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A Pilot Project Exploring Medical Students' Barriers to Screening for Intimate Partner Violence and Reproductive Coercion

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Abstract

Background: Multiple studies have shown that the majority of health care practitioners do not routinely screen for intimate partner violence (IPV); lack of provider preparedness and education is an often-cited barrier to screening. Our third-year family medicine clerkship includes a pregnancy options counseling objective structured clinical examination (OSCE) that requires students to review a preencounter online educational module that highlights screening guidelines for IPV and reproductive coercion. The goal of this study was to explore students' internal barriers to screening patients for IPV and reproductive coercion, and whether our curricular interventions adequately addressed these barriers.

Methods: We administered an immediate postencounter, anonymous, online survey with open-ended and Likert-type questions to 118 medical students during the 2016 academic year. We used an exploratory, iterative process to analyze qualitative responses and quantify recurrent and commonly identified themes.

Results: After the OSCE, students reported they were more likely to screen for IPV (94%) and reproductive coercion (82%) in future encounters. Qualitative analysis revealed two major types of barriers to screening: internal barriers concerning the screening inquiry itself and concerns regarding handling of patients' responses.

Conclusions: The online preparatory module and subsequent OSCE provided a low-stakes environment in which to practice screening. However, student comments about their barriers to screening suggest that a first or early curricular intervention folding IPV and reproductive coercion into an educational module on pregnancy options counseling did not optimally promote this screening behavior.

Introduction

Intimate partner violence (IPV) encompasses any form of assault intended to isolate and/or intimidate, including physical and psychological abuse, reproductive coercion, and stalking.[1] Reproductive coercion refers to any behavior that manipulates reproductive health outcomes, such as sabotaging birth control methods, pressuring a woman to get pregnant or a man to father a child, or exerting control over the outcome of a pregnancy.[2,3] Multiple studies have examined the prevalence of reproductive coercion in different populations of women, with reported prevalence ranging from 16% to 54%.[4-6]

While research suggests that most health care practitioners do not routinely screen patients for IPV, data on screening practices for reproductive coercion are scant.[7,8] An often-cited barrier to IPV screening is the lack of provider education.[7,9] One study conducted interviews with 15 medical students to elucidate their barriers to

screening, with fear of offending the patient, lack of training and knowledge, and time constraints frequently reported as concerns.[10]

As studies have shown that health care practitioners are more likely to screen if they have received IPV training, the Society of Teachers of Family Medicine (STFM) National Clerkship Curriculum supports the inclusion of this material in clerkships.[11] The extent of IPV education directly correlates with comfort and knowledge regarding the topic.[7,9,12] While nearly all US medical schools have required coursework on domestic violence, the quality of this course content is highly variable.[13,14] Recent reports have described specific interventions aimed at improving medical students' knowledge of IPV, but have not looked specifically at reproductive coercion.[15,16]

In order to optimize educational interventions, the objectives of our study were to further elucidate the internal barriers that medical students face when presented with the opportunity to screen for IPV and reproductive coercion, and to describe how our curriculum on this topic could be improved to better address these barriers.

Methods

During the 2016 academic year, immediately after the pregnancy options counseling OSCE, students completed an optional, anonymous survey with Likert-type and open-ended questions evaluating the self-perceived impact of this session on their IPV and reproductive coercion screening practices.

We completed an exploratory thematic analysis of responses to the open-ended survey questions using an iterative process. First, two coders independently coded the responses. We developed a final codebook through consensus, and responses were then recoded using this codebook. We used NVivo 11 (QSR International, Melbourne, Australia) for data management and to compute measures of interrater reliability (including kappa). We quantified the occurances of identified themes in order to identify their relative importance. Descriptive statistics for the quantitative items were computed using Stata 14 (College Station, Texas). The Florida International University Institutional Review Board granted exemption for this study.

Results

All students (n=118) on the family medicine clerkship completed the pregnancy options counseling OSCE; 87% (n=103) answered all quantitative survey questions. Table 1 shows quantitative results.

Of the 118 students who completed the OSCE, 100 (85%) provided qualitative comments. Of those, 88 students reported barriers to screening for reproductive coercion, while 12 students explicitly noted no barriers to screening. Ninety students reported a barrier to screening for IPV, while 10 students stated that they had no barriers. The identified themes related to student barriers to screening for IPV and reproductive coercion, along with selected supportive quotes, are reported in Tables 2 and 3, respectively.

Overall, the kappa coefficient for interrater reliability was moderate at 0.58, and absolute agreement was high at 98%.[19]

Discussion

Our findings build on the previous work of Aluko et al by looking at barriers to screening specific to reproductive coercion and by nesting our study within an evaluation of an existing curricular intervention.[10] Students reported a variety of barriers to screening for intimate partner violence (IPV) and reproductive coercion that involved both asking the questions and dealing with patients' potential responses. The reported barriers to screening for IPV and reproductive coercion were similar. Reproductive coercion had the added barriers of confusion about its relationship to IPV and the necessity of screening for it if questions about IPV have already been asked.

Even though the educational module included scripted screening questions, students reported another major barrier to screening was difficulty finding the words with which to ask the questions, thereby suggesting that simply

providing scripted questions was insufficient. A taped role-play encounter may be more effective, offering a performance model that can support skills acquisition.[20]

Many students reported not screening for IPV or reproductive coercion because of their lack of training in how to respond to a positive screen. Our analysis of students' reported internal barriers suggests that equipping them to provide initial management is an important component of promoting screening behavior. STFM also supports the incorporation of objectives related to both screening and management.[11]

Our study has several limitations. First, students who found this to be a useful session and a more pertinent or interesting topic may have been more likely to complete the post-OSCE assessment. Another limitation is that students self-reported whether they screened the standardized patient for IPV and reproductive coercion. Ideally, this self-reported data should have been corroborated by the standardized patient's record of whether a student effectively screened. Due to session logistics, we were unable to incorporate this into the OSCE. Additionally, we performed the study at a single medical school and did not involve a control group of students that was not exposed to the educational intervention being examined. Finally, our study did not allow for long-term follow-up to assess whether students did in fact screen future patients for IPV and reproductive coercion.

Despite these limitations, our preliminary findings support the need for a longitudinal curriculum in IPV and reproductive coercion, during which an appropriate emotional context could be built as a foundation for skills acquisition. This longitudinal approach is also supported by the literature correlating the extent of training with the likelihood to screen.[12] Future research should examine the ideal content and structure of curricula addressing IPV and reproductive coercion, and aim to provide more specific correlations between training interventions and screening practices. Additionally, future research should consider the impact of training on long-term IPV and reproductive coercion screening behaviors.

Tables and Figures

Table 1: Quantitative Survey Results on Students' Screening Practices During the Formative Pregnancy Options Counseling OSCE and Their Future Intentions to Screen

Survey Item		n (%)
During this OSCE, I screened the patient for intimate partner violence.[a]		
	Yes	92 (82)
	No	20 (18)
I am more likely to screen for intimate partner violence as a result of participating in this exercise.[b]		
	Strongly agree	75 (66)
	Agree	31 (27)
	Neutral	7 (6)
	Disagree	0 (0)
	Strongly disagree	0 (0)
During this OSCE, I screened the patient for reproductive coercion.[c]		
	Yes	44 (41)
	No	63 (59)
I am more likely to screen for reproductive coercion as a result of participating in this exercise.[d]		
	Strongly agree	54 (52)
	Agree	30 (29)
	Neutral	16 (16)
	Disagree	2 (2)
	Strongly disagree	1 (1)

[a]N=113, response rate: 96%.
[b]N=112, response rate: 95%.
[c]N=108, response rate: 92%.
[d]N=103, response rate: 87%.

Table 2: Themes Identified From Qualitative Analysis of Students' Self-reported Barriers to Screening for Intimate Partner Violence and Reproductive Coercion[1]

	Intimate Partner Violence (# of Students Reporting Barrier in Short-Answer Comments)	Reproductive Coercion (# of Students Reporting Barrier in Short-Answer Comments)
Internal Barriers to Screening		
Awkward topic	20	8
Difficulty finding appropriate wording to ask screening questions	10	12
Difficulty finding appropriate time to screen during the encounter	10	6
Assumption that screening was not necessary	13	13
Lack of experience-Never having screened before	2	4
Student's male gender	2	0
Confusion about difference between IPV and reproductive coercion—Belief that screening for IPV alone is sufficient	0	6
Concern About Handling Patient Responses to Screening		
Uncertainty about how to manage patients who answer affirmatively to screening questions	9	8
Concern about patient's reaction to screening questions	13	8
Concern about breaking rapport when screening	13	13
Concern about offending the patient	12	5
Concern that patient may not answer honestly	5	4
Uncertainty about how to screen if a family member is in the room	4	2

[1] 118 students participated in the pregnancy counseling options OSCE; 100 (85%) students provided qualitative comments.

Table 3: Representative Student Comments Supporting Identified Themes Related to Their Reported Barriers to Screening for Intimate Partner Violence and Reproductive Coercion

Internal Barriers to Asking IPV/Reproductive Coercion Screening Questions
• **Awkward topic** "Sometimes I think it may seem awkward. I think it may give the patient the impression that I think they have issues in their personal life. My own experience being screened made me feel sort of like I did something to suggest that I was the type of person who would be subjected to IPV (yes I realize the biases that go into that) so I consider that when screening other patients." • Difficulty finding appropriate time to screen during the encounter "If I jump ahead too soon during the interview then I feel like the question is out of place and makes it uncomfortable. It [sic] this happens, I usually continue the interview and try to build rapport and ask the question in a different way towards the end of the interview. It can be easy to ask the question too early if you fly through the rest of the history and the patient doesn't have too much medical history." • **Assumption screening was not necessary** "I personally forgot to ask for this. I think my own bias of her husband being a law student, it didn't even cross my mind that there could be domestic abuse. I think I am now aware that this is a situation anyone can find themselves in." "I only asked if she felt that she had a good support system and when to explore the possibility of why she got pregnant after being in OCP, so I feel because I did not see any "red flags" on her answers for those to questions I dismissed asking about partner violence." • **Confusion about difference between IPV and reproductive coercion** "I asked about IPV and since the patient said her husband was very supportive and never hurt her, I did not believe it was also necessary to ask about reproductive coercion." "Well in this case I asked about IPV, and the patient said she was not experiencing IPV, so I think I sort of ruled out reproductive coercion in my mind though they are two separate things." • **Lack of experience** "It's just still hard for me to remember to do since I don't have any experience doing that yet. Maybe encouraging asking these questions in our sexual histories in years 1 and 2 would help." "I completely forgot about it. I associated it with IPV and didn't distinguish it as separate from IPV. Barriers for me would be being too shy or scared to ask. I think in time these questions will become more comfortable to ask."
Concern Regarding Management of the Patient's Reaction
• **Concern about patient's reaction to screening questions** "Sometimes it can come as a surprise to the patient, and sometimes I feel like I'm prying particularly for those who do experience IPV (though it's most important in those scenarios), it's easy to forget if you were unaware of how common IPV is among pregnant women." • **Concern about breaking rapport when screening** "I feel that the biggest barrier is establishing rapport with the patient and getting them to trust you. This is a very delicate matter and your patient needs to feel they can rely on you and that you will not judge them or make them feel insecure." • **Concern about offending the patient** "I sometime feel patients might almost be insulted by the question, I am concerned that by asking something that doesn't apply to most people I will give the impression that I haven't connected with the patient or gotten to understand them by asking a question that seems irrelevant to them. I understand the importance of this risk, however, in making sure not to miss patient who are in dangerous situations." • **Uncertainty about how to manage patients who answer affirmatively to screening questions** "I have the barrier of perhaps being uncomfortable for what the answer might be. To whom should I turn - say "I will share this with the attending"? Turn to a social work-location for battered women? Recommending the patient take legal action? I learned long ago asking a question makes you responsible for the answer."

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