



# The Effect of a Short Educational Intimate Partner Violence-related Intervention on Real Case Identification in Slovenian Family Medicine Trainees

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## Authors' contributions

*This work was carried out in collaboration between all authors. Author PS conceived the study, managed literature searches and drafted the manuscript. Author IS helped to draft the manuscript; author NKG carried out the execution of the study. All authors read and approved the final manuscript.*

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## ABSTRACT

**Aims:** The aim of this study was to assess the relationship between participation in a short intimate partner violence (IPV) related educational intervention in family medicine trainees and the detection of IPV cases in clinical settings, given that expectations for an active and consistent response by primary health care professionals to patients experiencing the effects of IPV may not match the realities of professional preparation.

**Study Design:** In a multi-centre cross-sectional study, 70 family medicine trainees interviewed every fifth family practice attendee about IPV exposure as part of their specialisation programme.

**Place and Duration of Study:** The study was carried out from January 15, 2013 and finishing after 30 patients were interviewed or on February 15, whichever was the latest.

**Methodology:** The trainees were divided into two groups; the first was given a short educational intervention while the comparison group was not taught any additional knowledge about IPV dynamics and consequences. The structured case-finding procedure was explained to all trainees.

**Results:** There were no significant differences in gender, age and working period in family medicine between trainees in trained and comparison group. Of 1842 questionnaire sheets

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analysed (91.3% of collected), in 19.4% cases (n=358) some type of IPV experienced during the surveyed period was found. Patients recruited by each group of trainees did not differ in gender, age, marital status, number of children, residence, level of education and employment status. The trained group found significantly less physical IPV exposure cases ( $\chi^2=7.420$ ,  $P = .006$ ), but not psychological IPV exposure cases ( $\chi^2=0.739$ ,  $P = .390$ ). This could be due to the administered teaching method, which was not tailored to change awareness, attitudes and consultation skills in the trainees.

**Conclusion:** Non-simplified, comprehensive approaches to teaching IPV should be used and integrated fully into medical school curricula, since the IPV prevalence of approximately 19% is threatening and concordant with previous studies in Slovenian family medicine.

*Keywords: Educational intervention; family practice; traineeship; intimate partner violence; violence prevalence.*

## ABBREVIATIONS

*IPV: Intimate Partner Violence.*

*DV: Domestic Violence.*

*GPs: Family Medicine Doctors / General Practitioners.*

*TG: Supposedly Empowered / Trained Group.*

*CG: Comparison Group.*

*Psych IPV: Psychological intimate Partner Violence.*

*Phys IPV: Physical intimate Partner Violence*

*OR: Odds Ratio.*

*CI: Confidence Interval.*

## 1. INTRODUCTION

Intimate partner violence (IPV), also known as domestic violence (DV), is a leading health problem affecting approximately 50% of women during the course of their lifetimes [1]. Aside from the serious health consequences for women and children, a significant societal impact, including high financial costs, has been shown [2,3]. In Slovenia, several multi-centre cross-sectional studies were carried out from 2006 to 2013. In the 2009 study [4], 15.3% of patients had experienced some type of IPV during the previous five years, while the 2010 study showed the rate of IPV exposure to be 17.9% [5]. The results of previous research [6,7] showing at least a 15% prevalence of exposure to DV among primary care patients in Slovenia, and the female gender as a risk factor, were confirmed. In the 2012 study [8], an IPV exposure prevalence of approximately 17% was re-evaluated as a valid estimate, with a prevalence of psychological violence of 10.3%, and of concurrent physical and psychological abuse of 6.8%. All the patients exposed to physical IPV disclosed concurrent psychological violence. Since family medicine covers the adult population in Slovenia and the 2012 study was the fifth in a row on the prevalence of IPV amongst primary care patients in the country, it

has been suggested that an exposure rate of at least 17% should be addressed as a serious public health issue [8].

### 1.1 How to Address IPV in a Health Care Setting?

There have been many findings suggesting family doctors (general practitioners – GPs) have been missing opportunities to screen patients for intimate partner abuse in a variety of clinical situations [9]. In a survey aiming to identify the prevalence, determinants of, and barriers to clinician-patient communication about IPV, the most significant independent predictor of communication was direct GP questioning about IPV, while barriers significantly associated with lack of communication were patients' perceptions that GPs do not ask directly about abuse and lack the time and interest to discuss it, fears about involving the police and courts, and concerns about confidentiality [10,11]. Commonly cited barriers to identification and referral also included patients' fear of retaliation, lack of patient disclosure and follow-up, and cultural differences [9]. The most frequently reported facilitators were training, community resources and professional tools/protocols/policies [11,12].

### **1.2 IPV-related Interventions in Health Care: IPV-Specific Education**

Although GPs are in a unique position to identify and report IPV, detection rates are poor [13]. The need for additional training regarding IPV was a concern for GPs and nurses, more so for the latter [11], probably because of differences in role expectations and work environments. In Canada, a survey of educational opportunities available to future health care providers on the topic of IPV against women showed 57% of a total of 222 eligible programs offered some form of IPV-specific education, with undergraduate nursing and allied health programmes having the highest rates [14].

Three one-day workshops, each focusing on IPV, elder abuse or child abuse, and aiming to improve knowledge, skills and detection rates in physicians, were developed and followed-up in Israel [13]. The perception of knowledge and skills, routine screening frequency and reported case management all demonstrated significant improvement [13]. Knight and Remington [15] found evidence that moderately intensive training and focusing on results can increase resident physician screening rates for IPV, from only 0.8% to 17% of patients reporting that they were asked about IPV.

### **1.3 IPV-related Issues in Continuing Medical Education Programmes**

In the US, most residents agreed that IPV was a significant health care problem, and one where physicians can intervene effectively, yet 37% reported not screening for IPV; many residents expressed beliefs and practices that could inhibit the optimal care of IPV victims [16]. Conversely, it was also reported that although residents had poor knowledge of the epidemiology of IPV, they showed no racial or socio-economic status (SES) preferences in screening for it [17]. Another US study with clear implications for continuing medical education programmes as well as residency training programmes investigated the detection rate of IPV, and found routine screening with a small number of questions significantly increased its detection and enabled victims to begin to address their problems [18]. In obstetrics and gynaecology residencies, the incidence of IPV among clients was underestimated, and 75% of residents did not recognize at least one of the 10 common clinical scenarios as suggestive of battering [19].

In a study carried out in the Netherlands [20], training was found to be the most significant determinant for improving the awareness and identification of IPV, especially where there were non-obvious signs. In order to raise doctors' awareness of IPV in daily practice, they must first realize the extent of the problem, become more comfortable with their own attitudes towards it, and then feel more confident in their ability to help these patients [21].

### **1.4 Searching for the Optimal Model of IPV-oriented Training**

In 2007, Hamberger [22] estimated that medical schools and postgraduate residency programmes in the US mostly included IPV in their curricula. However, more recently Connor et al. [23] emphasized the shortage of exposure to IPV content documented in the medical school curriculum, and expressed the belief that any IPV education received by the students could be effective in increasing their confidence and perceived preparedness to address IPV with patients.

In Slovenia, educating family medicine trainees about IPV presents challenges, as most trainees lack awareness of IPV as a public health problem, have limited knowledge and erroneous beliefs about IPV, and are inexperienced in dealing with survivors. Providing formal education and training in a supportive environment should enhance family medicine trainees' knowledge of and skills in IPV. Examining the benefits and limitations of various pedagogical approaches for teaching this critical content to trainees is also of the utmost importance. The aim of the present study was to examine the relationship between participation in a short IPV-related educational intervention for family medicine trainees and the detection of IPV cases in clinical settings. The effect of this educational intervention was then indirectly assessed by looking at how it rubbed off on the effectiveness of the two groups of participating family medicine trainees on their respective patients, with special emphasis on their ability to detect IPV cases.

## **2. MATERIALS AND METHODS**

This was a multi-centre cross sectional study with the initial interventional component. The initial short educational intervention (SEI) was in the form of a lecture given to one group of family medicine trainees (TG) while the other

(comparison group (CG)) received no such training.

## **2.1 Participants: Family Medicine Trainees**

Family medicine trainees participating in the modular section of the specialisation programme in family medicine taking place from October 2012 to May 2013, i.e. four-year post graduate programme, interviewed every fifth family practice attendee about their exposure to IPV. The interviewing started on January 15, 2013 and finished after 30 patients were interviewed, or on February 15, whichever was the latest. As stated earlier, the trainees (n = 70) were divided into two groups, each of 35 subjects; the first group (TG) was given a SEI aiming to empower them (see below).

Participating family medicine trainees did not receive any incentives since interviewing patients about IPV exposure was part of the specialization curricula. Although participants in both groups were in the same program, the interviews were carried-out in different family medicine clinics without a risk of cross contamination between the groups.

## **2.2 Participants: Family Practice Attendees**

The subjects in the systematic sample of patients were aged 18 or over, had visited their GP for health problems, and were examined for any reason. Visits for administrative purposes were excluded, and no-one was accompanied by another person. The eligibility criteria were their age, purpose of visit, and willingness to participate anonymously. The short version of the Domestic Violence Exposure Questionnaire, described by Selic and co-authors elsewhere [4] was administered after the examination and consultation about the health problem that was the reason for the visit. Patients were invited to participate and told that it was not obligatory. Of 2064 invited patients, 2017 were assessed (97.7% response rate); the 47 (2.3%) people who did not want to participate were not asked to disclose their motivation.

## **2.3 Procedure: A Short Educational IPV-related Awareness-raising Intervention**

Since a case identification as a "diagnostic" approach requires an awareness of factors associated with IPV, including physical injuries,

mental health symptoms, and relationship issues shown to be related to recent or current abuse [24], a short educational awareness-raising intervention (SEI) was designed and given as part of the doctoral study by one of the authors to the first group of family medicine trainees participating in the IPV case finding procedure (TG). A 45-minute lecture focused on (1) those factors shown to be associated with exposure to domestic violence in previous Slovenian primary care studies [4-7], (2) other generally accepted risk factors, i.e. factors at both the personal level (e.g. alcohol abuse, adult onset of depression, personality disorders, low education level, low income and unemployment in patient) and at a relationship level (e.g. past experience of violence, conflicts in intimate partner relationship, and male dominance in the family), and (3) the impact of IPV on patients' ill-health (the physical, sexual and reproductive, psychological, and behavioural consequences) [25].

The second (comparison) group of trainees (CG) were not given any additional knowledge about the dynamics and consequences of IPV; however, the structured case-finding procedure was explained to both groups.

## **2.4 Procedure: Data collection**

"Case finding" in health care settings as an approach to the identification of IPV, especially abuse of women [26], was used as a routine inquiry for the study. Since experts in the field of IPV recognition have identified that a direct approach to violence screening is the most effective [27,28], a face-to-face interview with eligible patients was conducted by all of the participating trainees.

### **2.4.1 Defining the time frame**

All trainees were advised to define the survey time period (2008-12) at the beginning of each interview, e.g. "*What do you remember of the year 2008? Do you recall the 2008 elections? What were you doing in 2008? Do you remember the time after the year 2008? What was your situation?*". Since in 2008, there were elections in Slovenia and after that increasing economic difficulty in the nation, the issue of a recall bias was dealt with by this part of the interview.

The patients were told that the subsequent questions were to be considered within this time frame.

#### **2.4.2 Inquiring about intimate partner violence exposure**

Patients were then asked a series of questions about exposure to psychological or/and physical violence, i.e. *“In the past five years, have you ever been beaten, slapped, kicked or in any other way exposed to physical violence by your intimate partner?”*; *“In the past five years, have you been humiliated, subjected to threats, insult or intimidation, or in any way emotionally affected by your intimate partner?”*.

A question about coerced sexual intercourse followed. Due to patients' mainly negative response to this question, sexual violence is not presented as a special type of IPV in this study.

#### **2.4.3 Other survey questions**

Other survey questions were about gender, age, number of children, marital status, number of divorces, level of education achieved, current employment status and residence.

All the patients' answers were recorded in the short version of the questionnaire presented in the 2009 study [4].

### **2.5 Data Analysis**

The sample data was presented by frequencies and percentages. Bivariate comparisons were made using the  $\chi^2$  test, Fisher's exact test or independent samples t test. In multivariate binary logistic regression analysis, aimed to identify characteristics in patients recruited by TG and CG and associated with IPV exposure, the modelling included all the variables from the questionnaire. With regard to each predictive variable in the logistic model, the Wald  $\chi^2$  value, statistical significance (*P* value), odds ratios (OR), and 95% confidence intervals (CI) were calculated. Statistical analysis was performed with IBM SPSS 20.0 software (IBM Corp., Armonk, NY, USA). *P* < .05 was set as the level of statistical significance.

The National Medical Ethics Committee of the Republic of Slovenia approved the protocol of the study

### **2.6 Limitations to the Study**

There are several limitations to be mentioned. The teaching method (SEI) was found to be unsuitable for addressing the phenomenon of

IPV in clinical settings. Mentors, who are very important for professional development, attitudes and the adoption of good working practice in trainees, were not considered, i.e. they were not invited to participate, and their attitudes were not surveyed. Baig et al. [17] have already reported that trainees whose mentors advised them to actively inquire about IPV were more likely to do so. Furthermore, neither the level of knowledge of IPV of the trainees nor their satisfaction or not with the SEI were questioned. We missed the opportunity to ask trainees during follow-up whether they will continue to actively seek IPV cases when working independently, since the preparedness of healthcare providers' has emerged as a key construct related to whether GPs routinely initiate the topic of IPV [12].

The relationship between the family medicine trainee and the patient was also not taken into consideration. Family medicine trainees have yet to be chosen as “personal” GPs due to practice regulations in Slovenia. It is known that patients' perceptions and evaluation of a physician derives from the relationship between the two, with two key factors affecting the establishment of this relationship, i.e. the duration of the relationship and the physician's competence, knowledge, trust, loyalty and respect [29]. The GP's communication skills are the most important determinant in this process. In IPV-related communication, the IPV victims' perceptions of appropriate and inappropriate physician behaviour partially depend on the nature of the relationship between the patient and the health care professional [30]. Given all that, the trainees in our study were at a great disadvantage with regard to the duration of their relationship with the patients and also their own interpersonal competence. Another limitation is also related to communication skills; in spite of a structured interview procedure, the trainees identified only 20 cases of coerced sexual intercourse. This may be due to their lack of training or to a lack of motivation, or possibly to the patient-GP interaction or feelings of shame in the patients. Compared to other research this rate is extremely low and could be a false result but not necessarily. Reviewing the evidence on sexual violence, rates of coerced sexual intercourse range from 0.9 to 20.1%, with the majority in the range of 3.9 to 8.3% [26]. This missing data on sexual violence is therefore a limitation to the findings of this survey, as we are only able to present data on the prevalence of physical and psychological violence.

With regard to the prevalence and determinants of IPV, compared to a representative sample of Slovenian family clinic attendees [31], in the present study there were more female patients (63.2% vs. 54.8%), the mean age was slightly younger ( $49.4 \pm 16.1$  vs.  $51.7 \pm 19.0$  years) and level of education lower (10.0% vs. 11.3% people with college degree or above, 50.3% vs. 41.0% with elementary school). This also might have affected the findings, since higher education has been identified as a factor decreasing the odds of poorer health in Slovenian women [32].

### 3. RESULTS AND DISCUSSION

#### 3.1 The Family Medicine Trainees and Their Characteristics

Of the trainees, 57 (81.4%) were women; the mean age was  $34.0 \pm 4.3$  years ( $33.8 \pm 4.3$  years in the TG and  $34.1 \pm 4.4$  years in the CG), and their average period working in family medicine was  $7.2 \pm 4.5$  years. There were no significant differences in gender, age and working period in family medicine between the TG and CG. Most (59, 84.3%) were married or in an intimate relationship, and had children (50, 71.4%). At the time of the study, the majority of trainees worked in urban areas (50, 71.4%), and most (44, 62.9%) examined 40-60 patients per working day, with 26 (37.15%) examining more than 60 patients per day. They interviewed a total of 2017 patients. After exclusion of those with missing data, 1842 questionnaire sheets were analysed (91.3% of all); of them, 937 (50.9%) were collected by the TG and 905 (49.1%) by the CG.

In the TG, male trainees collected 20.8% and in the CG 22.7% of all questionnaires, while female trainees contributed 79.2% and 77.3% respectively. Of trainees working in urban settings, those in the TG collected 64.4% and in the CG, 68.2%. Others were acquired by trainees working in rural family clinics (35.4% by the TG and 31.8% by the CG).

#### 3.2 The Socio-demographic Characteristics and IPV exposure of the Recruited Patients

Of all interviewed patients, there was 8.6% prevalence of concurrent physical and psychological IPV and 10.8% prevalence of solely psychological IPV exposure. All people who disclosed physical IPV exposure also claimed to be psychologically abused. For the sake of clarity, when using the term "physical"

IPV exposure, we mean concurrent physical and psychological abuse. Of all interviewed patients, only 20 revealed coerced sexual intercourse during the research period. Due to these small numbers, sexual violence was not analysed separately. The majority of interviewed patients (80.6%,  $n = 1484$ ) had not been exposed to psychological or physical violence within the family, including coerced sex, during the previous five years (2008-12). The other 358 patients (19.4%) reported some type of IPV experienced during the surveyed period.

Of all interviewed patients, 63.2% were women; 73.8% were married or living in intimate partnership; 20.1% were childless, while others had one (24.3%) or two and more children; and 10.5% were divorced. Almost half of the patients (47.6%) lived in urban areas, and 35.8% were unemployed, with the educational structure being quite poor (50.3% elementary school, 39.7% high school, 10.0% college or more). Patients recruited by the TG and CG did not differ in gender ( $P = .746$ ), age ( $M_{TG} = 49.9 \pm 15.4$ ,  $M_{CG} = 48.8 \pm 15.7$ ,  $P = .109$ ), marital status ( $\chi^2 = 2.779$ ,  $P = .249$ ) or divorces ( $P = .610$ ), number of children ( $\chi^2 = 3.562$ ,  $P = .313$ ), residence ( $\chi^2 = 3.131$ ,  $P = .209$ ), level of education ( $\chi^2 = .603$ ,  $P = .740$ ) and employment status ( $P = .514$ ).

The TG identified 96 (10.2%) cases of psychological IPV exposure and 63 (7.0%) cases of physical abuse. The CG identified 104 (11.5%) people exposed to psychological and 95 (10.6%) cases of physical abuse. The TG found significantly less physical IPV exposure cases ( $P = .008$ ), but not psychological IPV exposure cases ( $P = .410$ ), while there were no significant differences between the TG and CG in psychological or physical IPV exposure case identification according to the location of the family clinic (urban/ rural) ( $P_{PhysIPV} = .860$ ,  $P_{PsychIPV} = .383$ ) or gender ( $P_{PhysIPV} = .527$ ,  $P_{PsychIPV} = .687$ ) and age of the trainees ( $33.9 \pm 4.3$  vs.  $34.4 \pm 4.2$ ,  $P = .162$ ,  $33.9 \pm 4.3$  vs.  $34.1 \pm 4.3$ ,  $P = .596$ ).

#### 3.3 The Associations between Socio-demographic Characteristics and IPV Exposure in Patients Interviewed by the TG and CG

Given that the only effect of the SEI when comparing the TG and CG was fewer physical IPV exposure cases identified by the TG, it seemed reasonable to perform multivariate logistic regression modelling aiming to identify factors which increase/lessen the odds of

patients being exposed to physical IPV. The results are presented in Table 1.

Female gender and formal divorce were identified as the most powerful risk factors for physical IPV exposure in patients interviewed by the TG and CG, while an age of 65 years or above and parenting of a single child lessened the odds of physical IPV in patients interviewed by the TG. The modelling explained 15.5% of the variance (Nagelkerke  $R^2=0.155$ ;  $P < .001$ ) in patients interviewed by the TG and 13.1% of the variance (Nagelkerke  $R^2 0.131$ ;  $P < .001$ ) in those interviewed by the CG.

Multivariate analyses were also performed to explore associations between only psychological IPV exposure and patient characteristics. Female gender ( $OR_{TG} 3.30$ ,  $95\%CI_{TG} 1.90-5.74$ ,  $P < .001$ ;  $OR_{CG} 3.31$ ,  $95\%CI_{CG} 1.93-5.68$ ,  $P < .001$ )

and formal divorce ( $OR_{TG} 2.00$ ,  $95\%CI_{TG} 1.01-3.95$ ,  $P = .047$ ;  $OR_{CG} 2.23$ ,  $95\%CI_{CG} 1.22-4.06$ ,  $P = .009$ ) increased the likelihood of psychological IPV exposure in all patients. Age of 65 years or above ( $OR_{TG} 0.25$ ,  $95\%CI_{TG} 0.10-0.64$ ,  $P = .004$ ) decreased the odds for psychological abuse in patients recruited by the TG, while unemployment ( $OR_{CG} 2.25$ ,  $95\%CI_{CG} 1.29-3.92$ ,  $P = .004$ ) increased the risk in patients recruited by the CG. The modelling process explained 9% of the variance of psychological IPV ( $\chi^2=45.088$ ,  $df=15$ , Nagelkerke  $R^2=0.097$ ,  $P < .001$ ) in TG-recruited patients and 11.0% of the variance ( $\chi^2=52.274$ ,  $df=15$ , Nagelkerke  $R^2=0.110$ ,  $P < .001$ ) in the CG-recruited cohort. Since the other independent variables were the same as presented in Table 1, the other results of these additional regression analyses are not presented.

**Table 1. Logistic regression model of the associations between physical IPV exposure and patients` characteristics in patients, interviewed by the TG and the CG of family medicine trainees**

	Interviewed by the TG			Interviewed by the CG		
	OR	95%CI	P	OR	95%CI	P
<b>Age (years)</b>						
Up to 35	1.00			1.00		
36-49	0.77	0.34 1.71	.517	1.21	0.64 2.28	.559
50-64	0.45	0.19 1.08	.075	0.91	0.45 1.84	.785
65 and above	0.13	0.04 0.44	.001	0.61	0.24 1.59	.316
<b>Gender</b>						
Male	1.00			1.00		
Female	3.32	1.66 6.65	.001	6.16	3.13 12.14	<.001
<b>Level of education</b>						
Elementary school	1.00			1.00		
High school	0.55	0.30 1.01	.054	0.92	0.57 1.48	.729
College degree or more	0.91	0.36 2.32	.850	0.86	0.39 1.86	.693
<b>Intimate partnership status</b>						
Living in intimate partnership	1.00			1.00		
Ending intimate partnership	2.17	1.00 4.71	.049	0.76	0.39 1.48	.423
Single	0.39	0.13 1.15	.089	0.85	0.33 2.20	.740
<b>Divorce</b>						
Never divorced	1.00			1.00		
Formally divorced	3.95	1.92 8.12	<.001	2.42	1.30 4.50	.005
<b>Employment</b>						
Yes	1.00			1.00		
No	1.87	0.94 3.73	.076	1.59	0.89 2.83	.120
<b>Number of children</b>						
No	1.00			1.00		
Single child	0.39	0.15 0.98	.046	1.28	0.60 2.76	.520
Two	0.41	0.16 1.05	.063	0.74	0.34 1.63	.458
Three or more	0.79	0.29 2.10	.633	1.06	0.45 2.47	.899
<b>Residency</b>						
Rural	1.00			1.00		
Suburban	1.35	0.64 2.83	.432	1.05	0.58 1.91	.865
Urban	0.92	0.48 1.74	.796	0.70	0.41 1.17	.175

### 3.4 Discussion

The aim of this study was to test the association between an IPV-related SEI for family medicine trainees and their performance in an IPV exposure case-identification procedure. The sole criterion was number of IPV-exposure cases identified. We found that trainees in the TG identified fewer physical IPV exposure cases. However, when exploring physical IPV exposure in the TG-recruited cohort, two characteristics were identified which lessened the odds for physical abuse (Table 1), which did not apply to patients interviewed by the CG. Conversely in CG-recruited patients one more factor was identified increasing the odds of being psychologically abused (i.e. unemployment). Of the 1842 questionnaire sheets, some type of IPV experienced during the surveyed period was found in 19.4% of cases. These prevalence findings are in concordance with previous studies in Slovenian family medicine [4,6,7]. Although the prevalence of psychological IPV exposure in family medicine attendees in Slovenia [33] was higher than in this study (12.1% vs. 10.8%), it is probably due to the research period in question (previous year vs. last five years).

Our study did not show that a SEI empowered family medicine trainees to identify more IPV in their patients. This is probably due to the teaching method used; it was not a workshop and did not follow any other kind of interactive skill-developing teaching model. It is therefore not a surprise to report findings similar to Coonrod et al. [34], who found that a tutorial on IPV conducted during orientation for residents did not significantly affect the rate of diagnosis of IPV. If the intervention was brief and harmless in that instance, our intervention made supposedly empowered trainees (TG) *less* successful in the identification of physical IPV exposure cases. In another study [23], no significant differences were found between medical students who received IPV education either before or during medical school, and those with no IPV education. However, after the IPV-related workshops, lack of knowledge and skills and psychological difficulties in GPs all diminished significantly [13], and focus group attendance on its own doubled awareness of partner abuse [20].

#### **3.4.1 The short educational intervention: where did it go wrong?**

The SEI in this study, a 45-minute lecture emphasizing the determinants and dynamics of

IPV, did not meet the authors' expectations. It was not tailored to change awareness, attitudes or consultation skills. The latter could have been achieved by a more interactive approach to address and improve the consultation skills of the trainees. Future educational approaches should therefore be directed at remedying the gaps in trainees' knowledge and attitudes in order to empower them for IPV detection and treatment. Furthermore, our SEI was not based on any previous survey of trainees' attitudes toward the issue in question. It has been shown that 51% of trainees have reasons for not documenting IPV, ranging from fear that the patient's partner might harm the patient or the physician, to concern that the patient may not be telling the truth; and 57% of residents said they would ask about IPV more often if state law required it [16]. In Slovenia, GPs are obliged to report DV cases, but not to actively seek them out.

It remains unclear whether the SEI used in the study would have been more effective if the interviews had been conducted by licensed GPs instead of trainees. In particular, it has been found that GPs' preparedness, self-confidence, professional support mechanisms, and practice pressures mostly determined whether an IPV-related inquiry was used in family medicine, while neither physician gender nor recent intimate partner abuse training had significant effects on reported new patient screening practices [10].

## 4. CONCLUSION

### **4.1 The Short Educational Intervention: Lessons to be Learned**

Aforementioned findings and curricular evaluations have generally supported the idea that IPV-related training increases knowledge, attitudes, and skills. In this study, when delivering SEI, attitudes and the need for skill development in trainees were overlooked, and lacked demonstrations of actual clinical behavioural competency. Based on the outcomes of this study, comprehensive approaches to teaching IPV should be fully integrated into medical school curricula, since a prevalence of approximately 19% should be considered a serious health-related issue, and also because. Given that clinician inquiry appears to be one of the strongest determinants of communication with patients about partner abuse in practice, future educational interventions should be more oriented towards skill-building.



#### 4.2 How to Proceed with IPV-Related Teaching

Some type of IPV experienced during the surveyed period was found in 19.4% of cases which need to be taken into serious consideration. For programs that have led to significant changes in physicians' behavior, the specific difference between those programs and the program developed for this study was that family medicine trainees did not firstly receive comprehensive training to develop interpersonal competence. While our outcomes did not have the desired effect, we would still recommend comprehensive training that emphasizes skill building and confidence rising.

Improvement of mentoring and educating family medicine trainees about IPV should enable them to accept IPV and its health effects on patients as constituting an important health issue that they will feel comfortable addressing.

#### CONSENT

Participation of patients was anonymous and voluntarily given. According to National medical ethics committee of the Republic of Slovenia policy, written consent was not needed.

#### ETHICAL APPROVAL

Authors have obtained all necessary ethical approval from suitable Institutional or State or National or International Committee, i.e. the National medical ethics committee of the Republic of Slovenia approved the protocol of the study, document number 111/0409; May 28, 2009.

#### COMPETING INTERESTS

Authors have declared that no competing interests exist.

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