

Missed Opportunities: Intimate Partner Violence in Family Practice Settings

By: Ann L. Coker, Ph.D., Lesa Bethea, M.D., Paige H. Smith, Ph.D., Mary Kay Fadden, M.P.H., and Heather M. Brandt, M.S.P.H.

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Abstract:

Background. For women experiencing partner violence, women health care visits represent opportunities for physicians and patients to address intimate partner violence (IPV), a significant health threat for women.

Objectives. The objectives were to estimate rates of physician documentation of IPV in medical records; characterize IPV+ women most likely to have IPV documented; and determine whether IPV screening increased IPV documentation.

Methods. Subjects were women ages 18-65 receiving primary care in two large family practice clinics. All were screened for IPV by study staff using a modified Index of Spouse Abuse and the Women's Experience with Battering scales. We selected and abstracted medical records for all women experiencing current IPV (N = 144) and a random sample of women never experiencing IPV (N = 147).

Results. Of 144 women screened as currently experiencing IPV, 14.7% were documented. Women most likely to have IPV documented were Caucasian, with higher WEB scores, and more likely to have an event that could trigger posttraumatic stress syndrome. Although the majority (41/56) of women currently in physically violent relationships did not plan to disclose IPV, those disclosing were significantly more likely to have IPV documented and documentation occurred after screening for 60% of women experiencing IPV.

Conclusion. IPV screening increased documentation. IPV screening can provide the opportunity for patients to disclose IPV. Physicians then have the opportunity to compassionately connect patients with appropriate resources.

Key Words: spouse abuse; violence; screening; women; prevention; mental health.

Article:

INTRODUCTION

Several professional organizations, including the American College of Nurse Midwives [1], American College of Emergency Physicians [2], American College of Obstetricians and Gynecologists [3], American Medical Association [4,5], American Academy of Family Practice [6], American Academy of Nurse Practitioners [7], and Emergency Nurses Association [8], have recommended routine screening for and documentation of intimate partner violence (IPV) in the medical records of patients. Specific protocols for IPV screening, assessment, and intervention in health care settings are available and are easily accessible [9-11]. An estimated 1.5 million women seek medical care for partner violence-related injuries each year [12] in emergency departments (EDs) [13-15] and primary care practices [16,17]. However, physicians infrequently ask women about partner violence or document this significant health threat in their patients' medical record [18,19]. These health care contacts by IPV-positive (IPV+) women may be viewed as missed opportunities for effective intervention.

Increased pressure for earlier identification and management of partner violence [20] in clinical settings has led to clinician-based interventions in EDs [21-30], prenatal care settings [31-36], hospital settings [37], and, less commonly, in primary care settings [38-41]. Bergman and Brismar [42] found that 18% (18 of 98) of acutely battered women seen in an emergency department had IPV documented in their medical records. Several studies indicate that IPV case identification increases with the addition of a chart prompt [24], a lifetime abuse question to patient's health history form [41], or a targeted protocol to increase documentation [22]. Four large intervention trials set in EDs [28-30] or primary care clinics [38,39] indicate that provider training interventions do change provider and patient knowledge and attitudes toward IPV screening but do not have a sustained effect on IPV identification or documentation. Thompson et al. [39] did find that training intervention increased clinicians' asking about IPV particularly by a questionnaire, yet case finding did not increase. High staff turnover, pressured workloads, and inconsistent institutional support may explain these inconsistent findings. The WomanKind program, which incorporates staff training, immediate and ongoing advocacy, and case management for IPV victims [37,43], may be an alternative to clinician-based short-term training interventions.

Interventions in prenatal care settings have not specifically addressed IPV documentation as a targeted outcome. McFarlane et al. [32] have demonstrated that a simple three-question abuse assessment screening is effective in rapidly and accurately identifying partner violence. A three-session counseling intervention reduced both physical and nonphysical partner violence at 6- and 12-month intervals postintervention [33]. McFarlane et al. [31] found that an intervention protocol to increase safety-seeking behaviors for pregnant abuse women was successful at increasing adoption of safety behaviors both during and after pregnancy. With longer follow-up periods, McFarlane et al. [44] found that although severity of partner violence decreased over time for all interventions, there were no significant differences in violence by intervention. The authors conclude, "abuse screening itself may be the most effective intervention" [44].

The objectives of this study are threefold: (a) to estimate IPV medical record documentation rates among women screened as currently experiencing IPV and those who have never experienced IPV; (b) to explore characteristics of those IPV+ women most likely to have IPV documented; and (c) to assess whether in-clinic IPV screening by study staff increased women's IPV disclosure and clinician documentation. To our knowledge, this is the first study based in a family practice setting to quantify medical records documentation of IPV by clinicians among women who did and did not screen as experiencing IPV. This is one of few studies, in any setting, to evaluate whether IPV screening increases IPV disclosure and medical record documentation.

MATERIALS AND METHODS

This medical record documentation study is based on a large (N = 1,402), cross-sectional study [45,46]. The purpose of the larger study was to estimate the frequency of IPV by type (physical, sexual, and psychological) among women insured either by a managed care provider or by Medicaid, to describe correlates of IPV, and to estimate mental and physical health outcomes that may be associated with IPV. Briefly, eligible women seeking medical care in one of two university-associated family practice clinics from February 1997 to January 1999 were recruited and screened for IPV. Eligible women were those ages 18 to 65 who were insured by a health maintenance or managed care organization or by Medicaid and had ever been in an intimate, sexual relationship with a man for at least 3 months. Women were invited to discuss study participation in a private room. Women graduate students, trained in asking these sensitive questions, in active listening, and in providing women with community resources, administered the in-clinic 5- to 10-min IPV screening interview. Study participation also included a 30- to 45-min telephone or in-clinic interview to assess current mental and physical health status and medical history.

Women were reimbursed \$5 for their time in completing the in-clinic interview and \$10 for completing the longer telephone interview. We used computer-assisted interviewing for both in-clinic and telephone interviews to reduce errors and rapidly provide scale scores for IPV measures. The University of South Carolina Institutional Review Board approved this project; written consent was required by the IRB.

IPV Screening Interview

Study staff conducted computer-assisted interviews with eligible women in private examination rooms. We screened for current IPV using both the Women's Experience with Battering Scale (WEB) and the Index of Spouse Abuse (ISA). Women screened as IPV+ if they scored as battered (>20 on the WEB) or as physically or sexually assaulted based on the ISA percentage score of >3. We modified the 25-item Index of Spouse Abuse—Physical (ISA-P) [47] to measure the severity of violence by current or most recent male partner. Our modification reduced the scale to 12 items measuring physical IPV (Cronbach's alpha = 0.96) and to create a 3-item scale assessing sexual IPV (Cronbach's alpha = 0.89). Our modification of the ISA-P has not been previously validated. We used the WEB to assess battering [48-50]. As reported elsewhere [48-50], the WEB has good construct validity, accurately discriminates battered from nonbattered women, and shows strong internal consistency reliability (Cronbach's alpha = 0.95 in current sample). Although the WEB and the ISA-P were designed to be self-administered, we chose to interviewer-administer these instruments because we were concerned about the reading level of the participant population [51].

After our screening interview, we told all women about community services for women experiencing IPV regardless of how they screened. We did this to provide information (a) to women who were not ready to talk about their own victimization and (b) for women who may be in contact with family or friends in need of these services.

Medical Records Abstraction of IPV Documentation

For this analysis of IPV documentation, we selected for review the medical records of all women ($N = 150$) who screened as currently or recently (defined as having experienced IPV within the past 2 years) experiencing IPV based on our modified ISA-P and WEB. We also selected a random sample of 150 from 645 women who had never experiencing any type of IPV in any past relationship. A random number was generated to start selection, at the rate of 1 in 4, among IPV negative (IPV—) women ordered by clinic identification number.

We then conducted in-depth medical record reviews for these women. The physician notes sections of the computerized medical charts of these 300 women were reviewed. We abstracted records for visits in the past 2 years. We selected this time window because we asked women about IPV in current or most recent intimate relationship in our screening interview. We believed that clinicians would be more likely to recognize or women would disclose current or more recent IPV (within the past 2 years). To reduce the potential for bias that may arise when abstractors know the IPV status of women, abstractors were blinded to the IPV status of the women. Graduate students were instructed to note any indication from physician notes that the woman experienced "family problems," "stress at home," "problems with partner or husband," or explicit documentation of IPV, "domestic violence," "partner violence," or "spouse abuse." We grouped IPV documentation into two categories based on the specificity with which partner violence was noted in the medical record. If partner violence was specifically noted (i.e., "physical assaults by a partner [or spouse]," "spouse abuse," "emotional abuse by a partner [or spouse]," "past spouse or partner abuse," "husband is abusive," "husband hits patient") this was coded as "yes." If a statement was suggestive of violence or abuse we coded this as "suspicious." Examples of documentation in this category were "wound doesn't match injury," "similar injuries in the past," "marital discord," "physician suspects violence in the home," "emotional stress in the home," or "bad living situation." Of the 21 women with any type of IPV documented, 43% were specifically documented as "yes" and 57% were "suspicious." For our final analysis we combined the "yes" and "suspicious" IPV documentation categories.

Of the 150 IPV+ and 150 IPV— women identified, we were able to complete a medical record review for 96% (144/150) of the IPV+ women and 98% (147/150) of the IPV— women. All women consented to have their medical records reviewed by study personnel. We were unable to locate nine medical records after repeated attempts.

Demographic Characteristics of the Woman and Her Partner

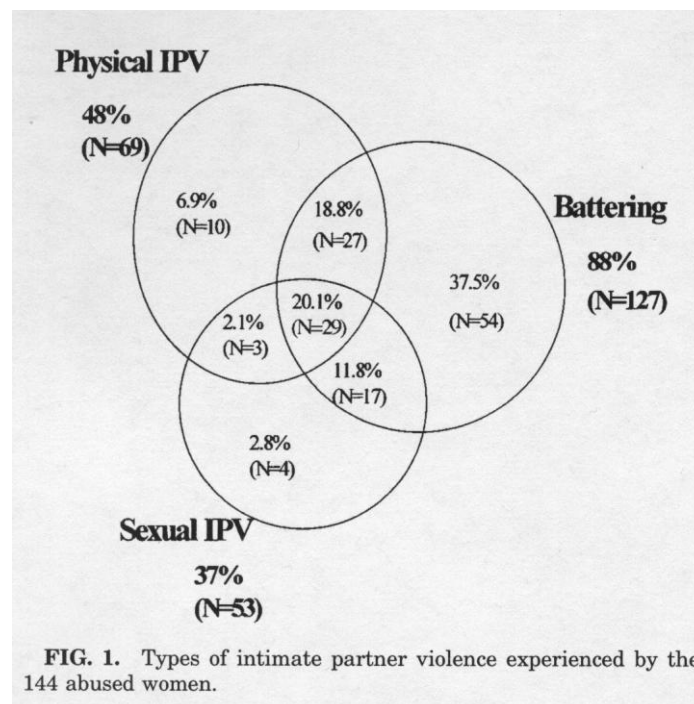
We also collected the following demographic characteristics from the women: current marital status, age, race/ethnicity, education, number of people living in the respondent's household, usual occupation, number of

guns in the household, whether she has an alcohol or drug use problem, and whether the respondent's father was either emotionally or physically abusive toward her mother. For their current male partners, we asked women: his age, race/ethnicity, occupation, and whether she perceives him to have a drinking or drug problem.

Mental and Physical Health Assessment (Health Follow-up Interview)

We conducted a subanalysis of IPV documentation and women's self-report of their health status. For this analysis, our sample size was limited to 99 IPV+ women or 68.8% of all women screened as IPV+. This sample size was smaller because not all women completed follow-up health interviews; women currently experiencing IPV were less likely to complete the follow-up health interviews. For the majority of women in the study, these health interviews were conducted later by phone. If women were currently in violent relationships, we urged women to complete this follow-up interview in the clinic after their clinic visit. If they could not stay for the interview we attempted to recontact women on subsequent visits to complete the health interview. Unfortunately, we were not able to complete the follow-up health interview in the clinic with 51 women currently in physically violent relationships and, for safety reasons, chose not to contact these women at home by phone.

The following describes the measures used in the follow-up interview to assess current mental and physical health status. Measures included the Drug Abuse Screening Test [52] (DAST) (Cronbach's alpha = 0.76), the TWEAK [53] to measure alcohol abuse (Cronbach's alpha = 0.71), an injury frequency and severity scale specific to partner violence (Cronbach's alpha = 0.76), the Spielberger State-Trait Personality Inventory [54] to measure anxiety (Cronbach's alpha = 0.77), the Center for Epidemiologic Studies Depression Scale [55] to measure depressive symptoms in the past 2 weeks (Cronbach's alpha = 0.79), and current posttraumatic stress disorder (PTSD) symptoms using the DSM-IV symptom checklist [56], and social support was measured using the Social Support Questionnaire—Short Form [57] (Cron-



bach's alpha = 0.89). We assessed current self-perceived mental and physical health with the following standard question, "Compared to others your own age, do you consider your current mental/physical health to be excellent, very good, good, fair or poor?" We asked women the number of times they were seen by a physician in any clinic or office-based facility in the year prior to recruitment, and the number of times they were hospitalized in the same time period.

We conducted an analysis to compare the number of health care visits reported in the past year by women in this follow-up health interview (mean 3.5 ± standard deviation 1.3) to the number of health care visits abstracted for medical records (mean 3.0 ± standard deviation 1.6) over the same time period. These means were not significantly different and indicate that either data source is comparable.

Statistical Analysis

All analyses were conducted using SAS Version 6.12 [58]. The distribution of IPV frequency by type among the IPV+ women is provided in Fig. 1. We then compared rates of IPV documentation in the subsample of women who screened IPV+ and women who screened IPV— and calculated the sensitivity, specificity, and positive predictive value [59] of the IPV documentation relative to the "truth" of the IPV interview (Table 1). Next, we provided IPV documentation rates among IPV+ women by demographic factors, WEB, modified ISA-P, and IPV-associated injury scores, and by current and past mental and physical health indicators (Table 2). We used stratified analysis to directly estimate relative risk as the measure of association between the demographic, IPV measures or health indicators, as independent variables with IPV documentation as the dependent variable. These relative risks are unadjusted; point estimates and 95% confidence intervals are provided. Finally, we addressed the impact of the intervention on women's intention to disclose IPV and on IPV documentation. All women in the study were screened; therefore, we do not have a comparison or unscreened population. This analysis is descriptive only. We can, however, address the timing of IPV documentation relative to screening.

RESULTS

Response Rates

Eleven percent of 1,543 women approached in larger cross-sectional study for participation (N = 141) refused. Those refusing were significantly more likely to be insured by Medicaid (32%) than were respondents (25%); we have no additional demographic data with which to characterize those women who refused relative to respondents. Forty women had never had an intimate relationship with a man and were not at risk (i.e., ineligible). Of those 150 women currently experiencing IPV, we were able to abstract medical records of 144 women (96%). Similarly, of 150 sampled women we were able to abstract medical records of 147 women (98%).

Of the 144 women screened as experiencing some type of IPV in a current relationship, 14.6% (21/144) had some documentation of IPV in their medical record (Table 1). Based on medical record documentation alone, 85.4% (false negative rate) of those experiencing IPV are missed. All women who screened IPV— had no IPV documented in their medical record (100% specificity). Relative to our combined use of a modified ISA-P and the WEB, IPV documentation in medical records had low sensitivity (14.6%) but high specificity (100%).

Figure 1 depicts the overlap between the types of IPV (physical, sexual, and battering) among those 144 women identified as currently or recently having been in a violent or abusive relationship. The majority (88%) scored as battered. However, approximately half (54/ 127) of those who scored as battered (WEB >20) did not score as physically or sexually assaulted within the

TABLE 1
IPV Documentation in the Medical Record of Women Screened as IPV+ and IPV—

IPV documented in medical record	IPV+ (WEB or ISA+)	IPV— (WEB and ISA—)	
Yes	21 (14.6%: True +)	0 (0.0%: False +)	
No	123 (85.4%: False —)	147 (100.0%: True —)	
Total	144	147	291

TABLE 2
**Factors Associated with Partner Violence Being Documented in the Woman's Medical Record
among All Women Screened as Experiencing Current IPV^a**

Strata	N	% IPV documented ^{MR}	Relative risk (95% CI)
Women reporting IPV in clinic interview ^b	144	14.6	
Woman's race ^b			
Caucasian	40	30.0	3.4 (1.6, 7.7)**
African-American	104	8.7	1.0 referent group
WEB Scale (continuous) ^b	144		1.03 (1.00, 1.07)*
Index of spouse abuse (continuous) ^b	144		1.02 (0.99, 1.05)
IPV-associated injury score ^{b,c}	107		1.13 (0.89, 1.43)
No. clinic visits ^{MR} (continuous)	144		1.06 (1.00, 1.11)*
Ever had a "problem" with depression that lasted at least 2 weeks? ^d			
Yes	75	17.3	4.2 (0.6, 33.3)
No	24	4.2	1.0 referent group
Ever had a "problem" with being too anxious? ^d			
Yes	46	21.7	2.9 (1.0, 8.3)*
No	53	7.6	1.0 referent group
Ever had a traumatic event outside the range of usual events? ^d (Event which could trigger PTSD)			
Yes	53	20.8	3.2 (1.1, 11.1)*
No	46	6.5	1.0 referent group
History of problem alcohol use	12	33.3	2.9 (1.1, 7.7)*
No history of alcohol abuse	87	11.5	1.0 referent group

^a Abuse in current or recent relationship (past 2 years).

^b Data from IPV screening questionnaire; 144 abused women.

^c Among women reporting physical or sexual IPV (N = 107/144).

^d Data from health assessment interview; 99 abused women completed questionnaire.

* P 0.01–0.05.

** P < 0.01.

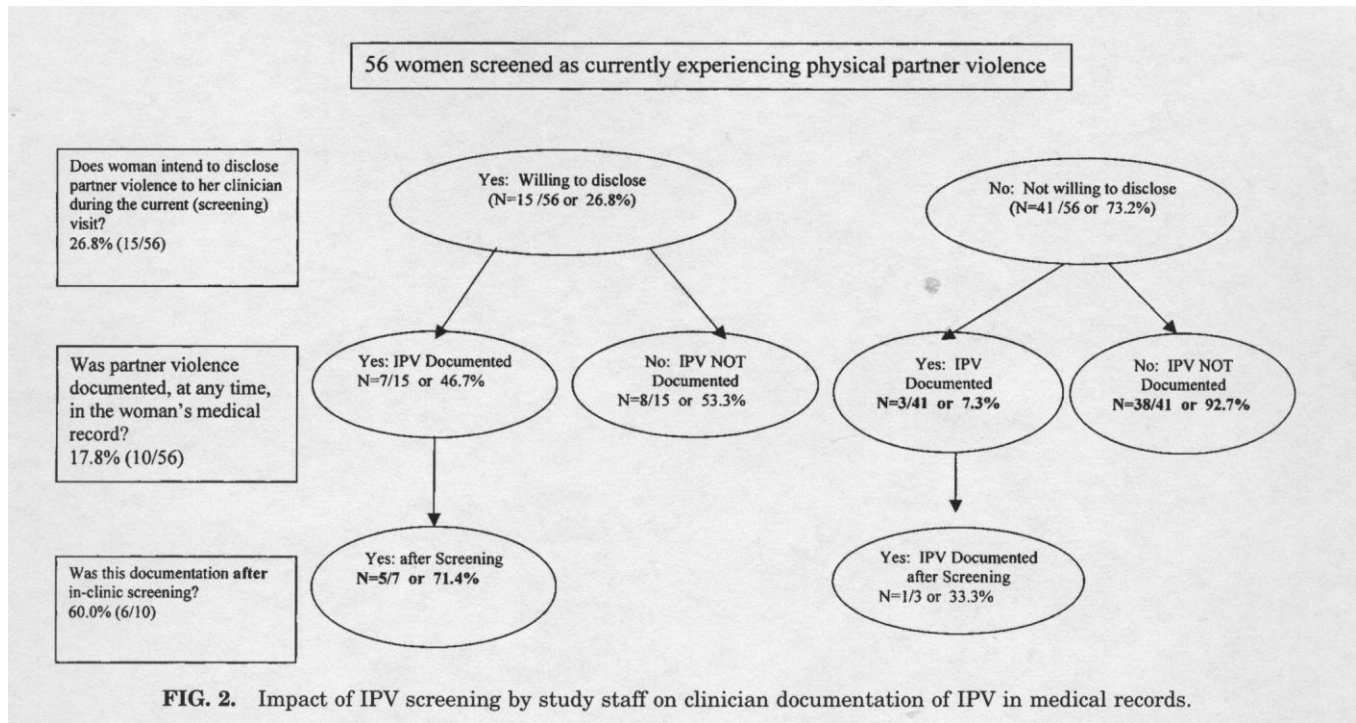
^{MR} In Medical Records.

past year. We described these women as psychologically battered. With the noted exception of battering, a minority of women reported only one type of IPV; 10 of 144 women reported only physical assaults and 4 women reported sexual assaults alone.

We examined demographic correlates of having IPV documented in medical records among those experiencing IPV (N = 144). Caucasian women were significantly more likely to have IPV documented (30.0%) than were African-American women (8.7%). Higher WEB scores were associated with a slightly increased likelihood of IPV documentation (P = 0.03) while neither our modified ISA-P (P = 0.15) nor the IPV-associated injury frequency scores (P = 0.21) were associated with IPV documentation. Women reporting an event that could trigger PTSD (P = 0.01) and those with a self-reported history of alcohol abuse (P = 0.01) were more likely to have IPV documented.

We did find evidence that IPV screening by study staff increased IPV disclosure by women and subsequent physician documentation of IPV. We restricted this analysis to include only women who were currently in physically violent relationships because it is for this group that screening intervention should increase documentation (N = 56 of 144 of the original sample). These results are presented in Fig. 2. We hypothesized that IPV screening by study staff could impact IPV documentation primarily through increasing the woman's willingness to disclose abuse to her clinician. Although we let clinicians know that their patient had been screened for IPV, we provided the results of screening only if the woman requested us to do so. Clinicians were of course free to ask about IPV as well. Study staff are not clinicians and did not have access to medical records to document IPV if identified in the screening interview. If screening increased IPV documentation, it should then increase the proportion of women disclosing IPV to clinicians and then having this IPV documented in the medical record after our study staff screened for IPV. Women were asked at the end of the screening interview with study staff whether they would tell their physician about IPV during this clinic visit. Only 26.8% (15 of 56) of those included in this study indicated that they would disclose the IPV. Those indicating that they would disclose IPV were six times more likely (RR = 6.4; 95% CI: 1.9, 21.5) to have the IPV documented when

compared to those who would not disclose IPV. Further, those who intended to disclose the IPV were significantly more likely to have the IPV documented as a direct result of the screening; of the 15 IPV+ women intending to disclose IPV following screening by study staff, 46.7% (7/15) had the IPV documented in their medical record and that documentation occurred on the day of screening or after



the screening for 5 of the 7. IPV documentation occurred on the day of screening or afterward for only 1 of 3 women who did not intend to tell her physician about IPV.

DISCUSSION

We find that IPV is infrequently documented in the medical records of women recently in violent or abusive relationships. Women with higher battering (WEB) scores and those with a history of PTSD were more likely to have the IPV documented in medical records. IPV screening by study staff impacted IPV documentation by increasing IPV+ women's intention to disclose the violence.

Deserving of comment is our finding that among women experiencing IPV, Caucasian (and perhaps more middle class) women were significantly more likely than African-American women to have their IPV documented. The overwhelming majority of clinicians in the two large family practice settings were Caucasian and approximately half of the clinicians were female. We do not have data to characterize the race and gender interaction of the patient—provider relationship. Gender of the clinician may be an important predictor of IPV documentation; 76% of the clinicians who documented IPV in medical records were female. One possible explanation for our finding that Caucasian women were more likely than African-American women to have IPV documented may be that Caucasian women were more likely to disclose abuse. We did not find that Caucasian women experiencing IPV were, however, more likely to report intending to disclose IPV to clinicians (16.7%) when compared with African-American women (21.4%). Clinicians may view it as more important to document IPV among those perceived to be at lower risk of IPV (Caucasian middle income women), yet we have no data to support this assertion. Clinicians may also be more likely to document IPV among those experiencing symptoms of mental illness (e.g., substance abuse and PTSD) associated with IPV.

We assume that IPV documentation is a desired outcome. Noting IPV in a patient's medical record may improve communication with other health care providers seeing the patient and provide a clearer understanding

of the underlying health and social problems for the patient. Documentation implies physician—patient communication about the violence, about safety, and about community service resources. Another benefit of IPV documentation is that woman may be able to use these medical records in court. As is true in most states, physicians are not mandated to report domestic violence to law enforcement agencies in South Carolina. Thus, noting IPV in the patient's medical record will not result in legal interventions.

We did find evidence that IPV screening by study staff increased IPV disclosure by the IPV+ women and subsequent physician documentation of IPV. This finding is consistent with the emerging literature addressing the efficacy of IPV screening [13,19,24,33,38,39,41,44,61]. Olson et al. [24] found that modifying the emergency department medical chart to clearly identify partner violence increased IPV identification and documentation. Similarly, Freund et al. [41] noted a dramatic increase in IPV identification when a lifetime abuse question was included in the patient's health history form. McLeer and Anwar [22] reported that 5.6% of female emergency department trauma patients had IPV documented in their medical records; this proportion rose to 30% with implementation of a protocol to improve documentation. In a large community intervention trial in an ED in Auckland New Zealand, Fanslow et al. (1998 and 1999) [29] found that a onetime training intervention produced a positive change in identification and acute management of abused women [28], yet these changes were not maintained at 12 months [29]. In a group-randomized controlled trial design in five primary care clinics within a large health maintenance organization, Thompson et al. [39] found that a skills training intervention for clinicians improved clinician self-efficacy in screening and decreased concerns regarding provider and patient safety from the batterer and the clinician's fear of offending the woman by asking about IPV. The intervention significantly increased clinicians' asking about IPV (adjusted Odds Ratio (aOR) = 3.9; 95% CI 2.5, 5.9) particularly by questionnaire use, yet case finding did not increase (aOR = 1.3; 95% 0.7, 2.7). In contrast, Campbell et al. [30] found that while a didactic information and team planning intervention significantly increased clinician knowledge and attitudes, patient satisfaction, and information available to abused women, this large randomized trial set in 12 hospital EDs did not change IPV documentation. The authors assert that inconsistent administrative support may explain this inconsistent finding [30]. The RADAR Training Project [38], a community health clinic intervention to increase screening, identification, and referral for abused women did increase provider knowledge and comfort in abuse identification, in the short term, yet IPV documentation did not change.

Other modes of IPV screening may be useful in busy clinic settings. Touch screen computer-assisted interviewing may be a confidential way to screen women for IPV in a setting that allows more women to disclose abuse. Rhodes et al. has applied this technology in the waiting room of EDs and found that those using computer-assisted interviewing were more likely to disclose sensitive health behaviors and to remember health information. Others have also described the utility of computer-assisted self-interviewing over written or face-to-face interviews [62,63].

Most experts agree that there is no single, standalone intervention that is effective with IPV victims. Computer-based screening approaches have been successfully used for sensitive topics [64], including violence [63]. Intervening effectively with women experiencing IPV requires a comprehensive array of services for the women, their children, and their intimate partners. These services must include advocacy, legal assistance, emergency shelter, counseling, victim support groups, batterers' groups, children's services, education, and financial assistance [65]. To be effective, interventions must be consistent with an empowerment model, promoting "survivor" behaviors such as decision-making, peer support, and an internal locus of control.

Not asking about IPV may negatively impact physician—patient communication. Plichta [66] found that abused women were significantly more likely to report dissatisfaction with their physician; poor communication was one of the primary reasons for this dissatisfaction. Statements by physicians to patients expressing empathy, concern, and legitimacy enhance patient satisfaction with care [66]. Caralis and Musialowski [67] found that the majority (74%) of women want their physicians to ask about IPV, most (68%) would report IPV if asked, yet only 12% were asked about IPV. Even when told of IPV, patients reported that physicians "did nothing" in 20% of the cases [67].

Patients are clearly receptive to IPV screening [68]. Unfortunately, many physicians may not feel prepared to address IPV. Clinicians who believe that partner violence is uncommon among their patients [69,70], that IPV is an issue more appropriately addressed by the criminal justice system than the health care system [69,70], and who do not feel prepared professionally are less likely to intervene [71]. Several researchers [40,71,72] have found that clinicians were more likely to identify characteristics of patients (i.e., unwillingness to disclose, minimize abuse/accepts abusive behavior as normal, fear of retaliation, fear of police involvement, lack of follow-up) as barriers to screening than characteristics of themselves, of their institutions, or mutual barriers (cultural differences, language differences). Thompson et al. [19] have begun to address these barriers using a promising ecological training model for all clinicians in a primary care facility.

As with most studies, this study does have limitations. Since our sample included insured women, we cannot generalize to uninsured women. We did, however, include Medicaid-insured women to include lower income women (22% of the sample). Our sample size is relatively small; therefore, we have limited power to detect small differences in IPV documentation. Finally, we assessed IPV documentation based on medical record abstraction. Therefore, we cannot know whether physicians addressed the partner violence and neglected to record this in the medical record. Patients may have asked physicians not to document the violence.

This study has several strengths deserving mention. We screened all women meeting the inclusion criteria (N = 1,402) over a 22-month period; thus those included in this sample are representative of the family practice clinic from which the women were sampled. To avoid bias introduced by abstractors' knowledge that they were reviewing the medical records of IPV+ women and potentially "looking harder" for IPV documentation, we included both women who had and had not experienced IPV and blinded abstractors to this IPV history. Finally, because women were not primarily coming to clinics for emergency care and we defined IPV to include psychological abuse, we expanded those phrases denoting IPV to include "problems in the home," "problems with partners," "marital problems," and specific statements of psychological or verbal abuse as well as physical assaults by a spouse or male partner.

There are concrete steps physicians can take to help women in violent relationships. Identifying IPV is the important first step because this action validates the woman's experience. Further, identification of partner violence by a health care provider places the violence in the context of a serious potential health threat. Safety planning is the second step. The important message to convey is "As your doctor, I am concerned for your safety." The essentials of safety planning include finding a safe place to go and having money, clothes, or other emergency items ready in the event that the patient needs to leave rapidly. The Family Violence Prevention Fund has an excellent web site, <http://www.fvpf.org/gethelp/index.html>, which details safety planning and provides a hotline number [(800) 799-SAFE (799-7233)] with local resources for women. The third message is "the partner violence or abuse is not your fault, your partner has a problem that he needs help with." Depending on the type and severity of IPV, referrals for supportive counseling may be appropriate. The fourth message is "As your doctor, I want to help you with this problem." Recent research [73] indicates that physicians who compassionately ask patients about abuse can provide the needed first step in assisting women to get help. Further, a supportive response to IPV disclosure may be crucial to the woman's longer-term mental health and perhaps to a positive resolution to IPV. The most important thing a physician can do is listen to his or her patients, help identify community resources for patients, and help his or her patients find support through family members, friends, coworkers, religious organizations, or community-based survivor support groups.

Many women experiencing partner violence are isolated. For many, the health care visit may be one of the few places abused women feel safe. Although this visit is frequently brief and hectic, it does represent an opportunity for identification of IPV. This violence is a significant health threat to women and frequently to their children, when applicable. For many women experiencing IPV, the chronic psychological or physical battering is the impetus for their clinic visit. Not identifying and documenting this violence may result in misdiagnosis and perhaps unnecessary treatment for the woman. In short, the health care visit presents clinicians with an important opportunity for effective intervention with women experiencing partner violence.

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