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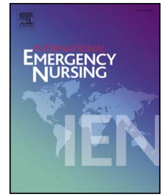

Forensic patients in the emergency department: Who are they and how should we care for them?☆

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ABSTRACT

Background: Patients who suffer violent, crime related injuries are likely to seek medical assistance in emergency departments. Forensic patients may not disclose the cause of their injuries leading to the impairment of evidence. We explored healthcare providers' perceptions of forensic patients and how they should be cared for.
Method: The perceptions of physicians and nurses regarding the profiles and care of forensic patients were explored in three urban emergency departments. The data were collected through a talking wall and analysed collaboratively, with the participants, using content analysis.
Results: Healthcare providers in emergency departments differentiated between living and deceased forensic patients. Healthcare providers identified living forensic patients as victims of sexual assault, assault, gunshots and stab wounds, and abused children. Deceased patients included patients that were dead on arrival or died in the emergency departments. Healthcare providers acknowledged that evidence should be collected, preserved and documented.
Conclusion: Every trauma patient in the emergency department should be treated as a forensic patient until otherwise proven. If healthcare providers are unable to identify forensic patients and collect the evidence present, the patients' human right to justice will be violated.

1. Introduction

Violence and crime is escalating at alarming rates around the world. The World Health Organization cites violence and crime as the fourth leading cause of death amongst adults [1]. Many victims survive violent and criminal incidents with severe to minor injuries and most seek medical attention in emergency departments [2–4]. Forensic patients are victims of violence and crime that require the involvement of the justice and healthcare systems due to the nature of their injuries [5]. Patients with traumatic injuries should therefore be treated as potential forensic patients until proven otherwise [6].

Victims of violence and crime enter the emergency department (ED) with evidence on their bodies, clothes and belongings that can assist with criminal investigations or investigations into violent incidents [7]. Despite this, emergency healthcare providers tend to focus on life-saving management, resuscitation and referral rather than on preserving and collecting evidence. For example, when a trauma patient enters the ED, regardless of the cause of injury, wounds are exposed for examination, cleaned and sutured, often resulting in the loss, contamination or destruction of evidence [8]. As a result, the manner in which evidence is handled in EDs may compromise and violate the victim's right to justice [1,9].

Potential forensic patients have distinctive physical and emotional needs that require sensitivity from healthcare providers in EDs to advocate for justice and protection of the patient. Fox and Cook [10] suggest that if awake and orientated patients perceive healthcare providers as insensitive, they may not disclose their need for management of evidence and referral to the justice system. Patients may fear blame from the healthcare providers or they may know and fear the perpetrators. In the chaotic environment of the ED, saving lives and treating patients in the shortest amount of time to make space for new patients tends to take precedence over identifying forensic patients and collecting evidence [11]. Furthermore, McBrearty [12] points out that patients may be so focused on their injuries that 'victimisation may not be apparent'. If medical management damages or destroys evidence on a forensic patient, case progression may be compromised. The destruction of evidence even leads to negative prosecution outcomes in sexual assault cases in the USA [13,14]. Healthcare providers in EDs are ideally placed to identify, collect and preserve evidence, and to document injuries within minutes to hours of a patient being injured.

☆ The authors contributed in the conception and implementation of the study, as well as drafting, critically reviewing and preparing the manuscript.

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Given the high rate of violent crimes in South Africa, Ward et al. [15] called for an assessment of the ability of healthcare services to screen and manage forensic patients. Simply caring for forensic patients both physically and emotionally is no longer regarded as sufficient. Healthcare providers in EDs have to take up their forensic roles and responsibilities to preserve and collect evidence that can be used to prosecute perpetrators [3,16]. This study explored South African healthcare providers' perceptions of the profiles of forensic patients and how they should be cared for. Exploring the perceptions of healthcare providers towards forensic patients provides an important baseline for future educational programmes and interventions aimed at simultaneous treatment of patients and collection of evidence.

2. Methods

This study was based on an action research design that strongly advocates for participants to be actively involved throughout the research process. The participants were involved in the creation of research questions, data collection and data analysis meeting the aims of action research, namely building relationships, communication, inclusion and participation [17]. We used this methodology to promote awareness amongst practitioners in their current practice, encouraging them to seek solutions applicable to their context.

2.1 Setting and sample

The healthcare providers – physicians and nurses - at three EDs in urban hospitals in South Africa participated in the study. Nurses were the most accessible participants while physicians were not as actively involved due to their work schedules. ED A was in a state hospital with 31 beds that was staffed by 70 nurses (23 professional nurses) and 23 physicians that on average attend to 1600 patients per month. Two of the ED's were in private hospitals, which provides care to patient with medical insurance, with 14 beds each. ED B was staffed by 28 nurses (22 professional nurses) and 22 physicians and, on average attend to 1200 patient per month. ED C was staffed by 33 nurses (15 professional nurses) and 25 physicians that on average attend to 2500 patients per month. An estimated 39% of the patients attended to in the selected EDs were potential forensic patients. An open invitation was extended to all permanently employed healthcare providers to participate voluntarily. The exact number of participating healthcare providers is unknown due to the open participatory nature of the data collection method.

2.2 Data collection

We collected qualitative data through the use of a talking wall. This ensured minimal interruption to daily activities in the participating EDs. The talking wall technique [18] was developed in the business environment to initiate discussion, explore issues, analyse problems and develop action plans [19,20]. Data was collected by writing questions, posed by the researcher, on a flipchart attached to a wall. Participants provided answers, by writing on the same sheet of flipchart paper.

The nurses as the most accessible participants identified a suitable wall space in the tea rooms of each of the EDs as all healthcare providers utilize the tea room. We posted the following question on the talking wall: Who are forensic patients and how should we care for them? Healthcare providers then wrote down their perceptions and opinions on the sheets of paper provided. The data was collection over a period of a month from 25 February to 2 April 2014. The talking wall worked well, for the reason that participants could answer the question in their own time. However exactly how many participants contributed is unknown as some points were added after discussions in the same hand writing while others obscured their hand writing or just made ticks behind the point they agreed with. The answers provided was written in the form of short statements.

Table 1
Results from the collaborative qualitative content analysis.

Theme	Categories	Data excerpts
Living forensic patient in the ED	Forensic patients	Victims of sexual assaults Assault victims Gunshots victims Victims with stab wounds Abused children
	Care rendered	Evidence collection Preserving evidence Documenting Referral to the police
Deceased forensic patient in the ED	The case of the unnatural deaths	Gunshot Stab wounds Motor vehicle accidents Pedestrians vehicle accidents
	Reporting to authorities	Informing the Police

2.3. Data analysis

After the data were collected from the talking wall, we invited all participants to participate in a generated collaborative data analysis [21] using inductive content analysis as proposed by Stringer [17]. Participants from the EDs volunteered to participate in data analysis sessions and included only professional nurses as no physicians volunteered to participate. Sessions were facilitated by one of the researchers and held separately in each ED. The responses provided on the talking wall were read and re-read out loud by one of the participants and then meaningful words, phrases and sentences were circled by the researcher. Two of the ED's namely ED A and ED C divided the responses from the data into living and deceased forensic patients and thereby created the two main themes. The words, phrases and sentences were then categorised to fit under care that should be provided to living and deceased forensic patients. The data from the three EDs were combined as the categories and themes identified were similar (see Table 1 for summary)

The research ethics committees of the Faculty of Health Sciences, University of Pretoria, South Africa (Reference number 364/2013), the hospitals approved the study protocol prior to data collection. The healthcare providers signed informed consent prior to the study and verbal process consent was obtained before each contact session.

2.4 RIGOR

The trustworthiness of the data was ensured through collaborative data analysis with participants from the selected EDs. After the data analysis was completed member checking of the raw data and the themes and categories in each ED was done by displaying the sheets of paper on the wall space in the tea room and requesting comments and additions as suggested by Loh [22]. The sheets were displayed for a period of two weeks to ensure that all the healthcare practitioners that participated had an opportunity to check the findings. No changes were made to the themes and categories.

3. Results

The two themes identified from the generated data were namely living and deceased forensic patients in the ED as participants differentiated between the service provided to living and deceased forensic patients. The themes are explained using categories and excerpts from the data recorded on the talking wall as summarised in Table 1.

3.1 Living forensic patients

The first category namely *forensic patients* identified the type of

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