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Introduction

The term intimate partner violence (or IPV) refers to a threat of abuse or actual psychological, physical, and/or sexual abuse perpetrated by a former or current intimate partner. IPV is an important public health issue that crosses socioeconomic lines. Approximately 4.8 million women experience physical or sexual assault perpetrated by their intimate partner each year in the US.[1] There are no reliable statistics for how many women suffer psychological abuse, but the numbers are likely much higher. Physical, psychological, or sexual injuries can have wide ranging effects, including increased mortality. Although it has been firmly established that the prevalence of IPV is high, physician involvement in screening and diagnosing IPV has historically been very low.

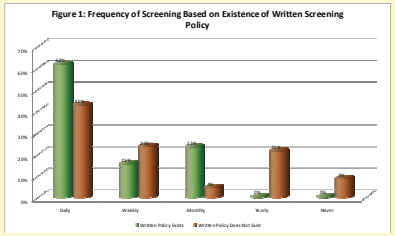
Previous studies have addressed IPV screening in other parts of the country. In one study, less than 15% of female patients reported being asked by a health professional about IPV, even though studies have shown that the majority of female patients would reveal their abuse if asked. Also, most physicians screened for IPV when the patient presented with physical trauma, but few screened all patients regularly. The more aware physicians were about IPV, the more likely they were to screen in all clinical settings.[2] While both men and women are victims of IPV, and IPV can have a large effect on the children of the abused, only the screening and treatment of women was explored here. The purpose of this study was to examine the state of IPV screening in Vermont. The objectives were as follows:

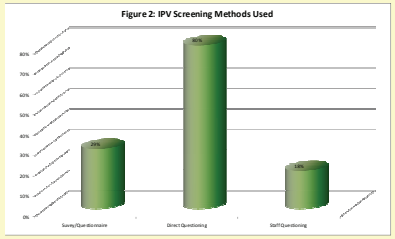
- **Estimate the IPV screening, intervention, and policy practices of Vermont physicians**
- **Examine the role of physicians in screening and intervention**
- **Explore physicians' knowledge of IPV resources**

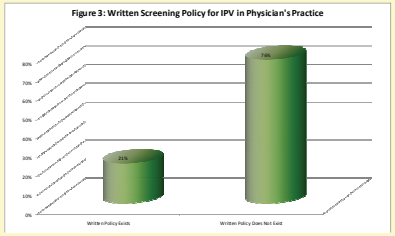
Methods

The study was administered through SurveyMonkey.com. It included multiple-choice and open-ended questions about IPV. Questions were based on background research and from consultation with Women Helping Battered Women. We consulted a statistician to verify our questioning format and design. An invitation to take the survey was sent out to physicians in Vermont hospital networks including Fletcher Allen, Porter Hospital, Southwestern Vermont Medical Center and UVM College of Medicine affiliates. Recipients were targeted in the following specialties: family medicine, internal medicine, psychiatry and gynecology. These specialties were chosen because they provide primary care services to women. In total we received 67 responses. Given the sensitive content of the survey and the narrow target demographic, it was not possible to obtain a larger sample size.

Results







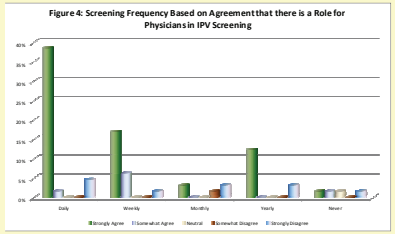
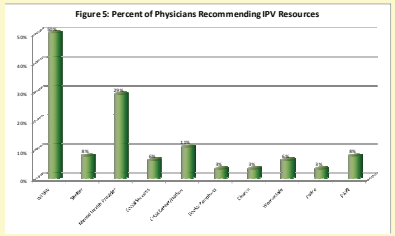


Figure 4 (above right): Physicians were asked to indicate how strongly they agreed or disagreed with the following statement: there exists a role for physicians to screen for intimate partner violence. This was then correlated with how frequently they screened for IPV.

Figure 5 (right): Physicians were asked what community or counseling services they would recommend to patients who screened positive for, or who were at risk for intimate partner violence. WHBW= Women Helping Battered Women. PAVE= Project Against Violent Encounters.



Demographics

Respondents included 67 Vermont physicians. Females outnumbered males by 23%. The majority (71%) practice in Chittenden County, with the remainder coming from Addison, Bennington, Windham, Franklin, Washington, and Orange counties. The majority of the physicians were between the ages of 35 and 50. Practice settings of respondents were split almost equally between Clinic/Community Health Centers, Private Practices and hospitals.

Discussion

Our results demonstrated that IPV screening is prevalent, although lack of written policies within practices implies that settings, incidence and methodology of screening are inconsistent. Together with WHBW, we suggest implementation of more rigorous IPV screening protocols.

The reason for sporadic screening may be related to the circumstances prompting physicians to ask about IPV. The majority (60.7%) inquired only when suspicious findings arose. About half of physicians would screen if the patient brought up violence themselves. Few physicians screened in other specific situations such as first visits (12.5%) or in patients with psychiatric conditions (34.4%). Screening as part of a women's annual exam, however, was more common (52.5%).

Standardized screening protocols should incorporate the actions that our respondents emphasized. The vast majority would recommend resources if a woman screened positive for IPV and would document abuse and counsel abused patients. Protocols should also cover legal intervention, and treatment of acute and chronic consequences.

Physician education is integral to successful IPV screening, especially since a significant minority saw no role for physicians at all. Continuing education courses and conferences, specialized Grand Rounds sessions, training sessions, and case consultations are all recommended methods.

Lessons Learned

- Some providers had very strong opinions regarding our topic. It would be helpful for groups in the future that have controversial topics to try to find topic experts, and invite them to provide critiques, prior to surveying the population as a whole.
- Accessing physician email lists and survey distribution was challenging. We would recommend that groups in the future start very early and try to find ways to send the surveys directly to physicians.
- Because Women Helping Battered Women did not have a specific project that they wanted us to accomplish, we had a lot of freedom in designing the study. This meant that a lot of time needed to be spent in study design. In that situation, we think that it is very important to involve the community agency as much as possible in brainstorming sessions and to ask for feedback regularly.

References

1. CDC Factsheet. Understanding Intimate Partner Violence. 2006
2. Michael A. Rodriguez; Heidi M. Bauer; Elizabeth McLoughlin; et al. Screening and Intervention for Intimate Partner Abuse: Practices and Attitudes of Primary Care Physicians. JAMA. 1999;282(5):468-474