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Update on Intimate Partner Violence and Medical Education

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A young woman sits in front of you in the office. Based on the statistics, there is a one-in-four chance that a serious condition may be adversely affecting her health—partner violence [1]. One quarter of women and almost 8 percent of men report sexual or physical violence by an intimate partner, which amounts to about 4.8 million women and 2.9 million men annually in the United States [2, 3]. Intimate partner violence (IPV), the preferred term, is present in every race, ethnicity, age group, class, and neighborhood in America. The problem appears worse in youth and young adults—70 to 88 percent of adolescent or college women experience at least one incident of either physical or sexual violence [4, 5]. One episode of violence also appears to put a patient at greater risk for future episodes.

Interrelationship violence can occur (1) in married or unmarried couples, (2) between couples who do not live together, (3) in heterosexual and homosexual relationships, and (4) any time after the inception of the relationship (versus pre-relationship dating), so it is more correctly termed IPV than dating violence. The Women's Health Education Program (WHEP) at Drexel University College of Medicine (DUCOM) works with Many Hands Working Together (c) [6] to promote a shift toward better integration of sexual-safety planning into delivery of clinical services [7]. Sexual-safety planning is a harm-reduction, model-based intervention to reach patients with the comorbidities of IPV and high vulnerability of HIV [7].

How Partner Violence Relates to Medicine

IPV is associated with several poor health outcomes including headaches, back pain, gastrointestinal disorders, posttraumatic stress disorder, depression, anxiety, substance use, eating disorders, cigarette smoking, sexually transmitted illness, and HIV/AIDS [2, 8-10]. It is also estimated that intimate partner violence results in 2 million injuries and 1,300 deaths annually [11]. Traumatic events from partner abuse have a devastating impact on victims, often creating deep emotional and psychological wounds. Thus, partner violence poses a significant threat to the physical and mental health of victims [12].

The central issue in intimate partner violence is control and unhealthy behaviors—it goes far beyond physical assault. Its clinical manifestations—emotional, psychological, financial, and physical—can be identified in all medical practice areas. Clinicians in primary care medicine need to be particularly alert and screen regularly. The increased risk of violence during pregnancy makes standard screening in ob-gyn imperative. Physicians in emergency medicine and orthopedic specialties

who are likely to witness the consequences of intimate partner violence must be alert to inconsistencies between an asserted mechanism of action (ran into a door) and the actual injury (orbital fracture). IPV has been found to be the most common cause of orbital fracture seen in ophthalmology [13]. Beyond accurate treatment, identification of violent cause is essential in averting future violence. A red flag for any physician should be a partner or spouse who seems overly controlling in an exam room, especially one who refuses to leave his or her partner alone in the exam room at the request of a physician or when privacy would be expected. Whether cardiologist, surgeon, or anesthesiologist, all physicians need an index of suspicion regarding partner violence.

Yet the gold standard of uniform screening is not achieved in most clinical settings. Since its inception in 1993, WHEP has been a leader in educating students about the influence of sex and gender on health care and has afforded them a venue to explore the interface of biomedicine and public health. IPV education is taught in the core curriculum, reinforced during clinical training, and practiced within system-wide extracurricular health-education service programming. The program's philosophy is to offer sex and gender health-disparities education in a discrete place with available resources and to employ integrated core curricula in addition to stand-alone interventions. This curricular framework is delineated in [Table 1](#). Extracurricular opportunities are highlighted in [Table 2](#).

Challenges

If primary care residency requirements include IPV screening, why isn't IPV screening a student competency? The reasons break down into three areas—perception of relevance, training opportunities, and resources.

Relevance

Physicians, like the general population, have difficulty addressing uncomfortable areas (e.g., end of life, poor prognoses, and sexual health). IPV falls into this category. Reasons to resist screening can include: "I don't have any time to do this." "What if they ask me something I can't answer?" "What if they start to cry? How do I handle that?" "I'm not a therapist or social worker—this isn't my job." "Why doesn't she just leave?" These concerns can be addressed in data-driven, clinically relevant, case-based educational interventions. Understanding the adverse health outcomes associated with IPV, developing skills to establish a safe clinical environment, and identifying multidisciplinary teams and agencies for referral can increase students' and physicians' comfort and improve outcomes.

Furthermore, the error and potential for escalating harm through misinformation (e.g., encouraging a woman to engage in couples therapy rather than find a safe place and develop a plan to leave) should be addressed and corrected. Lastly, although violence is unpleasant, students must recognize that all sections of the population—including "nice people"—can be in traumatic relationships, and that intentional blindness toward the issue results in widespread adverse health outcomes.

Training Opportunities

Perhaps the biggest reason why students don't screen is that they don't see clinicians screening. Good models and mentorship are essential for students. Effective screening practices employ a high level of expertise and integration of communication, clinical decision making, maturity, and professionalism. Physicians must be able to create safe space for a patient. Whether or not a patient divulges his or her situation, clinicians must assert that everyone deserves to be safe and invite further discussion at the next visit. Concurrent with the interchange, a physician evaluates verbal and nonverbal communication to assess risk. Will the patient be beaten up if she is caught with material about violence prevention? Has she considered where she might go if she leaves her home?

Physicians and residents often don't screen because they have not been formally trained and evaluated on IPV screening. Existing interventions such as objective structured clinical exams (OSCE) can aid in training and evaluation [14]. For example, DUCOM's WH Seminar series has trained students how to retain IPV skills despite discouraging messages from house staff when on the hospital units.

Resources

Beyond training, physicians must know how to connect with social service agencies and other health professionals so that referrals and consultations can be easily made. A senior DUCOM student is developing a tool that will put referral information close at hand.

Derived from its legacy and with support from the medical school, The Women's Health Education Program serves as a dedicated resource and connector for multidisciplinary resources. Other schools need to consider linking violence-prevention training to existing educational programs (those that support social justice, clinical skills, community experiences, multidisciplinary training, and humanism) to ensure ongoing instruction. Distance-learning video tools, such as those available at <http://www.doc.com>, can also serve as resources. Students with opportunities for community experiences might consider establishing connections with one of many agencies [15].

Lessons Learned

WHEP has learned the following lessons from providing training in IPV for 15 years:

- After initial exposure, students need reinforcement to develop effective skills for screening and responding to IPV.
- Problem solving using a team-based approach in a multidisciplinary format is well received. WHEPs interactive, case-based sessions for third-year students are highly rated as useful reinforcement of key objectives learned in earlier years. This refresher session allows students to ask questions and use case stories while practicing screening in diverse populations.

- Opportunities to practice improve proficiency. Whether through formative (non-graded) OSCEs or with role playing, medical students need to receive feedback on skill development.
- Identifying and supporting advocates for training are crucial to success.
- Resources—people as well as primers with clinical tips on initiating discussions and making referrals—are essential.

The Future

As health disparity markers are analyzed, the total cost of intimate partner violence both in dollars and adverse outcomes will be better delineated. Universal screening of emergent risks for all patients (e.g., identifying a man with inadequate anger management) will then be defined as a component of quality care. In addition to universal screening, regular and repeat risk assessment of groups with recognized high risk (e.g., incarcerated, dual-diagnosed, and pregnant individuals), should become policy and standard in clinical care delivery.

By incorporating trauma and health within practice, relational health may become more than an end-stage intervention; it may become an “early prevention and intervention practice” included in pediatric, adolescent, and primary care.

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Suggested Readings

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