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J Interpers Violence 2003; 18; 623

DOI: 10.1177/0886260503251133

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Assessing for Domestic Violence Exposure in Primary Care Settings

The Transition From Classroom to Clinical Practice

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To evaluate the ability of medical students to apply domestic violence training in an early clinical experience, a cross-sectional survey was undertaken among 2nd-year medical students from the University of British Columbia during their rural family practice practicum. Participants recorded whether they assessed adult patients for exposure to domestic violence during routine office visits. Domestic violence was discussed in 11% of the 341 recorded patient encounters. All discussions involved female patients. Domestic violence was discussed in 27% of the one-on-one encounters with patients versus 3.6% of the encounters in which a preceptor was present. Barriers that prevented medical students from undertaking assessment and counseling included lack of mentoring and role modeling and a perceived lack of privacy and time available. Application of classroom knowledge in this challenging domain requires preceptorship by appropriately trained supervisors in the clinical setting.

Keywords: *domestic violence; family practice/education; education; medical students; medical*

Domestic violence is widely recognized as a significant public health issue in Canada (Statistics Canada, 1993). In studies of the prevalence of domestic violence among patients in primary care settings, 12% to 28% of patients have reported current involvement in abusive relationships (Johnson & Elliot, 1997). Domestic violence has thus been widely recognized as a health

Authors' Note: The authors would like to acknowledge the efforts of the 2nd-year medical students who participated in the study.

JOURNAL OF INTERPERSONAL VIOLENCE, Vol. 18 No. 6, June 2003 623-633

DOI: 10.1177/0886260503251133

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issue ideally suited to universal screening (Chescheir, 1996). In 1992, the American Medical Association Council on Ethical and Judicial Affairs strongly endorsed the inclusion of screening questions regarding domestic violence in routine history taking. Routine screening has also been endorsed by groups such as the Canadian Association of Emergency Physicians and the College of Family Physicians of Canada (Hotch, Grunfeld, Mackay, & Cowan, 1995). Furthermore, studies have shown that patients want their physicians to routinely inquire about domestic violence, even if they have not been victims of abuse (Friedman, Samet, Roberts, Hudlin, & Hans, 1992).

Despite the recommendations, a recent survey from Quebec suggests that Canadian physicians do not routinely screen for lifestyle health risks such as family violence (Maheux, Haley, Rivard, & Gervais, 1999). In that study, only 3.2% of general practitioners who responded to the survey reported that they routinely ask their adult patients about family violence, compared to 82.2% who routinely ask about tobacco use. Furthermore, 86.5% of the physicians reported finding it "rather difficult or very difficult" to discuss family violence. These findings are consistent with those of U.S. studies (Hamberger, Saunders, & Hovey, 1992; Olsen et al., 1996). A lack of physician training in lifestyle risk assessment is often deemed to be a major explanatory factor. As evidence, the Quebec study noted that only 18% of general practitioners felt their level of training was adequate or excellent with regard to family violence.

Today's medical students, however, are generally receiving substantially more education than their predecessors related to assisting patients who are victims of domestic abuse. As part of the medical curriculum at the University of British Columbia (UBC), medical students are now receiving 9 hours of classroom-based training in assessment of exposure to domestic violence and response to disclosures. The unit involves lectures, video presentations, patient and expert panels, small group discussions, and role-playing for practicing specific skills. Course coordinators report that the sessions have high attendance rates and are extremely well received by students.

It is debatable, however, whether such learning modules are enough to facilitate the development of satisfactory skills in lifestyle risk assessment and counseling. After the 2nd year, medical students are catapulted into the clinical setting where apprenticeships supercede Socratic teaching methods and the educational environment becomes less standardized than in the pre-clinical years. At UBC, students participate in a 4- to 8-week rural family practice program immediately following the completion of 2nd-year exams. This experience forms students' first substantial foray into daily clinical practice. We sought to evaluate whether students were able to translate the domestic violence knowledge they had acquired in the classroom into usable skills

in an early clinical training experience. We conducted a pilot study to examine UBC medical students' experiences relating to domestic violence assessment in the rural family practice elective.

METHOD

Second-year medical students from the UBC medical class of 2001 were recruited on a volunteer basis. Recruitment was conducted by distributing a written description of the study to the 112 students and by a brief oral presentation to the class. Informed consent was obtained from the participating medical students, as well as from their individual preceptors. The study was completed over a period of 5 weeks, from June 1st to July 5th, 1999. For a period of at least 6 consecutive days, each participant used standardized data collection forms to record their experiences with all patients, 19 years of age and older, who presented to them during routine office visits to rural family practices. Patient encounters always involved the student but may have either been the student alone with the patient or the physician preceptor and the student together with the patient. Following each patient encounter, students completed a patient encounter form to record whether a discussion of domestic violence had occurred and to describe the specific factors that they perceived to have supported or inhibited the occurrence of a discussion. For those patients with whom a discussion took place, the student recorded whether a disclosure of any form of abuse had occurred. If abuse was disclosed and described during an encounter, the student used the patient's description of the nature and pattern of the abuse to complete a patient disclosure form.

Participants were not given any specific directions regarding clinical practice but were instructed to act based on the domestic violence education they had received, their own comfort levels, and the guidance of their preceptors. Patient data were completely anonymous, and students were identified by numeric code. Students were equipped with resource cards that identified provincial resources to which patients could be directed if there was a disclosure of abuse. Students were encouraged to discuss with their preceptors an approach to basic counseling and safety planning for those patients who wished to receive it.

Data forms were mailed anonymously to the study investigators. Frequency distributions were derived using Excel software. Following completion of the survey, selected students were interviewed regarding their participation in the study. Answers to open-ended questions were transcribed to a word-processing program and then grouped according to themes.

TABLE 1: Reasons for Withdrawal and Exclusion of Participants

<i>Participation Status</i>	<i>Number of Students</i>
Eligible to participate in study	112
Volunteered to participate in the study	26
Withdrawals (total)	20
Preceptor opposed to student's participation	3
Not enough time spent in the clinical setting	9
Personal reasons	5
No reason provided	3
Participated in study	6

The study was approved by the UBC Behavioral Research Ethics Board.

RESULTS

Of the 112 students apprised of the study, 26 (23.2%) initially volunteered to participate. Of these, 20 students withdrew (see Table 1). In all, 6 students, representing almost half of the students who were in appropriate settings, completed the study. Data sheets for 408 patient encounters were collected, 66 of which were excluded because the age of the patient was younger than 19 or unknown, and 1 was excluded because it was not reported whether a discussion of domestic violence occurred.

Valid data for 341 patient encounters were analyzed, of which one third involved the medical student one-on-one with the patient and the rest with the preceptor present. The patient population was characterized by a mean age of 49 years and was primarily female, White, and married or cohabiting (see Table 2).

Overall, domestic violence was discussed in 39 (11%) of all recorded patient encounters. Notably, all of the discussions involved female patients; as such, 18% of encounters with female patients involved a discussion of domestic violence. Domestic violence was discussed in 31 (27%) of the 116 patient encounters in which students were one-on-one with patients, versus 8 (3.6%) of the 221 encounters in which a preceptor was present (see Table 3). A current or past history of abuse was disclosed in 16 (4.7%) patient encounters. Physical abuse was reported in 10 of these cases; the rest were characterized as psychological abuse (2 cases), sexual abuse (1 case), or unreported (3 cases).

Screening for domestic violence was defined as having occurred when the student or preceptor initiated a discussion of domestic violence in either the

TABLE 2: Demographics of Patient Sample

<i>Demographic</i>	<i>Discussed Domestic Violence (n = 39)</i>		<i>Did Not Discuss Domestic Violence (n = 302)</i>	
Sex <i>n</i> (%)				
Male	0	(0.0)	119	(39.0)
Female	39	(100.0)	179	(61.0)
Ethnicity <i>n</i> (%)				
White	38	(97.4)	253	(83.7)
First nations	0	(0.0)	20	(6.6)
East Indian	0	(0.0)	8	(2.7)
Other	0	(0.0)	6	(2.0)
Unknown/unreported	1	(2.6)	15	(5.0)
Relationship status <i>n</i> (%)				
Single	7	(18.0)	25	(8.3)
Dating	1	(2.5)	9	(3.0)
Married/cohabiting	28	(72.0)	170	(56.2)
Separated/divorced	1	(2.5)	13	(4.3)
Unknown/unreported	2	(5.1)	85	(28.1)
Mean age (<i>SD</i>)	45.9	(17.0)	49.5	(17.0)

presence or absence of signs/symptoms suggestive of abuse. There were 36 cases in which screening was conducted, 33 of which involved students as the interviewer and 3 of which involved the preceptor as the interviewer with the student as an observer.

In 14 (39%) of the cases in which screening took place, there was a disclosure of a past or current history of victimization. In comparison, there were only 2 spontaneous disclosures among the patient encounters in which screening was not undertaken, representing a 0.7% disclosure rate when neither the student nor preceptor asked about domestic violence.

For 65% of the patient encounters in which domestic violence was not discussed, the most commonly chosen explanation (multiple reasons were permitted) was the statement, "You did not feel the need to talk to the patient about domestic violence *during this visit* because domestic violence was unrelated to the patient's chief complaint/reason for visit." The next most common reason for the absence of a discussion, chosen 18% of the time, was "You did not feel the need to talk to the patient about domestic violence *during this visit* because you did not feel that it was your position or role to discuss this issue with the patient." Students reported that in 10% of the encounters in which a discussion did not occur, they had "wanted to talk to the patient about domestic violence" but did not because they "did not have time to raise the issue." Ten percent of the time, students "did not feel that sufficient rap-

TABLE 3: Content of Patient Encounters According to the Role of the Student

<i>Content of Encounter Related to Domestic Violence</i>	<i>Student Alone Interviewed Patient</i>	<i>Student Interviewed, Preceptor Present</i>	<i>Student, Preceptor Both Interviewed</i>	<i>Preceptor Interviewed, Student Observed</i>	<i>Student Role Not Reported</i>	<i>Total</i>	<i>% of Total Sample</i>
Discussion	31	2	0	6	0	39	11.4
Screening	31	2	0	3	0	36	
Disclosure	11	1	0	4	0	16	
Discussion did not occur	85	17	15	181	4	302	88.5
Total	116	19	15	187	4	341	100

port with the patient had been established.” In 6.7% of patient encounters, students “were unable to see the patient in privacy (e.g., a spouse was present).”

DISCUSSION

Observations from this study provide preliminary insight into the difficulty of translating classroom medical school experience into the primary care teaching setting. It is clear that domestic violence screening did not occur on a regular basis in this sample of patient encounters, despite the initial enthusiasm for the project displayed by a small group of motivated students who volunteered for the study. Although 11% of the patient encounters included a discussion of domestic violence, only 1 student conducted a substantial amount of screening, which accounted for 82% of all cases in which domestic violence was discussed.

Although students who declined to participate in the study were not interviewed formally, informal discussions revealed that many students did not feel that it was their responsibility to undertake screening for domestic violence in a primary care setting. As 2nd-year students, they had already completed 1 year of a family practice continuum program in which they worked in primary care settings with family practice physicians 1 afternoon per week. In those settings, very few observed their preceptors assessing for intimate partner violence.

Among those who initially agreed to participate and then dropped out, this may have occurred either because of the nature of the setting or the practice of the preceptor. Some students indicated that they were unfamiliar with the community that they were placed in and neither they nor their preceptor knew how to appropriately make referrals for battered women. Others stated that there was no “framework” for screening, that is no documents or protocols that indicated screening should take place in the practice setting.

Among students who did participate, it is important to determine the barriers to employing the skills during their early clinical experiences in a primary care setting, given that they received more direct classroom training in domestic violence than many other areas of routine patient assessment, including blood pressure measurement and screening for tobacco use. First, it is important to note that the overall level of clinical exposure of students to domestic violence may have been artificially reduced, because some students understood that they were sometimes excluded from office visits in which “sensitive” topics were being discussed. Another factor might be the early stage in training at which the medical students were surveyed. It is likely that increased overall confidence and clinical expertise facilitate greater comfort

among medical students in terms of inquiring about sensitive topics such as domestic violence.

The most common reason cited for not venturing to ask patients about domestic violence was that it seemed unrelated to the patient's chief complaint or reason for the visit. Some of the students explained that the routine of family practice often dictates that the only issue discussed during patient visits is the chief complaint itself. It therefore felt awkward to ask, "out of the blue," about a potentially sensitive and complex lifestyle problem such as domestic violence. One student reported feeling comfortable raising the issue of domestic violence only when conducting a complete medical and social history. It may have been more realistic to expect that students ask about intimate partner violence in the context of an initial visit by a new patient, an annual health checkup, an antenatal visit, a visit related to a chronic illness when the patient had not been previously asked about intimate partner abuse, or a patient presenting with an injury.

One student commented that

although the learning modules reinforced that domestic violence occurs in all groups, genders, ages, living situations, socioeconomic levels, etc., in practice I found that I still employed a stereotyped view of domestic violence in clinical situations. . . . For some reason, I continued to subscribe to [this view] even though I know the true facts!

Therefore, students avoided raising the issue with patients with apparently unrelated presenting complaints, despite an awareness that it is impossible to "guess" at who might be a victim of domestic violence and that there are varied clinical presentations with no pathognomonic signs or symptoms of abuse (Hotch et al., 1995; McCoy, 1996). Domestic violence was never discussed with male patients, despite students having been previously informed of evidence that violence in relationships is often bidirectional (Kwong, Bartholomew, & Dutton, 1999).

With respect to the relevance of domestic violence screening to the primary care role, all participating students reported that their preceptors were supportive of the study and of dealing with domestic violence as a health care issue in the family practice setting. None of the preceptors, however, routinely screened for domestic violence in their own practices. In our survey, it was interesting that domestic violence was discussed far more frequently in one-on-one medical student-patient encounters than when the preceptors were present. Given that this study was limited to those encounters in which the student was either the interviewer or an observer, it would be interesting

in future studies to survey preceptors and students simultaneously to include those patient encounters in which the student was absent. Nevertheless, students clearly did not receive practical training in the clinical setting with regard to screening for domestic violence, as documented in Table 3. This strongly suggests that domestic violence education needs to extend beyond the classroom into the clinical learning environment, a concept that has been promoted in recent literature (Dickstein, 1997; Flitcraft, 1995). Although formal evaluation of the practicum experience does not currently take place, a checklist of competencies expected to be attained at the end of the practicum would highlight gaps in the primary care practicum. It would also direct continuing education priorities for the faculty of medicine aimed at clinical faculty.

One student commented on the impact of the education received in the classroom versus the reality of clinical practice with respect to time constraints: "Following the [educational] sessions, I had thought that I would screen for domestic violence; perhaps, I was being unrealistic about the true time pressures and discomfort that screening would be subject to." Time pressures have been similarly noted by physicians (Gremillion & Kanof, 1996). However, the time required to screen patients is often viewed by experts as a "pseudo-barrier" because routine screening need not take more than 2 to 3 minutes, allowing for time to explain to the patient that screening is a new practice and that every patient is being asked.

Even with the small sample size in this study, it is apparent that the absence of routine screening allows the majority of victims of abuse to go unrecognized. Although screening yielded a disclosure rate of 39%, the detection rate dropped to 0.7% among the patient encounters in which screening did not take place. This supports other studies that report that routine screening for domestic violence dramatically increases detection rates (Dickstein, 1997; Flitcraft, 1995; Gremillion & Kanof, 1996; Grunfeld, Ritmiller, Mackay, Cowan, & Hotch, 1994; Kwong et al., 1999; McCoy, 1996; McLeer & Anwar, 1989; Olsen et al., 1996).

The late 1990s have seen the introduction of domestic violence curricula in medical schools. To our knowledge, there have not been studies examining the transition from classroom learning to application in the clinical setting. We have provided preliminary data to show that there may be significant barriers preventing medical students from carrying skills related to domestic violence learned in the classroom into early experiences in primary care. Our study was limited by a much smaller sample of students than anticipated, in itself a significant outcome of the study. Given the self-selection of the participants, any error of bias that occurred would have tended to overestimate the

frequency at which domestic violence is dealt with in medical student–patient encounters.

Learning to ask about domestic violence involves the modification of attitudes and beliefs based on acquisition of knowledge and the opportunity to practice skills with appropriate demonstration and feedback. Although screening for domestic violence is now a standard of practice, prior to this study, it had not been included in the standards for history taking in the medical school curriculum. It has now been added as part of lifestyle issues in the framework for history taking in the clinical skills curriculum for 1st- and 2nd-year students at UBC. The expectation that family practice preceptors model screening skills does not seem premature at this time. Preceptor modeling of routine screening practices in teaching situations may be an effective means of validating and substantiating the students' knowledge, such that learned practices become comfortable clinical habits. The findings of our study indicate, however, the need to ensure that continuing education for community physician preceptors keeps pace with the undergraduate medical school curriculum.

REFERENCES

- American Medical Association Council on Ethical and Judicial Affairs. (1992). Physicians and domestic violence: Ethical considerations. *Journal of the American Medical Association, 267*, 3190.
- Chescheir, N. (1996). Violence against women. Response from clinicians. *Annals of Emergency Medicine, 27*, 767.
- Dickstein, L. J. (1997). Practical recommendations for supporting medical students and faculty in learning about family violence. *Academic Medicine, 72*(Suppl.), S105-S109.
- Flitcraft, A. (1995). Project SAFE: Domestic violence education for practicing physicians. *Women's Health Issues, 5*, 183-188.
- Friedman, L., Samet, J., Roberts, M., Hudlin, M., & Hans, P. (1992). Inquiry about victimization experiences: A survey of patient preferences and physician practices. *Archives of Internal Medicine, 152*, 1186-1190.
- Gremillion, D., & Kanof, E. (1996). Overcoming barriers to physician involvement in identifying and referring victims of domestic violence. *Annals of Emergency Medicine, 27*, 769-773.
- Grunfeld, A. F., Ritmiller, S., Mackay, K., Cowan, L., & Hotch, D. (1994). Detecting domestic violence against women in the emergency department: Nursing triage model. *Journal of Emergency Nursing 20*, 271-274.
- Hamberger, K. L., Saunders, D. G., & Hovey, M. (1992). Prevalence of domestic violence in community practice and rate of physician inquiry. *Family Medicine, 24*, 283-287.
- Hotch, D., Grunfeld, A., Mackay, K., & Cowan, L. (1995). *Domestic violence intervention by emergency department staff*. Vancouver, Canada: Vancouver Hospital and Health Sciences Centre.

- Johnson, D., & Elliot, B. (1997). Domestic violence among family practice patients in midsize and rural communities. *Journal of Family Practice, 44*, 391.
- Kwong, M. J., Bartholomew, K., & Dutton, D. (1999). Gender differences in patterns of relationship violence in Alberta. *Canadian Journal of Behavioural Sciences, 31*, 381-388.
- Maheux, B., Haley, N., Rivard, M., & Gervais, A. (1999). Do physicians assess lifestyle health risks during general medical examinations? *Canadian Medical Association Journal, 160*, 1830-1834.
- McCoy, M. (1996). Domestic violence: Clues to victimization. *Annals of Emergency Medicine, 27*, 764-765.
- McLeer, S. V., & Anwar R. (1989). A study of women presenting in an emergency department. *American Journal of Public Health, 79*, 65-67.
- Olsen, L., Anctil, C., Fullerton, L., Brillma, J., Arbuckle, J., & Skier, D. (1996). Increasing emergency physician recognition of domestic violence. *Annals of Emergency Medicine, 27*, 741-746.
- Statistics Canada. (1993). The Violence Against Women Survey. In *The daily*. Ottawa, Canada: Minister of Industry, Science, and Technology.

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