

Screening for Domestic Violence in an Oncology Clinic: Barriers and Potential Solutions

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This article has been chosen as particularly suitable for reading and discussion in a Journal Club format. The following questions are posed to stimulate thoughtful critique and exchange of opinions, possibly leading to changes on your unit. Formulate your answers as you read the article. Photocopying of this article for group discussion purposes is permitted.

1. What do we know about the prevalence of domestic violence in general or in our patient population? *Suggestion:* Invite someone to address the issue (e.g., social worker, community worker) or provide supporting information for discussion.
2. Can anyone relate a previous experience with a patient experiencing domestic violence?
3. Is the possibility of domestic violence a concern that warrants specific changes to our practice and procedures?
4. Considering our patient population, what do we see as our role with regard to screening for domestic violence?
5. What resources do we have if we become aware of a patient who is confronting domestic violence?
6. Can we identify any of the strategies listed in this article that we might want to incorporate into our approach to patients?

At the end of the session, take time to recap the discussion and make plans to follow through with suggested strategies.

Purpose/Objectives: To evaluate the implementation of a domestic violence screening protocol in an oncology clinic.

Design: A retrospective review of a random sample of clinic medical records and qualitative surveys of nursing staff.

Setting: A gynecologic oncology clinic in a large teaching hospital.

Sample: 204 charts were abstracted and six oncology nurses completed surveys.

Methods: A random sample of patients from clinic appointment schedules was selected 6 and 12 months after the implementation of a domestic violence screening protocol. A brief written survey of nursing staff also was conducted.

Main Research Variables: Documentation of domestic violence screening, barriers to screening and documentation, and potential solutions to the barriers.

Findings: Sixty-three percent of the charts reviewed had a domestic violence screening record present, but only 12% of the charts with a screening record had documentation. Patients with domestic violence screening documentation were more likely to have had five or more clinic visits during the study period. The most frequent barriers to protocol implementation cited by nursing staff were forgetting to screen or document domestic violence screening. Nursing staff recommended adding domestic violence screening questions to forms and providing reminders to screen.

Conclusions: Several barriers to successful implementation of a domestic violence screening protocol in a gynecologic oncology clinic, including documentation issues, were encountered.

Implications for Nursing: Nurses interested in implementing a domestic violence screening protocol in their oncology clinic should consider reviewing the barriers to domestic violence screening and documentation and the potential solutions identified in this study.

Domestic violence is a significant public health problem in the United States. According to recent estimates, about one in four women and one in seven men have experienced some form of lifetime domestic violence (Breiding, Black, & Ryan, 2008). Eighty-five percent of victims of nonfatal partner abuse are women, and about three times more women than men died at the hands of an intimate partner (Rennison, 2003). Because of the disproportionate

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Key Points . . .

- ▶ Domestic violence has been linked to delayed cancer diagnosis, difficulties obtaining treatment, and inadequate emotional and functional support for patients with cancer.
- ▶ As a result of the effect of domestic violence on health and health care, several national nursing organizations, including the American Nurses Association, have recommended assessing patients for domestic violence.
- ▶ A number of factors may facilitate domestic violence screening and documentation in oncology clinics such as providing ongoing training for and consistent reminders to staff conducting the screening and including screening questions on patient intake and follow-up forms.

effect of domestic violence on women, most research in this area has focused on women.

Domestic violence has been associated with a wide range of mental and physical health consequences (Campbell, 2002; Plichta, 2004), including three important risk factors for cancer: smoking, alcohol use, and unhealthy diet and/or obesity (Hathaway et al., 2000; McNutt, Carlson, Persaud, & Postmus, 2002; Weinbaum et al., 2001). Women experiencing domestic violence also are at increased risk of cervical neoplasia (Coker, Sanderson, Fadden, & Pirisi, 2000). In addition, domestic violence may contribute to cervical cancer risk directly through exposure to human papilloma virus (HPV) transmitted by nonmonogamous partners or cervical trauma from sexual assaults (Coker, Patel, Krishna Swami, Schmidt, & Richter, 1998). Domestic violence may promote cervical neoplasia indirectly by activating stress systems that may reduce the body's immune response to HPV (Hildesheim et al., 1997; Ung et al., 1999) and neoplastic cells (Ben-Eliyahu, Page, Yirmiya, & Shakhar, 1999; Hilakivi-Clarke & Dickson, 1995).

Although the prevalence of domestic violence among patients with cancer is unknown, one study found that 37% of female patients with cancer reported a history of violence as an adult (Modesitt et al., 2006). Patients who reported a history of violence were more likely to be diagnosed with advanced-stage cancer. Many factors may contribute to delayed diagnosis, but some women reported that the ongoing stress and anxiety of an abusive relationship made preventive health care, including cancer screening, seem less important (Lawson, 1998; Moy, Park, Feibelmann, Chiang, & Weissman, 2006). In addition to delayed diagnosis, domestic violence has been linked to difficulties obtaining cancer treatment and inadequate emotional and functional support (Martino, Balar, Cragun, & Hoffman, 2005; Schmidt, Woods, & Stewart, 2006).

As a result of the serious consequences of domestic violence on victims' health, several national nursing organizations have developed guidelines regarding the assessment of domestic violence in patients and related training for nurses (American Association of Colleges of Nursing, 1999; American College of Nurse-Midwives, 1997; American Nurses Association, 2000; Emergency Nurses Association, 2006). By identifying patients who are experiencing abuse, nurses

and other healthcare providers can offer appropriate support, safety planning, and referrals to domestic violence services. Although some oncology providers have indicated the need to address domestic violence among their patients (Mick, 2006; Schmidt et al., 2006), no reports were available on the implementation of routine domestic violence screening in an oncology setting. The current study sought to evaluate the implementation of a domestic violence screening protocol in a gynecologic oncology clinic at a large teaching hospital.

Domestic Violence Task Force

To better address the needs of patients experiencing intimate partner abuse, the Gillette Center for Women's Cancer at Massachusetts General Hospital (MGH) initiated a Domestic Violence Task Force in 2000. The multidisciplinary group included representation from oncology nursing, social work, and administration, as well as an on-site domestic violence advocacy program. The aim of the task force is to improve services for patients with cancer as well as staff experiencing intimate partner abuse.

Domestic Violence Screening Staff

The task force developed a domestic violence screening protocol for the Division of Gynecologic Oncology at MGH that was implemented in July 2002. The protocol called for screening all female patients for domestic violence, regardless of disease status. Domestic violence screening initially was conducted by medical assistants because they see patients alone while obtaining vital signs and specimens. The medical assistants, however, reported that asking about abuse at that time seemed awkward for patients and medical assistants. The task force agreed that the nurse practitioners and a colposcopy nurse should conduct domestic violence screening when getting the patient's history. The task force believed that the change would enable screening of most patients because the colposcopy nurse sees all colposcopy patients and nurse practitioners see patients with cancer on alternate visits with their physician counterparts. Nurse practitioners also have more time alone with patients than other nursing staff and often have an ongoing relationship with patients, which has been shown to facilitate domestic violence disclosure (Hathaway, Willis, & Zimmer, 2002).

Staff Training

Prior to implementing the screening protocol, the domestic violence screening staff received training from the task force on screening and documenting domestic violence and how to respond to abuse disclosures. Specifically, training included a video of a domestic violence survivor who also had cancer (HAVEN Program, 1998), domestic violence dynamics (Duluth Abuse Intervention Program, 2007) and health consequences (Family Violence Prevention Fund, 2002), domestic violence screening and documentation guidelines, domestic violence screening role plays, and information about on-site domestic violence services and other appropriate referrals.

Domestic Violence Screening Protocol

Oncology nurses were provided with domestic violence screening questions (see Figure 1) and were encouraged to adjust question wording as needed to fit the clinical situation and their relationship with the patient. Suggested screening

Introduction for First Screening

Because violence and abuse are so common in people's lives, we've begun to ask all our patients about it.

Many of the women we see at the Gillette Center are dealing with abusive or controlling relationships. Because we know it can be difficult to bring up, we've begun asking about it routinely with all our patients.

We've been learning more about abuse and violence and how they can impact a patient's health and treatment, so we've begun to ask some routine questions of all the patients who come to the Gillette Center.

Introduction for Repeat Screening

You may recall from your visit in _____ that we have been asking some routine questions about violence and abuse in our patients' lives. We'll be asking these questions from time to time as we continue to feel this is an important topic in our patients' lives.

Questions

Are you currently or have you ever been in a relationship where you were threatened, controlled, physically hurt, or made to feel afraid?

Do you ever feel unsafe or afraid of a partner or ex-partner?

Does your partner ever physically hurt or threaten you?

Does your partner put you down, call you names, or harm you emotionally?

Does your partner try to control you, where you go, and the things you do?

Helpful Responses

I am glad you told me. We have confidential resources here at the hospital that have been of help to many people. Would you like some information about these?

Thank you for telling me about this. We see many patients here in similar circumstances, and we've designed some services that can be of help. Can I give you some additional information?

Would you be interested in talking further about this with one of us today?

I'd like to help in some way if I can, but I'm not an expert in this area. I work closely with a social worker who has a lot of information you may find helpful.

Figure 1. Gillette Center Domestic Violence Screening Scripts

questions were based on published national consensus guidelines (Family Violence Prevention Fund, 2002). The questions covered issues of fear, safety, control, and physical and emotional harm. The task force periodically e-mailed "screening inspiration" reminders written by a domestic violence survivor to the nurses.

Nurses were asked to screen patients every three months because repeated screening is recommended by survivors of partner abuse and may facilitate later disclosure (Hathaway et al., 2002; Zink, Elder, Jacobson, & Klostermann, 2004). Patients disclosing past or current abuse were referred to the gynecologic oncology social worker and the on-site domestic violence advocacy program. Hospital security was called if immediate safety was of concern.

Screening results and referrals were to be documented on the screening record, a paper form attached on top of all other documents on the inside left cover of patients' charts by medical assistants, so that it would be easily visible on opening the chart. The form was developed to capture relevant information without overtly appearing related to abuse to protect patient confidentiality and safety. As a result, the screening record

did not include any domestic violence screening questions. See Figure 2 for documentation guidelines given to oncology nurses conducting domestic violence screening.

Study Purpose

The researchers conducted a retrospective review of clinic medical records to evaluate the effectiveness of the implementation of the domestic violence screening protocol in a large gynecologic oncology clinic. Barriers to domestic violence screening and documentation were examined, as well as potential solutions to the barriers through a survey of oncology nurses conducting the screening. The study was approved by the Partners Healthcare Human Research Committee.

Methods

Medical Record Abstraction

Data were abstracted from the charts of patients scheduled for gynecologic oncology or colposcopy appointments about 6 months (March 15–May 15, 2003) and 12 months (October 1–November 30, 2003) after nursing staff began screening for domestic violence in October 2002. Of the 4,490 patients scheduled during the two time periods, a random sample of 250 medical record numbers was selected using SPSS 14.0 (SPSS Inc., 2005). Paper charts maintained by the oncology clinic were used for the abstractions. Of the 250 medical record numbers sampled, 36 were excluded because the same medical record number was selected twice ($n = 25$), the patient was not seen during the study time period ($n = 9$), or the patient was male ($n = 2$). Of the remaining 214 eligible charts, abstractions were completed on 204 (95%) because 10 charts could not be located.

Chart abstractions were conducted by two of the authors who were not oncology clinic staff members. Data were collected for two time intervals: T1, the first six-month period following domestic violence screening implementation, and T2, the second six-month period following domestic violence screening implementation. Twenty percent of patients were seen in T1 only, 25% were seen in T2 only, and 56% were seen in T1 and T2.

For each chart, abstractors recorded whether the domestic violence screening record was present and, if so, whether any documentation was made to the form (date of documentation, provider, whether screening was conducted, domestic violence disclosure, referrals, date that the next screening was due, and any additional comments). The patient's pain level and cancer status for the date when domestic violence screening was documented were obtained from clinic progress notes. Cancer status was recorded as "improved/responding to treatment," "stable/no change," "worse/progressing," "still being diagnosed," "in remission," or "unclear" based on providers' notes. Patient demographics (age, race or ethnicity, primary language, type of health insurance, and marital status), visit history (date of initial clinic visit, date of most recent visit during the 12-month time period, number of visits during the time period, and usual providers), and clinical information (type of cancer, stage at diagnosis, pain level, and cancer status at the most recent visit during the 12-month time period) also were collected. Demographic data missing from the paper charts were obtained from patients' electronic medical records by clinic administrative staff.

- Good documentation of domestic violence or intimate partner abuse provides an opportunity for early intervention, referring survivors to needed resources, holding abusers accountable for their abuse, and responding adequately to a serious public health crisis.
- All documentation of domestic violence must be done in a timely manner and should be clear, concise, and objective.
- Avoid using judgmental or legalistic language and choose objective statements instead. For example, do not write “patient alleges” or “patient claims,” which may be interpreted as a sign of disbelief or wariness on the part of the healthcare provider when used in court. Instead, write “patient states” or “patient reports” when describing an account of abuse. Report what you observed in clear, behavioral, descriptive terms. For example, instead of “patient seemed distraught” write “patient was crying and shaking as she or he described the abuse.”
- Guidelines for documenting domestic violence
 - State the facts in objective terms.
 - Avoid judgmental language.
 - Avoid commentary and extraneous information, but include all relevant details.
 - When the patient is not interested in referrals or further services, record “patient declines services at this time” rather than “patient denies referral” or “refuses services.”
 - When physical injury is present, use body maps or photographs to record the location and extent of injury. If the patient describes the event(s) that caused the injury, document that in detail in the chart. For example, “Patient reports that last night, her boyfriend slapped her on the left cheek and came at her with a raised fist, which caused her to fall backward over a coffee table and land on her back.” (Then go on to describe injuries sustained.) When using photographs, special written consent is required. Call police and security because they are trained in the use of special cameras for use in domestic violence cases.
- Sample notes from positive screening
 - Example 1: Patient screened for domestic violence. Patient reports feeling afraid of partner. Patient reports partner recently threatened her when she was unable to cook dinner because of fatigue from current radiation treatments. Patient would like to see social worker and possibly HAVEN program advocate. Both referrals made.
 - Example 2: Patient screened for domestic violence. Reports history of physical and emotional abuse by current partner. States that at present he is supportive of her treatment and is helping with chores at home. Patient states she is not currently interested in related services. Provided education about in-house and community services and gave a card with domestic violence referral information and resources to patient. Reminded patient that services are available at any time should further concerns arise.

Figure 2. Documentation Guidelines for Domestic Violence Screening

Data from the chart abstractions were entered into a Microsoft® Access® database where they were cleaned (checked to ensure all data were within normal variable limits and that all value labels were consistent within each variable) and coded (text data were replaced with numeric codes or numeric data were grouped into categories). Then, the data were exported to SPSS 14.0 for analysis. Descriptive analyses of all variables and chi-square analyses of patient and visit characteristics by the presence or absence of domestic violence screening documentation were performed.

Gynecologic Oncology Nurses Survey

To more fully understand the barriers to domestic violence screening and documentation as well as potential solutions to those barriers, oncology nursing staff members conducting the

domestic violence screening were asked to complete an e-mail survey consisting of the following five questions.

- What do you see as the main barriers to screening our patients for domestic violence?
- Do you have any suggestions for things we can do or change to facilitate domestic violence screening?
- What do you see as the main barriers to documenting screening?
- Where is it most convenient for you to document domestic violence screening?
- Do you have any other comments on domestic violence screening or documentation?

Survey data were collected from February to April 2005. Six of the seven nurses and nurse practitioners conducting screening completed the survey.

Survey responses were transferred into Microsoft Word® for content analysis. For each question, responses were sorted into categories (e.g., forgot to screen, discomfort with screening) along with a tally of how many survey respondents raised each category. The analysis also was conducted by two of the authors who are not oncology clinic staff.

Results

Medical Record Data

Of the 204 female patients in the sample, 44% were aged 50–69 years (range = 18–100 years). Most were white, non-Hispanic (87%); spoke English as a primary language (93%); and had private health insurance (70%). Forty-nine percent were married, and 32% were single or never married. Forty-one percent of patients had not been diagnosed with cancer. Of the remaining 121 patients, the most frequent type of cancer was ovarian (48%). Of patients with cancer, 43% were diagnosed at stage III or IV (see Tables 1, 2, and 3).

The majority (63%) of charts reviewed had a screening record present, but only 7% (n = 15) of all charts, or 12% of charts with a screening record, had domestic violence screening documented on the form. Of the 15 charts with screening documentation, 13 patients reported no abuse, 1 reported past abuse by an ex-partner, and 1 reported childhood abuse. The patient reporting past abuse by an ex-partner was a 46-year-old woman being seen in the colposcopy clinic for an abnormal Pap test. In addition, a 48-year-old woman with cervical cancer in situ voluntarily disclosed to her gynecologic oncologist that she was being abused by a boyfriend. Because the patient was not screened for domestic violence, but disclosed voluntarily, she was excluded from the analysis of factors associated with screening.

Forty-seven percent of the patients in the study sample were seen by oncologists rather than by nursing staff conducting the screening. Of the 95 women, many had only one or two visits during the time period studied (43%) or saw an oncologist who did not collaborate with a nurse practitioner (22%). None of the patients' charts had screening documentation.

Patients with domestic violence screening documentation were more likely than those without screening documentation to have had five or more clinic visits during the study period (p = 0.03). Patients with domestic violence screening documentation did not differ significantly from patients without screening documentation in regard to age, race or ethnicity, primary language, type of health insurance, marital status, time period last seen, time period(s) ever seen, presence of

Table 1. Sample Demographics

Characteristic	Total Sample (N = 204)		Patients With Documented Screening (N = 15)		Patients With No Documented Screening (N = 189)	
	n	%	n	%	n	%
Age (years)						
< 30	29	14	3	20	26	14
30–49	51	25	5	33	46	24
50–69	90	44	5	33	85	45
70–89	29	14	1	7	28	15
≥ 90	2	1	1	7	2	1
Missing	3	2	–	–	2	1
Race						
White, non-Hispanic	177	87	13	87	164	87
Hispanic	10	5	–	–	10	5
Asian or Asian American	5	2	–	–	5	3
Other	11	5	2	13	9	5
Missing	1	1	–	–	1	1
Primary language						
English	190	93	15	100	175	93
Spanish	6	3	–	–	6	3
Other	6	3	–	–	6	3
Missing	2	1	–	–	2	1
Type of health insurance						
Private	142	70	10	67	132	70
Medicare	33	16	1	7	32	17
Medicaid or free care	13	6	2	13	11	6
Other	15	7	2	13	13	7
Missing	1	< 1	–	–	1	1
Marital status						
Married	100	49	9	60	91	48
Single	66	32	3	20	63	33
Separated or divorced	19	9	1	7	18	10
Widowed	14	7	2	13	12	6
Missing	5	2	–	–	5	3

Note. Because of rounding, not all percentages total 100.

cancer diagnosis, type of gynecologic cancer, cancer stage at diagnosis, or cancer status at the most recent visit during the time period studied.

Of the 15 patients who were screened, 10 had domestic violence screening documented in T1 compared to 5 in T2. That difference approached significance ($p = 0.06$).

Gynecologic Oncology Nurses Survey Responses

The age of the six participating nurses and nurse practitioners ranged from 31–45 years. All were female and had worked in oncology nursing for at least nine years (range = 9–20 years). Nursing staff reported several barriers to domestic violence screening and documentation as well as suggestions to address some of the barriers. The most frequently mentioned barrier was forgetting to screen ($n = 4$) or document domestic violence screening ($n = 3$). Suggested solutions included adding screening questions to patient intake or follow-up forms ($n = 4$), sending e-mail reminders to nurses regarding screening ($n = 2$), and asking medical assistants to check charts and indicate to nursing staff whether screening was needed ($n = 2$). Two nurses reported some discomfort with domestic violence screening, and one suggested that intermittent, mandatory domestic violence training would increase her comfort with screening. That nurse also recommended having more domestic violence posters and pamphlets in the clinic to increase

domestic violence awareness. Barriers to screening for which no solutions were suggested included time constraints ($n = 3$), patients having “more pressing issues” ($n = 3$), and lack of privacy because patients often were accompanied by family or friends ($n = 2$).

Forgetting to document domestic violence screening was cited by three nurses, but domestic violence screening also was not documented because domestic violence was not listed on the electronic form where nurses usually included progress notes ($n = 2$). In addition, domestic violence documentation might end up “in the wrong hands” ($n = 2$) and nurses were uncertain about the best way to word domestic violence documentation ($n = 1$).

All six respondents reported that documenting domestic violence would be most convenient in patients’ electronic medical record, which came into use about seven months after the domestic violence screening protocol was implemented. One nurse further noted that the abuse history recorded in the electronic medical record could be removed from some correspondences to increase confidentiality of the information. Two nurses stated, however, that documenting domestic violence also would be convenient on one of two paper forms still in use—the patient intake or follow-up form. None of the respondents stated that the domestic violence screening record was the most convenient location to document domestic violence screening.

Table 2. Patient Clinical Characteristics

Characteristic	Total Sample (N = 204)		Patients With Documented Screening (N = 15)		Patients With No Documented Screening (N = 189)	
	n	%	n	%	n	%
Time period last seen						
T1	101	50	8	53	93	49
T2	103	50	7	47	96	51
Time periods ever seen						
T1	40	20	1	7	39	21
T2	50	25	3	20	47	25
T1 and T2	114	56	11	73	103	54
Number of visits during T1 and T2*						
1–2	86	42	2	13	84	44
3–4	54	26	4	27	50	26
5 or more	64	31	9	60	55	29
Saw domestic violence screener						
Yes	109	53	15	100	94	50
No	95	47	–	–	95	50
Domestic violence screening record present						
Yes	129	63	15	100	114	60
No	75	37	–	–	75	40
Cancer diagnosis						
Yes	121	59	10	67	111	59
No	83	41	5	33	78	41

* $p < 0.05$

T1—first six-month period after domestic violence screening implementation; T2—second six-month period after domestic violence screening implementation

Note. Because of rounding, not all percentages total 100.

Discussion

This study is one of the first to evaluate implementation of routine screening for domestic violence in an oncology clinic. Most prior evaluations of domestic violence screening have taken place in internal medicine, obstetrics gynecology, pediatric clinics, and emergency departments. Despite the efforts of a highly motivated task force, only 12% of patients' charts in the gynecologic oncology clinic had documentation of domestic violence screening. A number of barriers were identified to domestic violence screening documentation as well as potential solutions to address those issues. Although the feasibility of screening patients who are severely ill or seeking brief consultations requires further investigation, no barriers were encountered that would preclude domestic violence screening of patients with cancer in general.

Many barriers identified in this study are similar to those found in primary care clinics seeking to implement routine domestic violence screening. They include forgetting to screen or document screening (Chamberlain & Perham-Hester, 2002; Elliott, Nerney, Jones, & Friedmann, 2002; Richardson, Feder, & Coid, 2002), discomfort with screening (Chamberlain & Perham-Hester), insufficient training (Elliott et al.), time constraints (Elliott et al.; Salber & McCaw, 2000; Taket et al., 2003), lack of privacy (Centers for Disease Control and Prevention, 1998), and concerns about abuse information remaining confidential (Taket et al.). Barriers in the current study that have not been reported elsewhere were inconvenient location for documenting domestic violence screening, infrequent patient visits, the assumption that most clinic patients were seen by nurses conducting the screening, and the severity of some patients' medical conditions.

Some common barriers described in other studies that oncology nursing staff in this study did not cite were inadequate domestic violence resources (Elliott et al., 2002), lack of effective interventions (Ernst & Weiss, 2002; Salber & McCaw, 2000), and mandatory reporting (Ernst & Weiss). The hospital where this study took place is fortunate to have oncology social workers knowledgeable about domestic violence as well as an on-site domestic violence advocacy program. In addition, the state of Massachusetts does not have mandatory reporting laws for all domestic violence. Abuse against individuals who are disabled or older than 60 years is reportable, but those reports are made to social service agencies rather than the police, and victims may refuse an investigation if they wish.

The Domestic Violence Task Force has implemented several changes to address some of the barriers encountered. To help remind nursing staff to screen for abuse, the question, "Do you feel unsafe or at risk of harm by anyone in your life?" was added to all patient intake and follow-up forms. Having that question on forms that patients complete alerts patients that oncology providers see abuse as an important concern, which may facilitate disclosure (Hathaway et al., 2002). Patients' responses to domestic violence screening now are documented in electronic medical records rather than on the Domestic Violence Screening Record. The electronic medical record is where most nurses currently record their progress notes. The "health maintenance" section of the electronic medical record has a specific field for domestic violence screening and can be programmed to remind providers when the next domestic violence screening is due.

The rate of domestic violence screening documentation was lower in T2 than in T1, which may have been a result of

the transition to an electronic medical record system during T2. Unfortunately, resources were unavailable to conduct additional abstraction of electronic medical records. Perhaps domestic violence screening rates simply decreased over time after nurses' initial training. To address nurses' discomfort with screening and request for more training, the task force conducted additional trainings for all clinic staff and a specific session on domestic violence screening and documentation for nursing staff.

Interestingly, the only factor that was associated with an increased likelihood of domestic violence screening documentation was having five or more clinic visits during the study period. Although more visits may have provided more opportunities for nursing staff to screen, nurses also may feel more comfortable screening patients they know better. Because patients experiencing abuse are more likely to disclose to providers with whom they have a good relationship (Hathaway et al., 2002), further studies should investigate the efficacy of screening patients with cancer who are seen for only a limited number of visits, such as for cancer risk assessment or second opinions.

The Domestic Violence Task Force decided that nursing staff should conduct domestic violence screening rather than medical assistants because its members believed that most clinic patients saw one of the nurses at some point during treatment. However, almost half of patients in the sample saw oncologists only. The lack of a physician on the otherwise multidisciplinary Domestic Violence Task Force may have contributed to that oversight. The task force now includes a gynecologic oncologist as a physician representative. Oncology clinics that aim to screen all patients for domestic violence should consider involving physicians in the development and implementation of domestic violence screening protocols.

The task force anticipated that patients with more severe physical symptoms would be screened less frequently. Three

nurses also cited "more pressing issues" as a barrier to screening; however, no significant differences were found in screening documentation rates by cancer stage or treatment status. That surprising fact may be a result of the training video that highlighted an actual case of an older woman with metastatic lung cancer who chose to leave her abusive partner after 55 years of marriage (HAVEN Program, 1998). Further research should investigate whether times exist during cancer treatment when screening for domestic violence is not appropriate or efficacious.

Findings from the current study are limited in several ways. As a result of limited resources, only a small percentage of clinic charts was reviewed, which may have biased the accuracy of the results. Although a random sample of patients was selected, data were not available to compare how representative the sample was of all patients seen in gynecologic oncology during the time period studied. Furthermore, the researchers were most interested in rates of domestic violence screening but were able only to directly measure documentation of domestic violence screening on the domestic violence screening record. That may have led to an underestimation of screening rates because nurses reported sometimes forgetting to document domestic violence screening and others may have documented domestic violence screening in a different form in the paper chart or in the patient's electronic medical record.

No prior studies have evaluated the implementation of domestic violence screening in an oncology clinic, although such screening has been recommended (Hara & Rose, 2006; Mick, 2006). Charts were sampled over 12 months following implementation of domestic violence screening, which allowed the researchers to detect trends that might not have been evident otherwise. In addition, the clinical variables that were collected related to cancer (i.e., presence of cancer diagnosis, cancer type, cancer stage, and cancer status at most recent visit) have not been examined previously for their potential

Table 3. Clinical Characteristics of Patients With Cancer

Characteristic	Total Sample (N = 121)		Patients With Documented Screening (N = 10)		Patients With No Documented Screening (N = 111)	
	n	%	n	%	n	%
Cancer type						
Ovarian	58	48	7	70	51	46
Cervical	22	18	1	10	21	19
Uterine	22	18	—	—	22	20
Other	19	16	2	20	17	15
Cancer stage at diagnosis						
I	33	27	2	20	31	28
II	11	9	—	—	11	10
III	38	31	6	60	32	29
IV	15	12	1	10	14	13
Missing	24	20	1	10	23	21
Cancer status at most recent visit during T1 or T2						
In remission	24	20	—	—	24	22
Responding to treatment	25	21	4	40	21	19
Stable or no change	35	29	3	30	32	29
Worse or progressing	24	20	2	20	22	20
Treatment status unclear or still being diagnosed	13	11	1	10	12	11

T1—first six-month period after domestic violence screening implementation; T2—second six-month period after domestic violence screening implementation
Note. Because of rounding, not all percentages total 100.

effect on domestic violence screening. Furthermore, the number of nursing staff surveyed was small, but their comments provided valuable insights into barriers and potential solutions to domestic violence screening and documentation, which would not have been evident from chart abstractions alone.

The Domestic Violence Task Force will continue to assess and refine the gynecologic oncology domestic violence screening protocol. Some remaining challenges include lack of privacy and documenting abuse disclosures safely. Patients may be placed at risk of harm or be prevented from obtaining health care at a location if the abusive partner sees documentation of abuse or domestic violence screening in the patient's medical record or insurance documents. Other challenges are time constraints, involving physicians in screening, and potentially "better" times to screen. To learn more about how oncology providers can best identify and support patients in abusive relationships, the researchers recently completed interviews with 23 patients who faced cancer while in an abusive relationship and are currently analyzing the interview data. Findings from that study will be forthcoming.

Implications for Nursing

Nursing staff were critical in the implementation of the domestic violence screening protocol in the gynecologic oncology clinic in this study. Although an ideal domestic violence screening protocol cannot be recommended based on the current study, nursing staff interested in implementing a domestic violence screening protocol should consider the following.

- Develop the protocol with a multidisciplinary team and, if present, on-site domestic violence staff.
- Provide initial and ongoing training for staff conducting the screening.

- Discuss domestic violence survivors' perspectives on screening during training.
- Display posters and provide informational pamphlets and resource cards for domestic violence in the clinic waiting area and women's restrooms.
- Include domestic violence screening questions on patient intake and follow-up forms.
- Provide ongoing reminders to staff members conducting domestic violence screening and documentation.
- Designate a location to document domestic violence screening on existing paper or electronic forms routinely used for progress notes rather than creating new forms for this purpose.
- Provide on-site domestic violence services when possible or establish connections with community-based domestic violence services.
- Anticipate future changes in the clinic that may affect screening procedures, such as changes in staffing levels or roles, new forms, or the transition to a different medical record system.

Additional resources about domestic violence for health-care providers are the "National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Healthcare Settings" (Family Violence Prevention Fund, 2002) and the American Medical Association's (2002) monograph *Roadmaps for Clinical Practice: Intimate Partner Violence*.

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