Background: Partner violence is associated with both short and long term, physical and psychological health consequences, and greater health contacts and service consumption (Campbell 2002). However, beyond studies of incidence and prevalence (Sethi et al 2003, Boyle and Todd 2004), little is known about the role played by emergency departments in cases of partner violence.

Partner Violence is experienced and defined by repeated acts of violence and coercion towards a person by virtue of an intimate relationship (Johnson 2006, Stark 2007). To reflect the lived experience of partner violence, this research looks beyond single episodes of emergency department contact to bring into view chronologies of emergency department contacts in a person’s life history as the matter of interest and aims to understand how people who live with partner violence access, utilise and navigate emergency department services and how decisions and outcomes are shaped before, during and after the contact.

Research Design:

Underpinned by critical realism, the research employs a mixed-method case series design, the first phase of which is a retrospective medical record review of cases to compare health service utilisation and management of emergency department contacts arising from partner violence. However, conducting partner violence research in health systems in England is methodologically challenging, in particular, the problem of ‘finding cases’ for a retrospective medical record review.

A Hidden Population:

Identification and confirmation of cases of partner violence is imprecise and multi-factorial. Clinical codes for partner violence do not exist in the A&E Data Dictionary (NHS DMDS 2010)

Finding Cases: Where to look?

Partner violence in the emergency department setting is primarily conceptualised by physical injury from assaults. International Classification of Disease Codes available for Battered Spouse (T74.1) and External Cause Partner Violence (Y07.0) for inpatients (WHO 2007)

Partner violence is often a ‘private sphere’ crime (Mooney 2000) and it is likely that the home is the most common location for assaults. Partner violence was recorded in 20% of the emergency department records of assaults on women; however the perpetrator was unrecorded in 42% of cases (Spedding et al 1999).

Sample Limitations:

Data from Hospital Episode Statistics1 and the Trauma and Injury Intelligence Group2 indicate likely variance in clinical coding practices in and between NHS Trusts. Imprecise data is confounded by ‘other’ and ‘unknown’ data field options representing 47% of assault location unrecorded. Sample selection bias is introduced through design that originates health data from pathology (physical injury from assault). Until data collection has taken place, sample size and power calculations are indeterminate.

Addressing Limitations:

Confirmed cases will be tracked retrospectively for a period of ten years to capture alternate case and contact characteristics; the numbers of contacts per case will be taken into account for weighting purposes. The case confirming episode will be excluded from overall inter-case analysis and treated to sub-group analysis so as not to inflate ‘assault’ in presenting conditions or incident types.

Conclusion:

Whilst not the ideal, the multi-stage sample design represents the ‘messy real-world’ to capture the lived experience of partner violence from this hidden population in hospital health systems.

Notes:
2. Trauma and Injury Intelligence Group (2010). Data extract (TII). Data from trauma audiology for the period of January 2007 to December 2009. Centre for Public Health, Liverpool John Moores University, Liverpool

References:

• Y07.0 Battered Spouse
• T74.0 Partner Violence
• ≥ 18 years old
• n – 40 cases (HES’)

Chronologies (n~120) of A&E contacts (n ~300 - 500) in cases of partner violence from three NHS Trusts in Lancashire.