Physician Readiness to Manage Intimate Partner Violence in Colorado

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PROJECT AIMS

Aim 1: Measure physicians' attitudes, beliefs, and behaviors (ABBs) regarding physician readiness to respond to intimate partner violence (IPV).
Aim 2: Compare ABBs according to physician background (age, gender, specialty, years in practice).
Aim 3: Compare ABBs reported by physicians working in clinics with formal IPV protocol, versus those without.
Aim 4: Compare ABBs reported by physicians with previous IPV training versus those without

BACKGROUND & PROBLEM STATEMENT

- In the general population identifying as women, the lifetime prevalence of IPV is 30%.[1,2]
- Victims/survivors of IPV experience higher rates of adverse chronic mental and physical health outcomes.[3]
- The lifetime cost of rape is $122,461 per victim.[4,5]
- Victims/survivors see healthcare as a place to seek help and are open to screening, but they often feel judged and blamed. They also report lack of safety precautions as a deterrent to engaging with the healthcare system. [6]
- Healthcare professionals report a lack of training and knowledge, time constraints, lack of adequate resources and privacy, feelings of frustration, powerlessness and personal discomfort with discussing the topic, and concerns about invading family privacy or offending the patient.[7]
- Previous research focuses on Emergency Medicine, OB-GYN, and Family Medicine separately

METHODS

Design: Cross-sectional survey employing a modified version of the Physician Readiness to Manage Intimate Partner Violence Survey, a validated instrument for measuring physicians' attitudes and perceived preparedness to care for female victims/survivors of IPV. [8-10] Surveys were sent to the Volunteer (community-based) Faculty Listserv at the University of Colorado School of Medicine from October 2022-March 2023.

Key Measures:

1. Demographic information
2. Specialty and years in practice
3. Preparedness to respond to IPV
4. Victim-Centered attitudes
5. Prior IPV training experience
6. Existence of IPV-related protocols and resources

References: 1. Wathen, C.N., et.al, *JAMA* (2003); 2. West, C.M., *Partner Abuse* (2012); 3. Campbell, J.C., *The Lancet* (2002); 4. Jones, A.S., et.al, *Women's Health Issues* (2006); 5. Peterson, C., et.al, *American Journal of Preventative Medicine* (2018); 6. NCIPC, *Costs of Intimate Partner Violence against Women in the U.S.* (2003); 7. Ulrich, Y.C., et.al, *American Journal of Preventative Medicine* (2003); 6. Reisenhofer, S., et.al, *J Clin Nurs* (2013); 7. Zijlstra, E., et.al, *J Interpers Violence* (2017); 8. Connor, P.D., et.al, *J Interpers Violence* (2011); 9. Djikanovic, B., et.al, *Journal of Family Violence* (2015); 10. Papadakaki, M., *Eval Health Prof* (2012); 11. ACOG *Obstet Gynecol* 2012) 12. U.S. Preventative Services Task Force, *JAMA* (2018) 13. Association AM. American Medical Association Physician Masterfile. In: Association AM, ed. Chicago2020.

RESULTS

Table 1: Participant Characteristics

	N	n (%)/ mean (SD)
Age (years)	182	48.3 (11.9)
Men	179	100 (55.9%)
Specialty:	182	
Family Medicine		42 (23.1%)
Emergency Medicine		28 (15.4%)
Internal Medicine		23 (12.6%)
Obstetrics/Gynecology		21 (11.5%)
Pediatrics		26 (14.3%)
Psychiatry		16 (8.8%)
Surgery		5 (2.7%)
Other		21 (11.5%)
Practice Setting:	178	
Inpatient		48 (27.0%)
Outpatient		130 (73.0%)
Number of years in practice	181	20.0 (11.9)
Received previous IPV training	149	58 (38.9%)
Number of hours of IPV training	53	8.8 (11.8)
Made IPV diagnosis in last 6 months	135	63 (46.7)

Figure 1 Screening for IPV by Symptom (N=105)

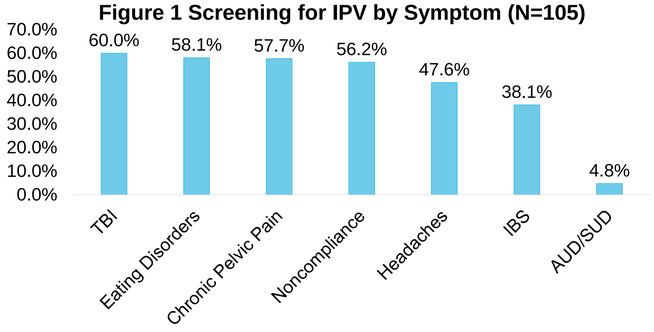

Figure 2 OB-GYN and Family Physicians Screening for IPV by Female Patient Population (N=63)

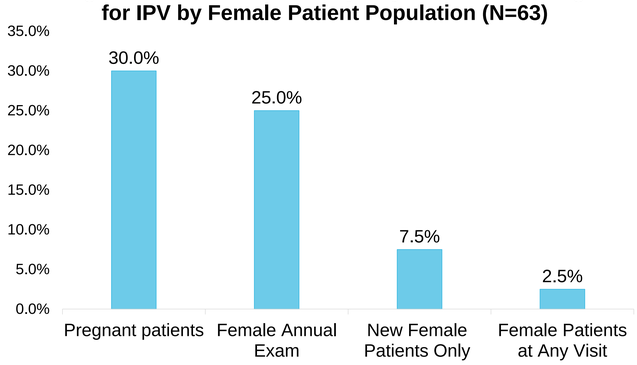

Table 2: Practice Issues

Issue	N	n (%)
IPV protocol present	172	68 (39.5%)
IPV referral resources available	172	72 (41.9%)
Pt education/resource materials available	171	77 (45.0%)

Figure 3 Average Total Preparedness by Specialty (N=182)

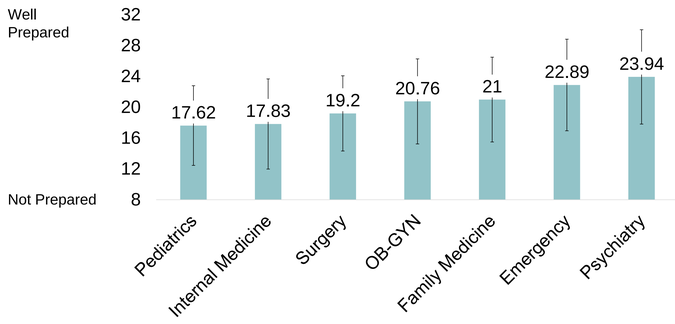

Figure 2 Percent of Participants Who Agree They Have the Necessary Skills to Discuss Abuse by Patient Population (N=182)

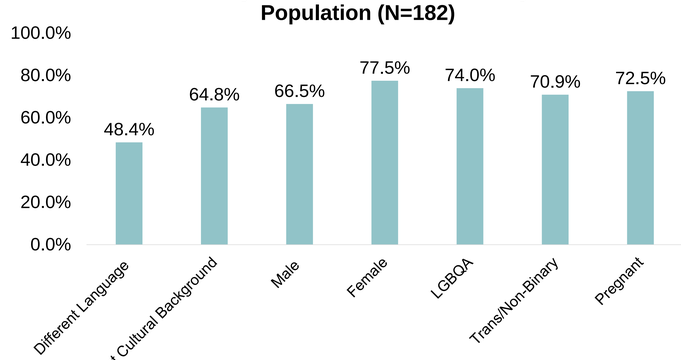

Table 3: Actions taken after making IPV diagnosis (N=75)

Actions	%
Counseled on options	56%
Documented pt statements in EMR	51%
Offered supportive/validating statements	51%
Referred to internal IPV resource	51%
Referred to external IPV resource	35%
Safety Assessment/Safety Planning	35%
Provided IPV education	33%
Referred to ED for forensic exam	23%
Document IPV with ICD-code	19%
Contacted law enforcement	14%
Photographed victim's injuries in EMR	10%
Used body-map to document injuries	8%
Other	5%
None of the above	0%

Table 4: Linear Regression Analysis IPV training or IPV Protocol Availability in Relation to Total Preparedness, Attitudes, and New Diagnoses Controlling for Age, Gender, Years in Practice, Practice Setting, and Specialty

	Total Preparedness [95% CI]	Attitudes [95% CI]	Making New Diagnosis [95% CI]
IPV Training	4.4 [2.4, 3.4]	1.06 [0.08, 2.0]	0.300 [0.14, 0.46]
Protocol	4.7 [2.7, 6.7]	1.9 [0.94, 2.8]	0.26 [0.10, 0.42]

DISCUSSION

- Low IPV screening rates among female and pregnant patients against national guidelines[11,12]
- Variables affecting preparedness, victim centered attitudes, and making new diagnoses were IPV training and presence of an IPV protocol at the clinic site when controlling for age, gender, practice setting, years in practice, and specialty.
- However, only 38.9% of participants received IPV training, and only 39.5% of participants reported an IPV protocol
- Only ½ of participants offered supportive statements or made referrals when IPV was diagnosed
- Participants did not screen for IPV after common complaints like sleep disturbance and chronic pelvic pain

LIMITATIONS

- Volunteer Faculty Listserv has an unknown number of physicians actively engaged in patient care → difficult to understand the response rate of the survey.
- Sample size of 182 hardly represents ~17,000 physicians in Colorado.[13]
- Physicians could opt-in to study participation after receiving an email → physicians more interested in IPV may be more likely to participate.
- Certain specialties were more represented in the study sample, like Family Medicine, than others → non-participation bias possible.
- PREMIS instrument modified based on limited expert panel. Internal validity analysis not conducted for modified tool.
- Results did not seek to understand quality of care, i.e. the impact the independent variables have on people experiencing IPV (feelings of support, empowerment, safety, morbidity, mortality, etc.)

CONCLUSION

- Healthcare systems, residency and fellowship programs, and medical schools should invest in IPV training and protocols
- There are other opportunities for improvement, such as increasing referral resources and making educational materials more available to patients.
- More research is needed to better understand screening rates and barriers to implementing screening
- More research needed to understand efficacy of training and protocol on quality of care