This Guest Editorial links my own career path with the intersection of forensics and emergency nursing. Advocacy for vulnerable patients affected by interpersonal violence has been a priority throughout my emergency career. I am an emergency nurse who applies forensic concepts at each patient encounter. Emergency nurses should consider forensic science concepts during patient care. For example, subtle chief complaint symptoms can actually be symptoms of interpersonal violence. In the following paragraphs I will share personal, impactful, and advocacy episodes in my emergency nursing career that have influenced me. Understanding the intersection of emergency nursing and forensic science is a complex issue. I will try to unravel the hidden vulnerabilities in an organized format: whom we should suspect; why emergency nurses should care; how emergency nurses should provide care; and when and where forensic science intersects with emergency care. In addition, I will outline strategies that enabled me to empower patients, families, the community, nurses, law enforcement, legal agencies, emergency services, and legislature.

Emergency Department Nurses Association Then, ENA Now

I have been a member of the Emergency Nurses Association (ENA) since 1979, the early years of the ENA, shortly after Judith Kelleher and Anita Dorr founded the Emergency Department Nurses Association (EDNA) in 1970. The ENA at that time offered the EDNA training course, where I learned and applied emergency nursing forensic concepts. In addition to the EDNA training, my first emergency nurse manager, Frances McDonough, RN, and charge nurse, Kitty Gerow, RN, provided comprehensive emergency nursing training that included medicolegal considerations and accurate documentation during emergency care. McDonough and Gerow took me to my first Beacon EDNA Chapter meeting in Lowell, Massachusetts, where I still remain a member.

To Whom Should Emergency Nurses Apply Forensic Science Considerations?

Emergency nurses should apply forensic science considerations to all patients in the emergency department. Patients across life span can be involved in hidden interpersonal violence situations. Forensic nursing concepts apply to victims of all ages who have been traumatized by interpersonal violence, child abuse, child neglect, elder abuse, and elder neglect, as well as people with developmental disabilities who have been abused and exploited. In addition, the forms of abuse include physical, emotional, and sexual abuse, exploitation, financial (economic) abuse, neglect, and abandonment. Forensic science considerations are especially important during care of patients in the emergency department who are persons under law enforcement custody or rape survivors, or are involved in interpersonal violence, intimate partner violence, human trafficking, near

Patricia A. Normandin, DNP, RN, CEN, CPN, CPEN, FAEN

Author Patricia A. Normandin in front of the Florence Nightingale Museum in London, United Kingdom.
strangulations, evidence collection, injury description, medicolegal documentation, death investigations, handling of biological evidence, mass disasters, and community crises.1

I can share 2 examples of women who presented to the emergency department triage with the chief complaint of dizziness. One was 25 years old and the other 48 years old; the 2 women came into the emergency department on different days with the chief complaint of dizziness for a couple of days. Fortunately, I was their triage nurse; while I was performing triage, their stories did not make sense. The red flags that alerted me that interpersonal violence may be involved included the following: both had a delay in seeking care; both were healthy; there was no visible bruising and no explainable reason, such as dehydration or low blood sugar, for dizziness; and both women lived far away and avoided many closer hospitals to seek emergency care. When I applied trauma-informed forensic interview strategies, which include gentle inquiry regarding past injury, both denied any injury. On further questioning in triage, both reported being hit on the head by their husbands; one had a cell phone thrown at the back of her head, and the other was hit on the back of her head in an area covered by hair so that any injury would not be visible. Each patient agreed when offered the opportunity to talk to our social services regarding their situation and to develop a safety plan. These are 2 examples of how emergency nurses who understand and apply forensic science are in a critical position to recognize hidden patients affected by interpersonal violence. Every emergency nurse must recognize the signs and symptoms of violence, and take action to stop the cycle of violence.1-6

Forensic nurses can be defined as health care professionals who perform in partnership with law enforcement during emergency care for individuals who are in the custody of the law or who may be involved in situations where nurses are mandated reporters.1 Federal and state laws regulate mandated reporters. Nurses are considered mandated reporters for cases of abuse or neglect of elders, children, and other vulnerable populations. Mandatory reporting of intimate partner violence depends on the state in which the nurse is working or resides. Emergency nurses as mandated reporters are trained to recognize the signs and symptoms of abuse or neglect and are required to report even if they only suspect abuse. Emergency nurses who incorporate medicolegal concepts during emergency care are applying forensic concepts. Forensic nursing skills are used during care of victims of abuse or trauma of all ages. Forensic nursing concepts are used during care of the patient affected by sexual assault, child abuse, elder abuse, intimate partner violence, human trafficking, strangulation, and any form of trauma, be it intentional or nonintentional.1

Why Should Emergency Nurses Care About Forensics?

The ENA, the international organization for emergency nurses, recognizes the importance of collaboration between emergency nursing and forensic nursing. The ENA and the International Association of Forensic Nurses have collaborated to write a joint position statement on intimate partner violence that can help guide emergency nurses during patient care.7 Emergency nurses should care about forensics because the emergency nurse may be the first person to begin the chain of custody and evidence preservation during care of patients involved in an abuse, neglect, or trauma situation. Emergency nurses must assess injuries from a forensic viewpoint during injury description and documentation. Emergency nurses and law enforcement frequently partner during patient care. This collaboration is the forensics approach during emergency care.

Early in my emergency nursing career, I felt outrage each time I was the bedside nurse for persons in potential interpersonal violence situations. Nurses can experience secondary trauma from witnessing interpersonal violence. To prevent a feeling of powerlessness, I chose empowerment to stop this violence. Whereas some patients admitted they were in unsafe situations, and I was able to refer them to social services, others did not self-identify. Patients in interpersonal violence situations often deny abuse and have children with them who witness the violence. I empowered myself by continuing my education on forensic science to improve my care of patients in the emergency department. Another strategy I used to empower myself was mentoring emergency nurses, nursing students, medical students, health care providers, other health care personnel, social services, and law enforcement in education regarding interpersonal violence.

Personally, I recognized the need to further my education in forensics, which resulted in my going back to school for a doctorate degree in nursing to actively pursue evidence-based research in what is now known as forensic nursing. I then became a member of the Forensic Nurses Association, while continuing to maintain my ENA membership. This pursuit of forensic knowledge led me to meet Virginia Lynch, who introduced me to the coroner’s office medicolegal death investigators.1 As an emergency nurse, I did care for those requiring medicolegal death investigations, which is what led me to learn more about what is involved when you care for victims of violence who are still living. When you care for patients who are still alive and whose care crosses medicine and the legal system, you are involved in living forensics.8 Living forensics is the forensic science associated with the legal cases involving living
victims. Emergency nurses interface with patients associated with living forensics during care of patients living with addictions, alcohol misuse, drug misuse, behavioral health conditions, intimate partner violence, interpersonal violence, child abuse, incest, sexual abuse, sexual assaults, rape, human trafficking, elder abuse, disabled persons’ abuse, neglect, drug tampering, poisoning, medical malpractice, nonfatal assaults, and motor vehicle crashes with and without pedestrian involvement. Any abuse while a person is in the custody of law enforcement and correctional facilities is considered a living forensics situation.

How Should Emergency Nurses Provide Forensic Care?

Emergency nurses must be trained in the collection of physical evidence when potential or known criminal acts may have occurred. Forensic evidence preservation involves the emergency nurse maintaining at all times the chain of custody of the evidence collected and accurate forensic documentation. Emergency nurses should apply trauma-informed care, which includes a therapeutic communication approach during care of all patients in the emergency department. Emergency nurses need to look at every patient with a forensic eye to see if they are entering the emergency system seeking a safe haven from a hidden abuse or neglect situation.

When Should Emergency Nurses Apply Forensics?

Emergency nurses must only apply forensics science considerations from the moment they meet a patient and family. I begin applying forensics science knowledge to across-the-room assessments of my patients. What is the person’s demeanor? Who is with them? What nonverbal and verbal behaviors do I notice? Does the child or adult have good personal hygiene, look well nourished, and have good dental hygiene? If the patient is a child, are the child’s immunizations up to date? Does the child have health insurance information and identification? Is the medical history available? A forensic science approach should be initiated from the beginning: that is, when the emergency nurse is taking the patient’s history, physical assessment, and documentation, because the medico-legal intersection may not be apparent right away. The emergency nurse should suspect interpersonal violence and/or human trafficking if nonverbal or verbal behaviors are incongruent.

Where Should Emergency Nurses Apply Forensics?

Emergency nurses should only inquire, with a trauma-informed approach, about interpersonal violence situations in a location where the nurse is alone with the patient. The setting where they work will influence the manner in which they apply forensics. In addition, where they work will guide the policies and procedures for mandated reporting laws.

Testimony During Rape Trial

When caring for a possible rape survivor, proper forensic care, maintaining the chain of custody, and documentation are critical for both the immediate care of the patient and the successful prosecution of the perpetrator. Keeping in mind that the trial of a defendant in a rape case may take place 1 to 2 years after the event, any statements that the patient makes, as well as the patient’s physical and emotional appearance, must be documented. As a staff nurse, I cared for hundreds of rape survivors. I was the emergency nurse for 1 rape case that went to trial, and I testified regarding the rape. In 1992, I provided evidence testimony regarding the care of this rape survivor. When I was this patient’s emergency nurse, I immediately followed the best practices for the care of a patient who is a potential victim of a rape, which included accurate medicolegal documentation and application of chain of custody with evidence. I stayed with the patient for the entire course of the treatment from triage to discharge. The rape case has been documented in Commonwealth vs Licata, 412 Mass. 654 (1992). My testimony was allowed under a “fresh complaint” doctrine, demonstrating the importance of nursing forensics assessment, planning, interventions, evaluation, and documentation during the emergency care of a rape survivor. A fresh complaint is the disclosure by the victim to a third party regarding the sexual assault. The third party is the first person to whom the victim of a sexual assault discloses the facts of the assault. The court testimony can be accessed at http://masscases.com/cases/sjc/412/412mass654.html.

First Responder Domestic Violence Training

My passion for the advocacy of patients in domestic violence situations led my name to become known among victim advocates in my local area. This led to a request by the Middlesex County Victim Advocates office in 2008 to help organize a conference to educate local law enforcement personnel, emergency medical services staff, and law professionals on how to respond to domestic violence
situations. Law enforcement personnel, emergency medical services staff, and first responders were encountering many cases of domestic violence. The Middlesex County District Attorney’s office had recognized a knowledge gap in the identification and care of patients affected by domestic violence by first responders and law enforcement. I accepted that responsibility and volunteered more than 100 hours as an emergency nurse to collaboratively organize and facilitate the “First Responder Domestic Violence Training” conference at Saint John’s Hospital in Lowell, Massachusetts, in 2008. Brigham & Women’s Hospital (where I work per diem) agreed to offer 5 free contact hours for nurses. St. John’s Hospital offered a free conference room, free lunch for all who attended, and free pens and writing pads. It was an exciting conference; prosecutors, victim advocates, police, emergency medical services staff, first responders, firefighters, federal forensic agents, and nurses collaboratively presented a roundtable, discussing the best practices for care of the patient affected by domestic violence. This free educational offering was well received by more than 50 attendees.

See, Pull, Cut the Threads of Violence

Organizing the “First Responder Domestic Violence Training” conference motivated me to go back to school for my doctorate to try and stop this cycle of violence. The emergency departments where I worked had many cases of patients affected by domestic violence. I came across a case that motivated me to become active in intimate partner violence research when I was working as the triage nurse on the evening shift in the emergency department. A mother ran into the emergency department holding her 3-month-old child, who, she said, was not well. It was an extremely cold, snowy winter night. I looked at the child sleeping comfortably in the mother’s arms, her color pink, body well developed, skin warm and dry, vitals signs normal, dressed warmly, and in no distress. When I looked at the mother, she looked distressed, with her hair disheveled, and anxious. I started a gentle inquiry by asking the mother if this was her first child; she said no, this was her third. I asked her if this child or the other children had been sick, she said no. The presentation of a mother of 3 children coming out to the emergency department late on a cold winter night, carrying a well-looking infant, was a red flag for me regarding her safety. I asked myself what the best approach was to ask the mother of a child being seen in the emergency department if she was involved in an intimate partner violence situation? Because I was the triage nurse, I brought the child directly to the room to see the doctor. The mother was very upset, so I chose to bring the child to the room to validate her concern regarding her child rather than asking about her safety first. I had learned, after conducting my doctoral research, that this was the correct approach. The presentation was very subtle except for the mother’s behavior and appearance. This occurred in Massachusetts where mandated reporters do not have to report intimate partner violence. Privately, I shared my concern and asked the doctor to inquire. He did not agree. The child was discharged without the mother being screened for safety. The lesson learned from this interaction was that if the symptoms of intimate partner violence are very subtle, emergency nurses should not leave the inquiry to anyone else but complete it themselves after the child is treated. It became my lifelong mission as an emergency nurse to ensure that all patients, including mothers of children brought to the emergency department, were screened for intimate partner violence and offered services, including safety plan and resources, if needed. The lessons learned from this case triggered my quest to identify an evidence-based approach, during my doctoral research, to determine the best way to screen mothers of children brought to the emergency department for care.

At that time, I applied to Regis College in Weston, Massachusetts, for my Doctorate of Nursing Practice. My area of interest was domestic violence, which has since evolved to become known as intimate partner violence. There I developed the “See, Pull, Cut the Threads of Violence” format, which was the focus of my doctoral research. “See” represents the emergency nurses’ need to recognize hidden signs and symptoms of intimate partner violence. “Pull” represents the trauma-informed approach and therapeutic communication strategies that are important to find out if patients are involved in intimate partner violence situations. “Cut” represents stopping the cycle of violence by offering the person resources as well as a safety plan, and active engagement by emergency nurses in proposing legislative bills to stop intimate partner violence in the community. While doing my doctoral studies, I found a gap in research on the screening of mothers of children who come to the emergency department by health care providers to see if they are involved in an intimate partner violence situation. Pediatric health care providers were not screening the mothers of patients who came to the emergency department for care, which resulted in a missed opportunity to screen for intimate partner violence. During my doctoral education, I had taken a Health Care Policy course that involved learning how to advocate for patients by legislative involvement. The Health Policy class required our going to the Massachusetts State House and learning how legislative bills were created to advocate for health
care policies. During this class we became informed about the role of lobbyists and the legislative process, which must be understood if people want change to occur in their area of interest. I loved learning about health care policy. I realized that if nurses were not active in the legislative process as public and patient advocates, then change would not occur. This motivated me to submit a legislative bill, which took many months of investigating which bills being submitted to the Massachusetts House of Representatives at the time were similar to my proposed bill. Support from legislative voting members is recommended to support any bill proposal. This information guided my decision to write a bill in collaboration with legal advice on increasing penalties imposed on repeat domestic violence perpetrators. Collaboration with my local legislator helped me prepare for my testimony at the Massachusetts State House. This involved development of a fact sheet on domestic violence to give to voting members in the Massachusetts House of Representatives to gain support of my bill proposal. After submission of the bill, I was asked to testify on the bill proposal of increasing the penalties imposed on repeat domestic violence offenders. This bill was cosponsored by 26 Massachusetts State Representatives as House Bill 4527 in 2010. A comprehensive violence bill that was passed years later included aspects of my proposal. Emergency nurses need to understand that empowerment stems from active involvement in the legislative process in the area that needs change. I would advise emergency nurses to take a health care policy class to educate themselves on the legislative process, and go to their local state house to learn how to submit a legislative bill.

Remaining at the Bedside

The experience of being a bedside nurse involved in the legislative process to try to establish laws to protect the survivors of domestic violence fueled my desire to stay at the bedside even more. Bedside nurses who have a doctorate can be the most powerful advocates for those being taking advantage of by perpetrators of violence. Since receiving my doctorate, I have taught at several universities, and I remain at the bedside. Frequently I am asked, and personally reflect on, how important it is that I stay at the bedside. It would be much easier for me to move away from the bedside, which would allow for a better schedule, enable me to meet my needs first, and give me more authority in a hospital, as well as give me control of my life, and, definitely, a higher income. For me, being a bedside emergency nurse is very important. Emergency nurses who have a doctorate are exactly the emergency nurses I want taking care of my family, friends, and patients. The advanced degree emergency nurse applies additional critical thinking skills as well as evidence-based research during each patient encounter, which provides emergency care of the highest caliber. My patients and their families are appreciative of my empowering them with an explanation of their emergency care choices.

ENA Certifications and Involvement

Along with recognizing the importance of staying at the bedside, I realized early in my career that it was important to obtain certifications in emergency nursing. I have maintained certifications in multiple areas (CEN, CPN, and CPEN), and I volunteer with the ENA at the local, state, and national levels to promote emergency nursing excellence. I take pride as a mentor of emergency nurses, medical and physician assistants, emergency medical technicians, and paramedic students. I was a contributing author for Trauma Nursing Core Course, eighth edition (2020), Chapter 16: “Special Populations: The Interpersonal-Violence Trauma Patient.” I was a contributing author and content reviewer for Emergency Nursing Pediatric Course, fifth edition (2020). My pediatric knowledge, clinical expertise, and evidence-based research practice have been valuable throughout my emergency nursing career. As an ENA volunteer I have been an item writer for the CEN exam for 10 years and part of the first CPEN exam writing. My current active ENA involvement includes being a Trauma Nursing Core Course instructor and Emergency Nursing Pediatric Course instructor. At the ENA 2017 National Convention in St Louis, Missouri, I gave an intimate partner violence presentation titled “See, Pull, Cut the Threads of Violence.”

Active ENA involvement since 1979 led to my ultimate ENA honor, in 2018, when I became a Fellow of the Academy of Emergency Nursing. After receiving my Fellowship, I felt empowered to make a difference through research. In the fall of 2018, I applied for and received the ENA 2018 Foundation Seed Research Grant. I am eternally thankful to the ENA Foundation for this grant, which helped support my development of an online human trafficking educational module for emergency nurses, titled “See, Pull, Cut the Threads of Violence.” This module includes comparisons of intimate partner violence and human trafficking so that emergency nurses can identify (See) and provide trauma-informed communication to obtain abuse information (Pull). In addition, the module supplies emergency nurses with many
Empowerment of Emergency Nurses Through Knowledge Dissemination

Now along comes another opportunity for me to volunteer in the ENA through the *Journal of Emergency Nursing*. Since 2014, I have been the *Journal of Emergency Nursing* Pediatric Update Section Editor with the support of Dr Anne Manton and, from 2019, Dr Jessica Castner. Writing and mentoring others to write is my passion and source of enjoyment. Many of my published articles are related to forensics. I am grateful to have been invited by Dr Meredith Scannell to coauthor the chapter on “Intimate Partner Violence” in the book, *Fast Facts About Forensic Nursing*. In January 2020, I was offered, and I accepted, the newly developed Clinical Editor position at the *Journal of Emergency Nursing*, while retaining my Pediatric Update Section Editor position.

Maintaining Emergency Nursing Resilience

Thankfully, during my 40 years in emergency nursing I have remained resilient in the face of the many difficult situations that almost made me stop being a bedside emergency nurse. Fortunately, I could not let any perpetrator harm vulnerable patients and think they could get away with it. I continue to be an active ENA member at the local, state, and national levels to advocate for patients in the emergency department. I feel blessed and fortunate for each patient in the emergency department, and their family members, who have helped me to continue to grow as an emergency nurse and a person. As I embark on an exciting additional journey as the *Journal of Emergency Nursing* Clinical Editor along with continuing my bedside emergency nursing and my mentoring, my quest for emergency nursing excellence is unending. I encourage each reader to feel empowered by my offer to mentor emergency nurses to publish their evidence-based case studies for the advancement of emergency nursing knowledge. All emergency nurses must understand that knowledge is power that can be obtained by attending educational offerings, studying to obtain emergency certifications, and advancing their education in emergency and forensic nursing. I encourage nurses early in their emergency career to consider developing a collegial relationship with a seasoned nurse in their department or the local ENA chapter. Active ENA involvement will be an asset for each emergency nurse to maintain the resilience to stay at the bedside and to provide the highest quality nursing care to vulnerable persons. Emergency nurses should educate themselves in forensic sciences because it interfaces with the care of the emergency patients. Forensic science knowledge will enable the emergency nurse to advocate for patients who are in vulnerable medicolegal and interpersonal violence situations. National ENA membership is a great way to have access to free courses as well as courses offered at a discounted cost. Find your emergency nursing passion! Remember you can do it!

Emergency nurses must build their individual and collective resilience. Even after all these years, I feel personally fulfilled at the end of my shift that, hopefully, I brought comfort, emergency expertise, and caring measures to lessen someone’s unfortunate situation. I wish for emergency nurses to feel passionate about themselves as professional emergency nurses who can make a difference at the bedside and in health care settings, and to feel the power to advocate for all patients in the emergency department. This year, 2020, is an exciting year to recognize the resilience of nurses Judith Kelleher, Anita Dorr, and Florence Nightingale. With 2020 being the 50th anniversary of the formation of the ENA by Kelleher and Dorr, how perfect that it is also the 200th anniversary of the birth of Florence Nightingale, the founder of modern nursing. We emergency nurses would not be where we are today without the power of our founders.

REFERENCES


