were held in tension. Examples from the data illustrating the destabilization of the



classification 'assault' by the prefix 'alleged' are presented, yet that this qualitatively alters practitioner perceptions of an assault is simultaneously refuted by practitioner respondents. Data of the recording of the classification of 'domestic violence' is introduced and its stability along with the stability of assault classifications are examined. I argue that the recording of the classification 'domestic violence' suggests that it is a qualitatively different classification to 'assault by partner'. I present data to claim that stabilization of classifications across locations is rare, even across proximal locations. Through further analysis I identify the most common elements of systems for classifying intimate partner violence and an embedded, professionalized configuration for recording of the elements of classification in medical records. I contend that these elements illustrate sites of ontological depth for the classification of intimate partner violence and signal sets of relations and causal properties of the systems of classification involved.

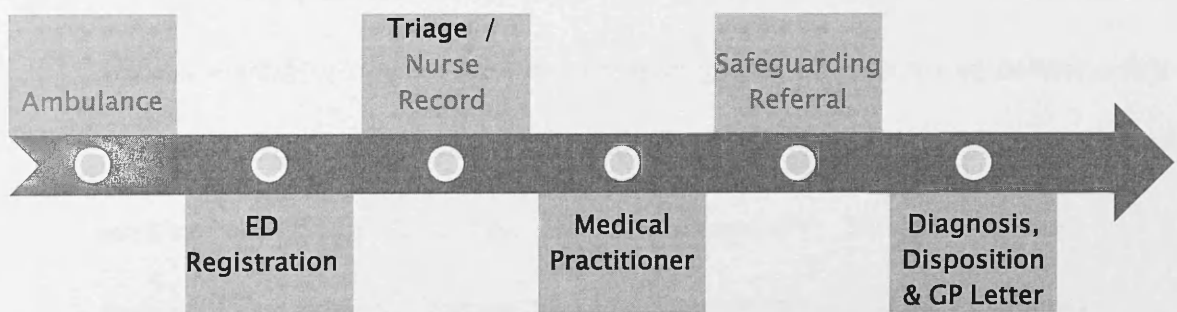
### **Introduction to Medical Record Review Data**

The first stage of sampling at the NHS Trust research site identified 491 emergency department attendances (225 male and 266 female) in 2010 that met the screening criteria: age sixteen years or older; incident type 'assault', and incident location 'home'. The mean monthly attendance rate of cases that met the criteria was 41, and the median 39; the standard deviation (10) and variance (91) indicated that there was no considerable variation from month to month. The two month sample of emergency department attendances (n=90) for the review represented 18% of cases in the sampling frame (six cases had been removed because they were not assaults).

### *Records: Locations and Actors*

Records of emergency department attendance are constituted by different sources of information collected by different actors for different systems at different locations during patients' emergency department consultations. Some information was inputted directly onto patients' electronic attendance record whilst some was handwritten on a hardcopy attendance record generated on patients' registration at the emergency department. Information recorded at different locations record a site of interaction between patients and other systems. Before I present findings detailing the classifications applied by different actors at different locations, the sites of recorded interaction: the where, when, how and by whom of the information that is collected and recorded onto patients' emergency department attendance records are first explained. Figure 5.1 illustrates the different locations of sources of information in the records of emergency department attendances in this sample and a brief description of each follows it.

Figure 5.1 Diagram of Emergency Department Data Entry Points



The locations are: ambulance; registration; triage/nurse record; medical practitioner; safeguarding referral; and diagnosis, disposition<sup>17</sup>, and GP (general practitioner) Letter. Some of the locations in Figure 5.1 are differentiated by lighter text indicating systems that although common, interaction with them was not routine.

Not every patient had accessed the ambulance service although many had. At emergency department registration an electronic and hard copy attendance record was generated for every patient by administration staff. During registration an administrator had entered demographic data and information about the presenting complaint, the incident type, the location of the incident, the source of referral to the department, and mode of arrival. Once registered, patients are 'triaged'. Triage is defined as:

*"...a face to face encounter which should occur within 15 minutes of arrival or registration and should normally require less than 5 minutes contact. Triage should be viewed as a brief intervention – it is not a consultation. Triage is a complex decision making process designed to manage clinical risk. A rapid assessment is made to identify or rule out life/limb threatening conditions to ensure patient safety. The result is the assignation of a priority to the patient thus helping manage workload and ensure the sickest patients are seen first. This process needs to be undertaken by a trained clinician"* (College of Emergency Medicine, Emergency Nurse Consultant Association, Faculty of Emergency Nursing and Royal College of Nursing: Emergency Nurses Association 2011).

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<sup>17</sup> Disposition refers to the outcome of an emergency department consultation in terms of whether the patient was discharged, referred for follow-up, transferred to another facility or admitted to hospital.

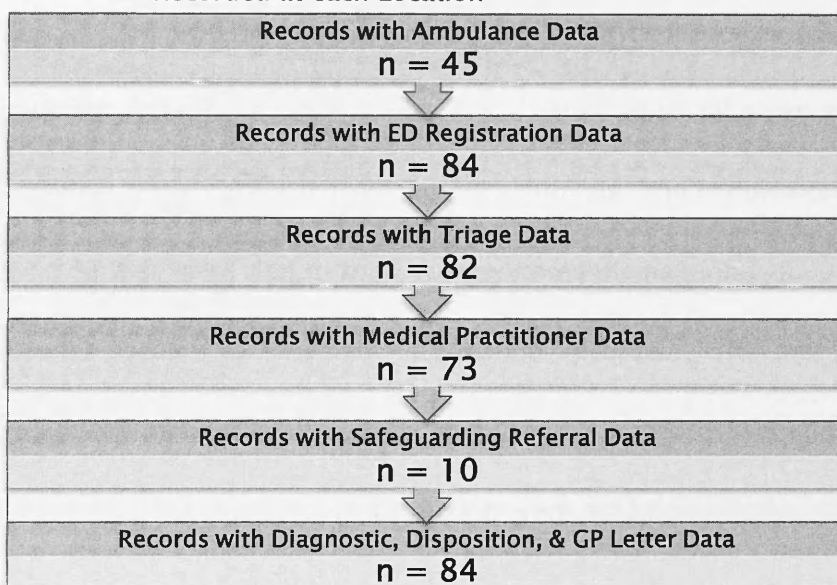
Triage is the location at which an assessment by a health practitioner first takes place and in England, 'triage' is normally undertaken by a Registered Nurse. Triage at the research site was modelled on the 'Manchester Triage' risk management framework. In the process of triage, data about the person's presenting complaint, the urgency of the problem, and the 'discriminator' or rationale for the urgency level was electronically entered onto patients' records. Nurses may record additional 'nurse records' but these were infrequent in this sample. After triage, the next data recording is done by the definitive 'seeing and treating' practitioner, who in this sample was most often a doctor although on some occasions this was a nurse practitioner. The term 'medical practitioner' is the term used to describe the actor documenting medical records at this location. Nurse records (albeit that these were often addendums to the record field designated 'triage') and the medical practitioner records were handwritten.

A 'Safeguarding Referral' form was completed on occasions of possible risk of harm to children from witnessing or from being in a household where 'domestic violence' ( i.e., from seeing or hearing ill-treatment of another) had taken place to record a referral made to children's social services and this was handwritten data.

At the end of consultations, the medical practitioner electronically entered data about patient diagnosis and disposition (follow-on care). From the electronically entered diagnosis and disposition information, a letter for the patient's General Practitioner (GP) is generated. There is also a free text box at this location (diagnosis, disposition, and GP letter) for medical practitioners to electronically enter additional information for a patient's GP.

The data are referred to as ambulance data, registration data, triage data, medical practitioner data, safeguarding referral data, and diagnostic, disposition and GP letter data to make clear the actors and locations involved in its production. Figure 5.2 identifies the number of records with data from each location and hence the variation of recorded data sample sizes across different locations.

Figure 5.2 Number of Records with Information Collected and Recorded at each Location



The electronically entered Registration, and Disposition, Diagnosis and GP Letter data was recorded for all emergency department attendance records included in the sample (n=84). This information (Registration, and Disposition, and Diagnosis form part of the NHS Accident and Emergency commissioning dataset<sup>18</sup> meaning that NHS service providers are mandated to record it.

<sup>18</sup> The Department of Health in England requires NHS providers to maintain and record specified health information known as commissioning data sets (CDS) about all NHS episodes of care and to submit this patient level health data

Included in the eighty-two records with triage data are five records whose triage record refers readers to an assessment recorded in the nurses' record section of the hard copy record. This data has been included as triage data as the recording practitioner indicated that the data was relevant to 'triage'. Two patients proceeded from registration to medical practitioner assessment bypassing triage and had no triage information recorded, and for another patient, the triage text recorded only that the patient had not responded to a call to be triaged yet had a triage discriminator and risk category recorded so was included. In addition to this patient who had left another eight patients left after triage but before medical practitioner assessment. One of these had information recorded by the medical practitioner and thus this record was included in the sample. The handwritten records were unavailable for a further three and in total seventy-three of the eighty-four records in the sample had some medical practitioner information recorded. Fifty-one patients were transported to the emergency department by ambulance, the records were not electronically available for four cases, and the ambulance records were missing from the electronic record for a further two, leaving forty-five records with ambulance recorded data. The high proportion of patients in the sample travelling to the emergency department in an ambulance was an unexpected finding from data collection. The ambulance data was included in the medical record review analyses but no interviews were undertaken with ambulance practitioners because they had not been included in the proposal for which permissions had been sought. And finally, ten records had safeguarding children data recorded.

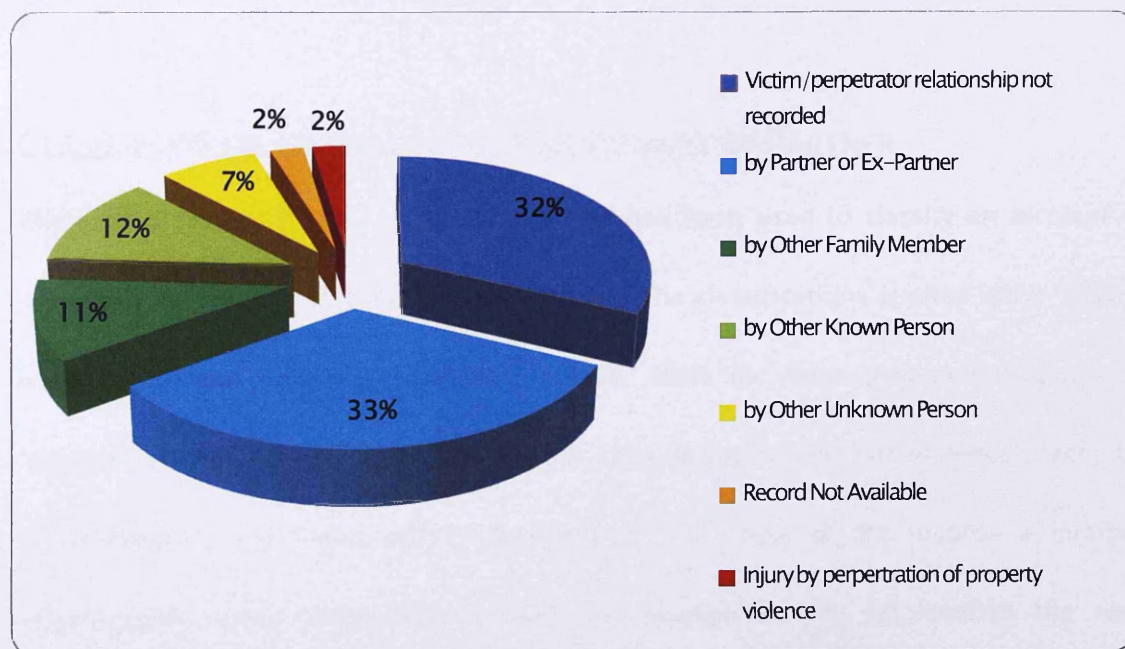
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to the Hospital Episode Statistics Secondary Uses Service managed by the NHS IC Core Data Warehouse. The schema for classifying and coding information for ED episodes of care is called the Accident and Emergency Data Dictionary Coding Tables.

## STRATIFICATION OF SAMPLE BY VICTIM/PERPETRATOR RELATIONSHIP

A sub-sample of 'assault by partner' was identified by examining the whole dataset for the recording of victim/perpetrator relationship at any of the locations. Figure 5.3 illustrates the percentage for the different types of victim/perpetrator relationships recorded. Of the eighty-four people attending the emergency department whose records had met the screening criteria of assault by location home, twenty-eight (33%) reported an assault by a partner, nine (11%) reported an assault by another family member, ten (12%) had reported an assault by someone known to them, six (7%) reported an unknown assailant, and in twenty-seven (32%) cases a victim/perpetrator relationship had not been recorded. In two records (2%) the injuries were attributed to the patient's violence towards property and for a further two, the hard copy record was unavailable and the electronically entered information was insufficient for victim/perpetrator relations to be assessed.

Figure 5.3 Assault (by Location Home) Sample and Recorded Victim/Perpetrator Relationship



Of the eighty records with data of victim/perpetrator relationship documented, forty-six were women and thirty-four were men. Victim/perpetrator relationship was more likely to be recorded in the records of women attending the emergency department than for male patients (see Table 5.1) and this reached statistical significance ( $p < 0.001$ ).

Table 5.1 Assault by Recorded Perpetrator Relationship and Patient Sex

Victim/perpetrator relationship		Sex		Total
		Male	Female	
<b>Not Recorded</b>	Count	20	7	27
	% within Sex	59%	15%	34%
<b>Recorded</b>	Count	14	39	53
	% within Sex	41%	85%	66%
<b>Total</b>	Count	34	46	80
	% within Sex	100%	100%	100%

The rest of the medical record review analysis in this chapter will focus on the subset sample ( $n=28$ ) of 'assault by partner'. In this subset an even greater majority were women ( $n=24$ , 86%) and the most common age range for attendance was 26 - 45 years of age ( $n=20$ ).

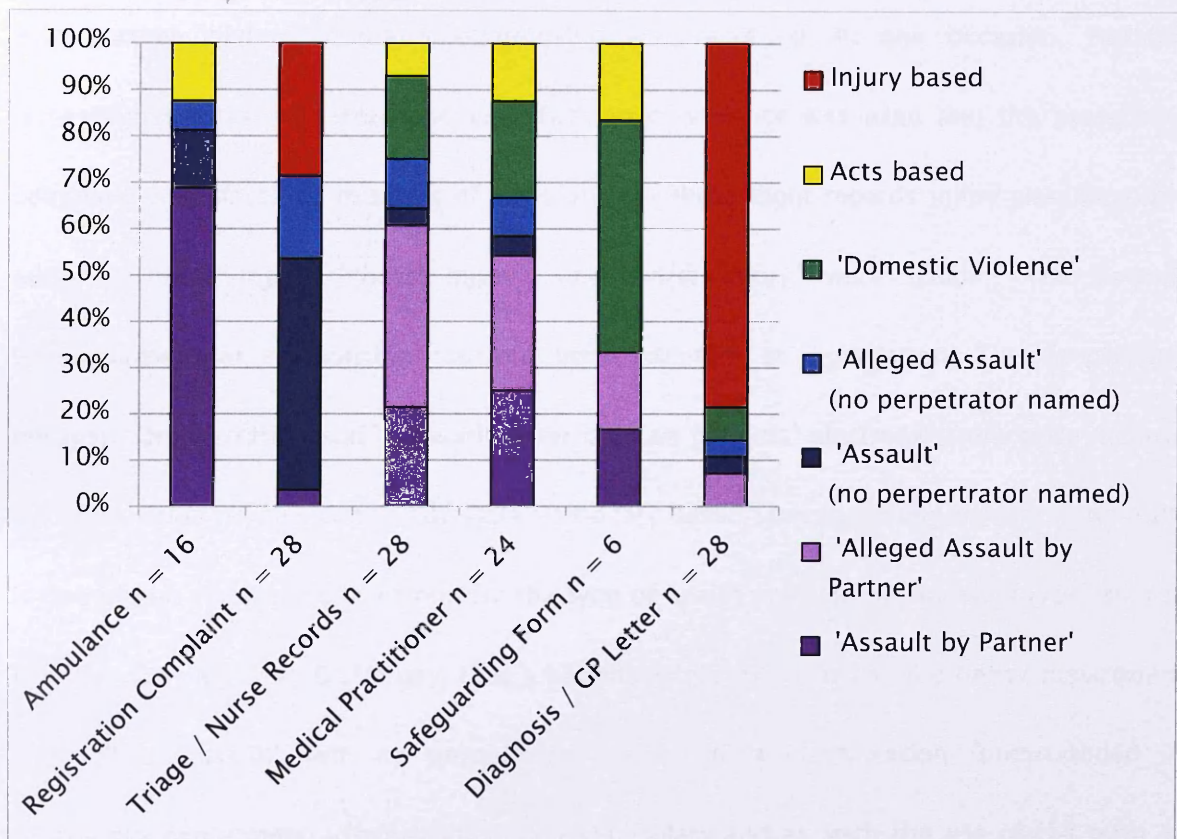
## CLASSIFICATIONS OF VIOLENCE FOR AN ASSAULT BY PARTNER

There were seven different classifications that had been used to classify an incident of an assault by partner across the different locations. The classifications applied were: 'assault by partner', 'alleged assault by partner', 'assault' (with no victim/perpetrator relationship), 'alleged assault' (with no victim/perpetrator relationship), 'domestic violence', 'acts-based classifications', and 'injury-based classifications'. In some of the records a number of classifications were simultaneously used, for example at the GP location the records identified here as classifying by alleged assault by partner, assault, alleged assault, or



domestic violence also had an injury classification recorded too. The purpose here is to principal the applications of classifications of violence some of which indicate intention and victim/perpetrator relationship. The different classifications of violence applied at the different locations are presented in Figure 5.4 below. The data is presented as proportional percentages, and for each location the sample size is given.

Figure 5.4 Classifications of Violence Used for an Assault by Partner at the Different Emergency Department Locations



The aim of the illustration in Figure 5.4 is to present an image of the disparate usage and range of classifications by different actors across different locations in this sub-sample of 'assault by partner'. The most common classification used in ambulance records was 'assault by partner' with eleven of sixteen (69%) having it. The classification 'alleged assault

by partner' was not used at the ambulance location. In three ambulance records partner victim/perpetrator relationship was not recorded and in these the classifications 'assault' (n=2) and 'alleged assault' (n=1) were documented. Two ambulance records classified by recording the violent act(s), for example 'punched', 'strangled', 'hit', and 'head-butted', and in one of these the partner victim/perpetrator relationship was recorded. At registration the most common violence classification entered 'free text' by administration staff to record 'patient complaint' was 'assault' (n=14, 50%), followed by 'alleged assault' (n=5). Assault with partner victim/perpetrator relationship was recorded on one occasion. For the remaining registration records no classification of violence was used and the presenting complaint was classified in terms of an injury, for these eight records injury classifications such as 'nose injury', 'head injury', and 'wrist injury' were used. The partner victim/perpetrator relationship received little attention at registration. This is perhaps because administration staff regularly enter data on patients' electronic attendance records into data fields framed by the A&E Data Dictionary based commissioning datasets. 'Assault' is one of just six options to categorise the type of health problem (or 'incident type' as it is called in the A&E Data Dictionary) that a patient may present to an emergency department with. Thus 'assault' with no perpetrator referent is a classification foregrounded in emergency department administrative data vocabulary and as such the use of the term in this way by administration staff to classify and record episodes of interpersonal violence is perhaps more likely.

At triage the most common classification was 'alleged assault by partner' (n=11, 39%), followed by 'assault by partner' (n=6, 21%). The classification 'domestic violence' first

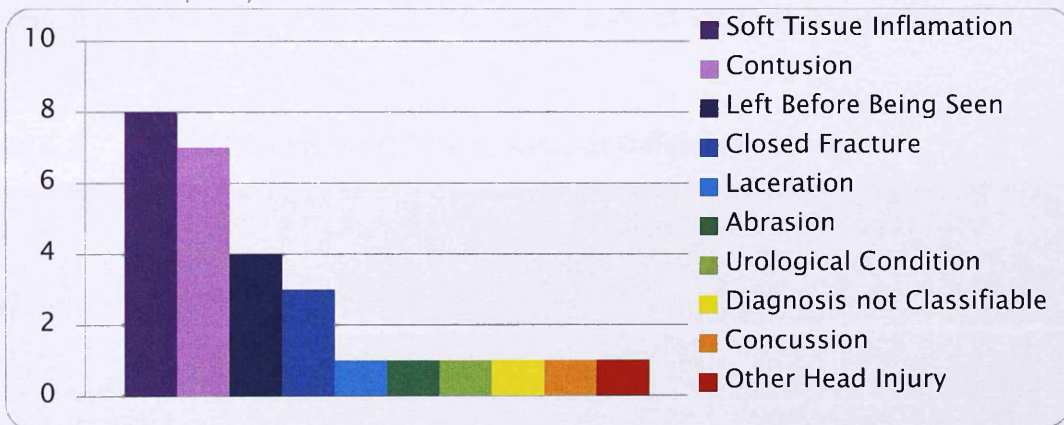
appeared in the triage data, and in this sample it was used here on five (18%) occasions. The partner victim/perpetrator relationship was not recorded in four triage records (14%), three of which recorded 'alleged assault' (11%) and one (4%) recorded 'assault'. Two (8%) triage records were classified by acts of violence, and one of these was ascribed partner victim/perpetrator relationship. The most even distribution of different classifications was found in the medical practitioner texts. The classification most often applied in medical practitioner texts was 'alleged assault by partner' (n=7; 29%). 'Assault by partner' was used in six medical practitioner records, and in five (21%), the classification 'domestic violence' had been recorded. 'Acts of violence' by a named victim/perpetrator relationship were recorded in three of the medical practitioner texts. Only three medical practitioner texts had no partner victim/perpetrator relationship recorded; in one, the violence was classified as 'assault', and in another two, as 'alleged assault'.

Children of seven of the twenty-eight people attending because of an assault by partner underwent referral to social services. Six of the safeguarding children referral forms were available to the review. In these six forms the classification most often used was 'domestic violence' (n=3; 50%). The other three safeguarding forms were classified as 'assault by partner' (n=1), 'alleged assault by partner' (n=1) and 'act(s) of violence by partner' (n=1).

The classifications recorded for GP Letters are electronically entered and constrained by A&E Data Dictionary data field options for diagnosis and disposition. The classification of violence, in terms of assault by partner as the causal mechanism and the partner victim/perpetrator relationship were seldom included in information for GP Letters. At this

location, the majority (n=22, 79%) had injury-based diagnosis classifications such as 'soft tissue injury', 'contusion' and 'laceration'. Medical practitioners had entered information about the assault as cause of injury in the free text box of six records. On one occasion, the medical practitioner entered 'assault by partner' and also that the patient had a domestic violence support worker. Two (7%) had documented 'alleged assault by partner', one recorded 'alleged assault, domestic violence'<sup>19</sup>, another two did not record the partner victim/perpetrator, recording only 'assault' (n=1) and 'alleged assault' (n=1). At the location of diagnosis, disposition and GP Letter, classifications of violence were most commonly excluded and the classifications had principally become injury-based. The range and frequencies of the injury-based classifications used at the GP Letter location are illustrated in Figure 5.5.

Figure 5.5 Injury-based Classifications at the Diagnosis, Disposition, and GP Letter Location in Frequency Order



The end of consultation injury-based classifications recorded for the twenty-eight records of emergency department attendance after an assault by partner are identified in the above

<sup>19</sup> Where combinations of terms were used in texts such as 'domestic violence' and 'alleged assault' or 'assault' and 'alleged assault by partner', the record was counted in terms of the most specific term used. In these examples the first record would be classified as recording 'domestic violence' and the second 'alleged assault by partner'.

graph. The most common diagnosis was 'soft tissue inflammation' (n=8), followed by 'contusion' (n=7), and 'closed fracture' (n=3). The diagnoses 'laceration', 'abrasion', 'urological condition', 'concussion', and 'other head injury' were each made on one occasion. The 'diagnosis not classifiable' was used for a patient in which the medical practitioner had recorded 'assault by partner', 'soft tissue facial injuries' and 'head injury advice'. There were no classifications for violence in the A&E Data Dictionary Coding Table's diagnosis classification so any recording of violence classification at this location was only possible if the practitioner had typed this information into the free text space for GP information, and, as previously reported, this occurred on six occasions in this sample.

An overview of the variation of classifications for intimate partner violence in the form of a physical assault used by different actors at the different emergency department locations is presented in Table 5.2 and the preferred classification at each site is emboldened.

Table 5.2 Classifications by Different Actors at Different Locations

	Assault by Partner	Alleged Assault by Partner	Assault no Perpetrator	Alleged Assault no Perpetrator	Domestic Violence	Act based	Injury based	Total
Ambulance n=16	<b>69%</b>	0%	12%	6%	0%	13%	0%	100%
Registration Complaint n=28	4%	0%	<b>50%</b>	18%	0%	0%	28%	100%
Triage / Nurse Record n= 28	21%	<b>39%</b>	4%	11%	18%	7%	0%	100%
Medical Practitioner n=24	25%	<b>29%</b>	4%	8%	21%	13%	0%	100%
Safeguarding Referral n=6	17%	17%	0%	0%	<b>50%</b>	17%	0%	100%
Diagnosis/GP Letter n=28	0%	7%	4%	4%	7%	0%	<b>79%</b>	100%

\*Numbers have been rounded

Ambulance personnel most often classified as 'assault by partner', registration personnel most often classified as 'assault', and triage and medical practitioners most often classified as 'alleged assault by partner'. The preferred classification at the Safeguarding Referral location was 'domestic violence', whilst at the GP Letter (diagnosis and disposition) location, classification was most frequently by injury. The only location in which 'violence' was not the classificatory rubric was the GP Letter (diagnosis and disposition) meaning that the background context of causal significance, an assault by a partner, was not routinely included here.

It could be claimed that overall there was a system that transformed classification from 'assault by partner', to 'alleged assault by partner' to 'injury-based classification'. Yet it is not that straightforward; across triage, medical practitioner and safeguarding referral locations the proportion of records classified by partner victim/perpetrator relationship and domestic violence increases before decreasing at the diagnosis, disposition, and GP letter location. Across the locations, partner victim/perpetrator relationship was recorded in 75% of ambulance records (n=12), in 82% (n=23) of triage/nurses records, and 88% (n=21) of medical practitioner records. So there was destabilizing of the classification 'assault' by the prefix 'alleged' and a concomitant stabilizing of the classification of partner victim/perpetrator relationship across these locations.

### **Prefixing Classifications of Violence as 'Alleged'**

Table 5.2 illustrates difference in the use of the prefix 'alleged' by different actors in different locations in relation to an incident of assault by a partner. There was only one

occasion (6%) that an ambulance crew used the term 'alleged', conversely, the word 'alleged' was used at triage in fifteen (54%) cases, and in eleven (46%) medical practitioner records<sup>20</sup>. So whilst the prefix 'alleged' was seldom used by ambulance personnel it was applied in roughly half of all triage and medical practitioner text. In one of the records in the review the triage text was recorded in typeface as 'BIBA<sup>21</sup> assaulted by partner' and seemingly in postscript the word 'allegedly' was inserted, handwritten above the typed text as this example illustrates:

*allegedly*

BIBA  $\wedge$  assaulted by partner

This addendum suggests a purposeful classificatory manoeuvre, and I asked health practitioners in the interviews about the words they would use to document intimate partner violence in the form of an assault by partner in their records. Six health practitioner participants (EDPN14; EDPD15; EDPN16; EDPN17; EDPD23; and EDPD28) reported recording it as 'alleged', and this is exemplified in the following account:

EDPD28: *"...in terms of the A&E card, like terminology is important and for someone who's obviously been assaulted you would always write alleged assault because that's what it is, it's alleged assault by the patient. And a lot of the times it's blatantly obvious that it is actual assault."*

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<sup>20</sup> These numbers for recordings of alleged are greater than those recorded in Table 5.2, this is because some records had more than one classification, for example 'alleged assault, domestic violence' may be written. For the purposes of Table 5.2, if two classifications had been recorded, the most specific classification, i.e. 'domestic violence' was counted.

<sup>21</sup> 'BIBA' is shorthand for 'brought in by ambulance'.

This account implies an inherent redundancy in the manoeuvre suggesting that it didn't change the practitioner's perception of events and nor did it dispute patients' accounts. This notion of superfluosity of the classification 'alleged' was echoed by other respondents (EDPD15, EDPD23, EDPN14, EDPD29).

To explain the prefix 'alleged', in the next account one of the practitioners articulates its concomitant importance and insignificance:

EDPD29: *"it's alleged because you haven't witnessed it but you do believe the patient and you may write things like, "as per, patient says, according to patient", so those are the terms you may use."*

Nurse and doctor respondents reported learning how to record interpersonal violence in this way as these extracts suggest:

EDPN14: *"Well, we were always told to write alleged, rather than write... So I tend to write alleged assault by partner..."*

EDPD28: *"Most doctors are trained to write alleged assault and they may write by patient's partner. Some doctors would just write alleged assault."*

Learning to classify and record phenomena in the 'right way' seems to be part of the systems of professionalization in becoming an emergency practitioner, interconnected with systems of classification and recording. A consultant (EDPD29) explained that it was a combination of 'on the job' training and professional training programmes. 'On the job' systems of professionalization are implicated in the following account in which a nurse recalls acclimatising to professional norms and systems of working in an emergency department.



EDPN16: *“When you first arrive and you start in looking at the triages, and I think it’s probably just followed on from that. Everybody just writes in the same sort of triaging system.”*

In these accounts the use of the prefix classification ‘alleged’ is presented as a technical, professional manoeuvre that is a simple matter of learned, professionalized systems of documentation and largely redundant, nonetheless, as an element of the classification system used for intimate partner violence it is one that is frequently applied. And, according to these accounts the use of prefix ‘alleged’ does not qualitatively alter practitioners’ perception of the reported assault.

## **(IN)STABILITY OF CLASSIFICATIONS OF VIOLENCE ACROSS LOCATIONS**

Table 5.2 illustrates the variation in and rates of application of classifications for an assault by partner across different locations. Simultaneously, the data indicates that the term ‘alleged assault by partner’ was the classification most often used by triage and medical practitioners and as such it is likely that this term will have greatest stability across these locations. I analysed the data for evidence of stability of classifications of violence across these two locations, presupposing that perhaps once a classification had been applied in one location it may be applied later in another.

Identical classifications of violence and partner victim/perpetrator relationship at triage and medical practitioner locations occurred on just five out of twenty-four possible occasions. Record 4 was classified as assault by partner/ex-partner and domestic violence; Record 6 was classified as alleged assault and domestic violence; Record 11 was classified as alleged

assault by partner; Record 12 was classified as assault by partner/husband; and Record 23 was classified as alleged assault by ex-partner. Still, even in these there were some differences; in Record 4 there was difference in terms of the victim/perpetrator relationship recorded as partner and ex-partner, and in Record 6 the recording 'by wife' was not recorded at triage but was recorded in the nurse record (NR). Identical *violence* classification was used across triage and medical practitioner locations in three more records (Records 15 and 28: alleged assault; and Record 25: act of violence) but not for the recording of victim/perpetrator relationship. Table 5.3 summarizes this extracted data from the eight records with the greatest stability of classifications applied for an assault by partner by different practitioners (triage and medical practitioner) at different locations and indicates that even once a classification was applied it was not stable. Furthermore, three of these eight cases had arrived by ambulance, in all of which the classification in the ambulance record was different to the triage and medical practitioners'.

Table 5.3 Extracted Data from Records with Greatest Stability of Classifications for Violence by Different Practitioners at Different Locations

Record	Ambulance	Registration	Triage	Medical Practitioner	Safeguarding Referral	GP Letter
4	Alleged assault	Assault	Victim of domestic violence; Assault by ex-partner	History domestic violence, assaulted by partner	**	***
6M	*		Alleged assault; domestic violence. NR: injuries caused by wife.	Alleged assault by wife; Regular victim of domestic violence	Domestic violence	***
11	Assault	Assault	Alleged assault by partner	Alleged assault by partner	**	***
12	*	Assault	Assaulted by partner	Assault – alleged. assaulted by husband last	**	***
15	*		Alleged assault by boyfriend.	Alleged assault	**	***
23	Act of violence	Assaulted	Alleges assaulted by ex partner	Alleged assault by ex-partner	**	Alleged assault by ex partner
25	*		Act of violence	Act of violence by ex partner	**	***
28	*	Assault	Alleged assault	Alleges assaulted by ex husband	**	***

Legend: NR denotes nurses record, \* denotes patient did not arrive by ambulance, \*\* denotes that a safeguarding referral was not made and \*\*\* denotes that no reference to violence was made in the data entered for GP letter, and 'M' denotes the record for a male patient.

### Classification of Assault by Partner as 'Domestic Violence'

The data presented in Table 5.2 illustrates that the classification 'domestic violence' was applied in some cases, and as such it would seem that this is a qualitatively different classification than that of assault by a partner. In total, ten of the twenty-eight records had the classification 'domestic violence' recorded at one of the different locations and the occurrences of this classification at each location are illustrated in Table 5.4 below. (The classification 'domestic violence' was not used in any ambulance records and hence this location is not included). For ease of reading the table, the occasions of the classification

'domestic violence' have been shaded darker. Other classifications may also have been used in each location but are not included as they are not the focus of this analysis.

Table 5.4 Classification of Assault by Partner as 'Domestic Violence'

Record	Triage or Nurses Note	Medical Practitioner	Safeguarding form	GP Letter
4	Domestic violence	Hx domestic violence, domestic violence	*	**
6M	Domestic violence	Regular victim of domestic violence	Domestic violence	**
8	Alleged assault by ex-partner	Assaulted by her ex-boyfriend. Domestic violence relationship	*	Assaulted by ex-boyfriend; has domestic violence support worker.
13	Ongoing domestic violence	Alleged assault by partner	*	**
14	Domestic violence	Assault, by husband	Domestic violence	**
18	Assaulted by partner	Act of violence	Domestic violence	Assaulted
19	Patient assaulted	Domestic Violence	Alleged act of violence by partner	**
21	NN: Assaulted; No previous domestic violence	Assault by ex-partner	*	Alleged assault by ex partner
26	Assaulted by ex-husband	Act of violence by ex husband Domestic violence protocol.	Alleged assault from ex-partner. Child witnessed the domestic violence.	**
27	Alleged domestic violence from husband	Alleged assault / domestic violence	*	Alleged assault Domestic violence

Legend: \* denotes that a safeguarding referral was not made, \*\* denotes that no reference to violence was made in the data entered for GP letter, and 'M' denotes the record for a male patient.

Of the ten records in which the classification 'domestic violence' was applied at one of the locations, it was applied at triage in five of them and in the nurse record for another. Of these six, the classification was again applied by the medical practitioner in half (n=3). The classification was first recorded in the medical practitioner text on another three occasions, and on one occasion, assault by partner is only classified in this way at the safeguarding referral location.

It is curious, given that all the records in this sub-sample are an assault by partner, that only some are classified as 'domestic violence'. The health practitioners, in the interviews, were asked about the recording of the classification 'domestic violence'. The following interview extract illustrates a medical practitioner's almost categorical non-use of the classification 'domestic violence'.

EDPD23: *"(...) if they said outright, "My partner's hit me" for example, then I would put alleged assault by partner. (...) But I wouldn't label it, I don't think as domestic abuse or domestic violence."*

Interviewer: *"So domestic violence or domestic abuse wouldn't get to the record?"*

EDPD23: *"No. I wouldn't say that, no."*

Interviewer: *"Would it get a differential diagnosis?"*

EDPD23: *"Not from me, personally, no."*

In the above extract 'domestic violence' as a recorded classification was implausible and other practitioners also articulated that the term 'domestic violence' would not be used:

Interviewer: *"If they [emergency department doctors] suspect that this was domestic violence or domestic abuse, would they write those terms down?"*

EDPD28: *"In my experience, rarely. I mean, I might be wrong. Alleged assault is the major one that you'll find is used."*

Despite a seeming rejection of the classification by some of the respondents, the classification, nonetheless, is at times applied, and applied in this way suggests that 'domestic violence' is a qualitatively different classification to 'assault by partner'<sup>22</sup>.

## **STABILITY AND FLUX OF CLASSIFICATIONS OF VIOLENCE IN TENSION**

Whilst variance and instability across and within the different locations by different actors, has been illustrated, there was, in tension with this, some patterns of preferred classification for violence at each location. For example, at the Ambulance site this was 'assault by partner', at Registration it was 'assault', although nearly 30% of registrations are framed by 'injury'. At Triage and Medical Practitioner locations the preferred classification was 'alleged assault by partner' (although there was no majority framing here) and at 'Diagnosis and GP Letter Information' the classificatory framing shifts to an injury-based one. Along this trajectory there was both classificatory stability and flux. To explicate classification at the sites of most flux (and the sites of principal interest for the project), I analysed the triage and medical practitioner text further to map the configurations of the elements of classifications of violence recorded at each of these locations. In these analyses no distinction is made for different classifications of violence used whether 'assault', 'alleged assault', or 'domestic violence'.

### **Configurations of Classifications Recorded at Triage**

Figure 5.6 presents a summary of the different configurations of classifications recorded at triage. This figure clearly illustrates an established model for classifications recorded in

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<sup>22</sup> The constructions of different classifications and distinctions between them are examined and explicated in Chapter Six in terms of classificatory attributes and in Chapter Seven in relation to classifications' entanglements with forms of intervention

triage documentation: the classifications in the documentation of eighteen records (64%) progressed from: 'assault' 'to 'act of violence' to 'injury'. An example of a triage document following this model would be:

*Patient allegedly assaulted by boyfriend this evening. Patient has received punch to face and has sustained swelling and bruising around right eye.*

Of these eighteen, fourteen had recorded that the assault was by a partner or was 'domestic violence' (n=9/11 and n=5/7). For seven of the eighteen records following this model, a fourth category followed that recorded the presence or not of children in the household or a patient's pregnancy.

Figure 5.6 Configurations of Elements of Classifications Recorded at Triage



Five records had the classification of assault recorded followed by injury with no record of the act of violence itself; of these five, four recorded an assault by partner or domestic violence. Another record had this configuration but with the additional recording children in household or pregnancy. One triage record followed a model of 'assault', 'act of violence', 'presence of children or pregnancy' without any form of injury documented. Both of these had the partner recorded as perpetrator. Three records first classified by 'acts' and then 'injuries'. These classifications recorded at triage can be understood as systems within the system for classifying intimate partner violence during emergency department consultations. The systems of classification can be understood in relation to Cause, Mechanism, Injury, and Risk.

- Cause:

The cause of the injury classified as assault or domestic violence was recorded in twenty five triage records (89%), and twenty (71%) had a victim/perpetrator relationship recorded (in one case this was implied by the use of classification 'domestic violence').

- Mechanism:

The mechanism of injury classified as acts of violence was recorded in twenty two triage records (85%).

- Injury:

The injury sustained from the mechanism and/or cause classified in terms of physical injuries was recorded in twenty seven triage records (96%).

- Risk:

The risk of harm classified as the presence of children and/or pregnancy was recorded in nine triage records (32%).



The most common system of classification applied at triage was an 'injury' (96%), followed by a violence classification (89%), acts of violence (85%), victim/perpetrator relationship (71%) and then risk to children (32%).

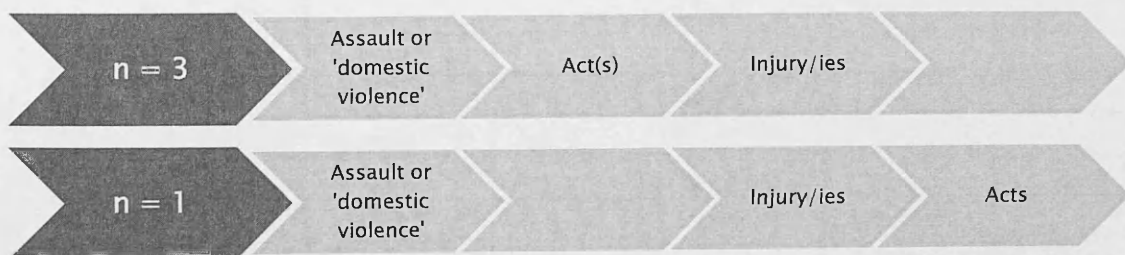
## Configurations of Classifications Recorded at Medical Practitioner

I analysed the medical practitioner text in the same way although the documentation here was more complex. The medical practitioners often recorded in a formulaic way that comprised of:

- PC – Presenting Complaint
- HPC – History of Presenting Complaint
- Examination
- Impression and Plan
- Diagnosis and Plan

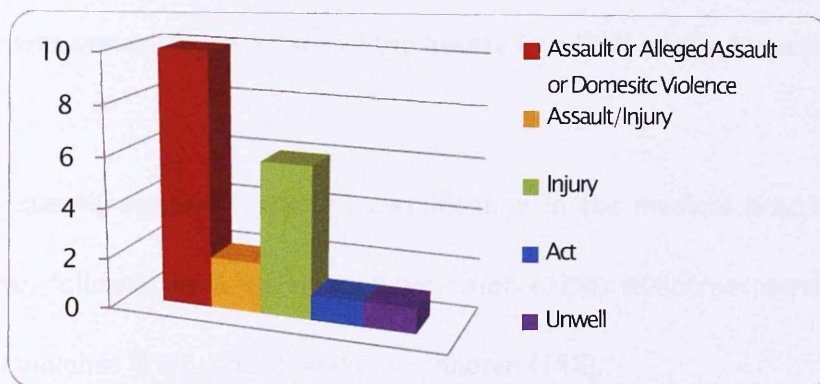
For four records the PC (presenting complaint) and HPC (history of presenting complaint) were merged into one narrative. As illustrated in figure 5.7, three of these records followed the system most common at triage: 'Assault', 'Act', 'Injury' and the fourth was similar but differently ordered.

Figure 5.7 Configurations of Elements of Classification: Medical Practitioner Text with Merged PC and HPC



Twenty records had a distinct 'PC' (presenting complaint) and half of these (n=10) recorded 'assault' or 'alleged assault' or 'domestic violence', a further recorded one of these classifications and an injury, and six records had an injury documented as the 'PC'. One record had the act of violence as the PC and another recorded 'unwell' (see Figure 5.8).

Figure 5.8 Classification of Medical Practitioner Presenting Complaint



This data illustrates that the leading classification in medical practitioner text was a classification of violence. Of those that did not document an 'assault' term in the PC (n= 8), half, as illustrated in Table 5.5, lead with it in the HPC (History of Presenting Complaint').

Table 5.5 Models of Elements of Classification in Medical Practitioner Text

'N'	Elements of Classification in Medical Practitioner Text					
	Merged PC and HPC:	'Assault'	'Act'	'Injury'		
3	Merged PC and HPC:	'Assault'	'Act'	'Injury'		
1	HPC:	'Assault'		'Injury'		'Act'
	PC:	HPC:				
5	'Assault'		'Act'	'Injury'		
3	'Assault'	'Assault'	'Act'	'Injury'		
1	'Assault'	'Assault'		'Injury'		
1	'Assault'			'Injury'		
1	'Assault/Injury'	'Assault'		'Injury'		
1	'Assault/Injury'		'Act'	'Injury'		
2	'Injury'	'Assault'	'Act'	'Injury'		
2	'Injury'		'Act'	'Injury'		
1	'Injury'	'Assault'	'Act'	'Injury'	'Children'	
1	'Injury'		'Act'	'Injury'	'Children'	
1	'Unwell'	'Assault'	'Act'	'Injury'		
1	'Act'			'Injury'	'Children'	'Assault'

Seven medical practitioner records (n=7/24; 29%) lead with the physical problem (injury or unwell) and a further two lead with a combination of the injury and its cause (assault) (n=2/24; 8%). At this location, at the beginning of the consultation, the leading classification was 'assault' (or alleged or domestic violence) (n=16; 67%). By combining the PC and HPC information, the data illustrates that the 'Assault', 'Act', and 'Injury' configuration of classification was present in seventeen of the twenty four (71% medical practitioner records).

The most frequently applied system of classification in the medical practitioner text was 'injury' (100%), followed by a violence classification (92%), victim/perpetrator relationship (88%), acts of violence (79%), and then risk to children (13%).

- Cause:

The cause of the injury classified as assault or domestic violence was recorded in twenty-two medical practitioner records (92%), and twenty-one (88%) had a partner recorded.

- Mechanism:

The mechanism of injury classified as acts of violence was recorded in twenty medical practitioner records (83%).

- Injury:

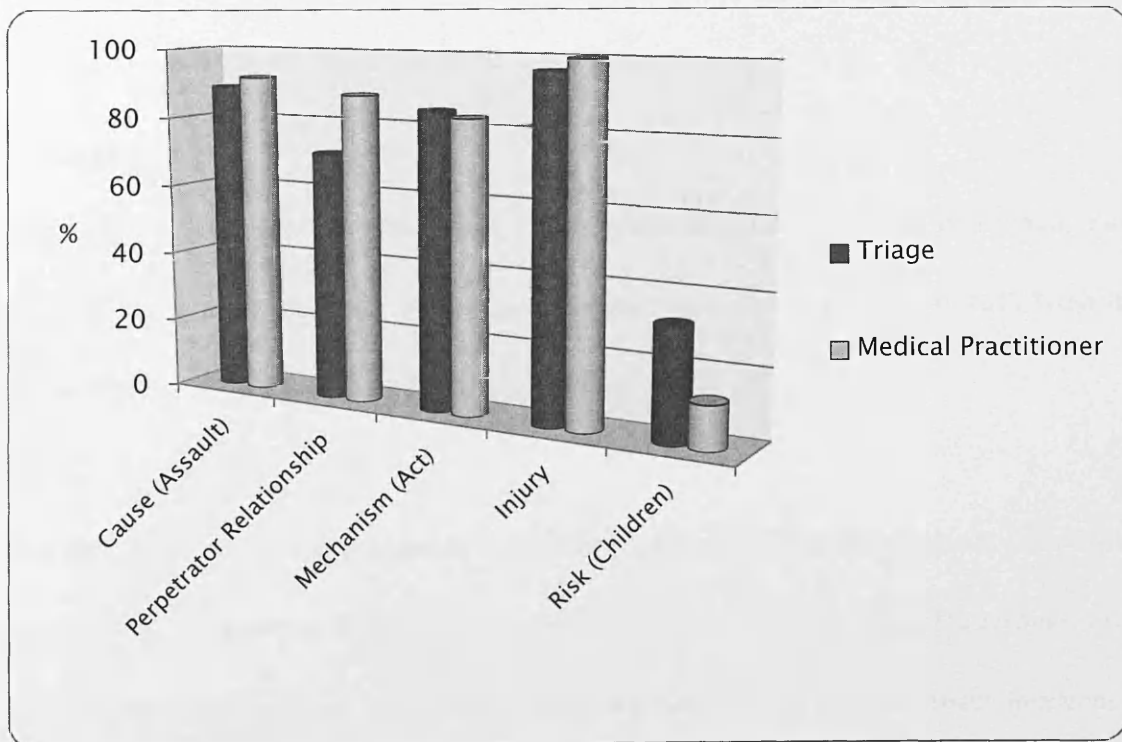
The injury sustained from the mechanism and cause classified as physical injuries were recorded in twenty four medical practitioner records (100%).

- Risk:

The risk of harm classified as the presence of children and/or pregnancy was recorded in three medical practitioner records (13%).

There appears to be greater flux at the medical practitioner site in the classifications of violence applied (Table 5.2) and also in the way the elements of classifications are configured (Table 5.5). The medical practitioner is the location of greater variance in the frequency distributions of the five classifications of violence, and greater number of configurations of elements of classifications recorded. Yet there are similarities between triage and medical practitioners in the rates of use of classificatory systems as the following graph (Figure 5.9) of proportional percentage illustrates. It can also be seen that medical practitioners more frequently apply partner victim/perpetrator classification, and triage more often apply risk, in the form of presence of children/pregnancy classification.

Figure 5.9 Classification Systems Applied at Triage and Medical Practitioner Locations



The data presented illustrates a preferred configuration for recording elements of classification indicating embedded professionalized systems of classification and recording across these locations. The preferred configuration was: 'assault', 'act of violence', and 'injury'; and for some this was followed by 'presence of children or pregnancy'. The frequency of the recording of the classification 'presence of children' indicates an eighth classification of intimate partner violence found in the review of emergency department attendances. The significance of the elements of classification of assault by partner and the different configurations of them is that they signal ontological or explanatory depth of classificatory systems in operation for the classification of intimate partner violence during emergency department consultations for further explicating stability and flux in the following chapters.

## CONCLUSION

The findings presented in this chapter illustrated the classifications of intimate partner violence recorded in a sample of emergency department attendances at an NHS Trust in the North West of England.

The locations and actors involved in recording classifications were explained, and identified as: ambulance, registration, triage/nurse record, medical practitioner, safeguarding referral, and diagnosis, disposition and GP letter. From the data recorded across these locations, the sample was stratified into victim/perpetrator relationship sub-groups. Victim/perpetrator relationship was more likely to be classified and recorded in the records of women than of men, and this reached statistical significance. The data from the sub-group 'assault by

partner' was then further analysed for the classifications used by different actors in different locations.

Initially, seven different classifications were identified for an assault by partner across the locations and these were: 'assault by partner', 'alleged assault by partner', 'domestic violence', 'assault', 'alleged assault', 'act-based classifications' and 'injury based classifications'. The data presented illustrated that whilst there was disparate usage of classifications across locations, each location had a preferred classification indicating both stability and flux of classifications in the records. At the location of ambulance the preferred classification was 'assault by partner', at registration this was 'assault', at the site of triage and medical practitioner systems this was 'alleged assault by partner', in the safeguarding referral location the preferred classification was 'domestic violence', and in the location of diagnosis, disposition and GP letter it was 'injury-based'. That said, the diagnosis, disposition, and GP letter is intimately connected with the A&E Data Dictionary systems of classification which does not have assault classifications as item options in its diagnosis data field. In addition, free text entries at registration which had the lowest rate of recording victim/perpetrator relationship was also a site where staff frequently enter data into A&E dictionary framed data fields and this was proposed as a possible explanation for this finding.

There was a classificatory transformation from 'assault' to 'injury' from ambulance to GP Letter. This transformation was formalized within the taxonomy of the A&E data dictionary in use in local and national institutions, however the transformation in records was not

straightforward. In records, transformation involved concomitant destabilizing and stabilizing for the classification 'assault by partner' by the application of the classificatory prefix 'alleged'. According to the practitioners in this study, the use of the prefix 'alleged' is indeed a purposeful manoeuvre but not one that reportedly alters practitioners' perception of the nature of the assault. Practitioner accounts of recording assaults as 'alleged', and of not recording 'domestic violence' evidence self-reproducing, locked-in systems of professionalization for learning how to classify and record interpersonal violence as an emergency department practitioner. Yet the classification 'domestic violence' was applied in ten records, but its applicability across locations varied. That this classification was used for just ten of the records for an assault by partner suggests that it was a qualitatively different classification to 'assault by partner'. 'Domestic violence' was the preferred system of classification at the safeguarding referral location. This pattern of classification and recording practice indicates a different configuration of interconnected systems with distinguishable classificatory properties for this location.

From analysis of the stability of classifications across sites once applied, only five of twenty four records used identical classifications at both triage and medical practitioner locations.

Given the variance and yet preferred classifications across locations, stability and flux of classification of violence were held in tension. On closer analysis of practitioner documentation a preferred configuration for recording classifications was found indicating embedded professionalized systems of classification and recording. The elements of and preferred configurations for practitioner recording of classifications intimate partner violence during emergency department consultations in this sample were: Cause: 'assault',

Mechanism of Injury: 'acts of violence', Injury: 'physical injury sustained', and Risk: 'presence of children/pregnancy'. The presence of children was identified as the eighth classification documented in the emergency department records.

Chapter Five has answered the research question *'Which classifications were applied during emergency department consultations for an attendance after an assault by partner?'*, and has begun to answer the third empirical research question, in relation to the use of 'alleged assault', of *'Why intimate partner violence is classified in different ways during emergency department consultations?'* There was an overall view that illustrated a transformation from an assault-based classification to an injury-based classification, but this was not straightforward. Six different locations in the emergency department were identified at which classifications of intimate partner violence, in the form of a physical assault were made, and that in total, across these locations, eight different classifications had been applied. Each location had a preferred classification, although this was not categorical, meaning that the classifications were simultaneously made stable and in flux. I reported the eight different classifications that had been documented as: 'assault by partner', 'alleged assault by partner', 'assault' (with no victim/perpetrator relationship), 'alleged assault' (with no victim/perpetrator relationship), 'domestic violence', 'acts of violence', 'presence of children', and 'Injury'. I contended that the records indicated a professionalized system of recording and argued that the different configurations of classifications recorded signalled sets of relations and properties from interconnected systems and sites of ontological explanatory depth of importance for the classification of intimate partner violence, in the form of an assault during emergency department consultations.



**CHAPTER SIX: 'DISTINCTIONS', CONSTRUCTIONS OF  
DISTINCTIONS OF CLASSIFICATIONS FOR INTIMATE PARTNER  
VIOLENCE IN EMERGENCY DEPARTMENT CONSULTATIONS**

## INTRODUCTION

The findings presented in Chapter Five evidenced that intimate partner violence in the form of a physical assault by partner was classified in eight different ways during emergency department consultations and that the classifications applied co-existed and were concomitantly both stable and in flux across the different locations and actors. The aim of this chapter is twofold, to present findings from the analysis of data to explicate and explain the construction of distinctions of classifications for ‘intimate partner violence’, in the form of physical assault in hospital-based, emergency department health care consultations and to begin to address the question of why an assault by partner is classified in these different ways.

The chapter begins with the presentation of data from interviews with emergency department practitioners that indicates elements of systems that are involved in making distinctions between different classifications for an assault by a partner during consultations. The elements of systems are explicated in turn in the chapter, and extracts of data from the record review and from interviews with service users and practitioners are used to explain the relationship between the elements and classifications for an assault by partner. The findings are contextualised and discussed, in relation to typologies of partner violence, as popularised versions of two types of intimate partner violence circulated in practitioner accounts. One, more serious type, was reportedly of low volume in emergency department caseloads whilst the less serious type was perceived as the type most commonly seen. However, I present data from the record review to claim that the converse is true: that the more serious form is high volume in the emergency department population ‘assault by

partner'. I also propose that there may be a systemically perverse response by emergency department practitioners to patients' report of intimate partner violence which lessened the need for classification and intervention. I present data to claim that there was a second perversity in the classification of 'domestic violence' during adult victim/survivors' emergency department consultations in that the classification 'domestic violence' was applied more frequently for children in the household or the patients' foetus than for adult victims alone.

My concluding argument is that for the population attending an emergency department after an assault by partner the distinction of 'domestic violence is not necessary and could result in misclassification of intimate partner violence and that the classification 'assault by partner' is sufficient in this population. The only elements required for classification of intimate partner violence in this population are assault; partner victim/perpetrator relationship, acts of violence; and injuries sustained.

## **EQUIVALENCE OR DISTINCTION OF CLASSIFICATIONS**

In the last chapter I introduced data from practitioner interviews that explained a preferred method for recording the classification 'assault by partner' with the prefix 'alleged'. The practitioners intimated that this was not a qualitative alteration of their perception of the violence that had taken place, just that they had not witnessed it. But there was another classification, 'domestic violence', sometimes recorded and in explicating the practices of recording a nurse respondent explained:

EDPN14: *"I tend to write alleged assault by partner, rather than victim of domestic violence, really. I don't know whether... I suppose there's different connotations to assault and domestic violence... somewhat different connotations, really, but it's the same thing."*

In this extract there is a double manoeuvre, the first distinguishes (*"different connotations"*) the classification from 'alleged assault by partner', and the second re-assimilates (*"but it's the same thing"*). On further questioning about the 'different connotations', the respondent explains:

EDPN14: *"I suppose assault, I would think of, again, an alcohol fuelled situation, where someone's lashed out and hit their partner, or been violent towards them. And I suppose domestic violence is a long-term, chronic problem that happens with or without alcohol. It's something that's an ongoing... Whether that's right or wrong, I don't know. But that's just what I would... But I suppose they should both be classed as domestic violence, really. The fact that alcohol's involved shouldn't have any bearing on it, really."*

For this practitioner, 'assault' is first rooted in 'one-off', extra-ordinary (*"lashed-out"*), 'alcohol-fuelled' event between partners whereas 'domestic violence' is ongoing, and not necessarily linked with alcohol consumption. These distinctions are then troubled in the narrative and the practitioner concludes that they are both constitutive of 'domestic violence'. Yet by claiming equivalence (*"I suppose they should both be classed as domestic violence, really"*) reinforces difference. In addition, the referent of 'lashing out and hitting your partner' draws on domestic violence myths of instinctive, 'couldn't help myself' versions of partner violence.

In talking about 'domestic violence', later in the interview the same practitioner goes on to say:

EDPN14: *"It's not something that's used in A&E very much at all. You don't hear anybody use that as the term; it is more assaults, you know, been assaulted by partner. And I don't know whether that's made it almost more acceptable as just something that happens. And I think domestic violence is more of a... has more serious connotations to it and people... if you hear someone's a victim of domestic violence you might be more worried. I don't know, I never thought that before, but that's just, perhaps... it's not a term that's often used in A&E, really, for whatever reason. I don't think I've ever used that in written documentation, actually. I don't know if that's right or wrong, I'm not sure! I think it's because we're always told to just write like fact, not to surmise, not to presume, to just write what's happened and just write it as it is."*

In this last account there is an inference to a prevailing system of classification and nosology for interpersonal violence that is seemingly autopoietic, or self-reproducing in this respondent's experience of everyday emergency department work. This system does not easily accommodate the classification of 'domestic violence'. Yet, 'domestic violence' as a classification circulates in practice and on occasion as the medical record review has indicated is used to document incidents of assault by partner. Indeed 'domestic violence' was recorded at one of the locations in ten (36%) of the assault by partner sub-sample (n=28). This data importantly indicates that an assault by a partner is insufficient for the classification 'domestic violence' during emergency department consultations.

Given that assault by partner is not sufficient for the classification 'domestic violence' and its problematic status in practitioner accounts raises the question, why is intimate partner violence, in the form of physical assault by a partner classified in different ways during emergency department consultations?

## **CONSTRUCTIONS OF CLASSIFICATORY DISTINCTIONS**

Whether an assault by partner was 'a one-off event', 'alcohol fuelled' or 'repeated incidents' of violence over time have been identified as elements of classifications for interpersonal violence having causal properties for classificatory distinctions. A distinction between 'more acceptable violence' classified as an assault, and 'more serious violence' classified as 'domestic violence', has also been made, with the latter being of greater concern for the practitioner. During the data abstraction for the record review further ontological elements of classificatory systems were also found to be recorded. Records had information about previous or ongoing partner violence documented. The gendered relations of intimate partners were described differently in terms of boyfriend, partner, wife, husband, and fiancé. Some records documented police involvement and some whether the patient was pregnant or had any children. The recording of these different elements suggests that they hold classificatory significance of a catalytic or causal quality.

In the next section I examine the relations and strength of relations between these classificatory elements and their significance for classificatory distinctions. These elements are: violence as 'one-off' or repeated acts of violence; gendered relations of the victim/perpetrator relationship; the severity of the violence perpetrated; the impact of the

violence in terms of physical injury; the location of the assault; the involvement of police services; disclosure of an assault by a partner; and the presence of children/pregnancy. These elements all have implications for the concept of 'risk' introduced in Chapter Two, in terms of either the risk to the patient or the risk to the patients' children. First I will present the findings in terms of 'risk to (patient) self', and then in reference to 'risk to (patients') children'.

### **One-off Incident or Repeated Acts of Violence**

In distinguishing domestic violence from an assault by partner, one practitioner explained:

EDPD23: *...the majority of things that I've seen have been, sort of, one off drunken, you know, I've had them go out tonight both the female and the male person drunk, and it's a sort of one off occurrence, at that point in time."*

For this respondent it seems that 'assault by partner' is normalised and routine and in some way not as concerning. Again one-off occurrence and alcohol related partner violence formed elements of the classificatory system. The respondent was satisfied with explanations given for 'one-off' occurrences as this next extract illustrates.

EDPD23: *"(...) the majority that I've seen they've come together and they're both there and I've never seen a case of male domestic violence so all the cases I've seen have been females assaulted by males. And generally the male's there and apologetic and the both of them have been, sort of like, the female's, sort of, been, "Well, I was hitting him at the same time and he's hit me back, ..harder than ..." Do you know what I mean? Those sort of cases really. But I would*

*always go on and I would ask the male to leave and ask the female in confidence.”*

In this example, the female injured party is accompanied by a male partner, a situation which as this practitioner indicates could be problematic for disclosure of ‘domestic violence’. The practitioner is sensitive to privacy yet the presence of a male partner even though outside the consultation room is likely to constrain a patient’s report. This scenario of mutual, low level partner violence in which women are more often and more severely injured alludes to the idea of ‘Common Couple Violence’, a type of violence, introduced in Chapter Two, and defined by normalised, bi-directional and gender symmetrical perpetration of violence between couples. This extract brings to the fore classificatory distinctions available during emergency department health consultations. The respondent perceives difference for how the assault could be classified; in one way the assault is normalised for intimate relations yet in another it could be deemed aberrant and problematic. The gendered dimension of relationships was raised, yet gendered differences in terms of bodily force (‘hitting harder’) left untroubled. Alcohol was ascribed as an explanatory factor of partner violence yet simultaneously used to negate the classification ‘domestic violence’.

The ‘one-off’ characteristic is also drawn on to discount a classification of ‘domestic violence’, yet simultaneously and paradoxically the pattern of ‘normal’ repeated ‘common couple violence’ is untroubled. This excerpt reveals competition between the classifications ‘common couple violence’ and ‘domestic violence’ for an assault by partner. Yet there is illogicality in this distinction; common couple violence is defined by low level violence (push,



grab, shove, slap), and in this scenario, the act of violence was a 'hit', the male partner is present, and the patient has an injury from an assault warranting medical assistance at an emergency department.

If 'domestic violence' is understood as a course of conduct form of violence, i.e. repeated acts of (myriad forms of) violence over time, then the 'more than one occurrence' definition is important. Data abstracted from the emergency department record review identified nine records in the assault by partner subset in which affirmative or negative previous partner violence was documented. If previous partner violence was recorded, the classification 'domestic violence' was more often used (n=5/8, 63%; and n=5/18, 28% respectively).

Distinction between classifications of partner violence based on one-off versus repeated acts of violence in which 'domestic violence' is defined by repeated acts and not an assault reportedly 'one-off', is in contrast to the definitions of domestic violence (any act of violence) forwarded by the Department of Health (2005, 2010) and Home Office (2013). Whilst 'any act' definition of 'domestic violence' is contested by others, as presented in Chapter Two, they nonetheless are included in policy definitions in England. However, contestation aside, the problem, as I understand it, is that constructions of violence as a 'one-off' incident distinct from 'domestic violence' would be more likely to preclude first occurrences of partner violence in its classification and is problematic for its tacit disregard of first occurrence intimate partner violence. The problem of discounting so called 'one-off' experiences is that 'domestic violence', even if defined as a course of conduct, is still

dependent on a first act. The significance of which is that classification by 'any act' could lead to earlier classification and intervention to prevent further violence.

### **Gendered Relations of Victim/Perpetrator Relationship**

An explanatory justification of 'one-off' violence also fails to recognise that once a first occurrence ('one-off') has taken place the *threat* of subsequent violence now exists, which is itself a controlling mechanism in intimate relations and reinforces gendered power relations. The previous interview data extract alluded to gendered differences in terms of bodily force ('hitting harder') as does the next. Here, inequality of bodily force is directly referred to but then marginalised in favour of normalised mutual violence. In this classification, mutual violence is not only normalised, but also constructed as a positive attribute for some intimate relationships.

EDPN22: *"Well, even so, sometimes, in a relationship, people enjoy a violent relationship, don't they? And it's... ..sometimes you look at the man and he's this big. And you look at the woman and she's that big. And they just enjoy that sort of violence. So, there's no victim and there's no perpetrator - do you see where I'm coming from? So they could go to, sort of, other counselling things, rather than..."*

The scenario described above could also be an example of 'Mutual Violent Control' (Johnson 2006) where both partners are perpetrators of instrumental violence, or it could be 'Violent Resistance' (Johnson 2006) where a partner is violent toward the other in self-defence, or it could also be unidirectional 'Intimate Terrorism' (Johnson 2006). However, the wider context

of gendered relations for 'mutual violence' is under-theorised in these accounts, conversely, Walby (2009) in her account of violence in society refers to the use of gendered bodies as weapons and in this conception gendered bodies as weapons embody wider systems of structural gendered inequality

Conceptions of bidirectional violence in heterosexual intimate relations recognise that whilst there may be bidirectional violence, the effects of such violence are most often gender asymmetrical, disproportionately injuring women (Straus 1980, Johnson 2006, Stark 2007). In constructing classifications of 'domestic violence', gendered power relations were alluded to in respondents' accounts relating to gendered physiological difference. Gendered power relations were recognised in terms of patients' expressions of fear. One practitioner referred to one woman as being "a bag of nerves" and "frightened to death" (EDPN21). In this account 'fear' was an element of the classification 'domestic violence'. A classificatory account based on patients' fear is problematic; fear may not be evoked by a first episode or early experiences of partner-perpetrated violence, firstly because a pattern of violence has not been established, and secondly, because the severity of partner violence, when allowed to continue, commonly escalates over time (Kimmel 2002).

### **Severity of Violence**

Data from the record review was tested for association between severity of violence and the classification 'domestic violence' being ascribed. Severity of violence for this study was assessed using the revised Conflict Tactics Scale (Straus 1996). The Conflict Tactics Scale (*ibid* 1996) has three levels of violence: Low Level Violence (push, grab, shove, slap, inc

hand squeeze, wrestling, poke in eye), Medium Level Violence (kick, bite, hit with fist, hit with something) or High Level Violence (beat up, choke, threat with gun, threat with knife, used a gun, used a knife). Data about the acts of violence from across the locations was used to assess the severity of violence documented for each record. The Conflict Tactics Scale (Straus 1996) defines low level acts of violence as 'Minor Violence', and medium and high level acts as 'Severe Violence'. In this sample over 90% of patients that had acts of violence recorded (n=24/26, 92%) had been subjected to severe (medium and high level) violence. Thus 'Low Level Violence' or 'Minor Violence' is infrequent in this sample of assault by partner. In this sample, significant force was deployed in the violence perpetrated, and as such a referent to low level, 'common couple violence' for this population would more likely be a misclassification.

## **Physical Injury**

Severity of violence can also be conceived in terms of the severity of injury sustained. To assess the severity of injury recorded for each emergency department attendance, a severity of injury level was calculated based on The Counting Rules for Recorded Crime (Home Office 2010b) which makes distinctions for classifications of assault crime in relation to the injurious consequence. The Home Office Counting Rules were used solely for the purpose of yielding commensurable assessment of severity of injury for the cases in this study. Data about injuries were classified into one of the following groups based on the most serious recorded injury:

- Low Level Injury: Actual but non-visible physical injury (pain, sprain, strain)

- Medium Level Injury: Actual Bodily Harm (bruising, black eye, haematoma, swelling, reddening of the skin, superficial skin cuts not requiring any form of closure)
- High Level Injury: Grievous Bodily Harm (Laceration requiring some form of closure, fracture, dislocation, broken teeth, disfigurement, sexual violence, psychiatric injury).

There was sufficient data to calculate a severity of injury level for twenty-five records, and of these 88% (n=22) had sustained medium or high level injuries. This finding indicates that the level of force used in the assault by partner was seldom low. Six records were calculated as having had high level injurious impact documented and sixteen as having had medium level injurious impact. In tests of association, no relationship was found between the level of injurious impact and the use of the classification 'domestic violence'. Approximately half of records calculated as having high or medium level injurious impact had the classification 'domestic violence' applied (n=3/6, 50%; n=7/16, 44% respectively). (None of the three cases of low level injury were classified as 'domestic violence'). The interview data suggested that greater severity of injurious impact will qualitatively alter practitioners' classification of an assault by partner yet there was little difference between medium and high level injury and the application of the classification 'domestic violence' found in the record review.

## **Location of Assault**

Whilst the notion of the 'domestic', private sphere as a geographical boundary for the classification of 'domestic violence' may be outmoded, location of assault is important in gendered distributions of assaults (data illustrating this is presented in Chapter Eight), and this was also the case for the population in the sample.

At registration, information about the location of an incident, whether it took place in a home or in public place is entered by administration staff electronically. The location information inputted was available to the record review but did not appear on the hard copy printed out for the attendance. In the process of data abstraction it became apparent that the 'location' of assault was infrequently recorded by practitioners, and I asked respondents in the latter interviews about whether information about location would reach them during a patient's attendance. The following extract illustrates that location was something that was not always treated with significance.

EDPD15: *"...It's [location] often recorded, if they've come in by ambulance, it'll often be recorded to some extent, at least where the call was or where the patient was found. I guess it probably usually does come up when you're talking to them. It's reasonably clear whether it was in a public space, in the streets, at home, that sort of setting. I'm trying to think if I make a point of recording that in my own notes or not. It's certainly not something I've made a particular point of documenting."*

For this respondent the source of information about location was stated as ambulance records, if it was required. The respondent indicates that location information would more often than not become apparent during the consultation but for most cases this was not something that would be significant to record. In two further accounts, location seemed to hold significance of 'domestic violence' as indicated in these following extracts:

EDPN14: *"It does all tend to happen in the home, it doesn't seem to happen... So I suppose domestic violence, to me, is violence that happens in the house, in the domestic setting. For the most part, that's where it seems to happen, just*

*from what I can remember. I don't know, I've not... Yes, just it all seems to happen in the house."*

EDPN16: *"it always crosses my mind whether it's domestic violence. I know you shouldn't make a judgment but I do, on that first look from triage as they're coming in I will look and if they're wearing heels and they've got their make-up all over their face and quite clearly been out in town and been assaulted it wouldn't cross my mind, domestic violence, initially. It's the ones who come in as slippers, still with their pyjamas on, and then bruising; that would automatically make me think."*

Location is significant for gendered relations, the crux of Morris' (2009) thesis of domestic abuse pivots on the notion of abusive household gender-regimes. So whilst for these respondents the home is associated with 'domestic violence', the significance of location for the classification of 'domestic violence' is not one that is translated into emergency department practice.

Interviewer: *"...you just mentioned that a lot of it [domestic violence] takes place at home. Is that something that's routinely asked about, where an assault takes place?"*

EDPN14: *"Er, probably not, no. But if they come in with the police, they usually give us that information, or if they come in the ambulance, they usually give us that information anyway, so we don't always have to enquire about it. But I suppose it probably does come out in triage, really. If you ask what's happened, you will find out exactly where it happened."*

Location has significance for the classification of intimate partner violence in the form of an assault, yet it is seemingly handled in an ad hoc way. Practitioners obtained information about location from police, ambulance records, and patients. There was no system for routinely recording location information so that it was accessible during a patient's attendance, and given that information about location is enquired about and inputted during registration, this seems strange and could be easily remedied.

### **Police Involvement**

One respondent (EDPD29) reported that women were much more forthright than they used to be in seeking help and indicated that the police were often called first, who then initiate an ambulance for the patient to come to the emergency department. The implication that the police were instrumental in referring women to the emergency department for medical treatment after an assault by partner recurred in another respondent's account:

EDPN21: *"...these days I think people are more willing to go to the police straight away anyway and they often come to us to say they need their injuries documenting and they need treating because the police have advised them to come, so they've already made that step."*

The instrumental role of the police in emergency department attendances for an assault by a partner was also indicated in the service user interviews. Six of the eight service user respondents had attended an emergency department for physical injury caused by their partner, four of which reported that the police had been called and had seen them prior to their attendance. Two of these service users also indicated that they would not have



attended an emergency department had it not been for the advice and support of the responding police officer.

That police services were already involved had been documented in twenty of the twenty-eight (71%) incidents of assault by partner. For some records this information was only recorded electronically, still, police involvement was recorded at the ambulance location on twelve occasions, at the triage location on ten occasions and in the medical practitioner text on five occasions. In this sample, police involvement prior to emergency department attendance was common. Accessing police services first was identified as usual by the practitioner respondents (EDPD14, EDPN16; EDPN17, EDPD29, and EDPN21), and it was also suggested that police-reporting had increased over time. Only three records in the record review of confirmed partner-perpetrated violence (n=28) had not had some form of interaction with emergency services (ambulance and / or police) prior to the emergency department attendance.

Patients that did not arrive by ambulance or police transport were more likely to have delayed access to the emergency department (defined as an emergency department attendance on the next day or later) ( $p = < 0.001$ ). Of the twenty-six records for which data of the timing of the assault was recorded, nine (34.6%) patients attended one (n=7) or two (n=2) days after the incident of violence (see Table 6.1). The health benefit of ambulance and police involvement for service users was immediate access to health care.

Table 6.1 Mode of Arrival and Access to Health Care

Mode of Arrival	Delayed Access				Total	
	None	1 day	2 days	Timing not documented		
Emergency Services: ambulance or police	Count	15	0	0	1	16
	% within Delayed Access	88%	0%	0%	50%	57%
Other modes of transport	Count	2	7	2	1	12
	% within Delayed Access	12%	100%	100%	50%	43%
Total	Count	17	7	2	2	28
	% within Delayed Access	100%	100%	100%	100%	100%

Police involvement seemingly impacted practitioners' classifications of an assault by partner. In the following account the presence of the police seemed to have the effect of negating responsibility for classification and also for intervention:

EDPN14: *"(...) often they come in with the police, the police are already involved. So whether we presume because the police are involved, we don't need to offer any other assistance. That's probably the wrong thing, because I'm not sure what the police can offer, other than from arresting the perpetrator."*

Of note is the respondent's unfamiliarity with police service responses for an incident of assault by partner, and that intervention was framed solely from a criminological perspective. More curious though, is that, for this respondent, police involvement lessened the need for intervention when surely the converse should be true in the context of a patient's stated desire for intervention.

### Disclosure of an Assault by a Partner

Data from the record review identified that almost 90% of patients attending after an assault by a partner had contacted emergency services and likely reported partner violence to

emergency services prior to their emergency department attendance. In the three cases that prior police involvement was not recorded the partner victim/perpetrator relationship had been documented at triage. Thus notwithstanding the entangled police systems of referral to an emergency department after an assault by partner, patients in this sample were principally instrumental in reporting partner violence *and* in accessing services. Indeed, of five service user interview participants who attended an emergency department after an assault by partner, two (SU24, SU49) reported that they self-disclosed to emergency department practitioners, two (SU28, SU43) reported that the police informed the health practitioners, and one service user (SU27) disclosed after being asked why the police had dropped her off.

Active report of an assault by partner was also indicated in practitioner respondent accounts, as this extract exemplifies:

EDPN14: *“Er, to be honest, most of them seem to be quite happy to disclose it, especially if they come with the police. Whether it’s because they’re used to it or it just seems to be that’s their life. They don’t seem to have any qualms about, they’re, like, this is what’s happened, which is quite shocking, really. But I’ve never had to probe anybody or... It’s generally information that’s volunteered, really.”*

This quote is interesting because the person’s matter of fact ‘this is what has happened’ statement appears to have been read as an acceptance, on behalf of the patient, of normalised violence, rather than as desire for intervention. Conversely, practitioner respondents also reported experiences of ‘having to ask’, and of ‘patients hiding things’,

and that this method of disclosure for an assault by partner was of concern. In this next account, non-report is intimately connected with 'domestic violence'.

EDPN22: *"...Normally you've to ask. And we always say to the girls, just ask. Because they're that controlled, some of them... I mean, obviously, there's different variations, isn't there? But sometimes they're that controlled that they're not allowed to say anything until they're asked. So they're waiting to be asked, aren't they? "*

The idea of having to probe, of having to ask, were elements of systems of disclosure that when activated mobilised practitioners to classify an assault by partner differently than in situations of patient-led reporting. From these accounts a reluctant, passive subject in need of intervention is situated in stark contrast to the actor reporting and accessing services. Though 'reluctance to disclose' held classificatory significance for interview respondents, 'unwillingness' to disclose events was only documented on one record. Still, even on this occasion 'domestic violence' had been documented at the triage location, indicating that in this construed context of 'unwillingness', the patient had still reported early on in the consultation. There is an important observation here; it would seem that, in practice, women's desire for intervention was not associated with their action of reporting violence, whilst reluctance to disclose mobilises practitioners to classify and intervene.

Three of the practitioners interviewed (EDPD29, EDPN14, and EDPN21) indicated that most patients readily disclose 'domestic violence', and four of the practitioners interviewed (EDPD15, EDPN16, EDPN17, and EDPN22) conveyed reluctance to disclose and/or non-disclosure as the norm in cases of 'domestic violence'. Reluctance to disclose was

evidenced by patients either limiting the amount of information disclosed or by providing a false account of events. Reluctance or non-disclosure did not typify service user accounts. For a significant proportion of practitioners interviewed, that patients are instrumental in disclosure was contrary to their classificatory frame of reference for 'domestic violence' in their caseload. The data presented here suggests that self-report, may for some practitioners, construct 'domestic violence' as 'invisible in plain sight' (in Stark's (2007) term).

### ***'Intuitive' Classification***

In these next accounts nurses describe the ability to know that something is wrong, and this ability to 'just know' in the face of non-report was based on professional experience.

EDPN21: *"But this is where, like I was saying, it goes back to experience, you just know sometimes that's something's just strange. The majority of people are just as they are, I've trapped my finger in the door, I did this, I cut it on a tin of corned beef, I've fallen and slipped on the ice and it's icy outside, it all adds up. And it is experience and I do think that maybe we do lose some, some slip through the net, because a junior member of staff or a doctor who's just like... yeah, yeah, yeah, yeah, yeah, Because they're not as in tune with it as we are as nurses and they're not. Some are very good but they see the patient, they don't see everything around that patient, do they, as much."*

Within the mundaneness of everyday emergency department work, the respondent evokes a notion of intuitive knowledge about something. In this construction 'domestic violence' is

somehow unintelligible to those lacking experience, it had become enigmatic. 'Just knowing' was also foregrounded in another account:

EDPN17: *"You often get the feeling that somebody's been a victim of domestic violence but they're actually blaming something else for it. ...they quite often can justify their injuries with something else, but I think you know don't you?..you can sort of probe a bit if they don't want to tell you..."*

The idea that classification of 'domestic violence' was obscure was further advanced by one of the medical practitioners as this next extract illustrates:

EDPD28: *"...for a start it relates to picking it up in the first place, which is often difficult. And as I said, it will be the nurse who intuitively picks it up, a female nurse in a female patient. Invariably these patients are seen by a relatively junior doctor, who won't have the insight or intuition to pick it up, and even if they do it's unlikely they will do a lot about it. It will be the nurse concerned who will initiate referral to domestic violence services."*

Again, intuitive skill makes 'domestic violence' intelligible, but with the added dimension of gender. In this account the classification of 'domestic violence' is esoteric, only understood by a gendered, violence against women enlightened group. Yet gender and professional role in terms of being female or a nurse were not always associated with good emergency department experiences, and furthermore, as in previous work (Dowd et al 2002, Hathaway et al 2002, and Yam 2000), service users in this study commonly referred to practitioners' consultations skills (sensitivity, empathy, listening, caring) in connection with a positive experience.

There is an argument that could suggest that 'domestic violence' constructed in this way (an obscure, enigmatic phenomena only intuitively intelligible) condones practitioner failure to classify and respond to 'domestic violence'. Rather I propose that the classification 'domestic violence' is not helpful as a classificatory frame of reference for the population attending emergency departments after an assault by a partner. Given that approximately 90% of the cases in the emergency department record review had experienced violence of severe force (92%) (as defined by the Conflict Tactics Scale, Straus 1996) and sustained medium or high level of injurious impact (88%) (as crime counting rules, Home Office 2010b), in this sample representative of emergency department consultations, the sub-classification of 'domestic violence' for 'assault by partner' for this population is unnecessary and likely to contribute to misclassification. This data supports the argument proposed from the emergency department attendances reported in the British Crime Survey (Britton 2012), that emergency departments in England see the most heavily abused women.

### **Presence of Children or Pregnancy**

In the last chapter I claimed that because the presence of children in the patient's household and/or a patient's pregnancy was only sometimes recorded indicated that it held classificatory significance for some cases of 'assault by partner'. From the data abstracted from the record review, ten records (36%) had the presence of children and/or pregnancy documented at one of the locations. The term 'domestic violence' was also documented at one of the locations in six of these ten records. In a test of association (chi square) the 'presence of children' was statistically significant ( $p < 0.05$ ) for assault by partner to be classified as 'domestic violence' in this sample (see Table 6.2). However, because the

frequencies were less than five, and chi squared tests of association are not considered as robust at this level, the test of association was repeated with Fishers exact test. On retest the result was  $p=0.0514$  which did not quite reach statistical significance. My claim here then is that there is an indication of significance of association between the recording of the presence of children and/or pregnancy and the classification of 'domestic violence', but it did not quite reach statistical significance using Fishers exact test.

Table 6.2 Presence of Children/Pregnancy and Recording of 'Domestic Violence'

			Presence of Children or Pregnancy Recorded		Total
			yes	no	
'Domestic Violence' term used	'DV' term used	Count	6	4	10
		% within Presence of Children Pregnancy Recorded	60%	22%	36%
'Domestic Violence' term not used	'DV' term not used	Count	4	14	18
		% within Presence of Children Pregnancy Recorded	40%	78%	64%
Total		Count	10	18	28
		% within Presence of Children Pregnancy Recorded	100%	100%	100%

This interconnection between systems to safeguard children and classification of 'domestic violence' in emergency department consultations was made clear by one of the practitioner respondents in response to a question about child protection policies in relation to an adult's experience of 'domestic violence':

EDPD15: *"Yeah, yeah. I think it changes the thresholds. While the competent adult, if they don't want to disclose it, at least up to a certain point, you have the right to do so. If there's a risk to underage children, so the ones who don't have the capacity, that certainly changes the equation quite a bit. And I think my threshold for flagging concerns if there were children present or at home,*



*would certainly be lower than it would be for an adult, if they were the only person involved with it."*

In this respondent's account the risk to children in the household alters the threshold of the classification for an assault by a partner as 'domestic violence'. This is an important and perhaps unintended consequence of the interface between health and social care systems: that children by their presence in the home where an assault by a partner has taken place are classified by 'domestic violence' yet the adult victim/survivor may not be.

## CONCLUSION

Chapter Six has presented findings from interview and record review data to address the empirical research question *'Which classificatory attributes are involved in the construction of different classifications of intimate partner violence applied during emergency department consultations for an assault by a partner?'* The findings presented identified classificatory attributes and explained the construction of different classifications. The classificatory attributes were not only involved in classificatory definitional boundaries but also in the process of classification in relation to the method of report of an assault by partner. Furthermore, and which is addressed in the next chapter, the findings presented also suggested that classifications of intimate partner violence were also entangled with intervention.

Popularised versions of typologies of intimate partner violence were evident in practitioner respondents' accounts, and principally, two of these typologies were drawn on to construct a distinction between 'domestic violence' and 'assault by partner'. Yet, the distinguishing of

'domestic violence' from a population of 'assault by partner' also troubled practitioners; sometimes distinctions were evoked but then repudiated. In practitioner accounts, the classification 'domestic violence' was low-volume in their caseload and was a more serious sub-classification of 'assault by partner'. Yet the data from the record review found that violence of severe force had been documented in 92% of records and injuries of medium or high impact in 88%. Based on these research findings, I claimed that rather than 'domestic violence', it was 'common couple ('assault by partner') violence' that was rare and low volume in this population and hence that the classificatory distinctions of 'common couple violence' and 'domestic violence' were not helpful classificatory frames of reference for the population attending emergency departments after an assault by a partner. Furthermore, I contended that because 'domestic violence', even if defined as a course of conduct, was still dependent on a first act, and as such reportedly 'one-off' or 'first occurrence' partner violence should not be excluded from classification in this population.

The findings indicated that patients in this study attending an emergency department after an assault by partner were instrumental in reporting partner violence to emergency department staff. Yet this method of reporting influenced the way in which an assault by partner was classified. Patients' self-report of an assault by a partner did not automatically mobilize the classification 'domestic violence'. Conversely, non-report mobilized practitioners to classify, meaning that the classification 'domestic violence' would be less likely to be applied when patients self-reported partner violence. 'Domestic violence' was constructed as unusual and its unusualness was also constructed as often intelligible which simultaneously transferred the responsibility for its classification and vicariously condoned

misclassification. The second perversity was that women's active report was not associated by practitioners as a desire for intervention, whilst reluctance to disclose would mobilize practitioners to classify and intervene; self report and police involvement, for some practitioners, lessened the need for classification and intervention during emergency department consultations.

The data presented indicated that practitioners constructed distinction between more and less serious types of assault by partner from: methods of reporting, alcohol consumption, frequency of violence, severity of violence, extraordinariness of violence, gendered power relations in the form of patients' fear, and the presence of children/pregnancy. On tests of association, no relationships between the recording of previous partner violence or severity of injury and the recording of the classification 'domestic violence' were found. There was an indication of association between the recording of the presence of children and/or pregnancy and a classification of 'domestic violence' being applied, but it did not quite reach statistical significance. I argued that it was perverse that children by their presence in the home where an assault by a partner has taken place were classified as 'domestic violence' more frequently than adult victim/survivors alone. Classification based on gendered power relations were evoked for situations in which patients expressed fear, but not in relation to gendered physiological difference or by the location (home) in which the assault took place. Thus in conclusion, from the classificatory distinctions of importance, four distinct classifications of an assault by a partner were constructed: 'assault by partner', 'domestic violence', 'presence of children', and to a lesser extent, 'risk of harm to the adult patient'.

**CHAPTER SEVEN: 'DIFFERENCE', INTERVENTIONS AND  
REFERRAL ROUTES FOR CLASSIFICATIONS OF INTIMATE  
PARTNER VIOLENCE IN EMERGENCY DEPARTMENT  
CONSULTATIONS**

## INTRODUCTION

The aim of this chapter is twofold; firstly to identify the interventions and referral routes for patients attending an emergency department after an assault by a partner, and secondly to explicate the relationships between the different classifications of assault by partner and the mobilization of interventions and referral routes. The research findings presented in this chapter draw on data from the record review, and practitioner and service user interviews.

In Chapter Two current policy guidance for health practitioners (DH 2005, THAVAW 2010) about how to respond to 'domestic violence' was introduced, broadly configured in terms of: 'Identify', 'Intervention', 'Referral', 'Recording'. This configuration of health service response loosely structures this chapter to first discuss the findings about 'identification', or in other words, classification of intimate partner violence, followed by interventions in the form of documentation of injuries, risk and the adult victim/survivor patient, referral routes, and risk and the patients' children. Research findings about systems of intervention at 'triage', 'triage and prioritization', and 'waiting to be seen' are presented as sub-groups within the section on 'Identification', and findings about body map and photographic recording of injuries are discussed in the section 'documenting injuries'.

The research findings are extended in the section 'The Rubric of Risk' to further explicate the meaning of risk states for patients attending an emergency department after an assault by partner and to argue that the systems for responding to the risk from intimate partner violence have adapted and co-evolved, and that the new systems has a perverse impact for women assaulted by a partner. I argue that these systems have decreased some forms of

emergency department initiated interventions for non-high risk groups, disavow some patients' self-report of an assault by partner, and have the effect of limiting women's access to health services.

## IDENTIFICATION AND INTERVENTION

Findings presented in Chapter Five established that for the majority of people in this sample that had attended an emergency department after an assault, the victim/perpetrator relationship was recorded (66%; n=53/80), and furthermore, for women patients, the percentage rose to 85% (n=39/46). 'Identification' as an outcome of emergency department responses is important in terms of whether 'identification' mobilizes 'intervention'.

One of the practitioner respondents reported feeling shocked by unreserved, clear and open reporting of an assault by a partner, yet this method of report was not always connected to the classification 'domestic violence'. Indeed, service user respondents (SU43, SU49, SU27, and SU28) recounted that practitioners seemed not to respond to their report of an assault by a partner. In the following account a service user recalls that the report of an assault by a partner was acknowledged but then treated with indifference.

SU49: *"I remember them saying you've got some nasty things here, and I was telling them that this woman had attacked me from behind, beat me up, she stamped on my head and stamped on my body and everything and beat me. And they said 'oh right', but I don't know if they were taking notes or what, but they were generally dealing with my wounds and everything, and they said, "Right, we'll get your arms x-rayed." (...) don't get me wrong, once I got*

*in there and they treated me and they did my things and they sorted my neck and that and checked my bites and everything, but it was right, "You need to come back then tomorrow to the fracture clinic." And I just went home in a daze and went back the next day,"*

In this account of report, interventions for the assault by partner were not addressed and the focus of intervention was the treatment of physical injury.

In Chapter Six an explanatory account was advanced by practitioner respondents in which patient report of partner violence and police involvement lessened the need for emergency department classification and intervention. Yet, paradoxically, as this following account suggests, a patient's desire for intervention was simultaneously evidenced by patient-led reporting.

EDPD28: *"From my experience, it depends on the relationship that the woman's in. And commonly... I mean, this is just anecdotal from my own experience, but if a woman's in a long term relationship with a partner who is occasionally violent then they are the ones who will not want to disclose. (...) Ones I've seen is an ex partner who assaults a woman and then the police are more likely to be involved in those. They're more likely to want something done about it. But it's the women who are trapped, well, or in a long term relationship, in a very entrenched set up, they're the ones who are less likely to do anything about it."*

In this account the respondent intimates a distinction for the responsibility to intervene based on a patient's desire for intervention. Thus one could suppose that non-disclosure indicates a person's desire for non-intervention. The account also suggests that women experiencing repeated assaults by a partner and who remain in a relationship with the perpetrator lack desire for intervention. In this account there are two versions for non-report: women who are trapped and women who are in a long term relationship who are not necessarily trapped. 'Trapped' suggests a context in which a patient's choice to report partner violence may be constrained and it is perhaps this interpretation that mobilizes practitioners to 'probe' and intervene. Mobilization to probe and intervene for this context does not signal recognition of the patient as knowledgeable expert of their situation: that intervention at this moment could be more harmful. From this perspective greater attention paid to the non-reporting of partner violence as illustrated in Chapter Six seems even more perverse. In the second version, a lack of desire for intervention was not underpinned by constrained choice as Kelly's (2007) concept of limited space for action would suggest, but rather by the desire for continuance of relationship and victim/survivors' acceptance of continuing violence. In this second scenario, the desire for continuance of relationship is associated with a desire for non-intervention. From this account it would seem that the systems of intervention are understood as ending the relationship to end violence.

One would imagine that a report of intimate partner violence would mobilize intervention during emergency department consultations but the data presented illustrates that the causal pathway for intervention after a disclosure of partner violence is multifarious, multi-directional and complex. Patient reporting may be associated with less intervention for



women construed as accepting of violence and lacking desire for intervention. Conversely, patient non-reporting may be associated with the need for greater intervention for women construed as being 'trapped' and having constrained choices. Patient report of partner violence was more often associated with less need for intervention. The classification of the reluctant patient is situated between these two. Patients who were perceived as reluctant to disclose or not reporting because of partner-induced constrained choices were more likely to mobilize emergency department intervention than patients who openly reported intimate partner violence.

The records of seven women (from the whole sample) attending after an assault did not have victim/perpetrator relationship recorded at any emergency department location and it's not possible to know why this was so. One was a high level violence (strangle), four were medium level violence (kicked in stomach, hit with thrown object, punched in face), and two were 'low level' violence (push to ground/on stairs). Neither enquiry about the victim/perpetrator relationship, nor patient preference not to report had been documented in these records.

From the data presented thus far, interventions were reportedly more likely to be mobilized for a classification of intimate partner violence defined by frequent, extreme violence and life-threat fear. Patients that self report would not necessarily meet these criteria to mobilize classification and intervention. Systems of intervention understood as ending the relationship to end violence could be another explanation as to why practitioners were indifferent to self report if there was a context of continued victim/perpetrator relationship.

## Triage

The partner victim/perpetrator relationship had been documented at the triage location for twenty-four of the twenty-eight assault by partner sub-sample of records suggesting that report of partner violence did not require 'probing' by emergency department practitioners. One of the service user respondents found the triage process to be '*very cold*' and '*discompassionate*' and provided an account of difficulty navigating the triage consultation process in the aftermath of a violent assault:

SU43: *"(...) And then you've got somebody there and they're asking you all these questions and they can be quite in your face kind of, they just want the answers and they're not giving you as much time as you need and I can't really answer them as quickly as they want me to answer them, I'm not understanding all the questions that they're asking me, my injuries, I'm not even probably aware of all of the injuries that I've got at that particular moment. A bit more understanding I think would've..."*

*(...) because it's an emotional psychological thing that you've just suffered from, your head's... all I can describe it is, it's like my head feels... discombobulated, (...) my head felt very fragmented and I just couldn't concentrate, you know what I mean, I didn't want to be there, I wanted it to hurry up, I wanted it to hurry up, hurry up, hurry up, I just wanted to be seen and be gone."*

This respondent's experience of being 'in shock' and 'not thinking straight' resonates with other service user accounts (SU24, SU49 and SU28). Service users (SU43, SU49, SU28, and SU24) spoke of the shock and emotional and psychological sequelae following an assault by

a partner. The data extract above forwards an account of not wanting to be 'there', in the emergency department. This respondent also stated that she would have left if the responding police officer had not stayed with her.

Previous research has indicated that women leave while waiting to be seen because of fear of being recognised, being seen, or the perpetrator finding out about their attendance (WNC 2010). The research findings here add to this body of work illustrating that patients experiencing medium or high level violence may also leave because of 'discombobulation' from the emotional and psychological impact of an assault by a partner. Thus patients attending an emergency department after an assault by a partner involving medium or high level violence would benefit from having a designated violence support worker.

### **Triage and Prioritization**

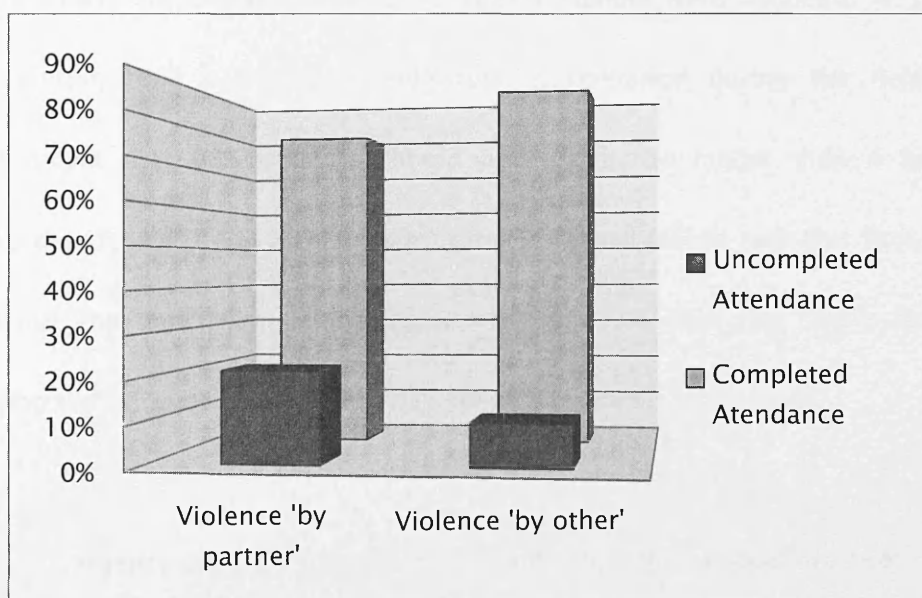
The recording of an assault by a partner did not seem to make any difference to the triage category; 25% of assaults were triaged as 'urgent' and 75% were triaged as 'non-urgent' for both assault by partner and assault by other victim/perpetrator sample sub-groups<sup>23</sup>. This data suggests that most patients attending an emergency department after an assault by partner will likely spend some time in the waiting room because of a non-urgent triage prioritisation, but as the findings just presented indicate this could result in unsupported patients leaving.

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<sup>23</sup> The composite variable for 'urgent' triage category comprised red, orange, and yellow Manchester Triage categories. The composite variable for 'non-urgent' triage category comprised green and blue Manchester Triage categories

Findings from the record review, assault by partner subgroup, identified that six patients (21%) left the emergency department before completing their attendance; four (14%) left before medical assessment and two left after medical assessment but before completing the visit. To put 'left without being seen' for an assault by partner in context of all assaults (n=78), when the perpetrator/victim relationship was known, more cases of assault by partner left before consultation completion (n=6/28; 21%) than cases of non-partner perpetrated violence (n=5/45;10%) (See Figure 7.1).

Figure 7.1 Early Self-discharge and Perpetrator Relationship



This finding indicates that more patients attending after an assault by a partner leave before consultation completion than patients whose assaults were perpetrated by an undisclosed or other victim/perpetrator relationship.

'Left without being seen' is an emergency department performance indicator because patients who leave are at greater risk of adverse events and the overall threshold for service

concern is stated as 5% of attendances (CEM 2011). The data from this study suggests that patients attending after an assault by a partner are a population at greater risk to leave without being seen and a population that, in addition to a violence support worker, would benefit from fast-tracking through to medical assessment and treatment.

## Waiting to be Seen

Triage categories determine the prioritization of patients attending emergency departments and are attributed with a maximum waiting time. The maximum waiting time for non-urgent triage categories, the category that most in this sample were ascribed, is 2 hours. In England, waiting time performance indicators in operation during the fieldwork data collection meant that 98% patients should have spent no longer than 4 hours in an emergency department (CEM 2011). Data from the record review indicates that apart from one occasion, the time spent in the department was less than four hours and of those patients who waited to be seen (n=24), half spent less than 2 hours there.

In terms of emergency department performance indicators this is good practice, however, as the following extracts indicate, waiting to be seen was experienced as uncomfortable and distressing by service users respondents in this study.

SU27: *"(...) at the best of times, you get quite a few weirdoes going in there. and you just don't feel safe."*

SU49: *"When I got to A&E I was put in a waiting room with drunks, who were slobbering over us [participant and family member] (...) and I felt very vulnerable, and obviously I was in a very bad way, and when I've looked back*

*in reflection I just felt that as a victim of such a violent attack I should have been isolated from drunks in an A&E department and I should have been responded to quicker than what I was."*

SU43: *"I had to go into the waiting room, which wasn't nice. I didn't like going into the waiting room. I was very on edge erm, obviously with my injuries, what had happened. To be honest, I couldn't at that particular time feel my injuries or..., it was more emotional, what was going on in my head. I really could've done with being somewhere quieter than sat in a room full of people where there were ....(?). You feel like you're on show kind of. And it's not handled in a way where... it's not kept private. You know, looking back over it, if it would've been handled I think a bit more delicately, I think I would say it should've been really."*

This finding is not new, previous research as illustrated in Chapter Two, has on many occasions identified privacy and safety as matters of concern and significance for women accessing health services after an incident of partner-perpetrated violence. Service users in this study also spoke of the 'stigma' of visible injuries. From the emergency department record review most patients were likely to have visible injuries as 86% (n=24/28) had been subject to acts of violence involving their face, head, neck or hair. Attending to privacy and safety should be routine for women attending an emergency department after an assault by a partner.

## INTERVENTIONS

In Chapter Two health service interventions (DH 2005, THAVAW 2010) for 'domestic violence' recommended by policy documents were identified, and these were:

- Recording the acts of violence perpetrated, the relationship of the patient to the perpetrator, whether it was a first episode and if not, noting the frequency and history of violence.
- Documentation of injuries in the form of drawings, body maps, and if possible photographs.
- Assessment of risk and safety for the adult patient
- Provision of information about and referral to domestic violence services
- Recording the presence of children in the household or patient's pregnancy
- Referral of children in the household or pregnancy to children's services
- Detailed record keeping of the above interventions.

Data from the record review identifying the proportion of records in which these interventions were documented is presented in Table 7.1.

Table 7.1 Summary Counts of Record Keeping in the ED Record Review

Record Keeping: Assault by a Partner		
Record of Violent Acts	88%	n=21/24
Record of Relationship to Perpetrator	100%	n=28/28
Record of Mode of Enquiry	0%	n=0/24
Record of Whether First Episode	5%	n=1/20
Record of Frequency of Violence	8%	n=2/24
Record of History of Violence	32%	n=9/28
Record of Injuries	100%	n=24/24
Body Map Record of Injuries	54%	n=13/24
Photographic Recording (or offer of) of Injuries	4%	n=1/24
Record of Risk to Patient	4%	n=1/24
Record of Children in Household or Pregnancy	36%	n=10/28
Record of Information Provided	0%	n=0/24
Record of Referral (or known) to Domestic Violence Services	4%	n=1/24
Record of Referral to Children's Services	25%	n=7/28

In summary, practitioners did well documenting violent acts (92%), perpetrator relationship (100%), and describing physical injuries suffered (100%). There was less attention to recording the context of the patient's experience of partner-perpetrated violence, whether it was ongoing (32%) or a first episode (5%) and its frequency (8%). This suggests that focus was placed on the presenting episode rather than the context of patients' experience of violence by a partner. Body map recording of injuries was undertaken for just over half, and the offer of photographic recording documented once. The most commonly recorded domestic violence specific risk assessment was risk to children (36%); risk of serious harm for the patient was identified and recorded once. The most commonly recorded domestic violence specific intervention was referral to children's services (25%); the provision of information about domestic violence was not documented on any of the records. Referral to domestic violence services was also not documented on any of the records; a patient's ongoing engagement with a domestic violence service was recorded once. Other than safeguarding children no interventions for domestic violence being initiated during the emergency department consultations were recorded.

The data in Table 7.1 is mostly presented in relation to completed emergency department attendances (n=24). However, 'victim/perpetrator relationship', 'history of violence', 'presence of children' and 'children's services' data are calculated for the whole sample (n=28) as this information, when it was recorded, was often documented on the triage record or next to it. In one record it was documented that a referral to children's social services had been made for the unborn child of a patient who left after triage but before being seen, indicating that information leading to child safeguarding was elicited early in



the consultation. It is notable that aspects of 'risk' important for the classifications of intimate partner violence are recorded at triage, yet on testing, 'assault by partner', 'history of violence' or the 'presence of children and/or pregnancy' were not associated with the appropriation of a higher triage risk category.

## Documentation of Injuries

In Chapter Six the findings presented illustrated that many of the practitioners and service users taking part identified the role of the police service in referring people to the emergency department. One of the service user respondents (SU27), recalled that after ringing emergency services, was advised by the responding police officer to attend the emergency department and *"have it checked out"*. The respondent stated that initially she hadn't thought to go to the emergency department as her injury *"wasn't too much of a problem"* but attended as the police advised her to go and to press charges *"to have the problem resolved so that she could get an injunction to keep him away from her"*. In this service user's account the emergency department attendance and pressing charges are entangled, and the record of the attendance acts as witness to the incident of violence for the purposes of legal proceedings. Indeed, the Department of Health (2005) provides *'guidance on the best way to keep records (for domestic violence) that might be used in future court cases'* (DH 2005:6). The responding police officer in this example, it seems, advocated the services of the emergency department to contribute to evidence that can be presented in court. Whilst arguably problematic in that the insufficiency of an individual's account of violence is implied, research has found that domestic violence legal proceedings are more often successful when there is observable evidence of violence presented to the

court (Hester 2005). The Crown Prosecution Service (2013a) states that medical evidence such as Accident and Emergency records or photographs of the person's injuries can be used as evidence. It seems that police referrals to the emergency department advance victim/survivors legal position through 'expert professional testimony' of injuries.

### ***Body Map Recording***

All of the records in the review had sites of pain and / or injury documented. Body maps to document injuries were used for just over half of the twenty-four cases that completed medical assessment, although some of the body maps were imprecise and roughly drawn. For eleven patients (46%) a brief descriptive account of injuries was all that was recorded. To explain possible different approaches to injury documentation, one practitioner explained:

EDPD15: *"(...) The standard card that we use here has got a basic silhouette and then scalp and hands for documenting some injuries. Other places I've worked have got rubber stamps of various body parts that can be used. And, well my artistic skills are quite limited, I'm quite a fan of a quick sketch sometimes to demonstrate exactly where something is. And then some documentation of size and orientation, and general appearance."*

Interviewer: *"So would you sketch yourself or would you use the maps?"*

EDPD15: *"If there was an appropriate map I would draw on it. But some of them are quite small, so if it's say, a wound to a lip, it's easier to sketch a picture myself to get a suitable scale to demonstrate it. Whereas if its just say, multiple bruises across the body, even quite a small silhouette is enough to indicate where they've been seen with some further details of size."*

This account indicates that hand drawn maps are likely used when the available printed or rubber stamp body maps were not of sufficient scale or not conveniently to hand and suggests that practitioners may not have access to printed body maps or body map stamps to fit their purpose.

### ***Photographic Recording***

In the review of records, photograph recording was documented on one occasion. In this record the practitioner documented that the offer of photographs was declined and that the patient had already taken photographs using a mobile phone. Whilst most statutory services would likely advocate professional photographs incorporating anatomical landmarks, scale, and confirmation of identity, the use of mobile phone technologies may serve not only to record injuries but also afford women greater control and autonomy of the recording of violence against them.

Given that most of the patients in this study had already accessed the police, photographic recording for this population was sometimes construed by practitioners as an unnecessary health service intervention for a population engaged with police services. However, two service users reported the value of emergency department based photographic recording of injuries. In the following extract, the respondent recalls the care and attention paid to the recording of her injuries by the medical practitioner despite a busy workload:

SU43: *"(...) the first time I went, (...) the doctor took the photographs with his own phone so he could do a detailed report of my injuries, which I thought that was really good of him because he was busy and he did say, "I am extremely*

*busy and I'm really sorry, I understand what you've been through and I really want to make sure I do a good job with this," and I thought that was really encouraging."*

That the photographs were taken on the practitioner's mobile phone is a cause for concern in relation to data protection, but simultaneously is perhaps indicative of a lack of systems for practitioners to record injuries. For another respondent the non-taking of photographs was a missed opportunity which surfaced at an appointment the next day at the fracture clinic, recounting that:

SU49: *"I think it was the guy in the fracture clinic (...) and he says, "You got photographs of these, didn't you, before you had the plasters put on?" I said no. He said, "Well we've got to put plasters on, proper plasters on, but you should have had this lot photographed. (...) So I just felt I was let down a lot (...) And at the time obviously I didn't know, it was all a whirl to me, it was only when I was asked about the photographs and then I'm starting to think, "Well hang on a minute, how much damage has been lost, because they were evidence?"*

These two respondents attended the same emergency department within a few months of each other and therefore it seems illogical that on the one hand the medical practitioner attending to SU43 was expressly keen to record a detailed account and took photographs to do so, whilst this was not the case during SU49's consultation despite a seemingly locked-in system of recording given the plaster technician's comments. Given that the respondent SU49 required plaster casts for her injuries, which would make it difficult for the police service to undertake a complete set of photographs at a later time, there was a greater

imperative for photographs to have been taken. Both respondents had reported to the police, the responding officer was present for the duration of the attendance in which photographs were taken whereas the police did not accompany the second. Conversely, police involvement was not documented anywhere in the record of the patient that had been offered photographs identified in the record review. The second respondent (SU49) expressed concern that the lack of attention paid to her assault was because of a lesbian partner victim/perpetrator relationship, and this may be so, nonetheless the data indicates the contingency of photographic recording of injuries after an assault by partner.

The practice of taking photographs of injuries during emergency department consultations varies across institutions. At a different NHS site, one of the practitioners recalled that this once common practice had lapsed:

EDPN22: *“Traditionally, we offered photographs and we used to take a lot of photographs, but only if the police weren’t involved or Women’s Aid weren’t involved. (...) But we’re having camera issues at the moment.”* [The cameras were lost].

There is a paradoxical relationship here: photographic recording during emergency department consultation has decreased at the same time as the role of the emergency department record as legal witness for injuries sustained from an assault by a partner has increased.

Photographing injuries for patients experiencing domestic violence attending emergency departments was a policy initiative originating in the late 1990’s. Photography policies at

this time were framed by the idea that patients may not want to contact the police or press charges at that moment but photographs along with a record of the violence could provide good documentary evidence in the future if so required. The research findings suggest that there has been a change over time and that most women attending an emergency department after an assault by partner now have already reported to the police. The findings also indicate that some practitioners consider that because women have already reported to the police that less emergency department intervention is needed. Yet the two service user respondents that gave an account of recent experiences valued the emergency department as a site for securing photographic evidence of injuries.

## **Risk and the Adult Patient**

For the record review I searched the attendance records for documentation in reference to 'risk assessment' and/or 'risk aversion interventions' for the patient. The Domestic Abuse, Stalking and Honour Based Violence (DASH) Risk Identification Checklist (RIC) for non-police agencies developed by Coordinated Action Against Domestic Abuse (CAADA 2013) was not, at the time of data collection, employed in the emergency department where the record review was undertaken. One record in the review documented a knife wound and that the patient was at risk of 'serious harm', and in response, referrals without consent were made to police services for the risk of serious harm. Other than this one case, there was no documentation about risk assessment or safety interventions for the other twenty seven patients.

'Risk' was most often expressed by practitioners (EDPD15, EDPD28, EDPD23 EDPN14) in reference to justification for referrals to the police or social services with or without consent on the grounds of the adult patient lacking capacity or identified as being at risk of 'serious harm'. Patients who did not display incapacity or risk of 'serious harm' were constructed as able people, capable of making decisions and acting to access intervention to end violence as this extract exemplifies:

EDPD28: *"It's to do with patient confidentiality and capacity. And often these patients will have insight and capacity to what's going on and they have the ability to consent or otherwise. And from a medical point of view, that's where we stand. If the patient's got capacity and insight then it's their choice. (..) And at what stage you would intervene in the patient's best interests under common law is difficult. It's a grey area."*

'Capacity' is a legal term and its use here is illustrative of medico-legal hybrid discourse circulating in everyday practice in relation to patients' autonomy and choice. Capacity and choice however sometimes slid into concepts of "*own volition to act*" (EDPD28), and on one occasion, of culpability in terms of "*putting themselves at risk by repeatedly going back to it, not wanting to help themselves*" (EDPD28). Here, again staying in the relationship was constructed as being complicit in the violence perpetrated and lacking desire for intervention. The following extract provides an account of a practitioner's construction of risk and risk intervention.

EDPD15: *"(..) as we speak to the patient, you get a feel for whether they are particularly vulnerable or have any exceptional needs. In most cases, the*

*people we see are perfectly competent, otherwise healthy adults. And even if there's a certain amount of coercion or the sort of nature of the relationship, it does make it very difficult to try and disclose information against their wishes. (...) But if they've made the decision they don't want to disclose it and it doesn't seem that anyone else is at risk, you then need to make a certain amount of judgment of, say how much risk they're at. If it's someone who's generally been beaten black and blue, or stabbed, or there's major injuries, you might have to rethink it. If it's someone who has been slapped or pushed into a wall, or something like that, I certainly wouldn't say it's acceptable, but it's something where you don't think their life is particularly at risk. And unfortunately I think it does come down to when, as and when they've had enough and are prepared to do something about it."*

Intervention for 'risk' was most often overtly constructed by practitioners in terms of high, life-threatening risk states rather than in relation to patients' everyday experience of violence or ongoing safety. Distancing from the perpetrator was recorded in three cases vicariously through documentation of the patient's partner arrest. Four practitioner respondents (EDPD29, EDPN16, EDPN21, and EDPN22) articulated that they would be concerned for patients' (classified as domestic violence) safety on discharge, and three articulated that they could, if the patient desired, arrange immediate shelter (EDPD15, EDPN21, and EDPN22). That safety assessment or intervention was not documented in any of the emergency department records in the review suggests that this was perhaps undertaken in an informal manner, verbally during consultations.



The findings from this study indicate there were two conceptions of risk assessment and risk intervention for an adult patient attending an emergency department after an assault by partner: A formal system for the risk of life threatening serious harm and which was recorded and an informal system for immediate safety intervention which was not recorded.

## REFERRAL ROUTES

The emergency department record review identified that the intervention of providing information about domestic violence services or referral to domestic violence services was not documented in any of the patients' records. On being asked about emergency department initiated interventions for an assault by a partner one service user responded:

SU43: *"Nobody offered me any help or assistance at all."*

One respondent (SU27) recalled being asked about whether she would be alright going home on her own but that information about specialist domestic violence services was not addressed as this extract indicates:

SU27: *"I didn't really feel that the Emergency Department really helped. They didn't even offer any other services afterwards, like places like (...) [the local domestic violence service] Centre - I had to find them out myself."*

A similar experience was shared by SU28:

SU28: *"they looked after me and they would, you know, make sure I was alright. But it's like some of them didn't help, you know, finding somewhere to go. I had to go back to him. They didn't help me in that kind of way, only since... because it had been going on for a while then they started helping me. So I were a bit annoyed over that situation."*

For some service users, safety going home was addressed yet for others it wasn't, indicating that safety assessments were contingent too.

In the next account a practitioner articulates 'domestic violence' intervention in terms of consented reporting to the police, non-consented reporting with a breach of confidentiality, and safeguarding children.

EDPD23: *"How far can you go? If somebody won't admit it for a start off, (...) tells you outright they don't want you to report it to the police, (...) and there's no other people involved, then you're a bit stuck really. You can't, they could then sue me for breaking confidentiality."*

From this it would seem that some emergency department systems lack a repertoire of formalized intervention beyond informing statutory services. When asked about what would happen if a patient without children disclosed 'domestic violence' the practitioner responded:

EDPD23: *"(...) I'm not aware of what we can actually offer for these ladies. So I would have to, if I had a case I would have to be asking somebody, "What can I do for this lady?"*

The two emergency department sites from which practitioners participated in the study were very different in terms of the current and historic engagement with interventions for domestic violence. The differences were notable in practitioner accounts from the different sites about interventions and are exemplified in these next interview extracts.

## Site 1:

*"For domestic violence against an adult usually the police. We would involve the police and take it from there, or the women's support in (name of town site 1). (...) There's really not much out there from our point of view. There might be if you go and look from a personal point of view. And I think we would probably do that if we needed to; we'd look into it more to get the right people. But I've not had to. (...) Children, it's CAF forms. (...) we never seem to offer like the help that perhaps we should (...) we don't seem to have any contact information for them to take it further to get help if they wanted to leave their home or stay somewhere else while it's being sorted out in whatever way. So really I think we could do with a follow up, give people specific telephone numbers: "This is where you can get help if you want it", and then you can at least leave it with them; they've got that information. (...) We should have a leaflet which we can give people with all the information on that they need." (EDPN17)*

For this respondent at Site 1, intervention was articulated in terms of police involvement and / or local 'women's services'. The respondent mentions systems of referral for children (although 'CAF forms<sup>24</sup>' are for requesting services for additional needs and not safeguarding referrals) but struggled to articulate other forms of intervention or referral to specialist domestic violence services. Systems of intervention such as injury documentation in the form of photographic recording, patient safety, or the provision of information about and referral to specialist services were not available in this respondent's account of everyday work practices.

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<sup>24</sup> CAF is an acronym for the 'Common Assessment Framework', a system for requesting services for children with additional needs (Department for Education 2013)

## Site 2:

*"(...) Just talking to them, (...) advising them on services available, what they want to do. We always say, don't ever tell them... (...) we advise on the dangers of when they're leaving and to always take... If that's what they decide to do, always get support from Women's Aid. With the CAADA DASH, obviously, we tell them that... (...) we do the CAADA DASH, put them in touch with people who can help. If we're really worried that they're really seriously injured and we think it could be a serious case then we'd inform the police - even if they said no. Make sure they've somewhere safe to go. Do they want to go home? Give them the advice numbers. Traditionally, we offered photographs and we used to take a lot of photographs, but only if the police weren't involved or Women's Aid weren't involved. (...) we'd see what they want. Would you like us to phone the police? Do you feel safe to go home? Can we... Would you like to go to the (name of local Women's Aid) Centre? Shall we ring them? Here's the phone number for it. If they refuse all that, no, I just want to go home. Can we take your photograph? And, sometimes, they just won't have anything. And we've to accept that, much as it's... doesn't sit well, you know. But sometimes they won't even take the phone number. But, there again, they've got a controlling partner at home and if you then start controlling then they're moving from one controlling environment to another, aren't they? So you've got to accept that," (EDPN22)*

The respondent from Site 2 was able to reel off a greater range of intervention options. This second account of emergency department intervention was also more service user centred, and services for a woman's experience of *domestic violence* were foregrounded whereas in the first account, statutory services were more readily advanced. The dialogue in these accounts differ in ideas of authority to act; the respondent from Site 2 acknowledges issues of promoting patient empowerment and control, whereas at Site 1, it appears that it is the practitioner rather than the service user that is in control and instrumental. However, some medical practitioners at Site 2 were unsure of the systems of interventions available other than safeguarding and children's social services.

Site 1 had little in the way of systems for providing service users with information about domestic violence or referral to specialist local domestic violence services and did not have a working relationship with local services. Conversely, Site 2 had systems for domestic violence intervention that included CAADA–DASH homicide risk assessment (CAADA 2013), information about domestic violence, provision of information about and referral to specialist services, safety assessment, and referral to the police. Nonetheless, even at Site 2 these were contingent, not all practitioners at this site knew of them and as such were not formalized and locked–in systems. Interventions for domestic violence were commonly articulated by emergency department practitioners as nurses’ responsibility (EDPD23, EDPD28, EDPN16, and EDPN21).

### **Risk and the Patients’ Children**

Safeguarding children was a much clearer concept for practitioner respondents and their accounts indicated little difficulty in identifying it and acting upon it as the next extracts suggest:

EDPD15: *“There sometimes needs to be a little bit of exploration if there are, say children at home as well, if there’s other family members who might be at risk. (...)*

EDPD23: *“(...) So, whereas children it’s a lot more clear.”*

In Chapter Six I presented data demonstrating that the recording of ‘the presence of children’ was associated with the classification of an assault by partner as ‘domestic violence’, here I present data (Table 7.2) illustrating that there was an association, which did

not quite reach statistical significance, between the recording of an assault by partner as 'domestic violence' and a safeguarding children referral being made ( $p < 0.0627$  Fisher's exact test).

Table 7.2 Safeguarding Children Referral and Recording of 'Domestic Violence'

Safeguarding Children Referral		'Domestic Violence' term used	'Domestic Violence' term not used	Total
Yes	Count	5	2	7
	% within 'Domestic Violence' term used	50%	11%	25%
No	Count	5	16	21
	% within 'Domestic Violence' term used	50%	89%	75%
Total	Count	10	18	28
	% within 'Domestic Violence' term used	100%	100%	100%

The location of 'Safeguarding Referral' evidences formalized systems for risk to children intervention. The findings from this research identifies that the system of classifications for an assault by partner to be classified as 'domestic violence' were greatest when there was a connection with the system of safeguarding children.

## THE RUBRIC OF RISK

'Risk' as an organizing device for justifying health priorities and services is not new. However 'risk' in relation to intervention for 'domestic violence' has changed over the last decade through a series of legislative and policy developments. First, risk from exposure to 'domestic violence' was legislated for through the principal of safeguarding children from harm from witnessing the ill-treatment of another, and second, Coordinated Community Responses in the form of Multi-Agency Risk Assessment Conferences (MARACs) provided an

avenue of referral for adult victim/survivors of 'domestic violence' identified at risk of 'serious harm'.

The Children Act (UK Parliament 1989) made the welfare of children paramount and placed a duty on practitioners to act for a child if 'significant harm' or its likelihood is considered. In terms of 'domestic violence', 'significant harm' was considered in terms of direct harm or ill-treatment perpetrated towards the child. The Adoption and Children Act (UK Parliament 2002) implemented in 2005 extended the legal meaning of 'significant harm' to include children's witnessing (hearing or seeing) ill-treatment of others. This extension legally defined children living in households where domestic violence was taking place to be 'at risk of significant harm'.

MARACs, first piloted in 2006, are police service-led multi-agency meetings at which a coordinated action plan is devised to increase the safety (i.e. reduce the risk of serious harm) of 'high-risk' victim/survivors (Coy and Kelly 2011). 'High-risk' can be established through the Domestic Abuse, Stalking and Honour Based Violence (DASH) Risk Identification Checklist (RIC) (CAADA 2013) which assesses an individual's risk of homicide. Risk of 'significant harm' for children and risk of 'serious harm' for adults constructs a duty for practitioners to intervene. The significance of these changes is that now, the duty bound threshold for intervention for an incident of intimate partner violence, is lower for an adult victim/survivor's child(ren) than that for the adult victim/survivor.

I present data to argue that the systems to respond to the risk from domestic violence have adapted and co-evolved, and that the new systems have a perverse impact for women assaulted by a partner and which denies some women access to health services.

‘Safeguarding children’, is in principal an unproblematic concept, however five of the women service users in this study articulated problems they encountered once they had become known to children’s services. Fear of the intervention of social services and loss of children has been previously identified as significant for women’s non-disclosure of domestic violence in mental health settings (Rose et al 2011) and family practice settings (Feder et al 2006). Indeed, the hypothesis of fear of safeguarding children intervention as the reason behind patients’ reluctant or non-disclosure was advanced by four emergency department practitioners (EDPD28, EDPN21, EDPD23, and EDPD15) in this study. Moving beyond what is already known about service users’ fear of safeguarding interventions, the analytical focus here is on service users’ experience of safeguarding and its relation to access to health care and the classification of domestic violence in this setting.

### **‘Keeping Things Quiet’ and ‘Being Tight with Children’s Services’**

Not all service users perceived children’s services as problematic, one of the respondents (SU24) praised the intervention of children’s services stating that *“social services saved my life”* despite *“being tight with social services”* previously, explaining that:

SU24:            *“(…) Social Services are not a bad thing, it’s how you look at your situation.  
                      (…) They’re there, they have a duty to protect our kids, and if we’re not doing*



*it someone's got to do it. (...) So no, they're not a bad thing. I think they're good. Just not enough of them, I'm afraid."*

However, it had not always been this way, and along with three other service user respondents referred to the idea of '*keeping things quiet*' so as not to alert social services to ongoing violence. Two women (SU24 and SU26) reported not accessing health services because of the risk of the statutory services becoming involved. Two women (SU27 and SU43) who had lost custody of their children reported perpetrators using aggression and violence to prevent them seeing their children subsequently at pre-arranged visitations. Women (SU21, SU26, and SU43) also reported that their partners directly obstructed and prevented their access to health services after incidents of violence. These findings suggest that the women respondents in this study were oftentimes positioned between the threat of violence from their partners and the threat of losing custody of their children, a position that was also exploited by perpetrators.

One of the service user respondents (SU26) had experienced domestic violence for over five years and in the following extract provides an account that illustrates interconnected systems of intimate partner violence against women and safeguarding children that prevented access to health care for herself and her children.

SU26: *"I was pregnant (...) and obviously he kind of laid into me, (...) I know now I must have been quite bad at the time but I just rested in bed for five days and didn't move, well I couldn't walk for two days. My friend was coming in. And he {partner} felt really bad as well because obviously, "She's pregnant. Shit, I shouldn't have done that," so guilt must have set in as well. And the*

*fact that I think he thought, "God, she can't go to hospital". (...) I really, really couldn't move. I knew in my own head that I needed to go to be checked but obviously it's, like, "I can't do that because I know things'll start coming up and stuff". (...) I kept a lot of my things quiet and obviously it got worse for me keeping things quiet when the kids were put on the Register because I felt like if anybody found out that things were still happening that they'd take my kids off me, which probably they would have. (...) So it was just easier for me to hide it, which a lot of women do do. (...) it's weird, you just think, "If I go... I need to go, but, but..." You worry more about the fact of... well I did. (...) My kids are my only little family I've got left so it'd devastate me if I lost them and to be in a situation that you are in, I think it's just easier to hide it and put up with the pain at home out of the way than any of it to go on record for Social Services or anybody like that to contemplate on taking them away. (...) there was times where I'd cancel appointments, "I wouldn't come today, we've got sickness and diarrhoea," do you know, just to keep them away whilst the black eye went down or..."*

In this account, 'child protection' works by accessing women and their children at risk of harm but one of its initial outcomes was to constrain access to health and social care resources. For this service user (SU26), child protection became a waiting game, once placed under statutory service surveillance it became more difficult to remain 'anonymous' to statutory services and stay under the radar; it was almost a test of endurance before reaching a critical tipping point. There is an argument here for proposing that the witnessing of violence by children in a household or a woman's pregnancy is too low a

threshold, or that the discrepancy between the thresholds is too great, for automatic referral without the adult victim/survivor's consent because it may prevent some women from accessing health and social care services.

'Safeguarding children' as exemplified here had the effect of preventing women from accessing health services and likely caused stress in relation to the perceived threat of loss of custody of children. Given the high proportion of service users in this study problematising safeguarding children systems and the sense of harassment from services that some women reported I examined the record review data to assess whether women were disproportionately targeted for safeguarding children intervention. For this analysis the whole assault by location home dataset was used bearing in mind that safeguarding children legislation identifies children 'at risk' if they witness (see or hear) the ill treatment of another and once identified should warrant the automatic referral to social services safeguarding teams.

From this analysis the presence (or absence) of children and/or a pregnancy was documented in the records of one (3%) male patient and seventeen (35%) female patients (see Table 7.3). Four of the eighteen records had the *non-presence* of children documented, all of which were records of women. Of the four women who had the non-presence of children recorded, three were cases of partner assault and one was a case of an assault by another male family member.

Table 7.3 Presence of Children (Whole Sample)

Presence of Children Pregnancy Recorded		Sex		Total
		Male	Female	
Yes	Count	1	17	18
	% within Sex	3%	35%	22%
No	Count	34	31	65
	% within Sex	97%	65%	78%
Total	Count	35	48	83*
	% within Sex	100.0%	100%	100%

\* The missing case was a resident in an older persons' care home

Records of female patients were more likely to have the concern for children documented than male patients, and this was statistically significant ( $p = < 0.001$ ). This is perhaps not surprising given that intimate partner violence and violence against women in the home is a consequence of and illustrative of abusive household gender regimes (Morris 2009). However given the legislation and policy directives presently in operation, that of children's risk of harm from witnessing the ill-treatment of another, women, I argue, are disproportionately subjects of safeguarding children intervention.

The underlying rationale for this gendered system of recording the presence of children is unclear. It could be that practitioners have an understanding of gender-based violence against women, and the home as a site where women more often experience physical violence, but the ongoing risk of violence against women (and vicariously their children) by people known to them was not documented in emergency department records. The gendered difference could also be because of systems that more readily ascribe parental responsibility for women than men. My question then is, if violence has taken place in the home, what then is the concern for children living there? Is it the harm from witnessing

'domestic violence' and/or greater risk of abuse of children in homes where 'domestic violence' (i.e. primarily violence against women by men) is perpetrated or is it as legislation states more broadly, children's witness of the ill treatment of another.

The findings from this study indicates that it is the first approach, the harm from witnessing 'domestic violence' classified as primarily violence against women by men, that is presently implemented in policy and practice. However to respond to the legislation in terms of 'children's witness of the ill treatment of another' a broader gender-based violence approach that recognizes different forms of gender regimes in kinships would be required. Under such an approach, when one family member is violent towards another there would be automatic concern for other family members in the gendered hierarchy. This appears to be the case for women presenting to the emergency department after an assault in the home by kin known to them but does not seem to be the case for men.

In her emergency department service research with women accessing refuge services in the United States, Yam (2000) presented qualitative data that portrayed women's concern for their children's exposure to 'domestic violence'. It is not unfathomable that women are communicating their concern for their children during emergency department consultations and this perhaps lies behind why the presence of children is recorded most often on the records of female patients. However, this would not explain the recording of *non-presence* of children on women's records. This is indicative of gendered bias. The data presented here illustrates an inconsistent interpretation and operationalisation of the law that discriminates against and disproportionately impacts women.

The following table (Table 7.4) summarizes the recording of the presence of children and victim/perpetrator relationship and indicates that the presence of children was recorded only in cases where a victim/perpetrator relationship was identified ( $p = < 0.001$ ). Thus the non disclosure of a victim/perpetrator relationship was a protective factor against a safeguarding children referral being made.

Table 7.4 Presence of Children and Perpetrator relationship (whole sample)

Presence of Children or Pregnancy Recorded		Perpetrator Relationship Recorded		Total
		Not Recorded	Recorded	
Yes	Count	0	17	17
	% within Perpetrator Relationship Recorded	0%	33%	22%
No	Count	27	35	62
	% within Perpetrator Relationship Recorded	100%	67%	78%
Total	Count	27	52	79
	% within Perpetrator Relationship Recorded	100%	100%	100%

The research findings presented have identified problematic consequences of systems for safeguarding children that may adversely impact women’s lives. These consequences are: impeding women’s access to health services, perpetrator exploitation of women’s surveillance, stress, and women’s loss of child custody. Furthermore there is a gendered bias that targets women for safeguarding children intervention. The problem with current safeguarding children threshold and policy implementation is that it will, for some, promote women’s non report of victim/perpetrator relationship and constrain women’s access to health and social care services.

Earlier in the chapter, I suggested that some practitioners may lack a ready repertoire for intervention beyond informing statutory (police or children's) services and conclude this section with a quote from a nurse practitioner.

EDPN21: *"That's not about anymore [taking photographs] and it's more based now on social services referrals and MARAC referrals"*

This quote foregrounds a shift from systems of emergency department intervention focused on supporting a woman victim/survivor of intimate partner violence to systems of risk implemented in England during the last decade and which privileges children over women seeking emergency department services for injuries after an assault by a partner.

## CONCLUSION

In Chapter Seven interview and record review data was used to illustrate the difference that different classifications made in terms of interventions and referral routes and answered the question *'What interventions and referral routes for intimate partner violence are initiated during emergency department consultations for an attendance after an assault by a partner?'* In terms of consequential difference, the eight classifications reported in Chapter Five and which were distilled to four in Chapter Six have been further explicated and identified as the classifications that made a difference for patient management. The entanglement of intervention and classification, further addressed the question which began in Chapter Six to answer *'Which classificatory attributes are involved in the construction of different classifications of intimate partner violence applied during emergency department consultations for an assault by a partner?'*

It was not possible to know the extent of non-statutory, yet specialist interventions initiated because these were not documented. Some practitioners reported providing specialist domestic violence interventions but the majority of service users reported that they had not. A further key finding in Chapter Seven was the paradoxical, based on reporting method, and multi-directional causal pathways of intervention that were entangled with which of the four classifications had been evoked. The data presented in Chapter Seven to support this argument addresses the research question. *'What are the relationships between the different classifications applied and the interventions and referral routes initiated for intimate partner violence during emergency department consultations for an attendance after an assault by partner?',* and further addressed the question in relation to the classificatory significance of intervention, *'Why is intimate partner violence, classified in different ways during emergency department consultations?'*

I have presented data to construct an argument that the classification 'domestic violence' has been appropriated to classify the risk to adult victim/survivors' children from witnessing intimate partner violence. Classified in this way, 'domestic violence' as 'the risk to victim/survivors' children' was the classification that most commonly mobilized recorded 'domestic violence' intervention, and the intervention specifically for 'domestic violence' most commonly mobilized and recorded was for the children of adult victim/survivors in the form of referral to children's services. This system of intervention was supported by formalized institutional systems. There was a gendered bias in its implementation and women were significantly more likely to be targeted. This system, though, is dependent on the reporting of a victim/perpetrator relationship by the adult patient.



For some service users in this study, the outcome of systems of intervention for risk to children was to restrict women's access to health care and this forms the basis for an argument that the witnessing of violence by children in a household or a women's pregnancy was too low a threshold for automatic referral without the adult victim/survivor's consent. Women were found to be more likely than men to be targeted for safeguarding children risk intervention; this finding indicates an inconsistent interpretation and operationalisation of the law that discriminates and disproportionately impacts women when accessing emergency department services after an assault in the home. Non disclosure of victim/perpetrator relationship is a protective factor against risk to children safeguarding intervention.

There was evidence of intervention for adult victim/survivors of an assault by partner that included photographing injuries and assessing the patient's immediate safety on discharge. Practitioners reported provision of specialist service information to adult victim/survivors of intimate partner violence and referral to specialist services but the service users in this study reported that they often did not receive information or referral, and none had received it during their first emergency department attendance after an assault by partner. Thus the mobilisation of intervention for adult victim/survivors seems infrequent and contingent, indicating that these were mobilized by informal systems of intervention. There were varying degrees of knowledge about interventions reported by practitioner respondents even in departments with proactive staff and protocols, and interventions for intimate partner violence were often identified as a nursing responsibility.

Patient reporting of partner violence and non-reporting of partner violence both had paradoxical multi-directional causal pathways. The self-report of an assault by partner did not necessarily mobilize intervention, and service users reported a seeming indifference to their report of partner violence. 'Identification' of an assault by partner was insufficient to mobilize intervention. Self-report signalled desire for intervention but self-report whilst remaining in the relationship signalled a lack of desire for intervention. Non-report signalled lack of desire for intervention and also mobilized intervention. Reluctance to report was associated with risk and constrained choices and was most often interpreted by practitioners with greater need for intervention. Perversely, practitioners associated self-report and police involvement with less need for intervention.

Even though information about risk was often obtained at triage, the information collected ('assault by partner', 'history of violence', or the 'presence of children and/or pregnancy') did not impact triage prioritization for an assault by a partner. Service users reported feeling unsafe and distressed in waiting areas and patients attending after an assault by a partner should be afforded privacy from arrival. Patients attending an emergency department after an assault by partner were found to be a population at greater risk of leaving before being seen, and as such would benefit from fast tracking through. Risk of the adult patient was seldom recorded, on the one occasion that it was for a risk of serious harm, a non-consented police referral was also recorded indicating a formalized system of intervention.

Some service users reported 'discombobulation' in the immediate aftermath of an assault by partner and it is likely that patients attending an emergency department after an assault by

a partner involving medium or high level violence would benefit from a designated violence support worker to help navigate their attendance and act as an advocate.

Findings from the research indicate that some practitioners did not have access to equipment (body maps and cameras) to document patients' injuries. There was a paradoxical relationship that photographic recording during consultation had reportedly decreased yet the role of emergency departments to record injuries sustained from an assault by a partner had increased. Even though service users most often reported to police, service users valued the emergency department as a site for photographic recording of injuries. Women were also likely to be increasingly using personal mobile devices to record the injuries from violence perpetrated against them by a partner.

In conclusion, the findings presented in this chapter indicate there were four conceptions of classifications of intimate partner violence with entangled intimate partner violence intervention applied during emergency department consultations after an assault by a partner. These four classifications made a difference to patients' routes through emergency department consultation. The four classifications of intimate partner violence and their interventions were identified in this study as:

1. **'Serious harm'**: The classification 'serious harm' involved a formal system of intervention for the risk of potentially life-threatening 'serious harm' for an adult patient attending an emergency department after an assault by partner. 'Serious harm' was a rare classification.

2. **'Domestic violence'**: For the classification 'domestic violence' there were informal systems of intervention for an adult patient attending an emergency department after an assault by partner. These interventions included photographing injuries and the provision of information about and referral to specialist domestic violence services but were found to be contingent and rarely documented. 'Domestic violence' was reported as a low volume classification.
3. **'Presence of children'**: For the 'presence of children' classification there was a formal system of intervention which was concerned with the risk of 'significant harm' for the children and/or pregnancy of adult patients attending an emergency department after an assault by partner. The threshold of risk for children is lower than for adult victim/survivors and this study found that intervention for the risk to children was more often recorded than intervention for the adult victim/survivor.
4. **'Assault by partner'**: The classification of 'assault by partner' did not have any interventions other than routine medical care entangled with it and was evidenced by the lack of mobilisation of intimate partner violence interventions for patients who self-reported an assault by partner. 'Assault by partner' was understood by practitioners as the most common classification of intimate partner violence present in their caseload.

# CHAPTER EIGHT: 'DATA', CLASSIFICATIONS OF INTIMATE PARTNER VIOLENCE IN HOSPITAL EPISODE STATISTICS

The following table provides a summary of the data on intimate partner violence (IPV) in hospital episode statistics (HES) for the period 2001-2002 to 2010-2011. The data is presented in two columns: 'Number of episodes' and 'Percentage of total HES episodes'. The total number of HES episodes for each year is also provided in the 'Total HES episodes' column.

Year	Total HES episodes	Number of episodes	Percentage of total HES episodes
2001-2002	1,000,000	100	0.01%
2002-2003	1,000,000	100	0.01%
2003-2004	1,000,000	100	0.01%
2004-2005	1,000,000	100	0.01%
2005-2006	1,000,000	100	0.01%
2006-2007	1,000,000	100	0.01%
2007-2008	1,000,000	100	0.01%
2008-2009	1,000,000	100	0.01%
2009-2010	1,000,000	100	0.01%
2010-2011	1,000,000	100	0.01%

## INTRODUCTION

In Chapter Two I identified the two administrative systems for the classification of intimate partner violence in the form of physical assault for Emergency Department and Admitted Patient Care Hospital Episode Statistics. For Emergency Department Hospital Episode Statistics the classification system is the Accident and Emergency Department Data Dictionary Coding Tables and for Admitted Patient Care Hospital Episode Statistics, the classification system is the International Classification of Disease version Ten (ICD-10). IN this chapter, the research findings on the classification of intimate partner violence, in the form of physical assault in the two types of Hospital Episode Statistics, Emergency Department and Admitted Patient Care, are presented in turn.

The data presented identifies the rates of applications for classifications of intimate partner violence in the form of physical assault for Emergency Department and Admitted Patient Care Hospital Episode Statistics. The Emergency Department Hospital Episode Statistics data are also examined in relation to systems for the provision of patient information for the patient's ongoing health care. The classifications used for intimate partner violence are analysed for their robustness to measure intimate partner violence, in the form of a physical assault, in emergency department and hospital-based populations. The data used in this chapter is drawn from: Emergency Department and Admitted Patient Care Hospital Episode Statistics (HES), data from the emergency department record review, data from the central record review, and interviews with emergency department practitioners, clinical coders, and service users.

In this chapter research findings are presented to construct two arguments. First, to claim that the specific classifications for intimate partner violence in the International Classification of Disease (ICD-10) are not robust for the classification of intimate partner violence in the form of a physical assault, and nor is the data produced by it a robust system of measurement for cases of intimate partner violence. Secondly, that the Accident and Emergency Data Dictionary Coding Tables system of classification, whilst still somewhat coarse for distinguishing *intimate partner* violence, was better; its clearer, simple taxonomy required little interpretation, and was commonly applied.

## **EMERGENCY DEPARTMENT HOSPITAL EPISODE STATISTICS**

The data items of classificatory interest for this chapter are 'Patient Group', 'Clinical Diagnosis', 'Attendance Disposition', and 'Location', and these correspond with the World Health Organization's Injury Surveillance Guidance data items: 'Intent: Assault', 'Physical Injury', 'Disposition', and 'Place', respectively. These items are of interest for two reasons. First, because they are used to inform patients' general practitioners about the health problem the patient attended the emergency department with, and secondly, because they form the most relevant classifications from emergency department consultations for an assault by a partner that are routinely collected and could be used to system monitor emergency department attendances and responses to intimate partner violence in the form of an assault. These data items and their classificatory options frame the classification of emergency department consultations for an assault by a partner in terms of 'Identification of cases' (patient group), 'the patient's ongoing health problem' (clinical diagnosis), and 'referral routes' (attendance disposition).

'Patient Group', of which there are nine classificatory options, is for classifying the type of health problem that the patient has consulted health services for. The nine 'patient group' categories are: Road Traffic Accident, Assault, Deliberate Self Harm, Sports Injury, Firework Injury, Other Accident, Brought in Dead, Other than above, and Unknown (NHS IC, 2009). All the patients in the emergency department record review were classified by patient group as 'assault'. 'Clinical Diagnosis' is for classifying a medical practitioner's diagnosis/diagnoses of a patient's health problem(s), and the A&E Data Dictionary has thirty-nine main 'clinical diagnosis' classifications. 'Attendance Disposition' is for classifying the systems of outcomes for emergency department consultations in terms of whether a patient was discharged, referred for follow-up or not, transferred to another facility, or admitted to hospital. In total there are thirteen 'attendance disposition' classifications. This section first examines the emergency department data for informing ongoing, individual health, and the second examines the emergency department data for informing local and national population health.

## **EMERGENCY DEPARTMENT HES DATA FOR INDIVIDUAL HEALTH**

### ***Clinical Diagnosis Classification and GP Health Problem Information Sharing***

The thirty-nine clinical diagnosis classifications of the A&E Data Dictionary largely pertain to bio-medical systems of the body, a small number of diseases, and types of injury. Only four of the classification options for clinical diagnosis concern non-physical illness/injury or health problems. The four non-physical related options are 'Psychiatric conditions', 'Social problems', 'Diagnosis not classifiable', and 'Nothing abnormal detected' (NHS IC 2009). The primary clinical diagnoses electronically entered by medical practitioners at the Diagnosis,



Disposition, and GP Letter location, for patients attending an emergency department after a partner-perpetrated assault were all injury-based (see Figure 5.5), and the most common diagnoses for patients in this study completing an attendance were 'Soft Tissue Inflammation' (n=8), 'Contusion' (n=7), and 'Closed Fracture' (n=3).

Up to three clinical diagnoses could have been entered on the patients' electronic record. Seventeen patients in the subsample 'assault by partner' (n=28) had multiple sites of injury documented as diagnoses in the handwritten record, yet a second diagnosis was only entered onto the electronic record of patients' emergency department attendance for eight cases. This research finding suggests that 'clinical diagnosis' was a good indicator for measuring patients' primary injury after an assault by partner, but under recorded multi-site injury for more than half of the attendances.

The clinical diagnosis electronically entered forms part of the information used for computer generated letters for the patients' general practitioners. Although practitioners were able to supplement general practitioner information by using the 'free text' space available, this was reported by respondents (EDPN21; EDPD15; EDPD23) and observed in the record review (n=6/24) as infrequent. In addition, free text information would not form part of system measurable data. Although not reaching statistical significance ( $p = 0.077$ ), information that the injury was in consequence to an assault by a partner was more often included in GP letters when the term 'domestic violence' (n=3/10, 30%) was recorded at some point in the patients record than when it was not (n=1/18, 6%).

Four of the six service users (SU24, SU28, SU43, and SU49) who had attended an emergency department after an assault by a partner indicated that they thought information about the assault and partner victim/perpetrator relationship would have been conveyed to their general practitioner. The other two service user respondents (SU25 and SU27) were unsure whether it would have been conveyed or not. Advantages of general practitioner information sharing were articulated by service users as helpful because their GP would know what was going on (SU43, SU28, and SU25) which would make follow-up and future discussions better (SU25 and SU28). Two of the service users (SU24 and SU25), whilst supporting the idea of general practitioners being made aware of intimate partner violence, advocated that the service user should be informed of any proposed information sharing and their consent obtained. It is not usual for emergency department practitioners to ask for consent to inform general practitioners about an episode of hospital based care and any prescription, specialist referral and follow-up advised and / or provided as this is done routinely. To not pass on this information should be a matter of exception than norm, and propose that patients attending an emergency department following an assault by a partner should have the option to opt-out of information sharing about an assault by partner, and with support from a health practitioner decide the level of information to be shared.

### ***Attendance Disposition Classification and Referral Routes***

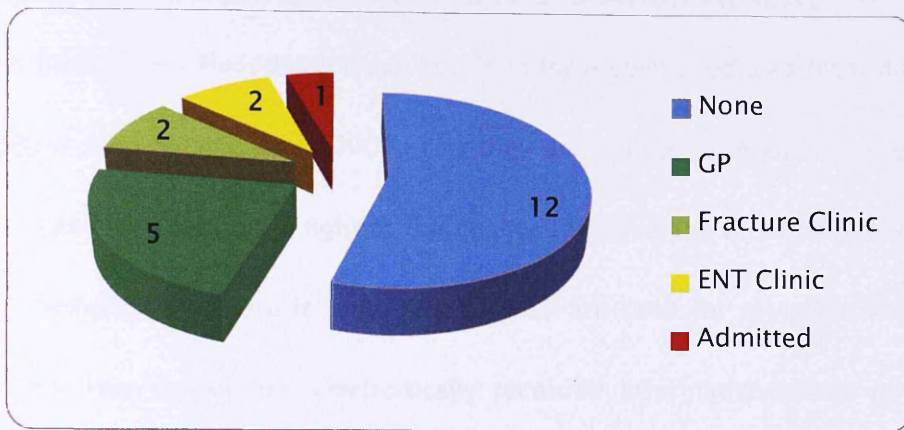
The data item options for 'attendance disposition' are (HSCIC, 2009):

- Admitted to hospital bed / became a lodged patient of the same health care provider
- Discharged – follow-up treatment to be provided by general practitioner
- Discharged – did not require any follow-up treatment
- Referred to A&E clinic

- Referred to fracture clinic
- Referred to other outpatient clinic
- Transferred to other healthcare provider
- Died in department
- Referred to other healthcare professional
- Left department before being treated
- Left department having refused treatment
- Other
- Not known

From this list, 'attendance disposition' can be understood more coarsely as whether the patient was referred on for further *healthcare* care or not. Apart from the 'other' classification there are no data item options for non-health service follow up in the data dictionary. For intimate partner violence, this means that referral to specialist services cannot be entered. The attendance disposition classifications entered by medical practitioners at the Diagnosis, Disposition, and GP Letter location for the subsample 'assault by partner' are detailed in Figure 8.1. Less than half (n=10/22) of the twenty-two patients that completed their emergency department consultation were referred for follow up with some form of further health service. Twelve patients were not advised any form of 'health follow up' suggesting that further health services were not considered warranted for the diagnosis ascribed.

Figure 8.1 Referral Routes



### *Referral Routes*

Of the six records in which assault information was manually entered for the GP letter, two were referred to their general practitioner for follow-up, two were not advised any follow up, one had a referral to another medical specialty and one patient had left before being seen. That not all the patients that had information about the assault conveyed to the general practitioner (n=6) were advised to follow up with their GP (n=2) suggests that for some practitioners the function of passing on information was not solely for immediate follow-up for the physical injury-based diagnosis. In terms of a GP letter being a conduit for informing ongoing primary health care, that the causal mechanism of patients' injuries was not routinely passed on seems curious given the long term health consequences associated with intimate partner violence. However, in the absence of classificatory options, the findings indicate that sometimes practitioners co-adapt systems for classifying health problems for patients' GP letters.

## EMERGENCY DEPARTMENT HES DATA FOR POPULATION HEALTH

Emergency Department Hospital Episode Statistics have been produced from direct input to the secondary uses service since 2007. Yet, they are still considered to be 'experimental data' to be used with caution in light of the quality and coverage of some data fields (HSCIC 2013b), nonetheless this data is important as they are used for research and monitoring purposes. For this section the electronically recorded information about patient group: 'assault' is examined. The findings presented are from an analysis of data obtained from a data request made to the North West Public Health Observatory in September 2010 for health data of emergency department attendances in Lancashire for assault disaggregated by age, gender and location. The following table displays the number of people, aged over eighteen years in 2009 that sought medical intervention in emergency departments in Lancashire<sup>25</sup>, and whose record was classified as 'Patient Group: Assault' cross tabulated with the classifications for 'Incident Location'.

Table 8.1 Emergency Department Attendances for Assault in Lancashire 2009

Location	Female	Male	Total Persons
Educational establishment	***	***	***
Home	502	500	1002
Other	242	739	981
Public place	403*	2093	2496
Work	***	***	***
Unknown	570	1690	2260
Total	1717	5022	6739

\*\*\*number masked because of low counts. \*contains a masked counts of up to 5<sup>26</sup>

<sup>25</sup> Two emergency departments in Lancashire (Blackburn and Burnley) did not collect data on location (Rooney 2012) and are not included in the analysis.

<sup>26</sup> It is standard practice to preserve data protection of patients' records for counts in released Hospital Episode Statistics Data to be masked, i.e., not revealed, if a category's count is less than six or could be worked out through deductions.

The adult age category for the data received from the North West Public Health Observatory was eighteen years and older. Sixteen and seventeen year olds were categorised in the group age ten to seventeen years and thus were excluded from the analysis. The data indicates that overall, many more men (76%, n=5022) than women (25%, n=1717) attended emergency departments in Lancashire in 2009 after experiencing an assault. The use of residual categories, such as 'other' and 'unknown' means that the location of violence is not recorded in nearly half of all cases (48%, n=3,241). There are similar rates of applications of 'other' and 'unknown' categories of location for males and females reporting an assault. 'Other' location was recorded for 14% of women and 15% of men, and 'Unknown' location was recorded for 33% of women and 34% of men. The use of residual categories threatens the robustness of the data. In the absence of other sources of emergency department data, the most robust way to manage these residual categories is to treat them as 'don't knows' and remove as missing data. This data with the residual categories as missing data removed is re-presented in Table 8.2

Table 8.2 All ED Attendances of Lancashire Residents in 2009, aged 18 years or Older, for Incident Type 'Assault', by Location 'Home'.

Location	Female	Male	Total Persons
Home	502	500	1002
Public place	403*	2093	2496*
<b>Total</b>	<b>905</b>	<b>2593</b>	<b>3498</b>

\*contains a masked count of up to five.

For the records for which a location was entered, 56% of assaults on women were classified as taking place in the home (n=502/905) compared to 19% of the assaults on men

(n=500/2593). This data indicates a gendered dimension to assault by location. This finding correlates with earlier research which found that women attending an emergency department in Scotland after an assault were more likely ( $p > 0.001$ ) to be assaulted in their home than men (Wright and Kariya 1997). The current A&E Data Dictionary commissioning dataset classifying violence by location offers the capacity for assaults, in particular the greater risk of violence in the 'home' location for women than men, to be measured and analysed over time.

### Monitoring Assaults by Location over Time

A recently published report suggests that the number of people accessing emergency department services in Lancashire after an assault in the home decreased by 15% from 2009 to 2011 (Rooney, 2012) but the research findings were not gender disaggregated. Given the significance of assaults in the home for women, gender disaggregated analysis of trends over time is important. The data obtained from the North West Public Health Observatory was used to undertake a gendered trend analysis of the people accessing emergency department services in Lancashire after an assault from 2007 to 2009. The first table (Table 8.3) illustrates that there was overall very little change in the gender combined rates of classified assaults from 2007 to 2009 (0.6%; n=1008 in 2007 and n=1002 in 2009).

Table 8.3 Number of patients attending an ED in Lancashire after an assault at home

Year	2007	2008	2009
Counts	1008	987	1002

The same analysis was undertaken but with gender disaggregation and the following table (Table 8.4) presents the numerical counts for female and male Lancashire residents, aged eighteen years or older, attending an emergency department after an assault for 2007, 2008, and 2009.

Table 8.4 Number of patients presenting to ED's in Lancashire after an assault in their home disaggregated by sex

Year	2007	2008	2009
Counts: Women	458	467	502
Counts: Men	550	520	500

The data here illustrates a year on year increase in the recorded number of women presenting to emergency departments in Lancashire after an assault in their home. Conversely, the data illustrates a year on year decrease for the recorded number of men attending an emergency department in Lancashire after an assault in their home for the same period. This diverging gendered trend of (approximately) 9% decrease in the rates of men and 10% increase in the rates of women presenting to emergency departments in Lancashire after an assault in their home clearly evidences the need for gendered analysis of Emergency Department Hospital Episode Statistics assault data.

The current Accident and Emergency Data Dictionary commissioning dataset does not have the option to classify and collect data of victim/perpetrator relationship which prevents analysis of the specific gendered power relations involved in assaults in people's homes. Given the health consequences, this is an important issue for women's health. This research identifies two problems with the current Accident and Emergency Data Dictionary



commissioning dataset as the system for emergency department classification of health problems associated with interpersonal violence. The use of the residual categories for 'incident location' for nearly half of the population, which if continued will persist to threaten data robustness, indicates either a problem with the system of classification in terms of the data item options available, or, a problem with the systems of data entry for the classification. Secondly, victim/perpetrator relationship matters; it matters because it informs the form of post assault support victim/survivors require, information that can better inform service commissioning and monitor effectiveness of policy initiatives to end intimate partner violence against women.

The A&E Data Dictionary commissioning dataset should collect data of victim/perpetrator relationship to permit better comprehension of trends of rates of gender-based violence requiring medical intervention in local and national populations. This recommendation, that emergency departments should record the victim/perpetrator relationship is also the position of the College of Emergency Medicine (CEM 2012a). This data collection would likely be feasible given the research findings presented in Chapter Five that identified that victim/perpetrator relationship was documented in patients' records for the majority of patients attending an emergency department after an assault in the home. However, until such time as victim/perpetrator relationship information forms part of the dataset, the current A&E Data Dictionary commissioning dataset classifications: 'Patient Group: Assault', 'Incident Location: Home', 'Age: Sixteen years or older', and 'Sex: Female' are collectively the best indicator for 'domestic' if not specifically 'intimate partner' violence against women.

## **ADMITTED PATIENT CARE HOSPITAL EPISODE STATISTICS**

Of the twenty-eight attendances in the record review of the sub-sample 'assault by partner' only one person was admitted to hospital directly from the Emergency Department. However, the data collected from Site 2 from inpatient records indicated that of sixteen admissions admitted after an assault by a partner, six had been discharged from the emergency department but later admitted for planned surgical intervention for fractures (n=4) or for further medical assessment (n=2) indicating that Admitted Patient Care Hospital Episode Statistics include more than those admitted directly from an emergency department.

## **ADMITTED PATIENT CARE HES FOR POPULATION HEALTH**

In this section I present data from two sources of administrative health information about the number of applications of the three ICD-10 classifications ('T74.1 physical abuse by partner', 'Y07.0 maltreatment by partner', and 'Z63.0 problems in relationship with partner') that were, as explicated in Chapter Two, most specific for intimate partner violence in Admitted Patient Care Hospital Episodes Statistics in England. The two sources of administrative health information are:

1. Publicly available Hospital Episode Statistics available on the Hospital Episode Statistics (HES) website.
2. Hospital Episode Statistics dataset obtained by request from the North West Public Health Observatory.

The main distinction between the two sources is whether the data includes only primary diagnosis or primary and secondary (up to nineteen) diagnoses. The Hospital Episode Statistics available on the HES website only publishes data of primary diagnoses whereas the

data requested from the North West Public Health Observatory includes primary and secondary diagnoses.

## ICD Hospital Episode Statistics on the Web

The number of (Finished Consultant Episodes (FCE's) in England for men and women aged fifteen years or older coded with one of the three ICD 10 codes, T74.1, Z63.0, or Y07 from 2006–2011 was extracted from annual 'Primary diagnosis: 4-character tables' on the Hospital Episode Statistics website. The data for 2010/11 are presented in Table 8.5.

Table 8.5 Number of Finished Consultant Episodes\* in England in 2010/11 for ICD 10 codes: T74.1, Z63.0, or Y07. Source: Hospital Episode Statistics Website

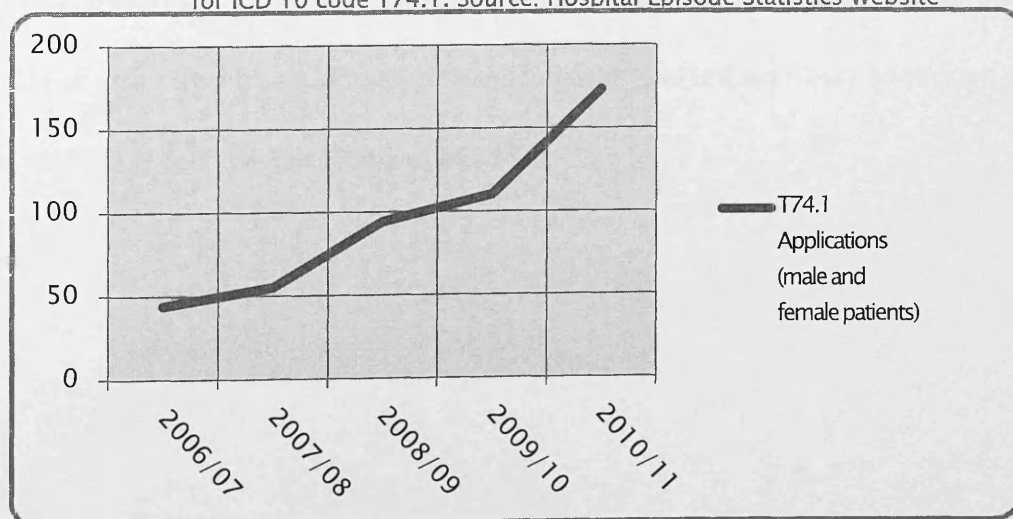
Code	Total Number of FCE's	Male FCE's	Female FCE's	0 – 14 years old FCE's	≥15 years old FCE's
T74.1	499	223	276	326	173
Z63.0	17	10	7	–	17
<i>The following 'External Cause' Codes available only at 3-character level</i>					
Y07	1106	405	701	568	538

Patients may have more than one consultant managing their care during an admission spell so there could be duplication of cases in this data. Copyright © 2012 Reused with the permission of The Health and Social Care Information Centre. All rights reserved.

The web-based HES data is aggregated so that gendered analysis with the exclusion of children and young people aged less than fifteen years old was not possible. The number of applications of the T74.1 (physical abuse) code for people aged fifteen or older (n=173) suggests that it is infrequently ascribed as a primary diagnosis.

As secondary diagnoses, the Y and Z codes should, in theory, not be present in these data for primary diagnoses and as such are misclassifications. However as they are present in the dataset I wish to trouble their representation. At this level of data the 'Y' codes are only available at the '3-character' level, that is Y07 not Y07.0 and so forth, the significance of the 4<sup>th</sup> digit is important. The 'Y' codes are part of the external causes 'Assault' section of the ICD and Y07 ('maltreatment') can be assigned with a fourth character of code that differentiates the victim/perpetrator relationship. For Y07, the addition of .0 indicates 'maltreatment' by the person's partner. Thus at this level of administrative data, intimate partner violence is conflated with other forms of kin and non-kin perpetrated violence. From this source, code Z63.0, 'problems in relationship with partner', is the only code at this level that permits gendered analysis of abuse directed at young people and adults by their partners. However, Z63.0 as a secondary diagnosis alone should also not be present in this data. Thus I have selected this T74.1 to further examine trends of applications (Figure 8.2).

Figure 8.2 Number of Finished Consultant Episodes\* in England 2006 to 2011 for ICD 10 code T74.1. Source: Hospital Episode Statistics Website



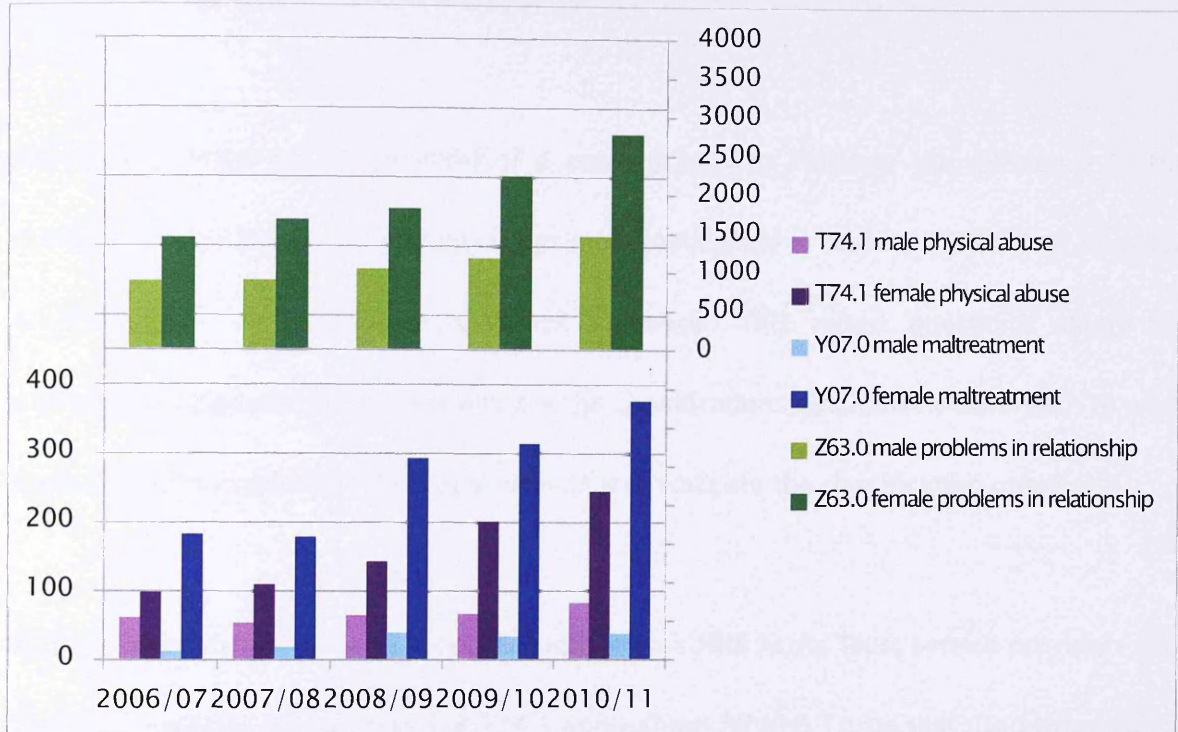
\*Finished Consultant Episodes: Patients may have more than one consultant managing their care during an admission spell so there could be duplication of cases in this data.

Numbers of applications of T74.1 'Physical abuse' have steadily increased since 2006/07. The numbers of cases per annum from 2005/06 were 44, 55, 94, 110, and 173 illustrating increases of rates of application of 25%, 66%, 17% and 57% respectively. Notwithstanding, the classification 'T74.1 physical abuse by partner' was an uncommon primary diagnosis.

### **ICD Hospital Episode Statistics from NWPHO**

The bespoke request made to the Northwest Public Health Observatory asked for the numbers of people aged sixteen years or older admitted to hospital in England from 2006 - 2011 for which the admission was coded with the ICD 10 codes T74.1, Y07.0 and Z63.0 disaggregated by sex, rank diagnostic classification (primary or secondary), and service provider (NHS Trust). The categories of data are constructed slightly differently to the previous HES website data. The website data is classified by finished consultant episode whereas the data produced for the bespoke request is by number of patients. In addition the data in this section is for patients who were aged sixteen years or older at the time of coding and as such minimises conflation with classifications for child abuse (the web-based data is disaggregates at age 15 years). Figure 8.3 presents data for the number of patients, aged sixteen years and older, admitted to hospital in England and that admission coded with the ICD-10 codes T74.1, Y07.0 and Z63.0

Figure 8.3 Numbers of Patients aged Sixteen Years and Older, Admitted to Hospital in England and that Admission coded with ICD-10 codes T74.1, Y07.0, and Z63.0 from 2006 - 2011



In the five year period from 2006/07 - 2010/11 there were a total of 18,673 people aged sixteen years or older admitted to hospital and whose admission was classified by ICD-10 code T74.1, Y07.0 or Z63.0. This is approximately twenty-five times more than the figure for primary diagnoses sourced from the website data. It is evident that these codes are indeed more likely to be applied as a secondary diagnosis. The data disaggregated by sex, as expected, illustrates a significant gendered distribution of the applied classifications. The annual number of T74.1 code applications range from 54 - 83 for men and from 99 - 245 for women. The annual number of Y07.0 code applications range from 13 - 40 for men and from 183 - 376 for women. The annual number of Z63.0 code applications range from 884 - 1467 for men and from 1440 - 2781 for women. Admissions for women were consistently

more frequently classified by ICD-10 codes T74.1, Y07.0 or Z63.0 than admissions for men and this was most noticeable for the code Y07.0.

The data is presented in the form of a panel graphs to illustrate the difference in the numbers of classification applications, but most particularly in respect of Z63.0 as opposed to T74.1 and Y07.0: thousands versus hundreds. This raised questions about the classificatory distinctions. In what way are the classifications qualitatively different? To what types of health problems were they ascribed? and, what are the classification qualifiers?

The numbers of applications of classifications across NHS Acute Trust service providers also had large variation. The numbers of T74.1 applications by NHS Trusts that used these codes were for male patients from less than six to fourteen, and for women from less than six to 107. The numbers of Y07.0 applications per NHS Trust ranged from less than six to nine for men and from less than six to seventy for women. For Z63.0, the ranges of rates of applications were, for men from less than six to 476, and for women from less than six to 629. There was a large difference in the rates of applications across NHS Trusts. The variance of rates of reported intimate partner violence by region in the Crime Survey of England and Wales (formerly the British Crime Survey) is statistically insignificant, and thus the variance in the rates of applications of classifications across NHS Trusts would seem greater than could reasonably be accounted for by differences in caseload populations. The variation in the rates of applications of classifications across NHS Trusts suggests local differences in the systems involved in the classification of inpatient records, namely systems

for classifying and coding inpatient records with the ICD-10, systems for recording intimate partner violence, and systems for reporting intimate partner violence.

### **Clinical Coding: Classifying Intimate Partner Violence by ICD-10**

Systems of reporting and recording intimate partner violence during emergency consultations from the interface between patient, emergency department staff, and patients' records have been addressed in chapters five, six and seven. In this next section systems of recording intimate partner violence in inpatient records and systems for classifying and coding inpatient records with the ICD-10 from the interface between patients' records, clinical coders, and the ICD-10 are further explicated with qualitative data from a group interview with a team of clinical coders. The work of a clinical coder involves classifying admitted patient episodes of care with classifications from the International Classification of Disease. The group interview focused on the International Classification of Disease classifications T74.1, Y07.0, and Z63.0.

During the group interview, the respondents indicated that code Z63.0 was mostly used for classifying admissions for self-harm, such as drug overdoses, for which mental health practitioners had documented problems with partner relationships as contributing to the patient's state of mind. The words and phrases that clinical coder respondents recalled as written in the notes for which they classified as Z63.0 were articulated in this extract:

CCFG21:        *"Sometimes they just put 'overdose, argument with husband', things like that, don't they? 'Argument with girlfriend' ....they sometimes put 'marital*



*problems' ....disharmony, they use, don't they? It depends on the doctor really what word pops in their head, doesn't it?"*

These words clearly connect with the first sentence of Z63.0's classificatory definition: *'Problems in relationship with spouse or partner'*. However these descriptors may not necessarily fulfil the second sentence of Z63.0's definition in the ICD-10 to account for:

*'Discord between partners resulting in severe or prolonged loss of control, in generalization of hostile or critical feelings or in a persisting atmosphere of severe interpersonal violence (hitting or striking).'*

From the review of central records (n=29), eleven had been classified with Z63.0, of which seven were for admissions for self harm; one was for an admission for following assault, and three others for complications in pregnancy. The data indicates that Z63.0 was most frequently applied to classify episodes of care for 'self harm', and was unlikely to be a robust classification for system monitoring of incidents of intimate partner violence, in the form of physical assault.

In chapters six and seven research findings indicated that an assault by a partner understood by practitioners as being a one-off incident would be less likely to be classified as 'domestic violence'. This same distinction about one-off incidents was raised during the clinical coder group interview. In the group discussion that follows, the coder respondents are referring to the T74.1 code for the classification 'physical abuse by partner'. Some respondents shared similar ideas about the exclusion of 'one-off' incidents, however as the group interview discussion progressed, uncertainty of the boundaries for the classification 'domestic violence' emerged, as this extract exemplifies.

CCFG21ii: *"That's what I don't understand. If you're hit by somebody, just because it's your husband, is it domestic violence or is it not? I'm not sure now. The one that I did I think the police were involved and she didn't go back home and he were taken away so I presumed it was, I suppose and maybe I shouldn't have done."*

From this account, pieces of information, such as 'being hit by your husband', the 'involvement of the police', of 'leaving home', and that the 'police took the partner away' had been drawn on to justify a classification of 'domestic violence' and indicate elements of the system of intimate partner violence classification. Yet, that this scenario perhaps shouldn't have been classified as 'domestic violence' also illustrates complex interconnections of systems for the construction, or not, of the classification 'domestic violence'. Troubling for this coder respondent was the revelation of coding based on a 'presumption' or interpretation of the health record rather than on what was categorically documented at some point in the record, an issue that will be returned to later.

'One-off' incidents again emerged as insufficient for the classification 'domestic violence' in relation to the classification T74.1 'physical abuse by partner' under the rubric of T74's 'maltreatment syndrome' as indicated in the following excerpt.

CCFG21ii: *"Well, if somebody's been, I don't know, got a fractured cheekbone or whatever because they've been assaulted, you'd just do the injury and the assault, but if she said she'd been assaulted by the husband and it was proved that he had done it then is that domestic... would that make it a*

*maltreatment syndrome, you know to use the T code or is it still just an assault? I don't understand that now I've thought about it. (Laughing)"*

*"Yeah, it's like that if they came in and they've been stabbed by their partner, is that? It could just be a one-off argument, couldn't it? Is that still classed as a T74? Yeah so I don't understand that...."*

However, the 'one-off' exclusion from classification was rejected by another respondent:

CCFG21i: *"Well yeah, it would be, couldn't it, because, like, you know, you could've both been out, you're really drunk, come home, had a big argument, but you may never have laid a finger on you ever before so... and he may never, ever again, so it's that one incident."*

'So it's that one incident' was to stress its inclusion in the classification 'T74.1 physical abuse by partner', and for this respondent alcohol consumption did not alter classification.

This respondent continued to trouble the 'one-off' incident classificatory 'rule' for 'domestic violence' that for some would exclude an assault by a partner from the T74.1 classification. T74.1 is a classification for both 'battered spouse syndrome/physical abuse by partner' and for 'battered child syndrome/physical abuse by parent'. In the next extract, the respondent proposes that a 'one-off' incident of violence by a parent towards a child would be classified as T74.1 and questioned why that would be different for violence by an adult partner.

CCFG21i: *"But if it were a child you'd definitely use a T code, that you'd abused your child, wouldn't you, so what's the difference then? And I'm not sure".*

In this account, the respondent attempts to justify 'one-off' incident inclusion in the classification of T74.1 (physical abuse by partner) by identifying, from what the other

respondents were proposing, inconsistency and illogicality for an ICD-10 classification of T74.1 for 'abuse' to be differently contingent for age and victim/perpetrator relationship.

From these accounts the classification of an act of violence perpetrated by a partner and that resulted in an admission to hospital as 'domestic violence' was difficult for some because of informal popular systems of classification and which lessened the likelihood of the classification of T74.1 'physical abuse by partner' being used for an assault by a partner. Conversely, the systems of classification for violence perpetrated against children by a parent as T74.1 'child abuse' was, for coder respondents, seemingly more straightforward and less complicated.

The application of the code T74.1 'physical abuse' also held particular anxieties for the clinical coders as one respondent explained:

CCFG21i: *"I think with the T74s... we're a bit careful around these codes, .... It's got to be, like, a hundred per cent sure before we would put the T code on. ....I think we've more a tendency to code the injuries and then the Y code."*

From this account there is a concern for the application of T74 (maltreatment syndrome – battered spouse syndrome / physical abuse) codes but not the Y07.0 (maltreatment syndrome by spouse or partner). This seemed to be in relation to the ICD construction of the Y07.0 classification of victim/perpetrator relationship as *causal* to the classification of an *injury* warranting hospital admission, rather than the T74.1 'physical abuse by partner'

designed as the primary diagnosis for admission, i.e., without the injury the admission would not have taken place. From these respondent accounts and from the Hospital Episode Statistics data, thus far, the code more likely and most often applied for admissions after an ‘assault by partner’ was the secondary ‘external cause’ diagnosis code Y07.0 ‘maltreatment by partner’.

In the last account, the respondent refers to the classification and coding of ‘injuries’ as primary diagnosis. From the clinical coder interview data and in respect of the omission of victim/perpetrator relationship classifications in some emergency department records, it is likely that some episodes of care for the consequences of intimate partner violence are distributed across the ‘S’ group of primary diagnosis codes, ‘injuries by anatomical site’.

### **Classification in Practice: Confidence in Certainty**

Earlier in this section, the notion that a classification was an interpretation of the medical record rather than the classification of what was categorically documented was introduced, and that for clinical coders this was troubling. ‘Certainty’ for classification was repeatedly in the repertoire of clinical coders reported practices, and seemingly an essential element of the system of ICD-10 classification as this next statement suggests.

CCFG21i: *“Unless we knew it was by the spouse you’d use a Y07 (other maltreatment person not designated) or if it did say ‘assaulted by husband’ or ‘assaulted by wife’ then we would, wouldn’t we?”*

[General agreement]

Confidence in the systems of coding involved classification based *only* on what was documented in the medical record. For the respondents, it seems, classifications could only be applied for the information documented, and sometimes as this next extract indicates, victim/perpetrator relationship was not always included.

CCFG21i: *"...if we haven't got that information documented then we can only use the Y04. So some of the Y04s could actually be domestic violence but if it's not documented in that case note we can't assume."*

From this account, in the absence of recorded victim/perpetrator relationship, the classification 'Y04 assault by bodily force' was applied. Cases of 'domestic violence' then may also be distributed under 'Y04 assault by bodily force'.

Certainty resided in the system of classification based on the documentary evidence of the health record. However, uncertainty for the classification 'Y07.0 maltreatment by partner' emerged after one of the coder respondents asked:

CCFG21ii: *"Would we only use the Y07, though, with a T74? Because it's saying 'maltreatment syndrome', isn't it, and that's the external cause where the T's actually the injury, isn't it?"*

In response to this question about the relationship between classifications T74 and Y07, a debate ensued about whether the actual word 'maltreatment' would need to be documented in the health record for the classification Y07 to be applied. These are extracts from the conversation that took place.

CCFG21ii: *"you can only trail maltreatment to use Y07 which we'll never use."*

CCFG21i: *"What's 'assault by' mean?"*

CCFG21ii: *"if I was to use that (Y07). It would have to state 'maltreatment' within the case notes, otherwise we would go for Y04 (yeah I think so (another interviewee)), it's just assault, you can't have assault by. You can only have 'assault by force', like hand or fist or foot, but it doesn't say, husband, spouse or parent."*

The first respondent is saying that the classification 'Y07.0 maltreatment by partner' would only be applied if the word 'maltreatment' was documented in the record because the words that are documented in the medical record are used to look-up classifications in the ICD-10 alphabetical index. The second respondent is suggesting that documented 'assault by a partner' is indicative of 'maltreatment'. The first respondent then reaffirms that to apply the classification 'Y07.0 maltreatment by partner' the word 'maltreatment' would need to be documented, and that because of this the classification 'Y04 assault by bodily force' would be applied, which does not permit victim/perpetrator relationship to be classified, only the body part that was used to inflict injury.

The discussion then led to a questioning of the classification by another respondent:

CCFG21v: *"What's the difference, though, between if somebody comes in and they've been hit by somebody and they say assault but then if they say, "My partner did it," does that make it 'maltreatment' or is it 'just assault'?"*

These extracts indicate that for some, documented 'maltreatment' was a prerequisite for the classification 'Y07.0 maltreatment by partner', whereas for others 'assault by' was sufficient.

The claim 'maltreatment' as requisite was that to trail 'assault' (i.e, look up 'assault' in the ICD-10 index) directs the coder to the classification Y04, and for which there are no sub classifications of victim/perpetrator relationship. The claim that 'assault by' was sufficient was made on the grounds that Y07.0 includes 'physical abuse'.

CCFG21i: *"It says includes physical abuse, doesn't it, Y.07. That's why I would... No, I think I'm right. I would do it that way, would you?"*

CCFG21v: *"if it said assault by partner...I would just trail assault."*

With reference to the classifications documented in the record review in Chapter Five and the findings from the clinical coder interviews indicates that if the patient was admitted some would classify the same record as Y07.0 and some would classify as Y04. The research findings suggest that a crux for formal systems of ICD-10 classification lies in the interpretation of coding rules, in terms of whether to only classify according to the words documented, or whether to use judgment to interpret the classification for the terms written in the record.

However, none of the coders could recall having seen the word 'maltreatment' documented in a patient's medical record, as these data extracts illustrate.

CCFG21ii: *"I don't think I've ever seen it written, 'maltreatment by husband' or 'assault by husband'."*

CCFG21i: *"No they don't write that do they?"*

CCFG21iv: *"No, they don't write 'maltreatment'."*



CCFG21ii: *“So that’s why I would just go for assault rather than maltreatment.”*

CCFG21i: *“Physically abused by husband’, I’ve seen that.”*

CCFG21iv: *“I’ve seen that in the history”*

The distinctions between the classifications of ‘assault’ and ‘maltreatment’ or ‘battering’ became increasingly challenging during the group interview. Later on in the interview the respondents acknowledged the places where difference in interpretation of patients’ problems could be introduced but seemed to consider that in coding practices, although initially interpreted differently, meaning would remain the same as this coder stated.

CCFG21: *“A lot of it is down to the documentation, isn’t it, and again, you know, the way they interpret. How I’d interpret something and how someone else would interpret, we could, you know, both do it very differently but it does mean the same.”*

And that difference was mediated through consensus.

CCFG21iv: *“But we tend to have conversations about these things within the office to try and come up with the right (coding).”*

The research findings indicate that the systems for recording the words most commonly written in emergency department records (‘assault by partner’) did not connect well with the system of language (‘battering’ and ‘maltreatment’) in the ICD-10 system of classification. The disconnect between the language used in these classification systems and different interpretation of the systems for classification (coding rules) provides an explanatory account for why intimate partner violence in the form of physical assault are classified in

different ways and distributed across different classifications in Admitted Patient Care (ICD-10 based) Hospital Episode Statistics.

## CONCLUSION

This chapter has reported on the research findings in relation to the local, national and international classification systems used to classify an episode of emergency department care for an attendance of intimate partner violence in the form of an assault. The Chapter addresses and reports the findings to answer three research questions:

*What are the rates of applications of classifications for intimate partner violence, in the form of physical assault by a partner, in a sample of Emergency Department Hospital Episode Statistics and Admitted Patient Care Hospital Episode Statistics?*

*In which Emergency Department Hospital Episode Statistics and Admitted Patient Care Hospital Episode Statistics classifications are cases of intimate partner violence, in the form of physical assault by a partner, most likely distributed?*

*Why are cases of intimate partner violence, in the form of physical assault by a partner, classified in different ways and distributed across different classifications in Emergency Department Hospital Episode Statistics and Admitted Patient Care Hospital Episode Statistics?*

Two classification systems were used to classify episodes of care after an assault by a partner, first the Accident and Emergency Department Data Dictionary Coding Table for the records of patients who were discharged and second, the International Classification of Disease for the records of patients who were admitted to hospital.

In relation to Emergency Department Hospital Episode Statistics for individuals' health, the research found that 'clinical diagnosis' was a good indicator for measuring patients' primary injury after an assault by partner, but often under-recorded second and third injury sites. One of the sample criteria for the record review was 'assault' and thus all had been classified as such. The research found that the formalized system for the provision of information to patient's general practitioners was not set up to provide information about an assault by partner as causal to patients' injuries. However, the findings illustrated that some medical practitioners adapted systems, using a free text box to provide information to patients' general practitioners about an assault by partner as causal to patients' injuries, and that this was done more often if 'domestic violence' had been documented in the patient's record. The majority of service users in this study were under the impression that information about an assault by partner was routinely provided to general practitioners, but proposed that this should only be done with patient consent. Based on the findings of this study it is proposed that information about an assault by partner should be routinely communicated to patients' general practitioners but patients should be offered an opt-out if desired.

In terms of monitoring population health, the limited taxonomy of the Accident and Emergency Department Data Dictionary Coding Table meant that it was a robust indicator of rates of assault in the emergency department population but its quality was affected by a large proportion of non-specified location data entries, still this was robustly dealt with. The research found that the rates of assaults against women that took place in a home setting were an important indicator of violence against women, and that in terms of whether they

are increasing or decreasing, were masked in reports that did not conduct analysis on data disaggregated by location and by gender.

The data presented illustrated a gendered dimension to assaults by location in the emergency department population and that women were of greater risk of experiencing an assault in the home than men. The research also found that there was a year on year increase from 2007 to 2009 for the recorded number of women presenting to emergency departments in Lancashire after an assault in their home. The A&E Data Dictionary commissioning dataset does not presently require the collection of victim/perpetrator relationship. Given the health consequences, of intimate partner violence (and other forms of kinship abuse) this is an important issue for women's health.

Systems for measuring 'location' and 'victim/perpetrator relationship' after an assault matter for monitoring violence against women. It matters for informing service requirements and configurations, and for monitoring effectiveness of violence prevention programmes over time. The research found that in the current A&E Data Dictionary commissioning data set the classifications: 'Patient Group: Assault', 'Incident Location: Home', 'Age: Sixteen years or older', and 'Sex: Female' are collectively the best indicator for 'domestic' if not specifically 'intimate partner' violence against women. From the research findings presented it is proposed that The A&E Data Dictionary commissioning dataset should require the collection of data of victim/perpetrator relationship to permit better comprehension of trends of rates of gender-based violence requiring medical intervention in local and national populations.

In terms of Admitted Patient Care Hospital Episode Statistics, the classification 'Z63.0 problems in relationship with partner' was found to be the most commonly applied for admissions to hospital. However it was also found that this classification was more often used for admissions for self harm and thus was not a robust classification for the system monitoring of incidents of intimate partner violence, in the form of physical assault. According to the clinical coder respondents in this study, the ICD-10 classifications 'T74.1 physical abuse by partner' and 'Y07.0 maltreatment by partner' were the classifications most likely to be applied for incidents of intimate partner violence, in the form of physical assault. However, one of the classificatory stumbling blocks was whether a one-off incident of partner violence was sufficient for classification; for some coders it was and for others it wasn't.

The classification T74.1 was also difficult to apply because of its construction as a primary diagnosis and the respondents were more comfortable in the application of the secondary 'cause' diagnosis 'Y07.0 maltreatment by a partner' for an ICD-10 'S' group injury-based primary diagnosis classification. From the clinical coder respondent accounts and from the Hospital Episode Statistics data, thus far, the research found that the code more likely and most often applied for admissions after an 'assault by partner' was the secondary 'external cause' diagnosis code Y07.0 'maltreatment by partner'. However the annual rates of application of this code nationally, whilst increasing year on year were still low in 2010/11.

In the absence of the recording of victim/partner relationships, intimate partner violence in the form of a physical assault was identified as likely distributed across the ICD-10 'S' group

of injury classifications. Under the rubric of medical record documented 'assault' it was also found that intimate partner violence in the form of a physical assault, whether the victim/perpetrator relationship was recorded or not, may also be distributed under the classification 'Y04 assault by bodily force'.

The research also found that the International Classification of Disease framing of the classification Y07.0 with the word 'maltreatment' meant that, for some clinical coder respondents, if the word maltreatment was not expressly documented in the medical record the classification would not be applied. The application of this classification was found to be contingent upon whether coders should only classifying according to the words documented, or whether they can use judgment to interpret the classification for the terms written in the record. The answer, for the purposes of information standards, seems straightforward: classify according to the words documented. However, for 'assault by partner' this would mean that the application Y07, the most commonly applied classification for intimate partner violence, in the form of physical assault, would be applied less than it is now as more 'assault by partner' would be classified as 'Y04 assault by bodily force'. The problem for which is that the victim/perpetrator relationship would not be accounted for in the assault classifications.

The research findings have identified that the systems of recording an assault by a partner in emergency department records ('assault by partner') does not map to the system of language ('battering' and 'maltreatment') in the ICD-10 system of classification of intimate partner violence. The disconnect between the language of these classification systems and

different interpretation of the systems for classification (coding rules) provides an explanatory account for the distribution of intimate partner violence in the form of physical assault across a number of classifications in Admitted Patient Care (ICD-10 based) Hospital Episode Statistics. Thus it is argued that in its current form the International Classification of Disease (ICD-10) is not a robust classification system for the classification of intimate partner violence in the form of a physical assault and nor is the data produced by it a robust system of measurement for cases of intimate partner violence in the form of a physical assault.

The research presented in this chapter illustrated that the classification items for Emergency Department Hospital Episode Statistics based on the Accident and Emergency Data Dictionary Coding Tables were the most simple and as such more likely to be understood by a larger number of people. The advantages of the A&E Data Dictionary for classifying intimate partner violence in the form of a physical assault, as 'assault' is that it requires little interpretation by person collecting the information from the patient and entering into the information systems. However, the disadvantage of the A&E Data Dictionary for classifying intimate partner violence in the form of a physical assault, as 'assault' is that it does not presently collect data about victim/perpetrator relationship or specialist service referral.

# **CHAPTER NINE: DISCUSSION: 'CLASSIFICATORY MULTIPLICITY'**



## INTRODUCTION

To address the principal research question *'How best can intimate partner violence, in the form of a physical assault, be classified to reduce misclassification, increase identification, mobilize intervention (according to patients' stated preference) in emergency department consultations, and collect data about it in hospital-based emergency department administrative systems?'*, systematic analysis has been presented in the empirical data chapters. The analysis examined its classifications by different actors, at different times and locations of emergency department consultations, and in different institutional information systems: emergency department hospital episode statistics and admitted patient care hospital episode statistics.

In this chapter the research findings presented in Chapters Five through to Eight are brought to together to construct the argument that there are a multiplicity of classifications of intimate partner violence (in the form of physical assault) that intersect in this domain and which interact to shape hospital-based emergency department responses to it and system measures of it. I argue that rather than understanding intimate partner violence as having different meanings, the explanation for disparate hospital-based emergency department responses arises from a multiplicity of classifications that are evoked at different times and places by different actors and systems. I claim that the classification 'domestic violence' is a qualitative conceptual classification that oftentimes fails to mobilize classificatory status or interventions for the adult victim/survivor of intimate partner violence physical assault and is a sub-classification 'out of place' in the context of hospital-based emergency department classification systems in England. In parallel, I claim that

empirical classifications are more successful in hospital-based systems. I establish the current best indicators for intimate partner violence against women in the form of a physical assault in hospital episode statistic and make recommendations for how it should be classified.

Bailey (1994) defines classification as:

*"(...) the ordering of entities into groups or classes on the basis of their similarity.*

(Bailey 1994:1)

Classification, or rather the multiplicity of them, is the organizing rubric for this chapter: to lay out, in turn, and discuss, the multiplicity of classifications for intimate partner violence in the form of a physical assault found in the different levels of hospital-based systems: emergency department consultations, local institutional patient records, and national Emergency Department) and Admitted Patient Care hospital episode statistics.

## **MULTIPLICITY OF CLASSIFICATIONS: EMERGENCY DEPARTMENT CONSULTATIONS**

In Chapter Five, six locations within emergency department consultations at which intimate partner violence in the form of an assault by partner was classified were identified, and these were: ambulance, registration, triage, medical practitioner, safeguarding referral, and diagnosis, disposition and GP Letter. These locations where the classification of an assault by partner was documented were populated by different actors. The different actors at these locations were: ambulance crew, administration staff (registration), nurses (triage), doctors (medical practitioner), nurses (safeguarding referral) and doctors (diagnosis, disposition and GP letter). Eight different classifications of violence had been documented at these locations,

and these were: 'assault by partner', 'alleged assault by partner', 'assault' (with no victim/perpetrator relationship), 'alleged assault' (with no victim/perpetrator relationship), 'domestic violence', 'acts of violence', 'presence of children', and 'injury'.

The research found that there was a preferred classification at each location, but this was not categorical as all locations had between three and five of these classifications recorded, meaning that stability and flux of classification co-existed at each location. The preferred classification in ambulance records was 'assault by partner'. At registration half were classified as 'assault'. The most frequently documented classification at triage and medical practitioner locations was 'alleged assault by partner' occurring in approximately one-third of all records. In the safeguarding referral documents, 'domestic violence' was the most frequently documented classification, recorded on half of the forms. The principal classification at diagnosis, disposition, and GP letter location was an injury specific diagnosis. Some records did not have a classification of violence and instead the classification was by the acts of violence perpetrated or by the injury sustained. When no classification of violence was used, the attendance was principally framed by 'acts of violence' at ambulance, triage, and medical practitioner, and by 'injury' at registration and diagnosis, disposition, and GP Letter. The research findings in Chapter Six and Seven identified that there were principally four qualitatively different classifications for an assault in use and which made a difference to patients' route through the consultation. These four distinct classifications were 'Assault by Partner', 'Domestic Violence', 'Risk of Serious Harm', and 'Significant Risk of Harm to Children'.

## **'Assault by Partner'**

Within the classification 'Assault by partner', there was variation; sometimes the assault was recorded as 'alleged', and sometimes the partner as perpetrator was not recorded. To address the variation, the elements of the classification, 'assault', 'alleged', and 'victim/perpetrator' are discussed individually.

### **'Assault'**

'Assault' is defined as 'a violent physical or verbal attack' (Thompson 1995). In law an assault *"is committed when a person intentionally or recklessly causes another to apprehend the immediate infliction of unlawful force"* (CPS 2013b), and hence the threat of violence that could be carried out is a crime itself. *"A battery is committed when a person intentionally and recklessly applies unlawful force to another"* (CPS 2013b), thus patients reporting acts of violence inflicted upon them during emergency department consultations are in law reporting an assault and battery. The term 'assault', meaning to attack has been in circulation since the late Fourteenth Century and its distinction in law as 'menacing' rather than battery since the late Sixteenth Century (Etymonline 2012).

Overall the classification assault was applied in 87% of records at ambulance location, 72% of records at registration, 75% of records at triage, 67% of records at medical practitioner, 34% of records at safeguarding referral, and 15% of records at diagnosis, disposition, and GP Letter. Its application during emergency department consultations for describing and recording interpersonal violence appears to be a hybrid term for an assault and battery. Used in this way, the classification of an act of violence as an 'assault' excludes it from unintentional and accidental acts of force (Etymonline 2012).

### *'Alleged Assault'*

The classification 'assault' was prefixed with the word 'alleged' for approximately half of the 'assault by partner' review sample at the triage and medical practitioner locations. Nurses and doctors in the study reported that ascribing an assault with 'alleged' was purposeful, a learned professional practice, not intended to dispute patients' accounts but rather in acknowledgement that they had not witnessed the assault. This seems curious; as a nurse it was not in my experience to have seen 'alleged' used in this way for other types of injury causation or patient reports, for example, it would be very unusual to see 'alleged car accident', 'alleged fall', or 'alleged chest pain' written in patient records.

The account from practitioners implies that the classification 'alleged assault' was used because of a lack of empirical evidence that an assault took place. Yet, the patient had injuries and was giving a credible account for them. There was also a notable difference in the use of 'alleged' between ambulance and emergency department practitioner locations. It was unclear why this was so (no ambulance practitioners were interviewed in the study), but given the emergency department practitioner report of non-witnessing, ambulance crews, conversely, would likely witness the scene of an assault and have direct communication with police also called to the location. The research findings suggest that practitioners classify an assault based on empirical, or in other words, observable evidence.

The emergency department practitioner respondents claimed that using 'alleged' did not alter their interpretation of patient report of an assault by a partner and nor did it alter their management plan. However, I propose that the use of 'alleged' does qualitatively alter the

classification. 'Alleged' is defined as: *"Represented as existing or as being as described but not so proved; supposed"* (Farlex 2013). From this definition the use of 'alleged' imbues some element of doubt into the account of an assault having taken place. There are three perspectives to support the claim that the use of 'alleged' does qualitatively alter the classification: the notion of verification, professional systems of documentation, and the duality of professional role.

### *Verification*

'Verification' or validating patients' experience of intimate partner violence is a corner stone of first response to reports of domestic and sexual violence. As an example, the Department of Health's (2005) guidance states that practitioners should: *"Validate and support women who do reveal abuse"* (2005:37) and *"Let the woman know that you believe her and make it clear that the abuse is not her fault. Tell her that abuse is unacceptable and she has the right to safety"* (2005:61). More recently, central messages behind social media campaigns, such as the Twitter '#webelieveyou', and the online 'Ending victimisation and abuse' are that reports of domestic and sexual violence will be believed. The documentation of 'alleged' in patient records is juxtaposed to socio-cultural norms of responding to reports of an assault.

### *Professional Systems of Documentation*

There is a large amount of literature about medical examination and documentation of sexual assault, but much less so for physical assault. In England, the College of Emergency Medicine guideline for the recognition and management of domestic violence in the Emergency Department (CEM 2010) does not offer guidance on medical record

documentation but does state that: *"The patient should be believed"* (CEM 2010:2), still, there is no mention that the report of violence should be recorded as 'alleged'. In the United States, specific guidance for the documentation of domestic violence advises practitioners to:

*"Avoid such phrases as "patient claims" or "patient alleges," which imply doubt about the patient's reliability. If the clinician's observations conflict with the patient's statements, the clinician should record the reason for the difference".* (Isaac and Enos 2001:3-4)

To my knowledge, there is no evidence or guideline advocating that emergency department practitioners should record the incident as an 'alleged assault'.

### *Duality of Professional Role*

Emergency department clinicians are sometimes called upon to provide witness statements to the police for use as evidence in court, and the College of Emergency Medicine in England has published practitioner guidance on how to structure such a statement. In this document it is stated that: *"A witness statement is usually related to a patient attending the Emergency Department with injuries due to an alleged assault"* (CEM 2012b:2), and that details of the *allegations* should be included. Witness statements are 'statements of facts' constructed from what has been written in the emergency department attendance record (CEM 2012b).

Emergency department practitioners responding to assaults have a dual role, the first as medical attendant and the second as legal witness. The classification of 'alleged assault' surfaces here in describing emergency practitioners' role as medico-legal witness rather

than as medical practitioner. Thus documenting 'alleged assault' in patients' records is likely hybridization from practitioners' duality of roles. Drawing on the work of Bowker and Star (1999), practitioners can be seen to be positioned at the medicine/law disciplinary boundary, and 'alleged assault' is a classificatory object that connects and satisfies two institutions, medicine and law. From this perspective the classification 'alleged assault' is a boundary object / or an 'object of cooperation' (Bowker and Star 1999:15) between two institutional systems. The distinction and use of the classification 'alleged assault' can be explained by the duality of emergency practitioner roles, yet there is no empirical basis for its use in records or in witness statements. An 'alleged assault' as an assault without verification constructs the event as open to doubt rather than real. The classification 'assault' groups acts of interpersonal force, there is no clinical justification to qualitatively alter a patient's account of an assault as an 'alleged' event; classification of an assault as 'alleged' in medical records is an unnecessary classificatory sub-division.

### ***Victim/Perpetrator Relationship***

The victim/perpetrator relationship was recorded at triage for the majority (86%) of patients indicating that this information was important, obtained early on in the consultation, and routinely recorded. Violence was more often classified by victim/perpetrator relationship at locations of patient/practitioner interaction (ambulance, triage and medical practitioner) that had free text space not intimately connected with administrative classificatory software systems. Given the widespread recording of victim/perpetrator relationship indicates that it was an important element of classification, yet, the research findings indicated, that it was not sufficient to mobilize the classification 'domestic violence' and corresponding



intervention and referral routes. This failure to routinely classify 'assault by a partner' as 'domestic violence' provides an explanatory account for the indifference to self-report of an assault by a partner articulated by service user respondents in this and other studies.

### **'Domestic Violence'**

Although some practitioner respondents categorically denied that they would write 'domestic violence' in records, and some reported that 'domestic violence' was a term not often heard in practice, over a third of records in the review had the classification 'domestic violence' documented in them. 'Domestic violence' did not hold equivalence with and was a separate classification to an 'assault by partner' in some practitioner accounts, understood to have 'more serious connotations'. The principal criterion for the classification of 'domestic violence' was the patients' fear of the perpetrator. Reluctance to report the assault or the victim/perpetrator relationship, and previous incidents of violence were strong but insufficient classificatory elements of 'domestic violence'.

The research found that although holding classificatory significance these elements, fear, reluctance, and previous incidents, were infrequently documented. 'Fear' was not recorded on any of the records, and reluctance to report *events* was recorded on one record, although even in this one, the report of intimate partner violence had been recorded early on in the consultation at triage. Previous incidents of violence were sometimes recorded, and when they were, the classification 'domestic violence' was more often documented indicating classificatory significance of repeated acts of violence for 'domestic violence'. Still, information about previous incidents was not always recorded, and a negative history of

previous violence was recorded only on one occasion. The Home Office and Department of Health define 'domestic violence' as *any act* of violence by a current or former partner, yet 'any act of violence' did not, on its own, mobilize the classification 'domestic violence' during emergency department consultations.

### **Not 'Domestic Violence' but 'Common Couple (assault by partner) Violence'**

Findings of the research indicated that assaults by a partner could be excluded from the classification 'domestic violence' if the violence was reported as alcohol fuelled, extra-ordinary, one-off, a result of playing around, mutual violence in which a female partner has come off worse, or an act for which the partner was sorry. These exclusionary criteria draw on domestic violence myths of instinctive, 'out of control', alcohol-induced violence (Refuge 2009), and also are a popularized version of the ideal-type: 'common couple violence'.

Drawing on the research findings for this study, I contend that 'common couple violence' defined as 'low-level violence' would more often be a misclassification of the report of an assault by a partner during emergency department consultations. I further propose that these conceptual ideal-types of violence, whilst acknowledging that women more often have greater injurious consequence, fail to take account of 'gendered violence', meaning the gender inequality inherent to all forms of interpersonal violence. In this section I claim that a classificatory distinction between 'domestic violence' and 'common couple (assault by partner) violence' is out of place in the context of emergency department consultations.

### ***Low-level violence***

In this study, an exclusionary criterion for 'domestic violence' based on low-level violence was concomitantly in context of an act of interpersonal violence with a resultant injury warranting intervention at an emergency department. The record review illustrated that, almost exclusively (92%), patients in this sample of assault by partner had experienced severe levels of violence as defined by Straus (1996) and 88% had suffered injuries that were of medium or high level, meaning, in crime terms, actual or grievous bodily harm. So whilst drawing on conceptual typologies of violence against women, I argue that this conceptualized distinction of 'common couple violence', mutual violence with low-level force and consequence, is out of place in emergency department contexts. Indeed, whether one agrees with Johnson's typology (1995, 2006) or not, one of his main arguments, and with which this study concurs, is that women experiencing intimate partner violence found in institution or agency populations were not experiencing, so-called, low-level 'common couple violence'.

### ***Gendered Violence***

The second problem with the classification 'common couple (assault by partner) violence' is that gendered power relations were left untroubled. The record review illustrated that the most important indicator for gendered relations, that of victim/perpetrator relationship, was the item most often recorded (88%), yet this alone was not sufficient for the classification 'domestic violence'. The home as location of violence perpetration held some classificatory significance for violence against women but was not expressly a foregrounded element for practitioners and was rarely recorded in the practitioner texts. From the practitioner

respondent accounts, power relations were acknowledged in terms of patients' expressed fear, physiological difference, and entrapment in relationships, but only 'fear' mobilized and sustained the classification 'domestic violence'.

### *One-off Acts*

The final classificatory element for 'common couple (assault by partner) violence' in respondents' accounts was the report that the incident was a one-off event. The classification of 'domestic violence' based on 'any act' versus 'repeated acts' is contested, but this is not the focus of this discussion. Rather, the problem with mobilising this classificatory element is that health services, and in particular, services such as emergency departments do not normally have a patient/service relationship beyond an episode of care, and most do not offer follow-up services. Emergency department systems are not configured to routinely connect present day received reports of intimate partner violence with past or future episodes of care. Furthermore, this study found that most patients had experienced medium or high level acts of violence, for whom, now, the potential for further medium or high level acts of violence now exists. In light of the research findings and the contextual characteristics of emergency department services, I argue that perceived one-off acts of violence should not be discounted from classification of 'domestic violence', nor from the mobilization of intervention.

In summary, the level of violence perpetrated and level of injury suffered, along with the comprehension of 'gendered violence', the configuration of patient/service relationship, and the threat of future violence, means that a classificatory distinction between 'domestic

violence' and 'common couple (assault by partner) violence' is out of place in the context of an emergency department population.

### **Risk of Serious Harm**

Practitioner respondent interview data suggested that severity of violence would impact how practitioners classify an assault by partner; greater severity would be more likely to be qualitatively classified as 'domestic violence', but no statistical association was found in the record review. Although none of the records assessed as low level acts of violence had the classification of domestic violence recorded, there was little difference in the frequency of domestic violence classifications applied for high levels of violence in comparison with medium levels of violence. The classification of 'serious harm' was qualified by respondents as repeated, extreme violence; life-threat violence; and/or patients' expressed fear, and practitioners were aware of formal 'risk of serious harm' intervention (notifying police) that could be undertaken without patient consent if necessary.

### **Risk of Significant Harm to Children**

An association, which did not quite reach statistical significance, was found between the recording of presence of children in the household and/or patients' pregnancy status and the recording of 'domestic violence'. This association can be explained by the lower threshold in law for 'risk' and statutory duty intervention in cases of 'domestic violence' for a patient's child(ren)/foetus from witnessing the ill-treatment of another than for 'risk of serious harm' for the adult patient. The lower threshold for intervention for patient's children, enforced through statutory duty, deflects the focus of intervention from the adult

patient to their child(ren)/foetus, the outcome of which for some service user respondents in this study meant exclusion from access to health and social services.

For some women in this study the potential of intervention by children's services meant that they would make the decision not to access health services. Fear of social services by service users in health service contexts is not a new research finding having previously been documented in mental health (Rose et al 2011), general practice (Feder 2006), and now emergency department, settings. However, the finding here is that of limiting women's *access* to healthcare, and from which there is a case for arguing that the current threshold in legislation and corresponding intervention of automatic referral without the adult patient's consent if necessary, to children's services from *witnessing* is too low.

This research found that the records of women attending the emergency department after an assault at home were more likely ( $p < 0.001$ ) to have concern for children documented than were male patients. Furthermore, the records of four women had the *non*-presence of children/pregnancy recorded. Women, in this study, were disproportionately targeted for safeguarding children assessment and intervention, and thus were exposed to a form of gender-based discrimination involving state surveillance that disadvantages women. This finding supports an argument that some women are increasingly squeezed by gendered power/knowledge relations, positioned between the coercion of abusive household gender regimes (Morris 2009) and increasing Foucauldianesque governmentality-type surveillance by institutions of the state (Peckover 2013).

## **SOCIOLOGY OF DIAGNOSIS**

Central to the sociology of diagnosis (Brown 1990, Jutel 2011) is comprehension that a 'diagnosis', or in other words a 'classification', is understood not only in terms of its definitional boundary, but also by classificatory processes and the classification's associated intervention(s). The previous section has laid out the multiplicity of classifications that were negotiated during emergency department consultations along with discussion and explanations of their classificatory boundary. In this next section I draw on 'classification as process' and 'classification as intervention' to explain how these too contributed to classifications' categories.

### **Report: Classification as Process**

The women in this study were instrumental in accessing services and reporting an assault by a partner, and the police were reportedly instrumental in referring women to emergency department services for medical attention and for the medical documentation of injuries. Yet this method of self-report did not fit with some practitioners' conceptualization of 'domestic violence' in which 'victims' were constructed as passive and reluctant subjects. In this classificatory rubric, some practitioners, more often nurses, who were reportedly highly skilled in intuitively picking up on 'domestic violence' were, once their suspicion had been raised, expected to have to coax patients for information on the cause of their injuries.

Missing or misclassifying cases of 'domestic violence' in the emergency department caseload was attributed by practitioner respondents as a consequence of patients not being seen by an experienced practitioner that would be able to recognize it, whereas this study

indicates that often self-report of an assault by a partner did not mobilize practitioners to classify the event as 'domestic violence'. There are two dimensions to this misclassification based on method of report that are problematic; the first is that women's disclosures may be treated with apparent indifference as some service users in this study reported, and the second, that interventions are then not mobilized. So whilst active report to pre-hospital emergency services resulted in immediate access to medical treatment there was not a corresponding mobilization of comprehension by practitioners of patients' desire for and expedience of domestic violence intervention and referral during emergency department consultations. The explanation for this perversity is multifaceted, the research presented here indicates that self-report i) contradicted some practitioners' conceptualization of the 'domestic violence' victim/survivor as a passive subject, and ii) patients' desire for intervention was constructed by some practitioners in relation to patients' continued investment or entrapment in the intimate relationship. The self-reporting adult with capacity and with continued investment in the intimate relationship was read by some practitioners as a lack of desire for intervention. Paradoxically, and also perversely, reluctance to report was not interpreted as a person's desire for non-intervention and was more effective for mobilizing classification of 'domestic violence' and interventions during emergency department consultations.

### ***Self-Report in the Policy Context of Screening***

The latest World Health Organisation (2013b) clinical and policy guideline for responding to intimate partner violence against women again does not advocate universal screening programmes because there was insufficient evidence of effectiveness in terms of reduction



in violence. However, it does state that: *'Health-care providers should ask about exposure to intimate partner violence when assessing conditions that may be caused or complicated by intimate partner violence'* (WHO 2013b:19) and one of the conditions listed is 'traumatic injury'. However, the scenario that women self-report intimate partner violence to health services and may not require asking is not mentioned, and WHO's (*ibid*) account of 'disclosure based on asking' rather than 'self-report' reinforces the idea of reluctant 'victims'. The finding, in this research, of women's self-report is of significance and importance for the wider academic and practice community working in this field because it indicates that in some contexts, what has been learned about method of report is out of date. This finding of self-report also troubles the notion often reported in guidance documents that systems of responses should be in place prior to the implementation of screening or enquiry, and whilst I agree with this position in principle, that service users self-report however, means that, irrespective of local screening policy, services can no longer not have systems of response in place.

### **Classification as Intervention**

This study has indicated that the causal pathways from report/non-report to intervention/non-intervention, and referral/non-referral during an emergency department consultation after an assault by a partner were complex, multifarious, and multidirectional. 'Non-report' mobilized more attempts to classify as 'domestic violence' and engendered a perceived need for intervention. Furthermore, not only did women's active report of intimate partner violence oftentimes fail to mobilize the classification 'domestic violence' and mobilize domestic violence interventions, police involvement further decreased the

mobilization of interventions and referral routes during an emergency department consultation, even when practitioners did not know what police intervention entailed. Surely, one would expect the converse should be true; that self-report would mobilize both classification and advocated 'domestic violence' interventions (i.e., forensic evidence collection (photographing injuries, body map recording, accurate description of events and injuries), record of the context of violence (ongoing or first episode), record of safety and risk assessment, record of previous and ongoing involvement and engagement with other services (specialist, social and police services) and record of provision of information about and referral to specialist, social and police services). Yet interventions were not routinely obtained by service users nor recorded on records, and those that were, were most commonly interventions set by statutory duty for individuals at risk of harm. 'Assault by partner' experienced by competent adults did not mobilize domestic violence intervention, as this population was understood as able to make decisions about intervention for themselves. The findings also indicated that classificatory elements (reluctance to report and previous incidents) were not able to sustain the classification 'domestic violence' alone; classifications were inextricably connected with classificatory effect, and the relationship between classification and the mobilization of interventions was important for which classification was applied.

### ***Forensic Evidence Collection***

Although some practitioner respondents understood photographic recording of injuries as a 'domestic violence' intervention, this was not the same for other forms of forensic evidence collection, i.e., body map recording, or detailed description of injuries. Given that this

population were reporting an assault, there is an argument to propose that a protocol for standardized 'forensic evidence collection' of intimate partner violence in the form of physical (non-sexual) assault be developed. The Department of Health (2005) provides guidance for what should be included in record keeping for cases of domestic violence and this is comprehensive. As indicated by the findings of this study this has not yet received universal implementation. That said, this study found that although there was an apparent increase in police referral to emergency departments for injury documentation, the tools needed to undertake detailed injury recording, cameras and body map outlines, were not commonly available. To circumvent the lack of a departmental camera, one of the service user respondents reported that the doctor used a personal mobile phone camera to record her injuries. This is a cause for concern given the potential for breach of data protection involving patient information. Photographic injury recording as an emergency department service was valued by some of the service users in this study, and should be offered especially for injuries to be covered by wound dressings, plaster casts, or splints. All of the records in this study had some description of injuries suffered, but the level of detail and the quality of the account was variable.

Forensic evidence collection has been one of the cornerstones of health service intervention for sexual assault for many years; it seems strange that this has not been the case for intimate partner violence physical assault. Indeed, 'assault' is not referred to other than in relation to 'sexual assault' in the recently published World Health Organisation (2013b) guidance, and nor was the concept of forensic evidence collection connected with incidents of intimate partner violence physical assault. Criminal justice legal recourse may not be the

chosen route for some victim/survivors, yet surely health services should offer to provide forensic evidence collection for an assault by partner whether or not the person has or intends to report to police.

### ***Psychological Aid***

Service users in this study reported feelings of acute stress and that emergency department services had not responded to the emotional aftermath of the assault. 'Triage' and 'waiting room' were further specified as locations difficult to handle in the immediate post-assault phase. This finding is not new; previous research from the United States and Ireland reports emergency department health environments as problematic, lacking privacy (Ramsden and Bonner 2002, Ellis 1999, Davis and Harsh 2001) and empathy (Yam 2000). This study adds to the body of literature that some women attending emergency departments after an incident of intimate partner violence were experiencing acute stress responses (SVRI 2011). Literature from the parallel field of humanitarian responses to rape and sexual assault in recognition of acute stress responses after sexual assault advocate that first responders should be trained in the provision of 'Psychological First Aid' (IASC 2007). Psychological First Aid is defined as 'a humane, supportive response to a fellow human being who is suffering' (IASC, 2007:119), and emergency departments providing services for intimate partner violence would likely benefit from investing in staff training to provide Psychological First Aid.

This research also found that patients in the assault by partner sample sub-group were twice as likely to leave the emergency department before treatment completion than those

who did not report a partner as perpetrator. Service users reported acute stress responses contributes to the body of evidence explaining why women attending emergency departments are at greater risk of leaving before being seen or treatment completion adding weight to previous recommendations (DH 2005, WHO 2013b) that attending to privacy and safety should be an immediate and routine intervention. Based on the finding of acute stress and increased risk of leaving before treatment completion, women attending an emergency department after an assault by partner would benefit from being fast-tracked through and from the support of a specialist violence worker.

### ***Intimate Partner Violence Interventions***

'Domestic violence' aware practitioner respondents in this study reported offering: photographic recording of injuries; undertaking safety risk assessments and providing women with safety advice; providing information about support and specialist services; and referring to specialist services for immediate refuge or later follow-up. It is likely then that some emergency department patients received a good service *if* their presentation mobilized the classification 'domestic violence' and which had these interventions entangled with it. Although reporting on a small sample, most service user respondents in this study who had self-reported an assault by a partner to emergency department practitioners had not received any of these 'domestic violence' interventions during their emergency department attendances.

Some practitioners in this study had little knowledge about interventions and referral routes other than for risk of serious harm to adults and risk of significant harm for children. Lack

of practitioner knowledge about interventions and referral routes will of course limit the service provided. Findings from previous studies have also reported 'informational factors', in terms of a lack of practitioner knowledge of interventions for 'domestic violence' (Ramsden and Bonner 2002, Davis and Harsh 2001, Ellis 1999). However, the findings of this research makes a further contribution to this field, that a misclassification into the category of 'assault by partner'/'common couple violence' rather than 'domestic violence' and which was qualified with no intervention and/or referral could explain the contradiction between service user and practitioner accounts of emergency department initiated interventions.

## **Knowledge Systems**

The research also found that even in emergency departments with seemingly embedded systems for responding to 'domestic violence' and staff training, not all practitioners knew about interventions and referral routes. This finding indicated that these organizational systems were inadequate to engender practice standards for domestic violence with equitable delivery. The different forms of embrained, embodied, encoded, and embedded knowledge (Lam 2002) were exemplified in this study in individual practitioner accounts of documenting reports of assault in records, and in the collective, formulaic and ordered way of documenting the health problem (cause of injury → mechanism of injury → injury). The research illustrated that the intervention 'safeguarding children referral' which had formalized systems and means of documentation was also the intervention most commonly recorded. Whilst it is acknowledged that the statutory duty entangled with this intervention has also likely contributed to greater rates of recording, nonetheless, standardized means of

documentation will likely increase and improve services' systems for recording intimate partner violence and also improve service delivery by acting as a prompts for interventions and referral routes and lead to embedded knowledge and practices.

## **MULTIPLICITY OF CLASSIFICATIONS: LOCAL INSTITUTIONAL PATIENT RECORDS**

Patient records had two types of data collected, electronic Accident and Emergency Data Dictionary defined items and free-text. The electronic patient record system was important for the collection of (mostly) standardized information about: patient group: assault; location: home; sex; age; diagnosis; and disposition/GP letter. Patients' records served two purposes, firstly to provide information about an attendance to the patient's ongoing clinical team, whether this was a hospital doctor or on discharge to a general practitioner, and secondly, (discussed in the next section) to provide information for a number of administrative functions (Taylor 2006; HSCIC 2013), of which the principal interest for this thesis was about system monitoring of intimate partner violence against women. The handwritten free-text record, principally documented by doctors provided information about: events leading up to the health problem, the health problem, the doctors physical examination, diagnostic tests, interventions, disposition, and follow-up. The ambulance and safeguarding referral data were from supplementary patient record documents. Registration, triage, and GP letter supplementary data were from character-restricted free text boxes. The electronic data items inputted for each patient that were part of the Accident & Emergency Department Commissioning Data Set (age, sex, assault, location, diagnosis, and disposition/GP letter) had high percentage rate input.

Most commonly, the classifications for both electronic and handwritten patient information, from service entry 'complaint' to 'disposition', commenced with 'assault' and finished with 'injury'. All patients that completed the consultation had an injury/illness diagnosis inputted, although second sites of injury were only inputted for approximately half of cases. The GP letters at the research site were automatically generated using inputted diagnosis information (injury/illness) but not assault information. On six occasions emergency department practitioners typed in the free text box information for the patient's general practitioner that the injury was caused by an assault. Service user respondents in this study more often than not thought that general practitioners would have been informed about the assault and victim/perpetrator relationship, and were agreeable to this as long as patients were asked for permission first.

'Location' was the electronic information of most classificatory importance for system monitoring violence against women. Although information about location of assault was routinely collected it was not readily available to practitioners during the consultation. This was not problematic because the practitioners did not consider location as important, rather, victim/perpetrator relationship was practitioners' preferred information to sub-classify the act of violence. The research found that practitioners' generally followed a common model of documentation indicating a learned professional system for recording health information for an assault. The format of this system was i) cause (assault by partner or domestic violence), ii) mechanism (acts of violence), iii) injury (physical injury), and for some iv) presence of children in household or patients' pregnancy status. That nurses were charged with undertaking safeguarding children referrals explains the greater frequency of



recording of presence of children in household or patients' pregnancy status at the triage location.

There was very little information about 'domestic violence' specific interventions and/or referral routes documented in patient records. The electronic data field items for follow-up care did not have options for non-health services follow up, meaning that there was no system for recording referral to specialist services that would be available for administrative health monitoring purposes. Statutory duty bound intervention, and in particular, for safeguarding children was the 'domestic violence' specific intervention most frequently recorded. The inextricable entanglement of classification and intervention for these items is proffered as an explanation for why significant harm and serious harm classifications were mobilised during emergency department consultations.

## **Standardized Documentation**

In Chapter Two, the World Health Organization (Holder 2001) Injury Surveillance Guidance was introduced to illustrate the similarities between it and the Accident and Emergency Commissioning Dataset. This document (*ibid* 2001) recommends at supplementary optional data level the recording of victim/perpetrator relationship, which as this study illustrates was routinely recorded by practitioners but not by the institution. The WHO Injury Surveillance Guidance (Holder 2001) is however limited in its specificity to guide information requirements for monitoring interventions for intimate partner violence. It is recommended that an intimate partner violence specific form to document emergency department consultations for an assault by partner in England is developed for widespread

implementation and which pays attention to patient stated preference for intervention, patient safety assessment and plan; forensic evidence collection and specialist domestic violence service referral.

## **MULTIPLICITY OF CLASSIFICATIONS: NATIONAL HOSPITAL EPISODE STATISTICS**

### **Classifications in Emergency Department Hospital Episode Statistics**

The Accident and Emergency (A&E) Data Dictionary Coding Tables is a limited taxonomy.

Acts of violence can only be classified as 'assault' and sub-classified by incident location.

Location was found to have classificatory significance for violence against women. From the

sample of emergency department records coded as an assault in the home in this study,

52% of women (n=24/46) reported a current or ex-partner as the perpetrator compared to,

12% of men (n=4/34). From this finding I claim that 'assault' by location 'home' is the

current best proxy indicator for intimate partner violence against women in Emergency

Department Hospital Episode Statistics.

### **Classifications in Admitted Patient Care Hospital Episode Statistics**

By definition the International Classification of Disease classifications most specific for

intimate partner violence were: 'Z63.0 Problems in relationship with spouse or partner',

'T74.1 Physical abuse by partner', and 'Y07.0 Maltreatment by partner'. The research found

that these codes were more often used for 'external cause', non-primary diagnosis, and as

such 'intimate partner violence' was more likely absent from Hospital Episode Statistics

web-based reports. The research found that the classification 'Z63.0 Problems in

relationship with spouse or partner' was not a robust measure for intimate partner violence

in the form of a physical assault. The research also found that year on year, there were low rates of application for the classifications 'T74.1 Physical abuse by partner' and 'Y07.0 Maltreatment by partner' even as a non-primary diagnosis and the rates of applications varied considerably between NHS Trusts.

Like emergency department practitioner respondents, the research found that clinical coder respondents had conceptual doubts about whether a one-off incident of violence, or an incident of violence after a night out, or an incident of violence associated with an argument, even though it may have been severe (stabbing), would qualify for the classification 'domestic violence'. From the clinical coder interviews, of these three codes, 'Y07.0 Maltreatment by partner' was the classification most likely to be applied as a secondary cause classification for an injury after an assault by a partner. As an example, a patient admitted for a broken jaw, from a punch during an assault by partner could be classified using:

S02.6 Fracture of mandible (lower jaw bone)

Y04.0 Assault by bodily force in a home setting

Y07.0 Maltreatment by partner

The clinical coder respondents advocated 'certainty' in classification because they didn't interpret medical records, rather, they classified the written word, and it was this method of classification that troubled the classification 'Y07.0 Maltreatment by partner'. Some clinical coders practiced more literally than others and if the word 'maltreatment' by a partner was not written, the classification 'Y07.0' would not be applied. For some, that the patient had

been assaulted by their partner equated with 'Y07.0 Maltreatment by partner' but for others it did not. None of the clinical coder respondents could recall ever seeing 'maltreatment' written in a medical record. The mismatch between the vocabulary of medical practitioner documentation and the International Classification of Disease intimate partner violence/domestic violence classifications along with the conceptual ambiguity of 'domestic violence' provides an explanation for why the codes most specifically for classifications of intimate partner violence have low rates applications. Based on the findings, it is hypothesized that intimate partner violence in the form of an assault is most likely distributed across the assault classifications, codes X85 – Y09. Furthermore, some may not have an assault classification if 'assault' was not documented, meaning that some will likely be distributed in injury classifications, codes S00 – T98.

The International Classification of Disease assault codes (X85 – Y05, Y08, and Y09) have a fourth character subdivision for the 'location' of assault, and do not have a subdivision for victim/perpetrator relationship. Only 'Y07.0 Maltreatment' and 'Y06.0 Neglect and abandonment' have a fourth character subdivision for victim/perpetrator relationship. In the absence of victim/perpetrator relationship subdivision and the low rates of application of Y07.0 and T74.1, the assault codes X85 – Y05, Y08, and Y09 to the fourth character subdivision 'location' home and Y06, Y07 and T74 to fourth character subdivision 'partner' are collectively the best proxy measures for intimate partner violence against women in Admitted Patient Care (APC) Hospital Episode Statistics.

## **Indicators for Intimate Partner Violence in Hospital Episode Statistics**

Location is an important indicator for intimate partner violence against women in Hospital Episode Statistics because presently victim/perpetrator relationship is not a data field for the most commonly applied classifications of assault in the A&E Data Dictionary and in the International Classification of Disease (ICD-10). Location as 'home' is the classificatory subdivision for both taxonomies that holds most specificity for intimate partner violence against women. There are only two classifications of ICD-10 external causes which have fourth character subdivisions for victim/perpetrator relationships, these are Y07 'Maltreatment' and Y06 'Neglect and Abandonment'. Yet practitioners routinely document the most accurate indicator, that of victim/perpetrator relationship. Given that the application of ICD codes is undertaken by clinical coders reading of medical texts it is curious if not incredulous that the research findings in this study identify that victim/perpetrator relationship was routinely documented and location rarely documented by practitioners in emergency department attendance records for an assault yet the A&E Data Dictionary and ICD-10 classify 'assault' by location and not by victim/perpetrator relationship.

The research has found a juxtaposition of the classificatory data that practitioners are professionally socialized to record in cases of assault and the classificatory elements of the Accident and Emergency Data Dictionary Coding Tables and the International Classification of Disease Version 10 health information classification systems. In this study the preferred classification of practitioners for recording intimate partner violence in the form of a physical assault was 'assault by partner', yet the health information classification systems

subdivide by location. It is unclear why the classification systems have focused sub-classification on location and not victim/perpetrator relationship. Both are important; arguably location holds more importance for 'public health', whereas victim/perpetrator relationship has more importance for 'individual health'.

'Public health' under the dominant liberal regimes of the West means that the State is charged with intervention only to prevent harm to others (Gostin 2012). 'Harm to others' likely explains the A&E Data Dictionary focus on location of violence, as urban public violence is reportedly the most epidemiologically prevalent form of violence and thus most harmful to the general public 'others'. Indeed, in England and Wales public health violence prevention schemes involve emergency departments sharing location of violence information with community safety partnerships for targeted, mainly urban and late night violence, prevention strategies (Florence et al 2011). There has been a reported year on year decrease in the numbers of people treated at emergency departments after being injured from interpersonal violence (Sivarajasingam et al, 2012; Rooney 2012) and community safety partnership intervention by location has been attributed as contributing to it (Florence et al 2011). However, the research presented in this thesis suggests that this was not the case for assaults against women perpetrated in the home in Lancashire from 2007 – 2009, for which a year on year rise was demonstrated. Furthermore there was a year on year decrease for male patients, which when aggregated, gave an impression, that epidemiologically, assaults in Lancashire had reached a stable plateau. It is possible that continued year on year increases for violence against women are masked by aggregated assault data as reported by Sivarajasingam et al (2012) and Rooney (2012). Thus in the

absence of victim/perpetrator sub classification of assault in health information classification systems, disaggregated gendered analysis of assault by location home is crucial for measuring the form of violence (intimate partner violence) that women are most exposed to and affected by.

## **CLASSIFICATION IN HOSPITAL-BASED EMERGENCY DEPARTMENT SYSTEMS**

Smith (2002) proposes simply, that there are two methods of classification: typology and taxonomy. Typology classifications are abstract, multidimensional conceptual constructions of phenomena that draw on Weber's (1949) construct of the ideal-type (Smith 2002). Understood in this way, they are not necessarily empirically found in the 'real world' but represent an idea of a phenomenon. Johnson's (1995; 2006) typology of partner violence that holds the conceptual construct of 'common couple violence' and 'patriarchal terrorism' are examples of ideal-type classifications. Conversely taxonomic classifications group things based on empirical, measurable features, and are more often rooted in traditional sciences. The international classification of disease is more taxonomic than typological.

I have proposed that a distinction of the classification 'domestic violence' was not helpful in the context of emergency department consultations after an assault by partner with reference to the level of gendered violence and injurious consequence normally reported. I have strengthened this thesis proposing that 'domestic violence' was an inappropriate classification for this context because 'common couple' or 'non-domestic violence' was a misclassification of an assault by a partner in the emergency department context and also because it was insufficient to mobilize intervention. In this section I propose a further layer

to the argument, that it was not helpful because it is a typological and not taxonomic classification.

### **'Domestic Violence': A Typological Classification**

This research has made clear the greater difficulty emergency department practitioners and clinical coders had in making a judgement about whether an act of violence perpetrated by a partner should be classified as 'domestic violence' or not. Often 'domestic violence' was constructed as a different classification to 'just' an 'assault by partner', yet the idea of 'taken as given', normalized intimate partner violence was troubling for respondents. Emergency department practitioner respondents invoked distinctions between these two classifications and then repudiated the difference. Clinical coder respondents, during the group interview, became increasingly uncertain about the classificatory elements that would qualify or disqualify an assault by a partner to be classified as 'Y07.0 Maltreatment by Partner' and 'T74.1 Physical Abuse by Partner'.

The conceptual ambiguity of 'domestic violence' resulted in the comprehension by practitioner respondents that 'domestic violence', was a low volume phenomenon in the emergency department caseload, and it may well have been historically. The findings from this research indicate that it is not low volume, but also that the population presenting to emergency departments after an assault by partner has likely increased over time because of police referral for medical attention and documentation of injuries for use in future court proceedings. It is likely that social messages about the unacceptability of intimate partner violence, to report violence, and movements to end violence against women victim-blaming



have also contributed to an increase of assaults by partner in emergency department caseloads. Yet, this does not seem to have translated into greater identification and mobilization of intervention for victim/survivors during emergency department consultations.

Its construction as 'domestic violence' inadvertently legitimizes failure to pick 'it' up. Yet the research findings here indicated that often there is nothing to 'pick up' for this was a population that had self reported an assault by a partner, and this alone should mobilize intervention. I have not said that this should mobilize 'classification', as the classification 'assault by partner', is itself adequate in the emergency department context, furthermore there is no advantage in practical terms for the distinctions of 'assault by partner' or 'domestic violence' only conceptual confusion.

### **Assault by Partner: a Taxonomic Classification**

The research presented in this thesis has illustrated that both emergency department practitioner and clinical coder respondents find classification easier when based on criteria that warrant little interpretation, in other words, simple, empirical taxonomies were better. Practitioners were successful in classifying an assault; victim/perpetrator relationship; risk to children by living in the household/pregnancy status; and risk of life–threat serious harm. In this thesis I have argued that the classification 'domestic violence' has no added benefit beyond the simpler, more empirically observable classifications just listed. Other than the interventions entangled with the classification 'presence of children', the findings suggests that the classification 'domestic violence' was ineffective to mobilize classificatory

significance in terms of 'domestic violence' specific interventions. There are two options for recommendation: to propose that all assaults by partner automatically qualify for the classification 'domestic violence', or to propose that the classification 'domestic violence' is unhelpful for classification and that the preferred classification is 'assault by partner'.

## **Conclusion**

The research findings indicated that it was unfeasible and hence it is unreasonable to expect emergency department practitioners to make judgments about conceptual qualitative classifications of violence in everyday practice. It has also been argued that the emergency department context of bounded episodes of care for discrete health problems, and 'any act of violence' policy definitions of intimate partner violence, means that 'domestic violence' understood as repeated acts, was not appropriate in the emergency department context. In addition, the severity of violence experienced and injuries suffered by this population along with the notion of 'gendered violence' constructed a claim that 'common couple violence', i.e., non-'domestic violence' was unlikely in this population. Organizing 'identification' and 'intervention' for adult patients under the classification 'domestic violence' was an explanatory factor for misclassification and failure to mobilize intervention in this research. Misclassification with its failure to mobilize intervention works in opposition to policy directives for early intervention to end a person's exposure to repeat acts of intimate partner violence. An argument has also been made that there was no empirical justification for practitioners to record a reported assault by partner as 'alleged'. Classifying intimate partner violence in the form of a physical assault in emergency department consultations, as the simple empirical classification 'assault by partner' rather

than 'domestic violence' would likely eliminate most classificatory confusion during emergency department consultations, and secondly would construct classificatory alignment ('assault') between the different layers of health systems classification: the consultation, the local institutional, and the National emergency department and admitted patient care hospital episode statistics.

In conclusion the preferred classification in the emergency department consultation for intimate partner violence in the form of an assault is the classification 'assault by partner'. This conclusion is conditional that the classification 'assault by partner' mobilizes a suite of interventions in response to patient stated preference for interventions that includes options of: patient safety assessment and plan; risk of serious harm assessment and intervention; forensic evidence collection; specialist service referral; social services referral; and police referral.

It is possible that the mobilization of interventions for all patients reporting an assault by a partner will result in early identification and earlier referral to specialist services. However, it could also mean, given the current statutory duty to refer children witnessing the ill-treatment of another, that more women will be placed under surveillance by children's services, which may result in decisions not to report or access services. In writing this thesis, I have problematised 'witnessing' by children as an automatic qualifier for the classification 'risk of significant harm'. I have problematised it because it has centred intervention on an indirect child 'victim' rather than the adult victim/survivor presenting for health care, and because for some women, it may mean that they do not get health

interventions that they otherwise would. Based on the findings of this study it is argued that the threshold for possible automatic referral to children's services without adult victim/survivor consent based on the witnessing of intimate partner violence should be reviewed.

The current best dataset indicator for intimate partner violence in Accident and Emergency Hospital Episode Statistics data is (collectively): Patient Group: Assault; Incident Location: Home; Sex: Female; Age: Sixteen years and older, and the current best dataset indicators for intimate partner violence in Admitted Patient Care Hospital Episode Statistics: International Classification of Diseases (ICD-10) Assault Codes X85 – Y09 to fourth character subdivisions: 'Location: Home' (X85 – Y05, Y08, and Y09) and 'Victim/perpetrator Relationship' (Y06 and Y07) and Female; Age: Sixteen years and older. However, to improve the specificity of health information on gender-based violence, and in particular intimate partner violence in the form of a physical assault, it is recommended that the Accident and Emergency Data Dictionary Coding Tables and the International Classification of Diseases should develop an assault classification subdivision of victim/perpetrator relationship.

The answer to the thesis question, *“How best can intimate partner violence, in the form of a physical assault, be classified to reduce misclassification, increase identification, mobilize intervention (according to patients' stated preference) in emergency department consultations, and collect data about it in hospital-based emergency department administrative systems?”* is that it is best classified as 'assault by partner'.

## CHAPTER TEN: CONCLUSION

## INTRODUCTION

In this final Chapter I set out the main findings of the thesis and the implications of them, and which address the research questions. By setting out the main findings and implications I also make clear the thesis' original contributions to knowledge. On occasions where findings are similar to those identified in previous work in the field this is acknowledged. Following the main findings and implications I make twelve recommendations to improve classification and response to intimate partner violence in the form of a physical assault in hospital-based emergency department systems in England. A statement about the knowledge claims in this thesis is made. I present a critical account of the classification of intimate partner violence in the form of a physical assault in hospital-based emergency department systems contextualised through structural gender inequality and power. I reiterate the importance of the theoretical frameworks that underpin this thesis. Based on the analysis and interpretation of the research undertaken for this thesis, I articulate the original contribution to knowledge that this thesis makes to the sociology of violence against women, the sociology of diagnosis, and health policy.

## IMPORTANT FINDINGS AND THEIR IMPLICATIONS

In this thesis I have made a claim that the answer to the thesis question, *'How best can intimate partner violence, in the form of a physical assault, be classified to reduce misclassification, increase identification, mobilize intervention (according to patients' stated preference) in emergency department consultations, and collect data about it in hospital-based emergency department administrative systems?'* is that it is best classified as 'assault by partner'.

This claim is based on the research findings that the classification 'domestic violence' was not helpful in the context of emergency department consultations after an assault by partner. I argued that it was not helpful because of the level of gendered violence and injurious consequence normally reported by this population, and thus the application of 'common couple' or 'non-domestic violence' was a misclassification of an assault by a partner in the emergency department context. I further argued that the multiple classifications in operation were insufficient to mobilize interventions for intimate partner violence. The final argument to support the thesis was that the classification 'domestic violence' more likely resulted in misclassification was because it is a typological and not taxonomic classification.

### *Classificatory Multiplicity*

In the current policy context of emergency department response to 'domestic violence', this research discovered six locations in emergency department consultations at which intimate partner violence was classified. These six locations were: ambulance, registration, triage, medical practitioner, safeguarding referral, and diagnosis, disposition and GP Letter. Across the six locations, eight different classifications of intimate partner violence had been applied and these were: 'assault by partner', 'alleged assault by partner', 'assault' (with no victim/perpetrator relationship), 'alleged assault' (with no victim/perpetrator relationship), 'domestic violence', 'acts of violence', 'presence of children', and 'injury'. At each location there was a preferred classification, in the sense of most used classification, but these were not categorical and this indicated that the classifications were simultaneously made stable and in flux.

### *Classificatory Attributes and Distinctions*

Four distinct classifications of intimate partner violence, distinct because of their different classificatory attributes and entangled classificatory interventions, were identified in this research. The distinctiveness of these classifications and entangled intervention is indicative of catalytic properties of classificatory systems for mobilising patients' routes through emergency department consultations. The four distinct classifications that made a difference to patients' routes through an emergency department consultation were:

Assault by Partner

Domestic Violence

Serious Harm

Presence of Children/Pregnancy

#### *Assault by Partner*

In this research the 'Assault by Partner' classification was found to be characterized by presence of alcohol consumption, report of the violence as extra-ordinary or one-off, or a result of playing around, or mutual violence in which a female partner had come off worse, or an act for which the partner was sorry. 'Assault by partner' was also reported by practitioners as less serious, associated with low level violence, and was reportedly the most common type of intimate partner violence that practitioners saw in their caseload. 'Assault by partner', because of its perceived unproblematic status, did not have any intimate partner violence interventions warranted for it other than routine medical treatment.



The importance of the finding of the 'assault by partner' classification was that the vast majority of patients reporting an assault by partner had not reported low level violence but had reported severe levels of violence and suffered medium or high levels of injury. Thus the classification of 'not-domestic violence but assault by partner violence' would have been a misclassification of intimate partner violence. The importance of this finding is that 'not-domestic violence but common couple assault by partner violence' was the classification that was low volume in this sample. The main implication of the 'assault by partner' classification is that it provides an explanatory account of the misclassification of self-reported intimate partner violence and its concomitant failure of mobilization of intimate partner violence interventions.

### *Domestic Violence*

This research found that the classification 'domestic violence' was characterized as a more serious type of intimate partner violence that was different to 'assault by partner'. 'Domestic violence' was reported by practitioners in this study as low volume in their caseload. The classification 'domestic violence' was used by practitioners in this study to distinguish the more serious type of intimate partner violence from the 'not-domestic violence but common couple assault by partner violence', the latter being understood as high volume in their caseload. The main criterion reported by practitioners in this study for the classification of 'domestic violence' was patients' fear of the perpetrator. Previous incidents of assault by partner held classificatory associations with 'domestic violence' for respondents in this study, but did not necessarily mobilize classification or interventions. The classification

'domestic violence' was also found to be more likely to be applied when patients did not report or whom seemed reluctant to report an assault by a partner.

'Domestic violence' was also constructed as difficult to identify and that the application of the classification was dependent upon knowledgeable, experienced, and intuitive practitioners who could 'pick up on it'. The importance of this finding is that, by stating unintelligibility of 'domestic violence', its misclassification is vicariously condoned and legitimized. The application of the classification 'domestic violence' was associated for practitioner respondents in this study with the mobilization of interventions. The 'domestic violence' interventions reportedly mobilized were: forensic evidence collection, safety assessment, provision of information about and referral to specialist services, and referral to police services. However, the findings from service user respondents indicated that interventions for intimate partner violence were rarely mobilized during emergency department consultations. This finding illustrates that non-statutory interventions for 'domestic violence' were informal systems that were rarely documented on patients' records even when the classification 'domestic violence' had been documented. There was also a perversity in the mobilization of 'domestic violence' classification and intervention because, paradoxically, self-report of intimate partner violence was not associated with the classification 'domestic violence' by emergency department practitioners, but the non-report of it was. Patient self-report of an assault by a partner was not always associated with a desire for intervention by practitioners in this study. Conversely, patients' non-report was more often associated with practitioners' mobilization of the classification 'domestic violence' and interventions.

### *Serious Harm*

The classification 'Serious Harm' was found to be characterized by repeated, extreme violence; life–threat violence; and/or patients expressed life–threat fear. The intervention associated with 'serious harm' was a formalized system of intervention that involved notifying the police of life–threat risk, either with or without patients' consent. 'Serious Harm' was a rarely applied classification because adult patients were understood as generally having capacity to act. The classification of 'serious harm' had some attribute overlaps with the classification of 'domestic violence' in relation to repeated incidents and patients' expressed fear.

### *Presence of Children/Pregnancy*

In this study, the classification 'Presence of Children' was characterized by the witnessing of intimate partner violence by a child member of the household. 'Witnessing' included children living in the household of the adult victim/survivor, even if they did not directly witness (see or hear) the violence perpetrated. This research found that the classification of 'domestic violence' was proportionately more frequently applied in association with the classification of 'presence of children' than for adult victim/survivors attending the emergency department after an assault by a partner. The rationale for the greater application of the classification of 'domestic violence' in association with 'presence of children' was explained by the lower threshold in law, of 'risk' for children than for adult victim/survivors, and the 'presence of children' classification mobilization of the intervention of safeguarding children referral. Safeguarding children referral involved a referral to children's social services for child witness of intimate partner violence (the seeing

or hearing ill-treatment of another) with or without the consent of the adult/mother victim/survivor. Importantly, this study found that the 'presence of children' classification was the most frequently recorded intimate partner violence intervention mobilized. The 'presence of children' classification was not associated with any other interventions. After 'assault by partner', 'presence of children' was found to be the most common classification of intimate partner violence applied.

The classification 'presence of children' held important classificatory significance for women in this study attending the emergency department after an assault by a partner; women were more likely to have the presence of children recorded on their records. An important finding was that women were disproportionately the subject of 'presence of children' classifications and had the non-presence of children recorded. A key implication of the gender discrimination in the application of the 'presence of children' classification means that technically, women cannot report intimate partner violence without their children being referred to social services. The significance of this finding was illustrated through service user respondents in this study indicating that they had not accessed services because of the risks that becoming known or re-known to children's services posed for them.

### ***Method of Report, Classification, and Intervention***

The causal properties for the mobilization of intervention after a report of intimate partner violence were identified as being multi-directional and complex. The method of report was important for the classification of 'domestic violence', and a perverse inverse relationship between self-report and non-intervention, and non-report and intervention was identified

in this study. In this research patient self-reporting of intimate partner violence was associated with less intervention for women construed by practitioners as accepting of violence and lacking desire for intervention. Paradoxically, practitioner respondents associated patient non-reporting with the need to mobilize classification and greater intervention because women non-reporting were interpreted as more likely 'trapped' in their relationship and as having constrained choices. Importantly, this research found that patients who were perceived as reluctant to disclose or not reporting because of partner-induced constrained choices, were more likely to mobilize emergency department intervention than patients who openly self-reported intimate partner violence. This research did not find an account in practitioner respondents that non-report may signal that classification and/or intervention may be considered by patients (as knowledgeable experts) as undesirable or more harmful for them at that moment.

One of the key findings from this research was that patients attending an emergency department after an assault by partner were instrumental in reporting partner violence to emergency department staff. Yet patient report of intimate partner violence was more often associated with less need for classification and intervention. This finding of patient self-report and the mobilization of the classification 'assault by partner', which had no classificatory intervention entangled with it, was proposed as the explanatory account for service user reported indifference during emergency department consultations in response to their report of intimate partner violence. Furthermore, this research found that the combination of self-report and police involvement was associated for practitioners with less need for emergency department initiated classification and intervention. This is juxtaposed

to the contemporary socio-cultural context of encouragement to report and the concomitant finding in this research of an increase in referrals to emergency departments by police services for medical attention and the recording of injuries suffered. Therefore, there is likely an increase in the number of women reporting intimate partner violence to emergency department services. However, the classifications of intimate partner violence found to be in operation in this study, means that there will not likely be a corresponding increase in rates of 'identification'. Correspondingly, unless the system of classification is changed, an increase in misclassification is likely because of the finding in this thesis, that classification of and intervention for intimate partner violence were not mobilized by self-report alone.

### *Classification and Intervention*

An embedded professionalized system of classification and recording of an assault by partner during emergency department consultations configured as: Cause: 'assault', Mechanism of Injury: 'acts of violence', Injury: 'physical injury sustained', and Risk: 'presence of children/pregnancy' was identified from the analysis of emergency department records. In the documentation of Cause: 'assault', this study also established that information of the victim/perpetrator relationship was routinely documented at triage and medical practitioner locations.

The classification 'alleged assault by partner' was recorded in approximately half of all records for an attendance of an assault by partner. From the findings of this research, it was proposed that medical practitioners' duality of professional role as 'medical attendant' and 'medico-legal witness' likely explained practitioners' recording of a reported assault as

alleged. Although practitioners proposed that recording an assault as alleged did not qualitatively change the classification, I argued that the prefix 'alleged' constructed the reported assault as open to doubt and that there was no justification to qualitatively alter a patient's account of an assault to an 'alleged' event.

Although the key characteristics of intimate partner violence, in terms of 'assault' and 'partner' as perpetrator were routinely collected early on in the consultation, an assault by a partner made no difference to patients' triage prioritization category. This finding means that women attending after an assault by partner often spend time in the public waiting room, the significance of which meant that service users' experiences of acute stress and emotional aftermath were not attended to. An important and related finding identified that patients attending the emergency department after an assault by partner were two times more likely to leave the emergency department before consultation completion than those with other victim/perpetrator relationships recorded. From the reports of service users in this study, the greater proportion leaving before consultation completion after an assault by a partner was likely because of the acute stress experienced by this population.

Interventions for intimate partner violence that had a statutory duty attached were found to be routinely recorded in patients records whereas other intimate partner violence specific interventions were not, indicating that even where protocols existed non-statutory interventions were not wholly embedded. Another important finding was that a number of practitioners, and even those from a department that had seemingly embedded systems for responding to intimate partner violence, were not aware of non-statutory interventions for

intimate partner violence. Rather than attribute this finding as previous research has done to practitioner informational factors limiting service responses, this study makes a further contribution to the field by claiming that it is misclassification that explains the failure to mobilize emergency department initiated interventions. Based on the findings in this thesis, and previous research in the field indicating that prompts rather than protocols alone increased the mobilization of intervention, it was proposed that the implementation of standardized documentation for an assault by partner with intervention prompts will likely increase classification, reduce misclassification, and mobilize interventions.

### **Classifications and Administrative Health Data**

This research identified that there were no data item options in the Accident and Emergency Department Data Dictionary Coding Tables for non-health service follow up meaning that there was no system to record referral to specialist services, the significance of which is that systems level monitoring of intimate partner violence specific intervention is presently not possible. Furthermore, it was also found that computer generated GP letters did not routinely include information about an assault by partner as the cause of patients' injury and emergency department attendance. This finding stands in contrast to service user understandings of the information provided to general practitioners; most of the service users in this study were under the impression that this information was likely included in GP letters. In regard information sharing with GPs, service users in this study intimated that the provision of information about a partner as perpetrator could be beneficial because it could make discussion of intimate partner violence easier at follow up consultations.



## Classifications in Hospital Episode Statistics

This research found that emergency department practitioners routinely documented the partner victim/perpetrator relationship, and this is the most specific classification for intimate partner violence, but neither the Accident and Emergency Department Data Dictionary Coding Tables nor the International Classification of Disease sub-classify assault by victim/perpetrator relationship, rather these classification systems sub-classify by location, i.e., where the assault took place. Thus, the classification 'assault by partner' found documented in records was distributed in the Emergency Department Hospital Episode Statistics classifications 'assault' and 'assault by location home'. It was not possible to identify in this study the proportion of those in the 'assault' classification who were exposed to intimate partner violence. This research found that the assault sub-classification of location was not known for approximately half of all emergency department attendances in Lancashire for an assault.

The two most specific classifications for an assault by partner in the International Classification of Disease ('Y07.0 maltreatment by partner' and 'T74.1 battering/physical abuse by partner') were established by this study as having low rates of applications in England. Rates of application were also found to vary significantly across NHS service providers and which could not be explained by variation in general population intimate partner violence prevalence data.

An important finding of this thesis was the disconnect between the classificatory vocabulary of practitioners documenting intimate partner violence in the form of a physical assault in

medical records and the classificatory vocabulary of the technical classification systems of health information systems. The difference between the classificatory vocabulary of practitioners for an assault by partner, and the classificatory vocabulary of the International Classification of Disease for the classifications 'Y07.0 maltreatment by partner' and 'T74.1 battering/physical abuse by partner', provided one of the explanations for the infrequent applications of these two classifications in England. Furthermore, this research found that that these two classifications were conceptually difficult for clinical coders to ascribe to an assault by partner. Analogous to emergency department practitioner distinctions between 'domestic violence' and 'assault by partner', 'Y07.0 maltreatment by partner' and 'T74.1 battering/physical abuse by partner' were constructed by some of the coders in this study as different to an 'assault by a partner'.

The sub-classification of assault by location was found to be an important measure for assaults perpetrated against women, and that 'assault' sub-classified by 'location' was the best proxy indicator for intimate partner violence against women in Emergency Department Hospital Episode Statistics. Based on this findings from Emergency Department Hospital Episode Statistics data, it was hypothesized that in Admitted Patient Care Hospital Episode Statistics, intimate partner violence in the form of an assault, was most likely distributed across the International Classification of Disease assault classifications, codes X85 – Y09, the specificity of which would be improved with fourth character location sub-classification.

## BEST CLASSIFICATION

In this study, classification was found to be easier when based on criteria that warranted little interpretation for both emergency department practitioner and clinical coder respondents, in other words, simple empirical taxonomies were better. Practitioners were successful in classifying an assault; victim/perpetrator relationship; risk to children by living in the household/pregnancy status; and risk of life-threatening serious harm. The classification 'domestic violence' was found to be unhelpful because it more likely resulted in misclassification and failed mobilization of intervention. In addition, in the context of emergency department consultations after an assault by partner, the classification 'domestic violence' was not advantageous because of the high level of gendered violence and injurious consequence reported by patients. This research also found the classification 'domestic violence' more difficult for practitioners to apply because it was a typological and not an empirical classification. From findings in this thesis, the best classification in emergency department consultations, Emergency Department Hospital Episode Statistics, and in Admitted Patient Care Hospital Episode Statistics for intimate partner violence in the form of an assault is 'assault by partner'. However, the classification 'assault by partner' as best is conditional that the classification when applied in emergency department consultations, mobilizes a suite of interventions, sensitive to patient stated preference, that includes options of: patient safety assessment and plan; risk of serious harm assessment and intervention; forensic evidence collection; specialist service referral; social services referral; and police referral.

## RECOMMENDATIONS

1. It is recommended that the classification 'assault by partner' is adopted to record and classify intimate partner violence in the form of an assault in emergency department consultations, in Emergency Department Hospital Episode Statistics, and in Admitted Patient Care Hospital Episode Statistics.
2. It is recommended that the classification 'assault by partner' in emergency department consultations mobilizes a suite of interventions, on condition of patient stated preference, that includes options of: patient safety assessment and plan; risk of serious harm assessment and intervention; forensic evidence collection; specialist service referral; social services referral; and police referral.
3. It is recommended that an intimate partner violence specific form to document emergency department consultations for an assault by partner in England is developed for widespread implementation and which pays attention to patient stated preference for intervention, patient safety assessment and plan; forensic evidence collection; specialist service referral; social services referral; and police referral.
4. It is recommended that women attending an emergency department after an assault by partner should be fast-tracked through and offered support from a specialist violence support worker. This recommendation is based on the finding of acute stress and increased risk of leaving before treatment completion in this population.

5. The findings from this study endorse previous recommendations that attending to privacy and safety should be an immediate and routine intervention for an assault by partner.
6. It is recommended that a patient's report of an assault by partner is not recorded as 'alleged'. The findings endorse Isaac and Enos' (2001) recommendation that phrases that imply doubt such as 'patient claims' or 'alleges' are avoided unless the practitioner has grounds to contest the report and which should also be recorded.
7. It is recommended that the threshold of 'risk for children' that makes possible automatic referral to children's services without adult victim/survivor patient informed consent based on the witnessing of 'domestic violence' be reviewed because this threshold may exclude women from accessing health services for themselves and their children.
8. It is recommended that information about an assault by partner as the cause of patients' injury and emergency department attendance is communicated to general practitioners in accordance with patients' stated preference for it.
9. For measuring intimate partner violence against women in Emergency Department Hospital Episode Statistics, the recommended current best dataset proxy indicator is collectively: Patient Group: Assault; Incident Location: Home; Sex: Female; Age: Sixteen years and older.

10. For measuring intimate partner violence against women in Admitted Patient Care Hospital Episode Statistics, the recommended current best dataset proxy indicator is collectively: International Classification of Diseases (ICD-10) Assault Codes X85 – Y09 to fourth character subdivisions: 'location: home' (X85 – Y05, Y08, and Y09) and 'victim/perpetrator relationship' (Y06 and Y07) and Female; Age: Sixteen years and older.

11. It is recommended that a victim/perpetrator relationship classification is created in the Accident and Emergency Department Data Dictionary Coding Tables and the International Classification of Disease External Cause Assault classifications so that system level monitoring of intimate partner violence is possible in administrative health data.

- a. In the Accident and Emergency Department Data Dictionary Coding Tables a new category of 'victim/perpetrator relationship' should be created.
- b. In the International Classification of Disease, a 5<sup>th</sup> character sub-classification of 'victim/perpetrator relationship' should be created for the External Cause Assault Codes X85 – Y09. The 4<sup>th</sup> character sub-classifications for Y06 and Y07 should be respecified as a location sub-classification for coherence across the Assault Codes.

12. It is recommended that patient disposition data item options for non-health service follow up such as specialist services are created for the Accident and Emergency

Department Data Dictionary Coding Tables so that system level monitoring of intimate partner violence specific intervention is possible.

## **STRUCTURAL GENDER INEQUALITY, POWER, AND CLASSIFICATION**

Violence against women was positioned in Chapters One and Two as a cause and consequence of structural gender inequality; similarly structural gender inequality was evident in the findings of this research in the way that the classification of intimate partner violence has been constructed and mobilized in emergency department consultations and technical classification systems.

Unequal power relations were revealed in the research findings, these were illustrated by the exercise of practitioner power during emergency department consultations in terms of which classifications were mobilized, when and by whom. The immobilization of classification 'domestic violence' by practitioners was even more explicit in respect of the finding in this research that most women self-report. The notion of patient reluctance to report or non-report by practitioners in this research positioned women (as the people with the ability to report or confirm abuse) as principal diagnosticians of intimate partner violence during emergency department consultations. Yet, from the review of records, this research found that 85% (n=39/46) of women reporting an assault at home also reported the victim/perpetrator relationship, and of these, 62% (n=24/39) reported their partner as perpetrator. This data indicated that practitioners routinely documented a partner as perpetrator in patients' records and yet did not always classify it as 'intimate partner violence'; 'domestic violence' was only recorded in ten records (36%). This research found

that only some classifications of intimate partner violence, for example life threat, and child protection, were sanctioned for classification and intervention by practitioners whereas others, for example, those considered to be alcohol fuelled, one-off acts, or bound by a perceived lack of desire for intervention, were not.

The conceptual and classificatory constructions of technical classification systems (International Classification of Diseases and Accident and Emergency Department Data Coding Tables) were also found in this research to hold power for which classifications of violence were possible and mobilized. In the Accident and Emergency Department Data Coding Tables, the victim/perpetrator relationship does not form part of the classification, thus obscuring prevalence of intimate partner violence against women in health data. This is paradoxical given the longstanding declaration of 'domestic violence' as a public health issue. Similarly, the 'assault' classifications of the International Classification of Disease did not have a sub-classification for victim/perpetrator relationship either. Furthermore, a woman's partner as abuser was found to be only possible in two International Classification of Disease classifications: the classification of 'maltreatment' and the classification of 'battering', but this research found that the vocabulary of these classifications and the vocabulary found in medical records were different. Consequently, the differences between the vocabularies of the medical record and the International Classification of Disease, along with adherence to clinical coding 'rules', meant that these two classifications would be infrequently and inconsistently applied, thus distorting prevalence data.

The power of the International Classification of Disease and its authors to determine which classifications were possible has resulted in inadequate classification of intimate partner



violence in administrative health systems. It is notable that the chair of the committee responsible for 'Chapter XX External Causes of Morbidity and Mortality' of the International Classification of Disease, failed to respond on three occasions for information about the construction and revision of the classifications for this research. The International Classification of Disease undergoes revision every ten to twenty years, but the processes of the construction of it, is not made public, and nor is it easily accessible (Bowker and Star 1999). That the assault classifications of the International Classification of Disease and Accident and Emergency Department Data Coding Tables are sub-classified by location, and not by victim/perpetrator relationship, likely indicates a hegemonic interpretation of the most common forms of violence, i.e., that of stranger perpetrated violence in public spaces. There is currently public consultation for the classifications for the next revisions of the Accident and Emergency Commissioning dataset. However, personal communication with an Information Standards Assurer for the Health and Social Care Information Centre in England has indicated that the classification 'assault by partner' is problematic information because someone other than the patient may be identifiable. Whilst, this concern may be understood in part from an anonymity and confidentiality perspective, this claim is weak because 'personal information', the information needed to *identify someone*, does not form part of the information; only victim/perpetrator *relationship* is needed. In addition, even if the abuser was identified by name in the medical record, this is a document highly secured by data protection law. Nonetheless, the non-classification of victim/perpetrator relationship illustrates structural gendered inequality in health systems of classification because the current classifications for interpersonal violence obscure the most common form of violence against women, intimate partner violence, in health data. In this system the abuser is

seemingly better protected than an adult victim/survivor because abusers' anonymity and confidentiality in health care systems has greater protection than women victim/survivors', whose anonymity and confidentiality has been found to be more often breached for statutory child protection purposes.

Power held by differently empowered groups was also evident in the determination of measures of effectiveness of interventions for intimate partner violence initiated in health services. Measures of effectiveness were important because they determine health policy for intimate partner violence screening. In Chapter Two, systematic reviews of effectiveness upon which decisions about routine screening for intimate partner violence had been based were identified. The measures of effectiveness that led to the rejection of routine screening were reduced morbidity and mortality as defined by the UK National Screening Committee (UKNSC 2006, Spiby 2013). In this scenario, other measures that women victim/survivors have identified, in this and previous research (Yam 2000, Feder et al 2006, 2009), as successful outcome from health consultations for example, reporting, discussing options, referral to specialist services, and forensic evidence collection were not considered by institutions and agents of institutions as sufficient outcomes alone. Furthermore, the structure of systematic reviews of effectiveness in the health sector privileges some types of research design over others. The 'gold standard' research design for Cochrane Collaboration systematic reviews of effectiveness in health is the randomized controlled trial (Sackett et al 1996), and this means that much research, not of this type (i.e., with a control group for comparison), but nonetheless evidencing effectiveness of interventions is often rejected. Methods of meta-synthesis of different types of research for reviews of effectiveness for

social science have been developed (Campbell Collaboration 2013, EPPI-Centre 2013), but as yet these have not been granted the same epistemic privilege in some fields of the health sector.

This research has found clear evidence of power relations and power held by differently empowered groups in the ways that classifications were mobilized in health consultations, in technical classifications systems, and in the determination of measures of effectiveness of interventions. The consequence of these differently empowered groups identified in this research, has been that women victim/survivors were denied classification and access to resources, and thus further disadvantaged.

## **IMPORTANCE OF THE THESIS' THEORETICAL FRAMEWORK**

This thesis has drawn on the sociology of diagnosis, in which structural inequality in 'diagnosis' is inherent (Brown 1995), and 'diagnosis' is conceptualized through its classification, process, and consequence (Jutel 2011). The importance of the sociology of diagnosis for this thesis has been an analytical approach to the research in which interconnected systems of each of these 'diagnostic' dimensions for the classification of intimate partner violence were intelligible and which deepened the ontological depth of analysis and interpretation of the research findings.

The importance of the synthesis of critical realism and complexity theory for positioning the thesis ontologically and epistemologically has been to extend analysis of the classification of and response to intimate partner violence in hospital based emergency department health

systems. This synthesis of critical realism and complexity theory in this research made the causal properties of interconnected dynamic systems which lay behind patterns of events and experiences intelligible. This research approach accommodated the fluidity of multi-directional causal properties of systems of classifications in consultations, technical classification systems, and systems of legitimating health intervention for the classification of intimate partner violence in hospital-based emergency department health systems.

Positioning the work in relation to structural gender inequality through the sociology of violence against women and hegemonic masculinity has been important for this research to comprehend structural gender inequality in different systems at different levels in the health service response to intimate partner violence. This thesis has identified gendered power relations in social institutions of the health sector involved in the classification of and response to intimate partner violence. It has also exposed the diagnostic authority of empowered groups to mobilize classifications and intervention, and highlighted the epistemic privilege of empowered groups to state the legitimacy of measures of effectiveness of interventions. The result of structural gender inequality in the social institutions of the health sector has resulted in a limited and disproportionate health sector response (given the health burden of intimate partner violence), which is detrimental to women and reproduces gender inequality.

## ORIGINAL CONTRIBUTIONS TO KNOWLEDGE

### *Sociology of Violence against Women*

For the sociology of violence against women, this thesis examines a precise section of the field, the most highly abused women attending emergency departments for injuries suffered in an assault by their partner. In this specialized and important section, this thesis contributes greater conceptual clarity of distinctions of the classificatory vocabulary and greater nuancing of empirical categories defining the field. This thesis identifies, discusses and analyses the applications of the wide vocabulary of terms used for intimate partner violence in hospital-based emergency department health systems (consultations, institutions, professional, and national and international technical classification systems). This thesis has clarified how the vocabulary is used for the classification of intimate partner violence and makes recommendations for how the concepts and vocabulary can be improved in the different levels of health systems.

### *Health policy*

For health policy, this thesis has examined the specialized emergency department health sector response to intimate partner violence for an important population who are likely the most heavily abused. The thesis contributes an original account of the classification and misclassification of intimate partner violence during emergency department consultations and in hospital-based systems of administrative data collection and based on the research findings provides original recommendations for policy and practice.

## *Sociology of Diagnosis*

For the sociology of diagnosis this thesis contributes an illuminating exposition of complex and multi-modal layering of structural gender inequality pervasive in social institutions and systems of the health sector response to intimate partner violence in hospital-based emergency department health systems. This thesis offers a nuanced clarity of differently empowered groups in systems of classification and systems for measuring the effectiveness of intervention in the interconnected dimensions of intimate partner violence 'diagnosis' (classification, process and consequences). In doing so, this thesis furthers sociology of diagnosis theorization through nuanced conceptualization of additional layers of ontological depth in relation to structural gender inequality and interconnections of dynamic systems for the analytical framework of diagnosis as classification, process and consequence.

## **CONCLUSION**

Despite the positioning of violence against women, of which intimate partner violence is the most commonly reported form, as being of epidemic proportions and with a huge health burden for women, the health sector across the globe has been slow to respond. This thesis started from a position, based on previous research in the field, that often when women attend an emergency department after an assault by their partner, the matter of their experience of intimate partner violence is missed. The focus of this thesis on the *classification* of intimate partner violence during emergency department consultations was developed through the analytical framework of the sociology of diagnosis in which criticality of 'classification' was central to 'identification' and 'intervention'. From this focus the main research question and empirical secondary questions were identified.

The review of the literature identified that women's experience of intimate partner violence was often unacknowledged during health consultations. So whilst the literature had recognized that cases were 'missed' the focus of empirical enquiry to date had been on systems that adversely or favourably support 'identification' and 'intervention' such as the introduction of protocols and practitioner training. The uniqueness of this project was to systematically analyse and understand its missingness through its classifications and misclassifications.

The claim made in this thesis is that the best classification of intimate partner violence, in the form of physical assault, is 'assault by partner'. This conclusion was based on research findings that indicated 'missed' intimate partner violence was a result of misclassification of intimate partner violence into classifications that did not mobilize intervention other than routine medical care. 'Assault by partner' was identified as best classification because there was no need for distinctions: most patients in this study had experienced severe violence and suffered medium and high levels of injury. In addition, 'assault by partner' was also identified as best classification because of the conceptual difficulty for health practitioners and clinical coders to classify 'domestic violence' within current taxonomies.

Classifying intimate partner violence, in the form of physical assault, as 'assault by partner' during emergency department consultations will likely result in fewer missed cases, earlier identification, and earlier recourse to prevent further violence. The classification 'assault by partner', if used systemically, could also align the health information classification systems

from consultation to administrative health data to improve health monitoring of intimate partner violence.

In this concluding chapter the important findings from the research of this thesis have been presented and their implications further interpreted. From the research findings, recommendations for policy and practice to improve hospital-based emergency department system responses to intimate partner violence have been made. The status of the knowledge claims made in this thesis has been specified. An explanatory account of structural gender inequality and sites of unequal power relations identified in this thesis in the classification of intimate partner violence in hospital-based emergency department systems has been forwarded. The importance of the theoretical framework underpinning this thesis has been reiterated and the original contributions that this thesis has made to the field have been stated.



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# APPENDIX ONE: INTERVIEW GUIDES

[The body of the page contains extremely faint and illegible text, likely representing the interview guides mentioned in the header. The text is too light to transcribe accurately.]

## Interview Guide: Service User Interviews

### Objectives for the interview:

- To explore the participant's health experiences and emergency department health contacts and perspectives of emergency department services for domestic violence.
- To explore participant's perceptions about factors that impact whether and how domestic violence becomes named and responded to during emergency department health contacts.

**Before Interview begins:** Ensure the interview room is private and comfortable, go through the research information sheet and consent form with the participant. Once consent is obtained the interview may begin. Remind the interviewee that they can ask for the interview to stop at any time.

It is not intended that the interviewer systematically ask all the questions in the guide but rather to start the interview with an open question and then to use the guide to assist probing of the interviewee's accounts.

**Introduction:** This study is about emergency department health contacts and services for women who have experienced domestic violence. I'd like to hear about your experiences and I may ask some questions about the issues you talk about.

**1. Tell me about your experiences of times that you went to be seen at an emergency department.**

**2. Experiences of domestic violence**

I'd like to hear about your experience of domestic violence. How and when did the domestic violence start? What types of violence were used? Did the violence change over time? How long did the domestic violence continue for? If stopped: What made it stop?

Do you think that the domestic violence has affected your health? If yes: In what ways?

**3. Experiences of going to the Emergency Department**

I'd like to hear about the times you went to an emergency department to be seen; (Introduce Event Memory Jogger if needed to help remember the different occasions). **When did you go? What did you go for? Did you have any concerns about going?** Who did you see? How did you describe the reason for your visit? Did you sometimes say different things at different times to different people? If yes: Why? What did the different people say to you?

**4. Experiences of telling staff and talking about domestic violence**

Did you tell the emergency department staff about the domestic violence? If yes: How did that come about? How long had the domestic violence been going on for when you first told someone at the emergency department about it? Had you told anyone else previously? What made it possible or impossible to tell and talk about it? What were the reasons behind telling or not telling people? What happened after you told staff about it? **Did the staff ask you about domestic violence?** If yes: How did that happen? On what occasions did they ask you?

How did they ask you? Where did they ask you? How did being asked or not being asked affect your experience?

**Were there times when you particularly did or didn't want to talk about domestic violence? Why was that?**

#### **5. What happened during the Emergency Department visits**

**What happened during the visit(s)?** What did different people understand the problem to be? What did all the different people do? What was done for the medical problem? Was anything done for the domestic violence? How did <what happened> come about? How were decisions made about <what happened>?

**Did what happened at the emergency department change anything, either at the time or later on?**

#### **6. Impact of Children**

**Did you have any children at the time of the visits? Do you think that having or not having children impacted what was said and what happened at the emergency department? In what way? Why was that?**

#### **7. Connections with other services**

**Were you referred to or advised to see anyone for ongoing health and domestic violence support?** If yes: Who? How did that come about? Did you access them after your visit? When? How did that happen? Did anything happen as a result of accessing these services after your visit?

**Were you aware of the health and domestic violence services available to you and how to access them prior to the emergency department visit(s)?** If yes: How did you find out about them? Had you accessed any prior to your emergency department visit? If yes: Which ones and when? How was information about domestic violence and services provided to you?

#### **8. Goals and impact**

**Were you able to address the things you wanted to during the visit? Why was that?**

**Did anything go particularly well or badly for you during the visit(s)? Why, what happened?**

**Did anything change or happen as a result of something that was said or happened at the emergency department? What happened? How did that happen?**

#### **9. Confidentiality and information sharing**

**Does what and how information about your emergency department visit is communicated to others influence what you choose to tell or not tell emergency department staff? Do you think that information about your experience of domestic violence is or should be made available to other health professionals caring for you? If yes: Would this include health visitors and school nurses in relation to your children's ongoing care? What are your views on information sharing to non-health professionals, such as domestic violence services, social workers, police, multi-agency risk assessment conferences? What does the term 'confidentiality' in health care mean to you?**

#### **10. Overall experiences and improvement to service:**

**Did you have to wait during your visit? If yes: why did you have to wait? Where did you wait? What did you think about waiting? Do you remember seeing any posters or information about domestic violence during your visits?**

**Would you go back to the emergency department? Why?**

**What could emergency departments do to improve their service for women who have experienced domestic violence?**

#### **11. Closure:**

**Is there anything else that we should have discussed in connection with your emergency department visits? Is there anything else that you would like to add?**

Offer thanks for time and willingness to talk.

Check that no distress has been caused by the interview and ask if there is anyone the interviewee would like to contact.

Have domestic violence information pack and local service contact details available.

# Interview Guide: Emergency Department Practitioners

## **Objectives for the interview:**

- To explore the participant's perspectives on emergency department health contacts and emergency department services for domestic violence.
- To explore participant's perceptions about factors that impact whether and how domestic violence becomes named and responded to during emergency department health contacts.

**Before Interview begins:** Ensure the interview room is private and comfortable, go through the research information sheet and consent form with the participant. Once consent is obtained the interview may begin. Remind the interviewee that they can ask for the interview to stop at any time.

It is not intended that the interviewer systematically ask all the questions in the guide but rather to start the interview with an open question and then to use the guide to assist probing of the interviewee's accounts.

**Introduction:** This study is about emergency department health contacts and services for women who have experienced domestic violence. I'd like to hear about your professional experience of responding to domestic violence and I may ask some questions about the issues that you talk about.

## **1. Emergency Department attendances**

**Tell me about your experiences of emergency department attendances of women you have seen in relation to their experiences of domestic violence?**

**How many cases of domestic violence have you attended to in the last year? What did they attend the emergency department for?**

**Do you think that there has been any change, over time, in the number and / or types of domestic violence cases that you see in practice? Why is that? Has your perception of domestic violence changed over time? Why is that?**

## **2. Asking and Talking about Domestic Violence.**

**How do cases of domestic violence become known to you?**

**Does the department have a policy about enquiry for domestic violence? How does that work in practice? When, during their visit, are patients asked? Who has responsibility for asking? What has led you to ask patients about domestic violence? How do people describe their experience of domestic violence?**

**Do you think that patients deny domestic violence sometimes when asked about it? Why is that? What do you do in those situations?**

**Have there been times when you've wanted to ask about or talk about domestic violence but couldn't? Why was that?**

## **3. What happens during emergency department attendances**

Can you tell me about instances in which specific interventions in relation to domestic violence have taken place during an emergency department attendance? (Prompt with examples: information giving, safety planning, risk assessments, refuge, photographs, body maps, or referrals to specialist services if needed). How did they come about? How are decisions made? How did they work? Did the interventions help? Why is that, do you have any examples? What happens in those cases where you suspect domestic violence but the patient denies it?

**Do you think there is too much intervention or too little intervention for domestic violence in emergency departments? Why is that?**

**Were there times when you wanted to intervene but couldn't? Why was that?**

#### **4. Impact of Children**

**Do you ask women about children in the household? Does the presence of children in the household impact what happens? In what way?**

#### **5. Follow up and referrals to other services**

**Which people or services do you refer patients to or advise them to see for ongoing health and domestic violence support? How do referrals come about? How and when are they made? How is information about domestic violence and services and helpline information provided to patients?**

**To what extent do you think patients know about and access health and domestic violence services available to them prior to the emergency department visit(s)?**

#### **6. Confidentiality and information sharing**

**How is information about a patient's emergency department attendance(s) and domestic violence shared and communicated to other health or social welfare professionals? How does that happen? How does that work? As an emergency department practitioner, how and when are the details of patients' previous emergency department attendances available to you?**

**Is domestic violence flagged in some way for emergency department or hospital practitioners who may see the patient in the future? If yes, How does this happen?**

**Does what and how information about the emergency department visit is communicated to others influence what happens? Why is that?**

**What are your views on confidentiality in cases of domestic violence? How does confidentiality work in cases of domestic violence? Do you think that confidentiality is an issue for women experiencing domestic violence? Why is that?**

#### **7. Training**

**Are there specific domestic violence training requirements for your job? If yes: What are they?**

**How does the training work in practice? Who provides it? How often is it available to you?**

**Are you able to get to the training as you need to? What happens if you don't get to the training?**

#### **8. Summation questions**

What do you think works well or badly in practice? Why, what happened? Can you give an example?

**How well do policies and systems specifically for responding to domestic violence work? Why is that? What accounts for any tension or disparity between policy and practice? In your experience, how has the emergency department response to domestic violence changed over time? Where is it heading?**

**If resources were available, what would you do to improve emergency department services for domestic violence?**

## **9. Closure:**

**Is there anything else that we should have discussed in connection with emergency department contacts and domestic violence? Is there anything else that you would like to add?**

Offer thanks for time and willingness to talk.

Check that no distress has been caused by the interview and ask if there is anyone the interviewee would like to contact.

Have domestic violence information pack and local service contact details available.



# Interview Guide: Wider Professional Stakeholders

## Data Managers and Clinical Coders

### **Objectives for the interview:**

To understand how clinical coding systems work in practice and to obtain the participant's perspectives on clinical coding systems in relation to domestic violence.

**Before Interview begins:** Ensure the interview room is private and comfortable, go through the research information sheet and consent form with the participant. Once consent is obtained the interview may begin. Remind the interviewee that they can ask for the interview to stop at any time.

It is not intended that the interviewer systematically ask all the questions in the guide but rather to use the guide to assist to explore the main interview themes.

### **Introduction:**

This study is about emergency department health contacts and services for women who have experienced domestic violence. I'm interested in how clinical coding systems work in practice and I'd like to talk to you about clinical coding systems and their use in relation to domestic violence.

### **1. Clinical Coding Systems**

**Which clinical coding systems do you use in your work?**

**If, ICD-10 (International Classification of Disease Version 10) codes**

I'm interested in how ICD-10 (International Classification of Disease Version 10) codes are applied to records in practice, in particular the ICD-10 codes that may be used for 'domestic violence', for example T74 maltreatment syndromes, T74.1 Physical Abuse: battered spouse, child or baby, T74.2 Sexual abuse, T74.3 Psychological Abuse, T74.8 Other Maltreatment Syndromes (mixed forms), Y0.70 Other maltreatment syndromes, and Y07.0 Sexual Assault by bodily force).

**OR**

**If, Accident and Emergency Data Dictionary**

I'm interested in how Accident and Emergency Data Dictionary Codes are applied to records in practice, in particular the categories of incident type 'assault' and incident location 'home'?

**Can you explain about how these codes are used and applied in practice? What happens if the coder is unsure or if it's the record is illegible?**

**How is the category 'other' used?**

**In what ways is clinical practice shaped by Clinical Coding Systems?** How knowledgeable are health clinicians, for example nurses, doctors, allied health professionals, about coding systems? In what ways do clinicians engage with clinical coding systems in their practice?

**Are you aware of any other coding systems in operation that classify domestic violence?** If yes: Which ones? Are they operationalised in your organisation? How do they work in practice?

**Does the emergency department or hospital have a system for coding or 'flagging' records to make cases of domestic violence known for future emergency department or hospital consultations?** If yes: How does that work in practice? If not: Why do you think this is so?

## **2. Overall impressions**

**What are your views on the sensitivity of clinical coding systems in recording a patient's experience of domestic violence?**

**In what ways do you think that coding systems and their application could be done differently to enhance services for women who have experienced domestic violence?**

## **3. Closure:**

**Is there anything else that we should have discussed in connection with emergency department contacts and domestic violence?** Is there anything else that you would like to add?

Offer thanks for time and willingness to talk.

Check that no distress has been caused by the interview and ask if there is anyone the interviewee would like to contact.

Have domestic violence information pack and local service contact details available.

# Interview Guide: Wider Professional Stakeholders

(NHS Acute Trust Domestic Violence Leads; NHS Acute Trust Hospital-based Social Workers; Specialist Domestic Violence Service Staff; Independent Domestic Violence Advocates, Sexual Assault Referral Centre Staff, Independent Sexual Violence Advocates; and General Practitioners)

## Objectives for the interview:

- To explore the participant's perspectives on emergency department health contacts and emergency department services for domestic violence.
- To explore participant's perceptions about factors that impact whether and how domestic violence becomes named and responded to during emergency department health contacts.

**Before Interview begins:** Ensure the interview room is private and comfortable, go through the research information sheet and consent form with the participant. Once consent is obtained the interview may begin. Remind the interviewee that they can ask for the interview to stop at any time.

It is not intended that the interviewer systematically ask all the questions in the guide but rather to start the interview with an open question and then to use the guide to assist probing of the interviewee's accounts.

**Introduction:** This study is about emergency department health contacts and services for women who have experienced domestic violence. I'd like to talk to you about your professional experience of responding to domestic violence and I have some questions about some of the issues that may be important.

## 1. Emergency Department attendances

**Based on the experiences of women that you have seen (or come across) in your work, please tell me your views about emergency department contacts for women in relation to their experiences of domestic violence? What has worked well for women? Can you give examples? What goes wrong for women? Can you give examples? What do women go to the emergency department for?**

## 2. Asking and Talking about Domestic Violence

**What do you think influences women's disclosure and their telling of their experience(s) of domestic violence in emergency departments? Why is that? Can you give examples?**

## 3. What happens during emergency department attendances

Are you aware of instances in which specific interventions in relation to domestic violence have taken place during an emergency department attendance? (Prompt with examples: information giving, safety planning, risk assessments, refuge, photographs, body maps, or referrals to specialist services if needed). How did they work? How did you become aware of them? Did the interventions help? Why is that, do you have any examples?

**Do you think there is too much intervention or too little intervention for domestic violence in emergency departments? Why is that?**

## 4. Impact of Children

Does the presence of children in the household impact what happens at emergency departments? In what way?

## **5. Follow up and communication**

**Do emergency departments refer women to you for ongoing health or domestic violence support?** If yes: What information is communicated to you? How is it communicated to you? Does the information from the emergency department normally include details about domestic violence? If no: Why is that? Is this information generally available to you before you see the person?

**Is a woman experiencing domestic violence generally already known to you / your service prior to emergency department attendances?**

## **6. Information sharing and confidentiality**

**If a person is identified as experiencing domestic violence, is this information readily available to other professionals inside and /or outside your organisation who may have consultations at that time or in the future with that person?** If yes: How does that work? If no: Why is that?

**Is domestic violence flagged in some way?** If yes, How does that work?

**What are your views about how information of patients' emergency department attendance(s) and experience of domestic violence and are shared and communicated to you?**

**Does what and how information about an emergency department attendance is communicated to others influence what happens?** Why is that?

**What are your views on confidentiality in cases of domestic violence?** How does confidentiality work in cases of domestic violence? Do you think that confidentiality is an issue for women experiencing domestic violence? Why is that?

## **7. Summation questions**

**What do you think works well or badly in practice?** Why, what happened? Can you give an example?

**How well do policies and systems for emergency departments responding to domestic violence work?** Why is that? What accounts for any tension or disparity between policy and practice? In your experience, how has the emergency department response to domestic violence changed over time? Where is it heading?

**If resources were available, what do you think emergency departments could do to improve their services for domestic violence?**

## **8. Closure:**

**Is there anything else that we should have discussed in connection with emergency department contacts and domestic violence?** Is there anything else that you would like to add?

Offer thanks for time and willingness to talk.

Check that no distress has been caused by the interview and ask if there is anyone the interviewee would like to contact.

Have domestic violence information pack and local service contact details available.