"I just keep my antennae out" - How Rural Primary Care Physicians (PCPs) Respond to Intimate Partner Violence (IPV)

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National Conference on Health and Domestic Violence
San Francisco, CA 3.30.2012

Disclosures

- None.

Primary care may be an important site for rural women seeking care for IPV

- 2011 IOM guidelines support screening and counseling for IPV in healthcare settings
- Prevalence of IPV in primary care settings exceeds community-based samples
- Identifying IPV in healthcare can improve health outcomes for women
- Enhanced role for primary care in rural settings

Rural primary care is a missed opportunity for responding to IPV

- In rural communities, there are significant barriers to IPV-related care (scarce referral services, poverty, social isolation, fear of disclosure)
- Rural PCPs were unsure how to properly screen and counsel patients
- Numerous barriers to IPV-related care exist in rural communities
- Little prior work has investigated IPV-related care from the rural PCP's perspective
  - The Rural Women's Healthcare Project
Methods – sample selection in the Rural Women’s Healthcare Project

- AMA Masterfile, 28 county region in central Pennsylvania
- PCPs – family practice, internal medicine, obstetrics and gynecology
- Rural Urban Commuting Area (RUCA) codes used to determine rural or rural-adjacent location

Data collection – interview guide

- Explore PCPs’ opinions and practices regarding primary care to rural adult women.
- Wording optimized via pilot testing and sequential revision
- After demographics, questions focused on four main topic areas:
  1. cancer screening
  2. preventive reproductive health
  3. intimate partner violence (IPV)
  4. mental health

Interview guide – IPV themes

- Defined IPV
- IPV screening in the PCP’s practice
- Perceptions of IPV as a health problem
- Current practices for responding to identified IPV
- Perceived barriers to care for victims of IPV unique to rural communities.

Data analysis

- Interviews professionally transcribed.
- Three members of the research team independently analyzed each transcript.
- Inductive codes were developed using modified grounded theory.
- Iterative process used for coding.
- Using NVivo8 software, quotes illustrating themes were selected.
Sample description

<table>
<thead>
<tr>
<th>Primary Care Physician Characteristics, N=19</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>47% (9)</td>
</tr>
<tr>
<td>Specialty</td>
<td></td>
</tr>
<tr>
<td>Family Medicine</td>
<td>63% (12)</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>27% (5)</td>
</tr>
<tr>
<td>Obstetrics-Gynecology</td>
<td>5% (1)</td>
</tr>
<tr>
<td>General Practitioner</td>
<td>5% (1)</td>
</tr>
<tr>
<td>Years in Practice—median (range)</td>
<td>21 (1-38)</td>
</tr>
<tr>
<td>Rural Location</td>
<td>42% (8)</td>
</tr>
<tr>
<td>In-person Interview</td>
<td>53% (10)</td>
</tr>
</tbody>
</table>

Routine screening for IPV in rural practice is not commonly performed

- Lack of time, competing priorities, lack of training and discomfort with IPV
- Screening for IPV could harm the patient-doctor relationship
- Lack of effective resources for referral and follow-up

IPV is suspected in clinical practice when alarm is raised

- ED referrals, broken bones, bruises uncommon
- Mental health problems common presenting symptom
- Partner control tactics may trigger IPV assessment
- "I just keep my antennae out."
IPV is suspected in clinical practice when alarm is raised

"I think the more common thing as you would expect, is more psychological. We see anxiety and depression as a very understandable result of that. We see non-compliance. We see lots and lots and lots of overutilization of services for reasons you can’t figure out why they’re coming in."

"If the partner is always back with them for every visit and won’t let them be alone in the visit. You sort of start to get a little suspicious."

Rural PCPs often use appropriate practices for counseling and referral

- Validation
- Danger assessment
- Safety planning
- Referral to services
- Creating a follow-up plan

Rural communities present unique challenges PCP caring for IPV

- Acceptance of traditional gender roles prevent rural women from seeking help.
- Lack of resources (financial, educational, transportation, referral) in rural communities prevents women from accessing care for IPV.
- Lack of privacy in rural communities is an important barrier for women to access care for IPV.
Rural communities present unique challenges PCP caring for IPV

“...a lot of the women can't afford to leave the situation they're in because they don't have jobs and they don't have money and they don't have cars and so they feel stuck.”

PCPs felt training not sufficient despite overall appropriate care

- All of the PCPs reported providing some aspects of guideline-concordant IPV care.
- PCPs may be underestimating their ability to provide appropriate care for women exposed to IPV.
- Improving PCPs confidence in providing effective IPV-related care could help to overcome an important barrier.

Strengths and Limitations

- Limitations
  - Limited racial and ethnic diversity
  - No patient data
- Strengths
  - Thematic saturation
  - Stratified analysis – PCP's gender, interview type
  - Robust findings

PCPs identified rural culture as a factor that mitigates effective responses to IPV.

- PCPs implied that rural women are less able to respond effectively to IPV.
- This perception might make IPV more difficult for the physician to address.
- Directive counseling may be more effective.
Multi-level interventions are necessary

- Provider education and training is necessary but will be insufficient.
- Competing time demands and scarce resources in rural communities remain significant barriers to optimizing IPV-related primary care.
- Competing time demands and scarce resources in rural communities remain significant barriers.

Acknowledgements

- Cynthia H. Chuang, MD, MSc
- Carol S. Weisman, PhD
- Amanda Perry, BA
- Marianne Hillemeier, PhD, RN, MPH

Penn State BIRCH Program, NIH Office of Research on Women’s Health BIRCH career development award, K12 HD05582

The Rural Women’s Healthcare Project was supported by a grant from the Penn State CTSI, UL1RR033184

Thanks to Sara A. Baker, MSW and Lara Rosenwasser, BA

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