Duchesne et al. BMC Emergency Medicine (2026) 26:40
https://doi.org/10.1186/s12873-025-01423-5

BMC Emergency Medicine

RESEARCH Open Access

Improving care for intimate partner violence in the emergency department: recommendations from a Canadian retrospective chart review

Emma Duchesne[1,2*], Alison N. Ross[1], Jane Lewis[3], Susan A. Bartels[1,4], Melanie Walker[1,4] and Nicole Rocca[1]

Abstract

Background Intimate partner violence (IPV) is prevalent among patients visiting the emergency department (ED). Studies show that patients experiencing IPV continue to have negative care experiences in the ED, leading to an increased risk of adverse physical, mental, legal, and economic outcomes. However, few studies explore ED care metrics and gaps in knowledge on how providers can improve.

Methods We sought to fill these gaps by collecting quantitative and qualitative electronic data on ED care parameters for patients experiencing IPV. A retrospective chart review was conducted for patients seen in our tertiary care center's ED and by our Sexual Assault and Domestic Violence Program between December 17, 2018 and June 16, 2021. Quantitative data, including sociodemographics, were summarized using medians/interquartile ranges and frequencies/proportions as appropriate using SPSS. This paper describes IPV care metrics across three domains: (1) ED mandatory reporting, (2) medical management of strangulation, and (3) discharge diagnosis containing IPV. Additionally, when documenting IPV encounters in charts, the use of trauma- and violence-informed care (TVIC) principles was evaluated as a secondary exploratory outcome.

Results A total of 124 clinical encounters were analyzed. Among these, 54 involved children in the home, and documentation of mandatory reporting was absent in 43% (23/54) of such cases. Twenty-five patients experienced strangulation; however, 88% (22/25) of these cases were inadequately investigated. Furthermore, IPV was omitted as a discharge diagnosis in 38% (47/124) of encounters. Overall, 64% (79/124) of charts demonstrated a lack of trauma- and violence-informed care (TVIC) principles in the documentation of IPV-related encounters.

Conclusions These findings highlight that gaps exist for ED patients experiencing IPV and illuminate areas for improvement of clinical care. We provide evidence-based recommendations for ED providers to improve their management of IPV, including review of mandatory reporting legislation, overview of clinical criteria requiring contrast imaging for strangulation, and discussion around the significance of including IPV in ED discharge diagnosis.

Clinical trial number Not applicable.

*Correspondence:
Emma Duchesne
19ed4@queensu.ca

Full list of author information is available at the end of the article

Keywords Intimate partner violence, Trauma informed care, Emergency medicine

Background

Four out of 10 women and three out of 10 men have experienced some form of intimate partner violence (IPV) in their lifetime [1]. Although IPV happens to all gender identities, women experience the highest risk of morbidity and mortality. As such, IPV is considered a form of gender-based violence. Data regarding IPV are staggering: a recent Canadian report found that more than two-thirds of all victims of femicide were killed by an intimate partner [2]. In Canada, one woman is murdered by her intimate partner approximately every 6 days [3, 4]. Of those killed by their abuser, 44% were seen in the emergency department (ED) in the two years preceding their murder [5]. In this context, the ED can play a pivotal role in preventing IPV-related morbidity and mortality.

Despite this, many ED providers feel uncomfortable discussing and managing IPV [6, 7]. Evidence suggests that ED providers often fail to ask about IPV, forgo offering safety planning and specialized services, or even avoid fully engaging when IPV is raised [8–11]. In addition, patients experiencing IPV often report overall negative ED care experiences [12], including feeling blamed and shamed by ED providers for their experiences of violence [13]. Negative provider attitudes directly harm those experiencing IPV by decreasing the likelihood of ending violent relationships [14]. Negative ED experiences can also lead to re-victimization [9], decreased future care-seeking [15, 16], as well as many adverse health, financial and legal outcomes [17, 18].

There are many local and international guidelines for the management of IPV and sexual assault [19–21], but despite this, medical management of IPV within the ED is often sub-optimal. The standard of care based on these guidelines includes avoiding harmful language in both interactions and documentation, completion of mandatory reporting, appropriate treatment of injuries, offer of referral to specialized IPV services, and inclusion of IPV in the patient's final discharge diagnosis. Despite these clearly articulated guidelines, literature suggests that fewer than 20% of patients coming to the ED for sexual assault are provided care in accordance with guidelines [22]. These shortcomings may be exacerbated by rising rates of health care provider burnout [23], which has been associated with victim-blaming attitudes towards patients presenting for IPV [24].

With regards to mandatory reporting, healthcare providers in all Canadian provinces and territories (as well as all American states) are required to make a report to their local Child Protective Agency (henceforth referred to as CPA, but also known as Family and Children Services (FACS) or Children Aid Society (CAS) in other regions) whenever there is concern that IPV is occurring in the presence of a child [25, 26]. Of the 148,536 investigations conducted by Ontarian CPAs in 2018, 74% were initiated after a report from a professional referral source, such as hospital personnel [27]. While there are some studies on the barriers to screening for IPV in pediatric EDs [28], there are few studies that assess ED provider compliance with mandatory reporting laws.

In terms of medical management, strangulation is unfortunately quite common amongst those experiencing IPV, with data from the Alberta Council of Women's Shelters suggesting that at least 55% of women staying in emergency shelters have experienced some method of strangulation [29]. Identification of IPV-related strangulation is critical, as having a history of prior strangulation is associated with an over seven-fold odds (OR 7.48, 95% CI 4.53–12.35) of being killed by an intimate partner [30]. Strangulation is associated with both an acute and delayed risk of morbidity and mortality, through arterial injury which can result in subsequent dissection [31], pulmonary edema [32], and hypoxic-ischemic brain injury [33]. While guidelines suggest that most strangulation be investigated using head and neck computerized tomography angiography (CTA) to rule-out vascular injury [34], there is little data to assess what percentage of patients are actually investigated with CTA after experiencing strangulation.

With respect to discharge diagnosis, not only does adequately labeling a presentation contribute to population-level data used for research and advocacy, but it also allows better patient–physician communication [35, 36]. There are many studies detailing how emergency room providers (ERPs) under-recognize IPV [36, 37]. For example, one study from Michigan found that, of all people identified as experiencing IPV by the county prosecutor's office, only 6% were identified by ERPs [37]. In addition, studies frequently use discharge diagnosis to capture trends on health care utilization and demographics of patients experiencing IPV, relying on standardized codes such as the International Statistical Classification of Diseases (ICD-11) [38] which utilize non-specific and sometimes even outdated terms such as "Battered Spouse Syndrome" [39]. However, despite the importance of accurate ED discharge diagnosis, there is a paucity of data detailing how ERPs conceptualize IPV within their final discharge diagnosis. In particular, no studies examine how providers may recognize a patient as experiencing IPV without including IPV in their discharge diagnosis.

Finally, numerous studies highlight the implicit and explicit biases that individuals experiencing IPV may face in the healthcare system, including within the ED [40, 41]. Negative language, such as questioning a patient's credibility, stereotyping or portraying patients as difficult, particularly when written in the medical chart, has been theorized to transmit bias and affect the quality of care that patients receive [42]. Discourse analysis is a method that studies and analyzes patterns in communication which depict a conception about the world [43]. Discourse analysis has been noted as a research strategy which can be used to explore the relationship between healthcare providers' language and their ideology [44]. We defined discourse as a written communication that depicts a narrative, in our case any beliefs held by providers regarding patients having experienced IPV. There are few studies that have examined the presence of negative discourses in ED provider documentation during care of patients experiencing IPV. Furthermore, it is well established that equity-deserving groups – such as 2-Spirited, Lesbian, Gay, Bisexual, Transgender, Queer or Questioning (2SLGBTQ+) individuals, Black, Indigenous and People of Color (BIPoC) and individuals with (dis)abilities – are more likely to have negative experiences and face bias within the healthcare system [45, 46]. Yet, few studies report on these groups specifically, despite the fact that they are disproportionally affected by IPV [47–50].

While conducting a recent retrospective chart review regarding IPV presentations to the ED during COVID-19 [51], our research team captured data regarding ED management for IPV that was often divergent from the above discussed guidelines. A literature review highlighted that there is little data investigating whether such clinical guidelines and recommendations are in fact being met. Therefore, we sought to fill this gap while also providing examples and recommendations on areas of improvement for ED providers in caring for patients presenting with IPV. Specifically, this analysis sought to examine three primary objectives: (1) ED compliance with mandatory reporting legislation, (2) medical management of strangulation, and (3) inclusion of final discharge diagnosis containing IPV. We also analyzed the language used by ED providers in Electronic Medical Records (EMR) of patients presenting with IPV as a secondary exploratory objective.

Methods

Study setting

This study took place within a two-hospital academic institution in Ontario, Canada with a catchment area serving 500, 000 residents [52]. Data were collected through retrospective chart review of the ED's EMR and documentation from the hospital's Sexual Assault and Domestic Violence Program (SADVP). The SADVP is a specialized service offering clinical and forensic care for IPV and Sexual Assault. All patients included in this study were initially seen in the ED and then referred to the SADVP, where they had detailed medical and forensic data collected, including demographics, presence/absence of children in the home where violence occurred, as well as the types of violence experienced, including whether strangulation had occurred. Data were collected for all ED visits between December 17, 2018 and June 16, 2021.

Study participants

Any patient over the age of 14 years old (the SADVP's age cut-off) who were seen in the ED and subsequently referred to the SADVP for IPV were included. IPV was defined as any behavior by an intimate partner or ex-partner that caused physical, sexual or psychological harm, typically as an attempt to assert power or control over the other [53]. Pediatric patients (< 14 years), or those seen by the SADVP for non-IPV forms of violence, such as non-partner sexual assault, were excluded.

Data collection

Clinical and sociodemographic data were extracted from the charts by two reviewers (AR, JL), while 10% of charts were audited by a third chart-reviewer (ED) for quality assurance. Data were de-identified and recorded in a spreadsheet. Sociodemographic data included age, sex assigned at birth, gender identity, (dis)ability status, language, religion, marital status, ethnicity/race, housing instability or homelessness, and current or previous mental health diagnosis.

For mandatory reporting, the presence of dependents at home was extracted from the SADVP charts (or elsewhere if present). If this was the case, mandatory reporting to CPA was considered complete only if it was explicitly documented in the ED chart. This process was repeated to assess the appropriate mandatory reporting of gunshot wounds.

In cases where strangulation was recorded as having occurred (whether in the ED or SADVP documentation), reviewers assessed charts for any historical or physical exam criteria requiring imaging with CTA (as per guidelines [34]). Strangulation was deemed "inadequately investigated" if criteria were met but CTA was not completed.

With regards to discharge diagnosis, ED charts were marked as containing IPV if "IPV" or another equivalent (including "abuse", "domestic violence", etc.) was recorded as one of the ED discharge diagnoses. Notably, IPV could be either the primary or a subsequent diagnosis (and this was recorded as well).

For our exploratory objective regarding documentation that did not align with TVIC in the charts, the following four terms of interest were identified a priori based on their negative connotations in the context of IPV: "Refuses/Refused", "Alleges/Alleged", "Claims/Claimed", "Denies/Denied". These terms were felt to reflect victim-blaming or stereotyping, paternalistic or controlling attitudes, disapproval of the patient, use of harmful legal terms, and/or discrediting or doubting the veracity of patients' experiences [21, 42, 54, 55]. They were chosen specifically based on the Canadian Association of Emergency Physicians' (CAEP) 2022 Position Statement on IPV as well as through discussion with our local content expert (JL). These words were noted as either *present* or *absent* during chart review. Using an approach adapted from discourse analysis [43], reviewers also recorded verbatim quotes of overtly negative terminology to provide qualitative examples. Of note, the term "Denies/Denied" was subdivided into non-medical (statements illustrating doubt of patients' truthfulness) and medical uses (statements expressing the absence of physical or mental health symptoms) for better contextualization.

Table 1 Sociodemographic characteristics of patients experiencing intimate partner violence seen in the emergency department between December 17, 2018 and June 16, 2021 (*N* = 124)

Demographic Characteristics	Total (% of *N* = 124)
Age (years)	31.0 (26.0-40.8) †
Gender	120 (97)
Women	
Marital Status	64 (52)
Single	46 (37)
Married/Common-Law	14 (11)
Separated/Divorced/Widowed	
Primary Language	119 (96)
English	5 (4)
Non-English (with or without interpreter)§,*	
Number of Dependants	35 (28)
None	27 (22)
One	27 (22)
≥ Two	35 (28)
Missing Data	
Employment	18 (10)
Employed	15 (15)
Unemployed/Student/Retired	91 (73)
Missing Data	
(Dis)ability	25 (20)
Any (Dis)abilityΩ	99 (80)
Missing Data	
Other Important Sociodemographic Features	90 (73)
Current or previous mental health diagnosis	10 (8)
Current homelessness or housing instability	17 (14)
Disclosed history of abuse/trauma	15 (12)
Previous SADVP Engagement	

† Data are median + inter-quartlier ranges

§ Due to small cell sizes, categorical data were combined

* Non-English included the following sub-groups: French, Other/No-interpreter, Other/Interpreter-used

Ω (Dis)ability included the following sub-groups: Mobility/Physical (Dis)ability, Mental Health Condition, Vision Impairment, Hearing Impairment, Intellectual or Learning (Dis)ability and Other/Unspecified (Dis)ability

This study received approval by the Queen's University Health Sciences and Affiliated Teaching Hospitals Research Ethics Board (#6033039).

Data analysis

All data were analyzed using SPSS Ver 27 [56]. Descriptive statistics included frequencies and percentages for categorical variables and median with interquartile for continuous variables. A systematic review [55] was utilized to identify providers' commonly held ideas related to patients experiencing IPV and to contextualize any non-trauma-informed language used when documenting IPV encounters in the EMR. The first step in analyzing the data was repeated reading of the documentation. This allowed the reviewers (AR and ED) to identify common non-TVIC beliefs, behaviors or language. These occurrences were identified by examining the content within the sociological and cultural context of the ED, using both explicit and implicit themes found in providers' documentation.

Results

Characteristics of the study population

There were a total of 124 presentations to the ED that subsequently resulted in a referral to the SADVP, including nine repeat visits. The median age of included patients was 31 years (IQR 26.0-40.8), with a range of 18–71 years. Most patients self-identified as women, representing 97% (120/124) of the study population. However, given that our EMR does not explicitly ask about gender identity, data on the proportion of trans- versus cisgendered women is incomplete. Data on religion, employment, (dis)ability, ethnicity/race and sexual orientation were frequently missing from charts, with 66% (82/124), 73% (91/124), 80% (99/124), 90% (111/124), and 99% (123/124) of data missing, respectively. A high percentage of patients (73% or 90/124) had a current or previous mental health diagnosis. A notable minority identified as experiencing homelessness or housing instability (8% or 10/124). Detailed demographic data can be found in Table 1.

Among the sample of individuals experiencing IPV and seeking care in the ED, many and often multiple, forms of IPV were reported: 85% (105/124) of presentations involved physical violence, 18% (22/124) involved sexual assault, and 54% (67/124) involved other forms of abuse (such as verbal abuse, psychological abuse, stalking, confinement/isolation, cyber-violence, spiritual abuse, and/or financial abuse). These exceed our sample size of 124 because they are not mutually exclusive.

Table 2 – Management of intimate partner violence investigations, documentation and mandatory reporting for ED visits that involved IPV ($N = 124$)

	Number of Charts (%)
Strangulation	
Presence of strangulation	36 (29.0)
Strangulation meeting criteria for CTA	25 (20.1)
Investigated with CTA	3 (2.4)
Not investigated with CTA	22 (17.7)
Mandatory Reporting for Children	
Patients with Dependents at Home	54 (43.5)
CPA explicitly notified by ERP	31 (57.4)
CPA not explicitly notified by ERP	23 (42.6)
Final Discharge Diagnosis	
IPV as only diagnosis	61 (49.2)
IPV and other diagnosis	16 (12.9)
IPV not listed at all	47 (37.9)

CPA - Child Protection Agency

CTA - Computerized tomography angiography

ED - Emergency Department

ERP - Emergency room physician

IPV - Intimate Partner Violence

Mandatory reporting

Of the 44% (54/124) of patients with children at home, 43% (23/54) had no documented notification to CPA by ED providers. These data can be found in Table 2.

Only one (0.7%) IPV-related gun-shot wound was seen in the study period. This was not reported to the police.

Strangulation

Among participants, 29% (36/124) of IPV encounters involved strangulation. Of these, 69% (25/36) warranted contrast imaging based on the Family Justice Centre Alliance Imaging Recommendations for the Medical/Radiographic Evaluation of Acute Adult, Non-Fatal Strangulation guidelines [34]. However, only 12% (3/25) of these patients were investigated with a CTA in the ED (Table 2).

Final discharge diagnosis containing IPV

Of the patients evaluated in the ED following IPV, 62% (77/124) were discharged with a diagnosis of IPV, while 38% (47/124) did not have IPV listed as a discharge diagnosis (Table 2).

Language

Of the 124 ED charts reviewed, 64% (79/124) contained at least one example of negative language and 20% (25/124) had multiple instances of non-TVIC language. The most frequently used negative terms were "*denies/denied*", which occurred in 53% (66/124) of charts. Among these charts that documented "denies/denied", 44% (29/66) of uses were in a strictly medical context, such as when a patient expressed "no" to questions related to physical symptoms (e.g. "denies headache"), but 56% (37/66) of these charts used "denies/denied" in non-medical contexts, such as inquiring whether the patient was intoxicated by drugs or alcohol during an assault. Other negative terms were also relatively commonplace among ED charts: with 11% (14/124) containing "refuses/refused", 7% (8/124) containing "alleges/alleged", and 2% (3/124) containing "claims/claimed". Other negative language was seen in 19% (23/124) of charts, including words such as "difficulty" ($n = 1$), "uncooperative" ($n = 1$), "non-compliant" ($n = 1$), "emotional" ($n = 1$) and "hysterical" ($n = 2$), among others. Demonstrative examples with verbatim quotations are highlighted in Table 3.

Discussion

Summary of findings

Our findings demonstrate persistent deficiencies in ED clinical care metrics for patients experiencing IPV. Specifically, in this retrospective chart review we observed that mandatory reporting is often missed, strangulation is routinely under-investigated, IPV is frequently omitted from discharge diagnoses, and the use of negative language in ED documentation is common. These findings highlight current gaps in assessment and management of IPV within the health care system, and the critical need for more education and training for providers. Similar conclusions have been drawn by the 2024 Ontario Domestic Violence Death Review Committee (DVDR), which summarized data from a 10-year period in Ontario [57], as well as The Ryan Inquest [58], a Coroner's inquest examining the tragic murder of Gladys Helen Ryan by her husband in the Coburg ED in 2017. The inquest produced several recommendations directed towards health care training programs, Local Health Integration Networks, Home and Community Care Support Services, as well as the Ministry of Health. Both these reports emphasized the need for enhanced training on elder abuse and IPV, as well as the development of structured institutional assessment and management strategies to better identify and mitigate risks for patients experiencing violence [57, 58]. Despite such recommendations being raised repeatedly, progress in implementing meaningful change has been slow.

Mandatory reporting

Data from this study highlights that ED providers frequently overlook inquiring about the presence of children in the home where violence is occurring, as well as documenting completion of mandatory reporting when it is indicated. Even more concerning is that this study most likely underestimates this phenomenon as some patients did not receive full SADVP evaluation and subsequent documentation of children in the home. In addition to rules governing mandatory reporting of minors

Table 3 Sample quotes of non-trauma informed language used in charts

Common Harmful False Stereotypes	
Theme 1: Perpetuating victim-blaming	**Theme 2: Perceiving patient as "difficult" or "hostile"**
• "pt came home and she and her partner got in an argument because she is an EtOHolic" • "Pt is still living with attacker"	• "pt giving ++ attitude to RN" • "[Patient is] Difficult" • "Pt not willing to talk without an interpreter present as pt is deaf"
Theme 3: Perceiving patient as "crazy" or "hysterical"	**Theme 4: Perceived discrimination based on mental illness, substance use or low SES**
• "[pt is a] challenging historian, very scattered recollection of events" • "emotional upset of same, rambling thoughts +++++" • "too hysterical to provide her name and dob" • "Patient whispering, but obviously able to speak in normal voice at times"	• "poorly dressed/disheveled, unkempt" • "Pt was ++ malodorous with smell of urine."
Common Harmful Words	
Refuses/Refused	**Alleges/Alleged**
• "pt was seen by EMS on scene though refused to come with them" • "pt refused further exam or investigation" • "pt refused to sit in chair" • "Pt refused to give consent and refused to talk with the SADVP nurse any further"	• "Allegedly assaulted by husband" • "[…] unlikely related to alleged assault" • Discharge Dx 1 is "Alleged Assault" • "describes being in an allegedly abusive relationship", "allegedly, she was sexually abused and physically abused"
Denies/Denied	**Claims/Claimed**
Examples in medical context • "denies hallucination" • "denies SOB" • "denies headache" *Examples in non-medical context* • "denies reciprocating" • "denies any sexual violence at this time", • "saw SADVP [previously], although pt denies this" *Examples related to substance use* • "denies recent substance use" • "denies crystal meth use in last days, denies IVDU" • "denies opioids/etoh/other substances"	• "[Pt] claims he struck her by punching her whole body" • "Pt also claims that she was punched in the head"

Dx - Diagnosis

EMS - Emergency Medical Services

Etoh - Ethanol

IVDU - Intravenous Drug Use

Pt - Patient

SADVP - Sexual Assault and Domestic Violence Program

SES - Socio-Economic Status

at risk, many Canadian provinces and territories have also adopted mandatory reporting policies for gunshot wounds [59]. While there was only one gunshot wound in the included study population, it went unreported despite regulations, suggesting another overlooked area of mandatory reporting as it pertains to IPV.

There are many potential reasons why ED providers may have failed to document these mandatory reporting instances, including forgetting to inquire in the first place, neglecting to document that a report was made, and/or purposefully avoiding asking about children in order to circumvent their duty to report and risk breaking their therapeutic alliance with the patient. It also is possible that ED providers simply assume that specialized IPV-care teams will complete a report on their behalf. However, this assumption is dangerous as it is not uncommon for patients to leave the ED prior to their evaluation by the specialized IPV care team, something that was seen more than once in this study sample. Regardless of the reason, these patterns place children at risk. It is well-established that exposure to violence as a child is associated with increased risk of negative physical, mental, and socioeconomic outcomes, as well as perpetrating and/or experiencing IPV later in life [60]. Therefore, reporting IPV that occurs in the presence of a child is an impactful opportunity for intervention by ED providers.

Medical management of strangulation

We observed clinical variability in the investigation of strangulation, including an alarming rate of under-investigation of strangulation that was associated with worrisome historical or physical exam features, such as incontinence, dysphonia, dyspnea or neck contusions [34]. Among the 25 patients who met imaging criteria following strangulation, only three (12%) were appropriately investigated with CTA, suggesting that many patients in the study population were under-investigated.

Many previous studies have highlighted the dangers of strangulation injuries, including the high mortality it carries [30]. Despite its lethality, patients experiencing violence often "normalize" strangulation, viewing it as equivalent to other forms of physical violence such as pushing [61]. This may explain why patients do not volunteer that they have been strangled without prompting, all of which highlights the critical importance of routine screening for strangulation among persons experiencing IPV.

Final discharge diagnosis

IPV is often unrecognized in the ED. In over a third of the cases we reviewed, physicians omitted a diagnosis of IPV altogether at ED discharge. This is in keeping with previous studies that found healthcare providers often use euphemisms to describe and discuss IPV, such as "conflict" [62], "assault by bodily force" [63] or "social problem" [64]. This may be due to providers' lack of comfort with IPV [65], or it may reflect negative stereotypes or victim-blaming attitudes more broadly [62]. The lack of modern language in ICD-11 coding for IPV diagnosis also likely represents a barrier to including IPV within the discharge diagnosis. Failing to appropriately classify a patient's ED presentation as related to IPV represents a misdiagnosis. This can negatively impact a patient's legal outcomes down the line [66] and also contribute to underreporting of IPV-related ED visits on a local and population-level. This underreporting can be detrimental to public health initiatives, research, and funding allocation for IPV and IPV care programs [54]. We recognize that in some centres, EMRs automatically print discharge diagnoses for patients prior to departure from the hospital, which may increase the risk of violence from an assailant. Therefore, we recommend a careful and context-specific approach to including IPV in discharge diagnoses. We strongly encourage providers to document IPV whenever it can be done without increasing the patient's risk of harm (as in our context) and to advocate for mechanisms such as "lock boxes" that allow for safe and confidential documentation.

Language

We found many instances of negative language being used by ED providers, which can have numerous negative repercussions for patients during their ED care and long-after. Previous literature has demonstrated that providers often perceive patients presenting for IPV as "*difficult*" or "*hostile*" [67]; "*crazy*", "*hysterical*" and "*unreliable*"; or as "incapable" because of mental illness, substance use, or low socioeconomic status [55]. These negative stereotypes and false beliefs regarding IPV are unfortunately reflected in our data, given multiple instances of patients being described in such terms. Given the gendered nature of IPV and the fact that most of our study population identified as women, these tropes may be rooted in misogyny [68].

Our study also highlights that victim-blaming attitudes from providers are also relatively commonplace, as evidenced by representative quotations in Table 3. These negative attitudes and stereotypes are not only hurtful for patients who subsequently read their own medical records, but can also perpetuate bias for the next provider who reads previous documentation during future medical encounters [69]. Evidence suggests that patients experiencing violence or trauma are hyper-aware of verbal and non-verbal cues from providers [70]. Therefore, if the negative language in charts reflects the providers' state of mind during the clinical encounter, these attitudes are likely to be noticed by the patient. This lack of TVIC leads to negative ED experiences, which results in further harm through secondary victimization [71]. This is supported by a recent study demonstrating that patients having experienced IPV have had negative experiences in the ED [12]. Ultimately, this leads to future care avoidance and contributes to worse physical and mental health outcomes from IPV [17, 18, 71–73].

Negative language in ED documentation can also have significant legal ramifications. The use of legal terms such as "*alleged/alleges*" implies doubt regarding the patient's experience which can impact legal outcomes. Physicians have been previously noted to be worried about legal repercussions or liability should they document a false report of IPV [74]. However, false reports of IPV are rare and have been estimated to occur in only 2–10% of cases [75]. Regardless, physicians are medical practitioners, not legal stewards, and they typically rely on patients' accounts of events without calling them into question. For example, when seeing a patient with an ankle fracture, one would not document the mechanism as "*alleged fall from sidewalk*". Furthermore, using terms such as "*deny/denies*" when asking about the patient's use of drugs or alcohol during the assault may imply distrust or even blame of the patient that could prove harmful in subsequent legal proceedings [66]. Although health care providers often employ terms such as *"deny/denies"*, definitions of this term in non-medical contexts include to "*refuse to admit or acknowledge (something)"* [76]. Ultimately, providers should aim to document visits involving IPV with the same principles as for any other medical presentations: in an objective, detailed, and complete manner. Beyond helping validate criminal charges, accurate documentation of IPV can have numerous positive impacts in patients' lives including facilitating the filing of a peace-bond or restraining order, qualification for special priority housing, gaining immigration benefits, and even accessing insurance [77–79]. Given these findings, it may in fact be harmful for providers to use language that implies skepticism of the patient's presentation. This exemplifies the many reasons why the language and attitudes expressed in provider documentation is important.

Strengths and limitations

Limitations

This study has some notable limitations. First, only patients who disclosed IPV during their ED care and were subsequently referred to the SADVP were included. Given how underrecognized IPV is within the ED, this means many patients experiencing IPV were likely not captured which represents a selection bias. Second, while we attempted to collect detailed demographic data, we were limited by the retrospective nature of this study and demographic presets of our hospital's EMR. In addition, charts with incomplete or missing data were encountered as some patients were referred to the SADVP but subsequently declined care, while others left after only a partial SADVP evaluation. Third, this was a single institution study with a relatively small sample size. The study population was largely Caucasian women and thus may not be representative of more diverse ED populations. Thus, results from this study lack generalizability to other geographic settings and to more diverse populations. Fourth, given the retrospective nature of this study that relied on medical records, limitations related to lack of blinding to the study purpose, presence of confounding factors, and possible inconsistencies in coding information may have been present. Examples of specific confounders in this study include the impact of COVID-19 related burnout on ERPs' ability to avoid biased documentation, the impact of contrast shortage on completion of CTAs, and EMR's impact on selection of final discharge diagnoses.

Similarly, because many study outcomes relied on language, limitations included language ambiguities and confirmation bias. To minimize these ambiguities, previously established definitions were used to minimize bias and increase consistency [42]. The term "denies/denied" was also subdivided into medical and non-medical contexts to be more representative of language encountered in clinical practice. In addition, because there was no control group, we cannot compare the use of negative language used by ED providers caring for patients presenting with medical complaints unrelated to IPV, or for other equity-deserving patient groups. Thus, more studies are needed to say with certainty if negative language is universally more frequent for patients experiencing IPV compared to those who aren't.

Lastly, it is likely that cases of strangulation were missed by providers and are subsequently underreported in our dataset. To begin, patients may not recall experiencing strangulation due to loss of consciousness or post-traumatic retrograde amnesia. Next, strangulation was only recorded during data collection when documentation explicitly stated its presence, thus, missing cases where providers did not ask about or did not document strangulation. Additionally, some patients may not understand technical language such as "strangulation" and may have been missed when providers did not ask questions in lay terms such as "being choked" or "having an object or hands around your neck". Lastly, the existence of dependents was recorded during the detailed SADVP intake interview. This was then compared to ED documentation. This may have led to a discrepancy in cases where ED providers asked about children or notified CPA without documenting it. In addition, no age was recorded for dependents and therefore some dependents may have been older than 16 years old, which would not necessitate mandatory reporting in our region.

Strengths

This study is the first to our knowledge to evaluate clinical care parameters for IPV such as ED mandatory reporting patterns, medical management of strangulation, inclusion of IPV as a final discharge diagnosis and non-TVIC language in official documentation. It is also one of few studies to specifically examine ED charts for the use of harmful legal terms and biased language. We employed duplicate review to establish inter-rater reliability and add validity to the chart abstraction. Inclusion of qualitative information from the charts allowed for contextualization of quantitative findings.

Recommendations

Recommendations for clinicians

Based on our findings, we present recommendations to improve ED care for patients experiencing IPV which can be found in Table 4. In summary, medical management of patients should include appropriate TVIC which includes avoidance of harmful language in documentation, as well as appropriate management of injuries from strangulation [79]. Departments should offer frequent educational opportunities regarding IPV to all providers in direct contact with patients, as well as offer reminders regarding legal duties of care based on their province/state policy. Providers should also be mindful of listing IPV within the discharge diagnosis when this does not place the patient's safety at risk. This should be the case even if the patient has presented for suicidal ideation, alcohol intoxication, physical injuries, or pelvic inflammatory disease. In these examples, it is important to consider IPV as a potential contributing factor and enter it as non-primary discharge diagnosis when a patient screens positive.

Table 4 Recommendations for clinicians

1. Create educational opportunities for ED providers surrounding:

◆ Providing Trauma-Informed Care
◆ Myths surrounding IPV
◆ Managing IPV in the emergency context

2. Avoid harmful language in medical documentation

- Implication of Doubt
  ◆ Use patient "states" or "reports" instead of "alleges" or "claims"
  ◆ Avoid documenting "alleged assault"
  ◆ Avoid using "denies" in a non-medical context
- Bias Check
  ◆ Believe your patient
  ◆ Be cognizant of the impact of biased language in medical records on future visits
  ◆ Document "declines/declined" instead of "refuses/refused"
  ◆ Document "states/stated no […]" or "does/did not report […]" instead of "denies/denied"
  ◆ Emphasize thoughtful and informed shared-decision making
- Harmful Stereotypes
  ◆ Perceiving patients as manipulative or hostile
  ◆ Perceiving patients as incapable because of mental illness, substance use, or low SES
  ◆ Perceiving patients as "crazy", irrational or unreliable
  ◆ Perceiving patients as deserving of violence (victim-blaming)

3. Complete appropriate mandatory reporting

- Review Local Requirements for Mandatory Reporting
  ◆ Ask and document about presence of children
  ◆ Remember gunshot wounds require reporting
  ◆ Consider Duty to Warn and Protect in cases of serious risk of homicide
  ◆ Don't rely on other providers to report in your place
  ◆ Consider legal ramifications of not performing all duties of care

4. Assessment of strangulation

- Screen
  ◆ Screening questions examples include:
    • *Does your partner ever put their hands or an object around your neck?*
    • *Does your partner ever sit/kneel on your chest or back, making it difficult to breathe?*
    • *Does your partner ever put a hand/object over your nose and/or mouth?*
- Image
  ◆ Complete contrast imaging of head and neck when indicated:
  ◆ *History*: loss of consciousness, visual changes, incontinence, seizures, amnesia or dysphonia
  ◆ *Physical Exam*: decreased level of consciousness, facial, intraoral or conjunctival petechiae, neck contusions or subcutaneous emphysema

5. Indicate the appropriate discharge diagnosis

- Include IPV or equivalent within the discharge diagnosis if it does not jeopardize patient safety

IPV - Intimate Partner Violence

SES - Socio-Economic Status

Recommendations for future research

Future research should include larger scale prospective studies allowing for more reliable detection of trends in provider behaviors. Given the disproportionate risk of bias within the healthcare system, under-recognition of IPV, and lack of specialized resources for diverse populations [80, 81], more research focused on IPV-related ED visits among men, 2SLGBTQ + and BIPoC patients, as well as other equity-deserving groups should be undertaken. Future studies should also focus on medical management and care experiences of patients seen in the ED without subsequent SADVP or specialized outpatient follow-up. To foster this, providers and administrators should consider the automatic incorporation of detailed sociodemographic information related to race, sexual orientation, gender, and (dis)ability in EMRs to facilitate more inclusive data collection and equitable care.

Conclusion

Many gaps remain in the assessment, management, and documentation of IPV in the ED. These include failing to document presence of children at home and subsequent mandatory reporting, suboptimal clinical management of strangulation, omitting IPV from the final discharge diagnosis, and use of non-TVIC language in charting. This study allows for reflection on avenues for improvement of providers' approaches to IPV and offers several tangible recommendations for clinical practice. These include ensuring appropriate medical management of strangulation, avoiding harmful language in documentation that conveys doubt or perpetuates harmful stereotypes, and prioritizing the selection of an accurate discharge diagnosis whenever safe.

Abbreviations

2SLGBTQ+	2-Spirited, Spirited, Lesbian, Gay, Bisexual, Transgender, Queer or Questioning
BIPoC	Black, Indigenous and People of Color
CPA	Child Protective Agency
CTA	Computerized Tomography Angiography
ED	Emergency Department
ERP	Emergency Room Provider
IPV	Intimate Partner Violence
SADVP	Sexual Assault and Domestic Violence Program
TVIC	Trauma- and Violence-Informed Care

Acknowledgements
The authors thank Patrick Norman for advice on biostatistical analysis of data.

Author contributions
ED: study conception and design, data collection and quality review, data analysis and interpretation, drafting of manuscript, critical revision of manuscript. AR: study conception and design, data collection, data analysis and interpretation, drafting of manuscript, critical revision of manuscript, statistical expertise, acquisition of funding. JL: study conception and design, data collection, critical revision of manuscript, data analysis and interpretation and content expertise. SAB: study conception and design, critical revision of manuscript, data analysis and interpretation. MW: study conception and design, critical revision of manuscript, statistical expertise, data analysis and interpretation, acquisition of funding. NR: study conception and design, critical revision of manuscript, data analysis and interpretation, acquisition of funding.

Funding
This project was supported in part by the Queen's University ***Fund for Scholarly Research and Creative Work and Professional Development (Adjuncts**, **PI: M. Walker)***. The funding body did not play a role in any part of the study design or completion.

Data availability
The data that support the findings of this study are not openly available due to reasons of sensitivity and are available from the corresponding author upon reasonable request and with permission of the Queen's University Health Sciences and Affiliated Teaching Hospitals Research Ethics Board.

Declarations

Ethics approval and consent to participate
This study received approval by the Queen's University Health Sciences and Affiliated Teaching Hospitals Research Ethics Board (#6033039). The need for consent to participate was waived by the Queen's University Health Sciences and Affiliated Teaching Hospitals Research Ethics Board (#6033039). The Queen's University Health Sciences and Affiliated Teaching Hospitals Research Ethics Board operates in accordance with the standards developed by the Tri-Councils: the Canadian Institutes of Health Research (CIHR), the Natural Sciences and Engineering Research Council (NSERC), and the Social Sciences and Humanities Research Council (SSHRC).

Consent for publication
Not applicable.

Competing interests
The authors declare no competing interests.

Author details
[1]Department of Emergency Medicine, Queen's University, Kingston, ON, Canada
[2]Department of Emergency Medicine, University of Ottawa, Ottawa, ON, Canada
[3]Ontario Network of Sexual Assault/Domestic Violence Treatment Centres, Women's College Hospital, Toronto, ON, Canada
[4]Department of Public Health Sciences, Queen's University, Kingston, ON, Canada

Received: 11 October 2024 / Accepted: 24 November 2025
Published online: 06 January 2026

References

1. Cotter A. Intimate partner violence in Canada, 2018: An overview. Juristat. Statistics Canada Catalogue no. 85-002-X. 2021.
2. Canadian Femicide Observatory for Justice and Accountability. #CallItFemicide - Understanding sex/gender-related killings of women and girls in Canada, 2018–2022. 2023.
3. Canadian Women's Foundation. The facts about gender-based violence. [Internet]. 2022. Available from: https://canadianwomen.org/the-facts/gender-based-violence/
4. Armstrong A, Jaffray B. Homicide in Canada, 2020. Juristat. Statistics Canada Catalogue no. 85-002-X. 2021.
5. Huecker MR, King KC, Jordan GA, Smock W. Domestic Violence. Domestic violence. Treasure Island (FL): StatPearls Publishing. [Internet]. 2023. Available from: https://www.ncbi.nlm.nih.gov/books/NBK499891/.
6. Dawson AJ, Rossiter C, Doab A, Romero B, Fitzpatrick L, Fry M. The emergency department response to women experiencing intimate partner violence: insights from interviews with clinicians in Australia. Acad Emerg Med. 2019;26(9):1052–62.
7. Dowd MD, Kennedy C, Knapp JF, Stallbaumer-Rouyer J. Mothers' and health care providers' perspectives on screening for intimate partner violence in a pediatric emergency department. Arch Pediatr Adolesc Med. 2002;156(8):794.
8. Leppäkoski T, Paavilainen E, Astedt-Kurki P. Experiences of emergency care by the women exposed to acute physical intimate partner violence from the Finnish perspective. Int Emerg Nurs. 2011;19(1):27–36.
9. Pratt-Eriksson D, Bergbom I, Lyckhage ED. Don't ask don't tell: battered women living in Sweden encounter with healthcare personnel and their experience of the care given. Int J Qual Stud Health Well-being. 2014;9:23166.
10. Rhodes KV, Frankel RM, Levinthal N, Prenoveau E, Bailey J, Levinson W. You're not a victim of domestic violence, are you? Provider patient communication about domestic violence. Ann Intern Med. 2007;147(9):620–7.
11. Rhodes KV, Kothari CL, Dichter M, Cerulli C, Wiley J, Marcus S. Intimate partner violence identification and response: time for a change in strategy. J Gen Intern Med. 2011;26(8):894–9.
12. Bartels SA, MacKenzie M, Douglas SL, Collier A, Pritchard J, Purkey E, et al. Emergency department care experiences among members of equity-deserving groups: quantitative results from a cross-sectional mixed methods study. BMC Emerg Med. 2023;23(1):21.
13. Yam M. Seen but not heard: battered women's perceptions of the ED experience. J Emerg Nurs. 2000;26(5):464–70.
14. Matlow RB, DePrince AP. The impact of appraisals and context on readiness to leave a relationship following intimate partner abuse. Violence against Women. 2015;21(9):1043–64.
15. Loke AY, Wan ML, Hayter M. The lived experience of women victims of intimate partner violence. J Clin Nurs. 2012;21(15–16):2336–46.
16. Tower M, McMurray A, Rowe J, Wallis M. Domestic violence, health & health care: women's accounts of their experiences. Contemp Nurse. 2006;21(2):186–98.
17. Campbell R, Raja S. Secondary victimization of rape victims: insights from mental health professionals who treat survivors of violence. Violence Vict. 1999;14(3):261–75.
18. Ahrens CE. Being silenced: the impact of negative social reactions on the disclosure of rape. Am J Community Psychol. 2006;38(3–4):263–74.
19. World Health Organization. Clinical and policy guidelines: responding to intimate partner violence and sexual violence against women. [Internet]. 2013. Available from: https://www.who.int/publications/i/item/9789241548595
20. World Health Organization. Guidelines for medico-legal care of victims of sexual violence. [Internet]. 2003. Available from: https://apps.who.int/iris/handle/10665/42788
21. Khatib N, Sampsel K. CAEP position statement executive summary: where is the love? Intimate partner violence (IPV) in the emergency department (ED). CJEM. 2022;24(7):691–4.
22. Patel A, Roston A, Tilmon S, Stern L, Roston A, Patel D, et al. Assessing the extent of provision of comprehensive medical care management for female

sexual assault patients in US hospital emergency departments. Int J Gynaecol Obstet. 2013;123(1):24–8.
23. Salyers MP, Bonfils KA, Luther L, Firmin RL, White DA, Adams EL, et al. The relationship between professional burnout and quality and safety in healthcare: A Meta-Analysis. J Gen Intern Med. 2017;32(4):475–82.
24. Ferencik SD, Ramirez-Hammond R. Trauma-informed care best practices and protocols for ohio's domestic violence programs. Ohio Domest Violence Netw. 2013;1(2):95–6.
25. Canadian Medical Protection Association. Protecting children — Reporting child abuse. [Internet]. 2024. Available from: https://www.cmpa-acpm.ca/en/advice-publications/browse-articles/2012/protecting-children-reporting-child-abuse
26. Child Welfare Information Gateway. State Statutes Series. [Internet]. 2023. Available from: https://www.childwelfare.gov/resources/mandatory-reporting-child-abuse-and-neglect/
27. Fallon B, Filippelli J, Lefebvre R, Joh-Carnella N, Trocmé N, Black T, et al. Ontario incidence study of reported child abuse and neglect-2018 (OIS-2018). Child Welf Res Portal. 2018.
28. Loza-Avalos SE, Thompson E, Beulah B, Murray A. What are we missing? Evaluating an intimate partner violence screening program in a pediatric emergency department. Pediatr Emerg Care. 2022;38(2):e462–7.
29. Cairns K, Hoffart I. Keeping women alive – assessing the danger. Alberta Council of Women's Shelters. [Internet] 2009. Available from: https://endvaw.ca/wp-content/uploads/2015/12/dangerassessment-fullreport_final_acws_2.pdf.
30. Glass N, Laughon K, Campbell J, Block CR, Hanson G, Sharps PW, et al. Non-fatal strangulation is an important risk factor for homicide of women. J Emerg Med. 2008;35(3):329–35.
31. Patch M, Anderson JC, Campbell JC. Injuries of women surviving intimate partner strangulation and subsequent emergency health care seeking: an integrative evidence review. J Emerg Nurs. 2018;44(4):384–93.
32. Dunn RJ, Sukhija K, Lopez RA. Strangulation injuries. StatPearls. Treasure Island (FL): StatPearls Publishing. [Internet]. 2022. Available from: https://www.ncbi.nlm.nih.gov/books/NBK459192/
33. Monahan K, Purushotham A, Biegon A. Neurological implications of nonfatal strangulation and intimate partner violence. Future Neurol. 2019;14(3):21.
34. Smock B, Green B, Sturgeon S. Family Justice Centre Alliance imaging recommendations for the medical/radiographic evaluation of acute adult, non-fatal strangulation. [Internet]. 2023. Available from: https://www.familyjusticecenter.org/resources/recommendations-for-the-medical-radiographic-evaluation-of-acute-adult-non-fatal-strangulation.
35. Wen LS, Kosowsky JM, Gurrola ER, Camargo CA Jr. The provision of diagnosis at emergency department discharge: a pilot study. Emerg Med J. 2013;30(10):801.
36. Choo EK, Nicolaidis C, Newgard CD, Hall MK, Lowe RA, McConnell MK, et al. Association between emergency department resources and diagnosis of intimate partner violence. Eur J Emerg Med. 2012;19(2):83–8.
37. Kothari CL, Rhodes KV. Missed opportunities: emergency department visits by police-identified victims of intimate partner violence. Ann Emerg Med. 2006;47(2):190–9.
38. World Health Organization. International statistical classification of diseases and related health problems. 11th ed. World Health Organization; 2019.
39. Btoush R, Campbell JC, Gebbie KM. Visits coded as intimate partner violence in emergency departments: characteristics of the individuals and the system as reported in a National survey of emergency departments. J Emerg Nurs. 2008;34(5):419–27.
40. Corbally MA. Factors affecting nurses' attitudes towards the screening and care of battered women in Dublin A&E departments: a literature review. Accid Emerg Nurs. 2001;9(1):27–37.
41. Inoue K, Armitage S. Nurses' Understanding of domestic violence. Contemp Nurse. 2006;21(2):311–23.
42. Park J, Saha S, Chee B, Taylor J, Beach MC. Physician use of stigmatizing Language in patient medical records. JAMA Netw Open. 2021;4(7):2117052. https://doi.org/10.1001/jamanetworkopen.2021.17052.
43. Lupton D. Discourse analysis: a new methodology for Understanding the ideologies of health and illness. Aust J Public Health. 1992;16(2):145–50.
44. daSilva F. Deconstructing patients: a discourse analysis of IBD patients' medical records. Orebro University. Master's Thesis. 2017.
45. Casanova-Perez R, Apodaca C, Bascom E, Mohanraj D, Lane C, Vidyarthi D, et al. Broken down by bias: healthcare biases experienced by BIPOC and LGBTQ+patients. AMIA Annu Symp Proc. 2024;2021:275–84.
46. VanPuymbrouck L, Friedman C, Feldner H. Explicit and implicit disability attitudes of healthcare providers. Rehabi Psychol. 2020;65(2):101–12.
47. Jaffray B. Intimate partner violence: Experiences of sexual minority men in Canada, 2018. Juristat. Statistics Canada Catalogue no. 85-002-X. 2021.
48. Jaffray B. Intimate partner violence: Experiences of sexual minority women in Canada, 2018. Juristat. Statistics Canada Catalogue no. 85-002-X. 2021.
49. Hyman I, Forte T, Du Mont J, Romans S, Cohen MM. Help-seeking behavior for intimate partner violence among Racial minority women in Canada. Women's Health Issues. 2009;19(2):101–8.
50. Savage L. Intimate partner violence: experiences of women with disabilities in Canada, 2018. Juristat. Statistics Canada Catalogue no. 85-002-X. 2021.
51. Ross AN, Duchesne E, Lewis J, Norman PA, Bartels SA, Walker M, et al. Urgent care-seeking and injury severity for intimate partner violence during COVID-19: a Canadian retrospective chart review. BMC Public Health. 2023;23(1):2169. https://doi.org/10.1186/s12889-023-16991-z.
52. Kingston Health Sciences Center. [Internet]. 2023. Available from: https://kingstonhsc.ca/sites/default/files/legacy/documents/basic-page/mda_f22-23.pdf
53. World Health Organization. Violence Info: World Health Organization. 2022. [Internet]. Available from: https://apps.who.int/violence-info/intimate-partner-violence/
54. Khatib N, Hoang R. EM Ottawa Blog. Where is the love intimate partner violence in the emergency department. [Internet]. 2018. Available from: https://emottawablog.com/2018/01/where-is-the-love-intimate-partner-violence-in-the-emergency-department/
55. Duchesne E, Nathoo A, Walker M, Bartels SA. Patient and provider emergency care experiences related to intimate partner violence: a systematic review of the existing evidence. Trauma Violence Abuse. 2023;24(5):2901–21. https://doi.org/10.1177/15248380221189622022:15248380221118962.
56. Statistical Package for the Social Sciences. IBM Corp. Released 2021. IBM SPSS statistics for Windows, version 28.0. Armonk, NY: IBM Corp.
57. Saxton M, Bukhari S, Jaffe P, Scott K, Rajan P, Reif K, et al. How to prevent domestic homicides: a qualitative study of recommendations from a Canadian domestic homicide review committee. J Fam Violence. 2024;40(6):1183–96.
58. Office of the Chief Coroner. Inquest into the deaths of: Gladys Helen Ryan and William Thomas Ryan. [Internet]. 2023. Available from: https://www.ontario.ca/page/2023-coroners-inquests-verdicts-and-recommendations
59. Canadian Medical Protective Association. Physician interactions with police. [Internet]. 2023. Available from: https://www.cmpa-acpm.ca/en/advice-publications/browse-articles/2011/physician-interactions-with-police
60. Wathen CN, Macmillan HL. Children's exposure to intimate partner violence: impacts and interventions. Paediatri Child Health. 2013;18(8):419–22.
61. McLean M. Strangulation identification. PEI Family Violence Prevention. [Internet]. 2012. Available from: https://www.princeedwardisland.ca/en/publications
62. Djikanovic B, Celik H, Simic S, Matejic B, Cucic V. Health professionals' perceptions of intimate partner violence against women in serbia: opportunities and barriers for response improvement. Patient Educ Couns. 2010;80(1):88–93.
63. Kivelä S, Leppäkoski T, Ruohoniemi J, Puolijoki H, Paavilainen E. The documentation and characteristics of hospitalized IPV patients using electronic medical records data: a follow-up descriptive study. J Fam Violence. 2019;34(7):611–9.
64. Robinson R. Myths and stereotypes: how registered nurses screen for intimate partner violence. J Emerg Nurs. 2010;36(6):572–6.
65. Portnoy GA, Colon R, Gross GM, Adams LJ, Bastian LA, Iverson KM. Patient and provider barriers, facilitators, and implementation preferences of intimate partner violence perpetration screening. BMC Serv Res. 2020;20(1):746.
66. Cory J, Hankivsky O, Ruebsaat G, Dechief L. Reasonable, doubt: the use of health records in legal cases of violence against women in relationships. [Internet] 2003. Available from: https://cewh.ca/wp-content/uploads/2012/05/2003_Reasonable-Doubt.pdf.
67. Delgado-Alvarez C, Sanchez-Prada A. Stereotypes about battered women and victim's self-defense: legal implications. J Interpers Violence. 2022;37(21–22):21019–44.
68. Tasca C, Rapetti M, Carta MG, Fadda B. Women and hysteria in the history of mental health. Clin Pract Epidemiol Ment Health. 2012;8:110–9.
69. Haskins J. Negative Language in patient records can affect care. Nation's Health. 2018;48(6):29.
70. Battaglia TA, Finley E, Liebschutz JM. Survivors of intimate partner violence speak out: trust in the patient-provider relationship. J Gen Intern Med. 2003;18(8):617–23.

71. Laing L. Secondary victimization: domestic violence survivors navigating the family law system. Violence against Women. 2017;23(11):1314–35.
72. Office for Victims of Crime. [Internet]. Available from: https://ovc.ojp.gov/program/vtt/what-is-vicarious-trauma
73. Dworkin ER, Menon SV, Bystrynski J, Allen NE. Sexual assault victimization and psychopathology: A review and meta-analysis. Clin Psychol Rev. 2017;56:65–81.
74. Fay-Hillier TM. A qualitative study on intimate partner violence screening practices by registered nurses in the emergency department. Drexel University. Doctor of Public Health Thesis. 2016.
75. Lisak D, Gardinier L, Nicksa SC, Cote AM. False allegations of sexual assault: an analysis of ten years of reported cases. Violence against Women. 2010;16(12):1318–34.
76. Merriam-Webster Dictionary. deny. [Internet]. 2025. Available from: https://www.merriam-webster.com/dictionary/deny
77. ATrain. ATrain education: continuing education for healthcare providers. [Internet]. 2025. Kentucky: Domestic Violence. Available from: https://www.atrainceu.com/content/12-documenting-domestic-violence
78. Isaac NE, Enos VP. Documenting domestic violence: how health care providers can help victims national institute of justice. National Institute of Justice: Research in Brief. [Internet]. 2001. Available from: https://www.ojp.gov/pdffiles1/nij/188564.pdf.
79. Short LM, Johnson D, Osattin A. Recommended components of health care provider training programs on intimate partner violence. Am J Prev Med. 1998;14(4):283–8.
80. Scheer J, Martin-Storey A, Baams L. Help-seeking barriers among sexual and gender minority individuals who experience intimate partner violence victimization. In Russell B, editor. Intimate Partner Violence and the LGBT + Community: Understanding Power Dynamics. Cham, Switzerland: Springer. c 2020;pp. 139–158.
81. Petrosky E, Blair JM, Betz CJ, Fowler KA, Jack SPD, Lyons BH. Racial and ethnic differences in homicides of adult women and the role of intimate partner violence - United States, 2003–2014. MMWR Morb Mortal Wkly Rep. 2017;66(28):741–6.

Publisher's note