



Published in final edited form as:

Health Care Women Int. 2012 ; 33(3): 250–261. doi:10.1080/07399332.2011.646368.

Provider Barriers and Facilitators to Screening for Intimate Partner Violence in Bogotá, Colombia

ARSHIYA A. BAIG,

Department of Medicine, University of Chicago, Chicago, Illinois, USA

GERY W. RYAN, and

The RAND Corporation, Santa Monica, California, USA

MICHAEL A. RODRIGUEZ

Department of Family Medicine, University of California, Los Angeles, Los Angeles, California, USA

Abstract

We conducted interviews with 27 health care personnel in Bogotá, Colombia, to examine provider barriers and facilitators to screening for intimate partner violence (IPV). We used systematic qualitative analysis to identify the range and consistency of beliefs. We found that respondents did not routinely screen for IPV. Providers listed numerous barriers to screening. Ways to improve screening included increased clinician training, installing systematic IPV screening, providing patient education, and implementing health care setting interventions. Improving the care for IPV survivors will involve translating health care personnel preferred solutions into more systematic IPV screening interventions.

BACKGROUND

Intimate partner violence (IPV) is a global public health problem (United Nations [UN], 1995, 2000). The reported lifetime prevalence of physical or sexual partner violence varies from 15% to 71% across 10 countries worldwide (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2006). Intimate partner violence (IPV) leads to many physical health consequences, including 50% to 70% increase in gynecological, central nervous system, and stress-related problems (Campbell, 2002; Campbell et al., 2002; Einstat & Bancroft, 1999; Ojeda, Ordóñez, & Ochoa, 2005; Silverman, Decker, Saggurti, Balaiah, & Raj, 2008; Silverman, Raj, Mucci, & Hathaway, 2001; Tjaden & Thoennes, 2000). These health consequences of IPV necessitate the involvement of the health care system and health care personnel in the identification and management of IPV survivors (Ellsberg, Jansen, Heise, Watts, & Garcia-Moreno, 2008; Kernic, Wolf, & Holt, 2000; Ribero & Fabio, 2005). More importantly, understanding effective ways to respond to violence against women is critical in developing countries, such as Colombia (Garcia-Moreno et al., 2006; Heise, Raikes, Watts, & Zwi, 1994; Watts & Zimmerman, 2002). In our study we interviewed Colombian health care personnel in assessing their barriers to screening and their proposed solutions to improving IPV screening in their patient population. Since IPV continues to be a global problem, the findings from this work may give insight into how IPV screening can be improved in other international health care settings working toward improving their care for IPV survivors.

Addressing violence against women in less-developed countries is of increased importance (Garcia-Moreno et al., 2006; Heise et al., 1994; Watts & Zimmerman, 2002). Among Colombian women of reproductive age, 39% reported physical abuse by a current or former intimate partner (Ojeda et al., 2005). Furthermore, it is estimated that only 24% of Colombian women report their abusive partners to legal authorities for committing violent acts (Ojeda et al., 2005). Considering the low rate of reporting to the authorities, the negative health consequences of IPV, and the high exposure of health care workers to victimized women, the involvement of the health care system presents an important opportunity for identifying needs of female survivors of IPV in Colombia.

Understanding the perspectives and screening behaviors of health care personnel is key in addressing low screening rates and developing effective approaches to improve management of victimized women (Ullman, 1996). Although many studies have examined IPV screening rates in the health care setting, our qualitative study of health care workers in Colombia is the first to our knowledge to assess the attitudes of Colombian health care personnel in regards to IPV detection among their patient populations (Klevens, 2001; Rodriguez, Bauer, McLoughlin, & Grumbach, 1999; Sagot, 2000). In this study we sought to describe the barriers that Colombian health care personnel reported in identifying survivors of IPV and their proposed solutions to improve detection of IPV in the health care setting.

STUDY DESIGN AND METHODS

We conducted semistructured interviews with a diverse sample of 27 health care personnel from eight hospitals in Bogotá, Colombia, from March 2008 to April 2008.

Participants

We purposefully sampled nine public and private hospitals that delivered primary, secondary, and tertiary levels of care in Bogotá to represent a wide range of hospitals. Of the nine hospitals, three offered primary care, two offered secondary level of care, and four offered tertiary care. Letters of invitation were sent to the medical directors or scientific director of the nine selected hospitals informing them of our study. Of the nine selected health care settings, eight directors were interested in having us interview personnel in their hospital for the study. One hospital did not respond. We set up times to visit the hospital and conduct our interviews on site. To better understand the screening practices and management of IPV survivors, we approached health care personnel whose patient populations were at least 50% of women of reproductive age. These included a range of health care personnel, such as physicians, nurses, social workers, and psychologists who practiced across multiple specialties, including obstetrics/gynecology, internal medicine, general medicine, and emergency medicine. We excluded physicians from medical subspecialties since they were less likely to see a majority of female patients of reproductive age. At the site visits, we approached 28 health care personnel who met eligibility criteria. One person was unable to be interviewed due to time constraints. All participants provided written consent to participate in the study. The University of California, Los Angeles (UCLA) institutional review board and the ethics committee from the Fundación Santa Fe de Bogotá approved all study procedures.

Data Collection and Measures

We conducted semistructured interviews with eligible participants who agreed to participate in the study. In the interviews, we asked participants about their awareness of IPV, including questions on how they defined IPV, as well as their perception of the prevalence of IPV in Colombia and their patient populations. Participants also were asked about their screening behavior, barriers to detecting IPV in their patients, and ways to overcome these barriers.

Interviews were conducted until we reached theme saturation. All the interviews were conducted on site at the clinic or hospital where the participant was recruited and conducted in Spanish by the principal investigator. The participant interviews were digitally recorded and transcribed verbatim. All analyses were completed in Spanish. We also administered a brief structured survey in Spanish after the interview to measure the current knowledge, attitudes, and behaviors of IPV screening and management.

Analysis

We used descriptive statistics to assess the participants' demographic characteristics and responses to the brief survey. To identify key themes from the qualitative portion of the interviews, the principal investigator used a set of analytic procedures well described by Lincoln and Guba (1985) and further elaborated on by Ryan and Bernard (2003). First, the principal investigator read through each transcript and categorized the text into four core components in the process of care, namely, the following: (a) health care personnel awareness and training in IPV; (b) initial detection; (c) management of care for IPV survivor; and (d) follow-up. To identify further subthemes within each of these four components, the principal investigator in collaboration with the coinvestigators read through the quotes for each component and sorted them into piles based on their similarity. This two-step sorting technique allowed us to identify the full range of beliefs and practices related to IPV, to determine which issues were most salient to our participants based on how often they were spontaneously mentioned and to assess what degree these beliefs and practices were shared across different hospitals and types of health care professionals. Although we examined all four core components mentioned above, in this article we present findings from the first two components. In our analysis, we refer to physicians as health care personnel with a medical degree who treat and manage patients as attending physicians. The term nonphysicians refers to health care personnel such as nurses, social workers, and psychologists.

RESULTS

Awareness and Training in IPV

In Table 1 we describe the demographic characteristics of our participants. We interviewed a wide range of health care personnel who practiced across many different specialties. The majority of our participants were female and worked in outpatient settings. In Table 2 we describe our participants' practices in identifying and managing IPV. We found that only seven participants (26%) always asked patients about domestic violence. Seventy-four percent had received training in IPV. When asked, "Have you cared for patients who have been survivors of domestic violence," 67% of the respondents stated they had. Seventy percent of the participants reported having a protocol for managing IPV survivors, and 96% knew where to refer an IPV survivor.

Current Practices and Barriers to Detecting IPV

Respondents noted varying degrees of screening for IPV among their female patients. The majority of respondents mentioned asking about domestic violence only when they "suspected it," if the patient came in with a "physical injury," or if the patient brought up "problems at home or with the family." Some mentioned inquiring about IPV if they noticed "subtle clues during the interview" such as signs of depression, anxiety, or sleep disturbances; if the patient came with multiple complaints; or the patient gave inconsistent stories. Only three respondents mentioned routinely screening for domestic violence in their patients. Two of these three personnel mentioned a "form used for outpatient adult visits has an explicit question about violence."

Responsibility of detecting—Participants noted that many people in the process of care had the responsibility to ask about violence in the home. Most noted the important role that physicians played in diagnosing IPV, with one emergency room nurse even noting that she “never asks because the patient comes diagnosed. The physician has already diagnosed the violence.” A few participants, including nurses and social workers, mentioned that everyone was responsible for detecting IPV: “from the security guard to the specialist physician, everyone ought to be vigilant.”

Lack of time, training, and personnel—Respondents listed many barriers to screening, including lack of time, lack of training, and the need for more personnel. The most frequently cited barrier noted was the “lack of time” and the “sheer quantity of patients” that did not allow an opportunity to ask about IPV. One physician summarized: “One rarely has the time to sit and talk for a long time with a patient.”

Many respondents, physicians, and nonphysicians noted lack of training and lack of personnel as barriers to identification. One outpatient OB/GYN noted, “We have not been trained [to screen for IPV] and do not know how to ask these types of questions.” Some respondents mentioned not asking because they did not “know what to do once the patients answered affirmatively,” citing the “lack of timely treatments” once the patient is identified as an IPV survivor. One social worker noted the lack of personnel and social workers as an additional “filter” to detect violence in case the patient slipped through the physician encounter.

Focus on physical health and difficulty in detecting emotional problems—

Many respondents, both physicians and nonphysicians, noted that usually the physician focuses on stabilizing the patient physically and tends to the medical problems and not the emotional/psychological problems. One respondent summarized, “The health care provider focuses on healing what he is seeing, the physical part, and does not enter into investigating the mental health part.” Many noted the difficulty in detecting emotional or psychological abuse and that “when there is no physical abuse it is very difficult to ask about IPV.” As one participant reported, “[IPV] is not detected because it is not asked about. If you don't look for it, you are not going to find it.”

Privacy concerns and the fear of legal involvement—Respondents also noted that another barrier to screening was the patient's unwillingness to disclose a history of domestic abuse and personal fear of legal involvement in the case. Many respondents spontaneously mentioned that one of the largest barriers to detecting IPV was “the patient putting limits on what they wanted” to tell their physician, the patient “remaining quiet” about abuse, or patients believing that “it was of no concern” to the physician. A few respondents, however, felt that female patients were “very receptive” to physicians asking about violence and had experiences where female patients were “free in expressing” being victimized once they were asked about it. Many mentioned that they did not want to “invade the patient's private life,” “they did not want to get involved,” or feared further legal involvement or having to testify in legal proceedings.

Lack of patient–physician relationship—Many physicians mentioned the lack of a patient–physician relationship as a barrier to inquiring about IPV. Physicians in urgent care settings noted that they did not have the relationship with the patient in which they were able to communicate well with to the patient to inquire about such personal issues. Several respondents suggested that screening for IPV was better left to outpatient physicians who have a relationship with the patient. Some felt that that asking about IPV could also be

difficult in the outpatient setting, however, especially during the first visit, if the patient did not have a relationship with one general physician, or if the signs of abuse were not obvious.

Ways to Overcome the Barriers to Screening

The respondents noted many provider, patient, and organizational-based solutions to overcome the barriers in screening for IPV.

More training—The majority of respondents noted that they wanted more training in detecting IPV. As one physician noted, “The most important thing is training, so we all know to look for [violence], to learn how to get the patient to tell us she is abused. There must be questions to ask patients to get at the answer.” Others noted that we “need to train all personnel, not just physicians, because the women do not always tell their physician; they may leave and say something to the women at the lab or the cleaning lady.”

More emphasis on screening—Many believed that “questions [about IPV] should be a part of the clinical history.” One nurse mentioned that “physicians ought to ask a bit more [about IPV]; certainly if you search for more cases, you are going to detect more cases.” One nurse proposed that to detect more IPV in patients “we need to start inquiring more about the mental health of our patients and not just focus on the physical part.” Many mentioned changes in health care personnel behaviors, such as taking more “exhaustive patient histories,” making it a “norm to ask everyone about IPV,” and inquiring about mental health.

Patient education and building trust—Respondents noted patient-centered solutions that involved educating female patients on their rights and building a trusting relationship with their health care provider. Participants noted that many women might feel ashamed or embarrassed to talk about violence in their home, although they have the right to disclose the violence. One physician noted that just asking more about IPV would not solve the problem of detection because he was “not so sure that patients are always going to disclose it.” Respondents agreed that “women needed to be educated that they have rights and that if they have problems they can go to institutions to be detected early and treated” and they needed to rise above the “social stigma” of being an IPV survivor and report the violence. A few respondents noted the important role of health care personnel in “establishing a relationship with the patient so that one can further inquire about abuse.”

Organizational changes: more time, more personnel, protocols in place—Many respondents mentioned institutional changes, such as increasing time for patient visits, more health care personnel, and implementing IPV protocols for health care settings. The majority of the respondents mentioned giving physicians and staff more time to speak with the patient. One psychologist noted, “the time of outpatient visits with physicians ought to be increased so that the physicians can generate some empathy with the patient, so the patient can speak.” Some respondents wanted to increase the number of health care personnel, especially one social worker who wanted a “24-hour social worker at the hospital in case the patient escaped the filter of the physician.” Others mentioned wanting “protocols” to detect IPV survivors, “hospital committees that could take charge of IPV victims,” or “hospital-based programs” for IPV survivors.

DISCUSSION

Considering the health consequences of IPV, the involvement of the health care system presents a critical opportunity for identifying and helping female survivors of IPV. We found that Colombian clinicians face many barriers to screening for IPV and are interested

in interventions in the health care setting to improve screening and management of patients. The lessons learned from this study may elucidate barriers that providers in other health care systems internationally may face in screening for IPV and how they may potentially identify areas for intervention in their particular settings.

We found that many Colombian health care personnel most often asked about IPV when they suspected victimization. By only screening sporadically, health care personnel may lose many opportunities to detect violence when the signs are not obvious. The lack of systematically screening all female patients has been reported in other studies, corroborating that health care personnel may exhibit similar screening behaviors despite the country or health care setting (Elliott, Nerney, Jones, & Friedmann, 2002; Fikree, Jafarey, Korejo, Khan, & Durocher, 2004; Rodriguez et al., 1999; Sagot, 2000). Yet, unique to our study, we found that respondents felt it was primarily the physician's responsibility to screen for and detect IPV. The importance placed on the role that physicians played in the detection of IPV is one that is not repeatedly found in the literature and may be specific to Colombia, though few studies have included medical and nonmedical personnel in understanding IPV detection within a health care system.

Even though the global medical and public health community acknowledge IPV as a public health problem that should be addressed by the health care setting, health care personnel noted many barriers in detecting IPV in their patient population. Our respondents noted various barriers to detection, such as lack of training, lack of time and effective interventions, personal discomfort, fear of legal involvement, and patient nondisclosure. Many of these barriers to screening for IPV have been reported in studies of providers worldwide (Fikree et al., 2004; Rodriguez et al., 1999; Sagot, 2000). These findings may demonstrate the lack of medical training and systems in place that encourage and facilitate addressing IPV in the health care setting. Since these findings are not uncommon among providers, the potential to replicate and test interventions conducted in other countries to improve IPV screening within the Colombian health care system may be promising (Bonds, Ellis, Weeks, Palla, & Lichstein, 2006; Snider, Webster, O'Sullivan, & Campbell, 2009).

Colombian providers were interested in interventions in the health care setting to improve IPV screening rates. Responders were interested in receiving training in IPV screening and increasing awareness of the importance of screening for IPV among health care staff. Respondents also noted patient-centered solutions including empowering the patient and educating her on the value of reporting the violence to authorities. Organizational changes such as the development of protocols, increasing time for patient visits, embedding IPV screening questions into intake forms and patient histories, and more hospital programs for survivors were noted as ways to support and guide health care personnel in detecting IPV survivors. Considering the multiple barriers that our participants noted in detecting IPV, the respondents offered many feasible provider, patient, and organizational solutions to improve the detection of IPV among their female patients and were interested in implementing these interventions within the health care setting. Translating these individual-aimed solutions may be critical in acceptability of these interventions by providers and ultimately may improve provider screening rates of IPV within the Colombian health care system (Nelson, 2004).

Our findings also may inform how to improve IPV detection rates in settings outside of Colombia. We found it was critical to include a wide range of health care providers in understanding the continuum of detection and management of IPV screening. Through conversations with physicians, nurses, psychologists, social workers, and other health care personnel, we were able to understand the process of IPV detection and identify barriers to screening. While many of the barriers to IPV screening that the Colombian providers listed

were ones that have been described in other settings internationally, we also found that in Colombia, physicians played a larger role in screening (Elliott et al., 2002; Rodriguez et al., 1999; Waalen, Goodwin, Spitz, Petersen, & Saltzman, 2000). Thus, researchers in other settings may need to delineate the roles that providers have in the detection process in order to effectively improve screening rates. Many barriers to screening may be unique to particular health care systems within a specific community, country or region. Additionally, since these providers are experts in how their system works, they were best prepared to describe potential solutions to mitigate their barriers to IPV screening. Speaking to a variety of personnel, understanding their barriers to IPV detection, and asking them to propose ways to improve screening may best inform the design of interventions that are tailored to address IPV screening in a particular setting.

Limitations

Although our study has many strengths, we also have some limitations. Our interviews were conducted using a convenience sample, though our participants were key people in the process of identifying and managing IPV survivors and had a high likelihood of contact with female, reproductive age patients. Also, the participants may have been unable to speak freely about a topic that may have been perceived as taboo or perhaps gave socially desirable answers, limiting the variability in our responses to some questions. Yet, we found that the respondents repeated the same stories across institutions and professions, reassuring us that we did capture the most common responses as well as a wide range of beliefs.

CONCLUSION

Through sampling a wide range of providers, we were able to identify the different roles that providers had in IPV detection and find ways to facilitate screening for IPV. We found that health care providers globally face similar barriers in addressing IPV among their patient population, however, there may be slight variance across health care setting and region. Overall, providers were interested in improving detection rates and offered many potential ways to overcome these barriers. Researchers will need to clarify how specific hospital policies, training of personnel and other interventions can reduce the barriers to identification of IPV survivors in the health care setting and how these lessons can be applied to other international settings.

Acknowledgments

We thank the Centro de Estudios e Investigación en Salud of the Fundación de Santa Fe de Bogotá, the School of Government at the Universidad de los Andes, and the Colombia Fulbright office for their support and assistance in carrying out this work. We also thank the directors and the staff at the UCLA Robert Wood Johnson Clinical Scholars Program for their encouragement and support of this project. Dr. Baig's effort was supported by the Robert Wood Johnson Foundation Clinical Scholars Program and United States Fulbright Commission. Dr. Rodriguez's research was supported by the National Institutes of Mental Health Center for Culture, Trauma and Mental Health Disparities (grant no. 1P50MH073453 - 01A1) and the National Institutes of Health funded DREW/UCLA Project EXPORT. Dr. Ryan's effort was supported by RAND staff development.

REFERENCES

- Bonds DE, Ellis SD, Weeks E, Palla SL, Lichstein P. A practice-centered intervention to increase screening for domestic violence in primary care practices. *BMC Family Practice*. 2006; 7:63. [PubMed: 17064413]
- Campbell J. Health consequences of intimate partner violence. *Lancet*. 2002; 359:1331–1336. [PubMed: 11965295]
- Campbell J, Jones AS, Dienemann J, Kub J, Schollenberger J, O'Campo P, Wynne C. Intimate partner violence and physical health consequences. *Archives of Internal Medicine*. 2002; 162:1157–1163. [PubMed: 12020187]

- Einstat S, Bancroft L. Domestic violence. *New England Journal of Medicine*. 1999; 341:886–892. [PubMed: 10486421]
- Elliott L, Nerney M, Jones T, Friedmann PD. Barriers to screening for domestic violence. *Journal of General Internal Medicine*. 2002; 17:112–116. [PubMed: 11841526]
- Ellsberg M, Jansen HA, Heise L, Watts CH, Garcia-Moreno C. Intimate partner violence and women's physical and mental health in the WHO multi-country study on women's health and domestic violence: an observational study. *Lancet*. 2008; 371:1165–1172. [PubMed: 18395577]
- Fikree FF, Jafarey SN, Korejo R, Khan A, Durocher JM. Pakistani obstetricians' recognition of and attitude towards domestic violence screening. *International Journal of Gynaecology & Obstetrics*. 2004; 87:59–65. [PubMed: 15464785]
- Garcia-Moreno C, Jansen HA, Ellsberg M, Heise L, Watts CH. Prevalence of intimate partner violence: Findings from the WHO multi-country study on women's health and domestic violence. *Lancet*. 2006; 368:1260–1269. [PubMed: 17027732]
- Heise LL, Raikes A, Watts CH, Zwi AB. Violence against women: A neglected public health issue in less developed countries. *Social Science & Medicine*. 1994; 39:1165–1179. [PubMed: 7801154]
- Kernic M, Wolf M, Holt V. Rates and relative risk of hospital admission among women in violent intimate partner relationships. *American Journal of Public Health*. 2000; 90:1416–1420. [PubMed: 10983199]
- Klevens J. Physical violence against women in Santa Fe de Bogotá: Prevalence and associated factors. *Revista Panamericana de Salud Pública*. 2001; 9:78–83.
- Lincoln, Y.; Guba, E. *Naturalistic inquiry*. Sage; Newbury Park, CA: 1985.
- Nelson HD. Screening for domestic violence—Bridging the evidence gaps. *Lancet*. 2004; 364:s22–23. [PubMed: 15967139]
- Ojeda, G.; Ordóñez, M.; Ochoa, LH. *Colombia salud sexual y reproductiva: Encuesta nacional de demografía y salud 2005* [Colombia sexual and reproductive health: National and demographic health 2005]. Macro Internacional, Inc.; Calverton, MD: 2005.
- Ribero, R.; Fabio, S. *Determinants, effects and costs of domestic violence* [Document CEDE, 2005-38]. Universidad de los Andes; Bogata, Colombia: 2005.
- Rodriguez MA, Bauer HM, McLoughlin E, Grumbach K. Screening and intervention for intimate partner abuse: Practices and attitudes of primary care physicians. *Journal of the American Medical Association*. 1999; 282:468–474. [PubMed: 10442663]
- Ryan G, Bernard HR. Techniques to identify themes. *Field Methods*. 2003; 15:85–109.
- Sagot, M. *La ruta crítica de las mujeres afectadas por la violencia intrafamiliar en América Latina* [The critical path of women affected by family violence in Latin America]. Organización Panamericana De La Salud; Washington, DC: 2000.
- Silverman J, Raj A, Mucci L, Hathaway J. Dating violence against adolescent girls and associated substance use, unhealthy weight control, sexually risky behavior, pregnancy, and suicidality. *Journal of the American Medical Association*. 2001; 286:572–579. [PubMed: 11476659]
- Silverman JG, Decker MR, Saggurti N, Balaiah D, Raj A. Intimate partner violence and HIV infection among married Indian women. *Journal of the American Medical Association*. 2008; 300:703–710. [PubMed: 18698068]
- Snider C, Webster D, O'Sullivan CS, Campbell J. Intimate partner violence: Development of a brief risk assessment for the emergency department. *Academic Emergency Medicine*. 2009; 16:1208–1216. [PubMed: 20053241]
- Tjaden, P.; Thoennes, N. *Extent, nature, and consequences of intimate partner violence. Findings from The National Violence Against Women Survey*. Department of Justice; Washington, DC: 2000.
- Ullman SE. Do social reactions to sexual assault victims vary by support provider? *Violence & Victims*. 1996; 11:143–157. [PubMed: 8933710]
- United Nations. *The Fourth World Conference on Women* [A/CONF.177/20]. Author; New York, NY: 1995. Retrieved from <http://www.un.org/documents/ga/conf177/aconf177-20en.htm>
- United Nations. *The United Nations Millennium Declaration Resolution* [A/54/959]. United Nations; New York, NY: 2000. Retrieved from <http://www.un.org/millennium/declaration.htm>

- Waalén J, Goodwin MM, Spitz AM, Petersen R, Saltzman LE. Screening for intimate partner violence by health care providers. Barriers and interventions. *American Journal of Preventive Medicine*. 2000; 19:230–237. [PubMed: 11064226]
- Watts C, Zimmerman C. Violence against women: Global scope and magnitude. *Lancet*. 2002; 359:1232–1237. [PubMed: 11955557]

TABLE 1

Descriptive Data for Study Participants ($N = 27$)

Demographics	Mean \pm SD or N (%)
Age	39 \pm 7
Female	18 (67)
Marital status *	
Married	10 (37)
Living with partner	3 (11)
Divorced	3 (11)
Separated	4 (15)
Single, never married	6 (22)
Type of health care personnel	
Physician	12 (44)
Nurse	7 (26)
Social worker	5 (19)
Psychologist	3 (11)
Specialty	
General medicine	6 (22)
Internal medicine	1 (4)
Emergency medicine	2 (7)
OB/GYN	4 (15)
Pediatrics	1 (4)
Family medicine	1 (4)
General medicine and OB/GYN	1 (4)
Internal medicine and pediatrics	1 (4)
Epidemiology	1 (4)
Preventive medicine	1 (4)
Psychology	3 (11)
Social work	4 (15)
Not reported	1 (4)
Years since training **	13 \pm 8
Primary clinical setting	
Outpatient	11 (41)
Inpatient	3 (11)
Emergency room	6 (22)
Inpatient and emergency room	2 (7)
All settings	5 (19)
Level of care provided at institution	
Primary	10 (37)
Secondary	5 (19)
Tertiary	12 (44)
Type of institution	

Demographics	Mean \pm <i>SD</i> or <i>N</i> (%)
Public	15 (56)
Private	12 (44)

Notes: Due to rounding, percents may not add up to 100. Plus–minus values are means \pm *SD*.

*
1 response missing.

**
2 responses missing.

TABLE 2Domestic Violence Knowledge and Screening Practices (*N* = 27)

Topic	<i>N</i> (%)
How frequently ask about IPV	
Always	7 (26)
Only when suspect	17 (63)
Sometimes	2 (7)
Never	1 (4)
Have received training in IPV	20 (74)
Have taken care of an IPV victim	18 (67)
Know where to refer an IPV victim	26 (96)
Have a protocol for managing IPV victims	19 (70)
Know a victim or a perpetrator of IPV	25 (93)

Notes: Due to rounding, percents may not add up to 100.