proven effectiveness, and thus have been unable to recommend for or against screening for IPV.

IPV is a multifaceted health and social problem and involves another individual, the abuser, whose actions cannot be controlled. Although the primary focus of IPV intervention is to increase the safety of the abused, numerous media accounts underscore the fact that an abuser who is motivated to harm or even kill his estranged partner or family members often succeeds.

For decades, community agencies have assisted victims of domestic violence and administered programs for perpetrators. Health agencies, in contrast, have been slow to respond to this issue. McClennan and colleagues[1] suggest that implementing policies and procedures that respond to the need of patients who are exposed to IPV should be a priority. I could not agree more. However, let us not wait for the impossible — a one-fits-all intervention that is proven to be effective and can therefore justify screening for IPV. There is simply no panacea intervention that will bring an end to this perplexing health, social and community ill.

In many respects IPV is analogous to the issue of drunk driving, where public perception and community standards can influence behaviour. Media attention on the victim impact of drunk driving has encouraged a number of strategies, including more responsible drinking, designated drivers and the use of taxis. Family violence has not had the benefit of sustained public awareness campaigns targeted at reducing abuser behaviour. Most abusers do not appreciate the profound impact their actions have on others. We cannot begin to solve the problem of IPV until abuser behaviour is systematically addressed. Public awareness about the nature of domestic abuse and its impact on the family is a critical part of that solution. I believe there is an essential role for our EDs in this effort, at a minimum by displaying posters and providing information on abuse and community resources for victims and perpetrators. Although the benefits remain unproven, I also believe universal screening for victimization is appropriate in the ED. The victim is in the ED already, and is likely to come again if she or he continues to be abused. Identifying the problem, validating the abused as not being at fault, encouraging safety behaviours and documenting the situations are all feasible in the brief period of time during the patient encounter. This is potentially very cost-effective because the system is already seeing the patient and the intervention is predominately one of empathy and providing information. Asking about IPV opens the door to invaluable healing and may help reduce morbidity and mortality from this serious public health issue.

Competing interests: None declared.

Keywords: domestic violence, intimate partner violence, emergency department, screening, public awareness

References

1. McClennan S, Worster A, MacMillan H. Caring for victims of intimate partner violence: a survey of Canadian emergency departments. CJEM 2008;10:325-8.

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Erratum

A CAEP Update about the Canadian Emergency Department Triage and Acuity Scale (CTAS) adult guidelines in the March 2008 issue contained an error. Box 1 should have listed the classification of bleeding severity for moderate, minor bleeds as Level III, not Level II. We regret the error.

Reference

1. Bullard MJ, Unger B, Spence, J, et al; the CTAS National Working Group. Revisions to the Canadian Emergency Department Triage and Acuity Scale (CTAS) adult guidelines. CJEM;10:136-42.